

*The bio-psycho-social model:
The future of Psychiatry*

Abstracts Book

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World Association
for Social Psychiatry

21st WORLD CONGRESS **Social Psychiatry**

29 June - 3 July 2013
Lisbon, Portugal

**Lectures, Symposia,
Workshops, Oral Presentations**

29 June - 3 July 2013
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Lectures
Symposia
Round Table
Workshops
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29 June - 3 July 2013
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Lectures

THE BIO-PSYCHO-SOCIAL MODEL : THE FUTURE OF PSYCHIATRY

Driss Moussaoui

President, World Association for Social Psychiatry

Psychiatry has been historically based on psychopathology during the 19th Century, on clinical, biological and therapeutic approaches during the 20th Century, and has largely forgotten its social aspect.

How can we apprehend the complexity of a human being, in good or bad health, without including in the equation the social environment: culture, beliefs, structure of the family, religious practice, traditional practices to fight illness, perception of gender, urban environment, all kinds of existing pollutions, and the impact of globalization?

The bio-psycho-social model must remain at the heart of psychiatry, not in adding the biological, the psychological and the social determinants of mental health, but in making them interact in the most sophisticated way. A number of examples will be given to illustrate such complexity.

DIAGNOSTIC ISSUES FOR TRAUMATIZED REFUGEES

Marianne C. Kastrup¹

¹.Competence Centre for Transcultural Psychiatry, Psychiatric Centre Ballerup, Denmark

Background: In the first half of the 20th century the prevailing thought was that traumatic life events per se did not leave lasting consequences for mental health but were a result of a premorbid vulnerability. Following the Second World War studies of concentration survivors and war sailors revealed that exposure to different forms of extreme stress may induce fairly comparable mental problems among previously well individuals.

Results: PTSD has been a nosological entity since DSM-III (1980) attempting to unite different stress responses. Subsequently, revisions of DSM have modified diagnostic criteria and ICD-10 has introduced two diagnostic categories (F 43.1 and F 62.0) covering consequences of traumatic stress.

The tendency to inclusiveness of a biomedical paradigm has been criticized from several sources claiming that this is a Western trend that does not sufficiently take into consideration the socio-political context.

The paper will discuss the advantages and shortcomings of current diagnostic categories including the latest DSM revision vis-à-vis reflections of the universe of traumatized refugees.

SOCIAL PSYCHIATRY IN THE ERA OF NEUROSCIENCE

Jin Van Os¹

¹. Maastricht University, Netherlands

Background: The human brain has evolved as a highly context-sensitive system, enabling behavioural flexibility in the face of constantly changing environmental challenges. Bottom-up sensory stimuli interact with top-down cortical expectations, giving rise to affectively meaningful representations of the social world that motivate adaptive, goal-directed interactions. Multidimensional psychotic and affective syndromes can be understood as an imbalance in the cycle of adaptation to the social context. At the symptom level, paranoid delusions express alterations in experience of the social environment, and cognitive impairments associated with psychotic disorder reflect difficulties in the ability to read the emotions and intentions of other people, contributing to the reduced social competence that accompanies symptoms. We have developed technology to directly assess *situated* phenotypes indexing dynamic, within-person environmental and mental reactivity as substrate for molecular genetic studies and diagnostic systems; and to increase the translational potential to study developmental social-reactive mechanisms associated with psychotic disorder.

However, as DSM5 and ICD11 are being completed, new pressing questions arise. Particularly, how can the concept of clinical staging be applied in psychosis, depression and mania? And, even more importantly, how can a mental disorder diagnosis be individualized? To date, the most commonly used attempt at individualization is based on assigning individuals to diagnostic categories, in combination with rating individual psychopathology across different dimensions. In theory, this system of ‘dimensionalised categories’ ought to yield acceptable precision, given that two individuals within the same diagnostic category will nearly always have different psychopathological profiles. While attractive, recent research nevertheless indicates that it is based on the false premise that symptoms always vary together as a function of a latent dimension or a latent category – which research suggests is not the case. Instead, it has been argued that mental “disorders” in fact may represent sets of symptoms that are connected through a system of causal relations that may explain the co-occurrence of different symptoms. For example, the depressive and manic symptoms of bipolar disorder, and the negative and positive symptoms of schizophrenia have partly independent courses and aetiological factors appear to operate at the symptom level rather than the diagnostic disorder level. Therefore, there is increasing interest in how multiple symptoms in individuals arise not as a function of a latent construct, but as a function of symptoms impacting on each other

Results: The notion that traditional diagnostic categories and dimensions need to be transformed to represent the dynamics of symptoms impacting on each other over time in a final ‘mental causal pathway’ is tantalizing, and relevant for bipolar disorder. It implies that special methodology is required to collect repeated measures of symptoms over time in the flow of daily life, both at the momentary level and over more extended periods that subsequently need to be analyzed in such a way that the pattern of symptoms impacting on each other can be described systematically

POVERTY AS A FACTOR IN SOCIAL CRISIS AND HUMAN DISASTERS

Ruiz P¹
¹.WPA

Abstract: Studies conducted over the last one hundred years have clearly demonstrated the relationship that exists between social class and mental illness. The work of E. Durkheim vis-à-vis suicide behavior, of R.E.L. Faris and H.W. Durham related to schizophrenia, of M.H. Brenner with respect to levels of unemployment and mental hospital admissions and of A.B. Hollingshead and F.C. Redlich insofar as the relationship between social class and mental illness have all clearly demonstrated the impact of poverty as a factor in social crisis and human disasters.

Other similar studies have more recently demonstrated the relationship that exists between the economic status and levels of stress vis-à-vis health and mental health related outcomes; thus, poverty, stress and mental illness clearly interrelate among themselves, and can lead to a large variety of mental disorders. It is also important to realize and study the mediators that exist between stress, poverty and mental illness; for instance, age, marital status, education levels, social class, cultural factors and health status.

In this presentation, we will present, address and discuss the close relationship that exists between stress, poverty and mental illness.

Educational Objectives: At the end of this lecture, the attendees should be able to identify and address:

1. The relationship between poverty and mental illness
2. The role of disparities in the current health care system of the U.S.A.
3. Identify the set of values that need to be implemented in the current health and mental health care system in the U.S.A.

References:

1. Disparities in Psychiatric Care: Clinical and Cross- Cultural Perspectives. Philadelphia, Pennsylvania, Lippincott Williams & Wilkins, 2009.
2. 133rd Presidential Address: Addressing Patient Needs: Access, Parity and Humane Care. American Journal of Psychiatry
3. Addressing Culture, Race and Ethnicity in Psychiatric Practice. Psychiatric Annals.

COMORBIDITY OF MENTAL AND PHYSICAL DISORDERS: A MAIN CHALLENGE FOR MEDICINE IN THE EARLY 21ST CENTURY.

N. Sartorius¹

MD, PhD, FRCPsych

Background: The comorbidity of mental and physical disorders has acquired epidemic proportions in most parts of the world. What is worse is that it is likely that this type of comorbidity is likely to grow in the years to come and that this development is simultaneous to the continuous fragmentation of medicine into subspecialties.

Results: The presentation will summarize the current findings about comorbidity and discuss reasons for the prediction that the simultaneous presence of a mental and one or more physical illnesses will increase in absolute and relative numbers.

INNOVATIONS IN PSYCHIATRIC CARE: THE ROLE FOR SOCIAL PSYCHIATRY

Tom K J Craig

Kings College London, Institute of Psychiatry, London, UK..

Background: The golden age of social psychiatry is often said to have been the middle decades of the last century where there was a blossoming of our understanding of the ways in which personal relationships play an important role in the cause, course and outcome of mental illness. The logical extension of these insights has been the more recent emphasis on psychological processes and brain-based mechanisms that might translate the social experience into individual pathology. Exciting though these developments have been, they have not led to any step change in treatment and the time is ripe to consider how a re-focus on the earlier lessons from social psychiatry may inform the development of improved treatments and services for our patients and their families.

When patients are asked what they want from contact with mental health services, they are often more interested in what we can do to help them address problems of unemployment, social exclusion and discrimination than they are in symptomatic relief. Not to say that the latter is unimportant, but rather that the goal of symptom reduction may be neither necessary nor sufficient to achieve good functional outcomes. In this lecture I will review the opportunities and challenges of tackling mental ill health through interventions primarily focused on the social arena and illustrate what may be possible by reference to recent research and to studies underway. These studies include interventions to enhance social support in chronic depression, the prevention of milder forms of post natal depression and interventions that tackle social exclusion head on. Few of these interventions are directly delivered by the psychiatrist and beg the question of the future role of a highly trained medical professional. In the last part of the lecture I will outline why I believe we will continue to be needed and the key part we have to play in developing socially informed mental health care.

29 June - 3 July 2013
Lisbon, Portugal

Round Table

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	WCSP LISBON: ASIA- PACIFIC ROUND TABLE: 'THE PRESENT STATUS AND PROSPECTS FOR SOCIAL PSYCHIATRY'			
Chairperson	Roy Kallivayalil, General Secretary WASP, India			
Co-chairperson				
Abstract				
References				
Speakers	1."Social Psychiatry in Asia: Current scenario, relevance and future perspectives- Prof Roy Abraham Kallivayalil, Secretary General, WASP (Moderator) 2.Importance of service users and carers in service development in Asia/ Pacific- Dr Afzal Javed (Secretary for Sections- WPA) 3.New developments in therapy in Asia/ Pacific- Prof BS Chavan (Chandigarh, India) 4. Impacts of aspects of society/economy on mental health in Asia/Pacific- Prof Mohan Isaac (Australia) 5.Present status and prospects for Social Psychiatry in Japan- Prof Mizuno Masufumi (Japan)			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Social Psychiatry in Asia: Current scenario, relevance and future perspectives			
Speaker	Prof Roy Abraham Kallivayalil, Secretary General,			
Abstract	Asia represents more than half of humanity. Most of the countries represent traditional societies, with deep cultural values and influences. Families had been strong with very important role in everyday life. Mental illness was considered more a problem of the western societies, and hence most countries accorded low priority to mental illness. The mental health infrastructure in most countries is woefully inadequate. Besides, there is severe dearth of mental health professionals. Widespread stigma, poor funding, lack of support from planners, politicians and administrators complicate the situation further. Some countries also have substantial number of illiterate people. Globalisation has added its own problems. It is now recognized, psycho social factors play a key role in the causation of mental ill health in Asia. To cite an example, it was long believed, suicide rates were very low in countries like India and that majority were due to mental illness. But recent data suggests, not only suicide rates are higher but also psycho social factors like economic burden, loneliness or break in relationships play a more important role than mental illness in the causation of suicides here. It is also seen, social factors play a key role in treatment compliance and well being. Social Psychiatry needs to get a new focus and renewed			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Psycho education programme for the Caregivers: Experience from Pakistan			
Speaker	Afzal Javed, Pakistan Psychiatric Research Centre and Fountain House Lahore, Pakistan			
Abstract	The increased focus towards community care of psychiatric patients is leading to an increase in care giving responsibility on family and friends. It is a demanding and challenging task and places great demands on the caregivers. This change highlights the relevance of emotions and affections within a family, as well as the great amount of burden experienced by the family while taking care of a psychotic patient.			

	In Pakistan, family plays a vital role in patients' life keeping in view of the closed family system /norms & Families are considered the backbone of the healthcare system. Mostly the primary caregivers are patients' parents, spouses, siblings and children, who are providing physical and emotional support to patient for long period of time varying from months to years. The responsibility of caring can affect physical and mental health of caregivers adversely. Having a psychiatric patient as family member can lead to greater amount of burden on whole family like economic burden, feelings of hopelessness, depression, disturbed and unhealthy home environment, lack of social support, fear of stigmatised attitude, dysfunctional family roles. Keeping in view the needs for involving families and care givers, a psycho education programme was started at Fountain House, Lahore. The aim of this service was to explore psychological and emotional stressors or burden in caregivers who are caring for patients with psychiatric illnesses and to provide them support to deal with these stresses. This talk will give a brief outline about this programme and would argue about the effectiveness of mental health promotion services in a low income country.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Present status and prospects for Social Psychiatry in Japan			
Speaker	Masafumi Mizuno, Vice-President, The Japanese Society for Social Psychiatry, Chair, Department of Neuropsychiatry, Toho University			
Abstract	Japanese Society for Social Psychiatry (JSPS) is a national membership organization founded in 1981 to advance research for social psychiatry and contribute toward promotion of mental health. Masaaki Kato was the first president of the society followed by Ichizo Sato, Kenshiro Ohara, Yoshibumi Nakane, Tetsuya Hirose, and Shimpei Inoue. Its membership includes mental health professionals of all disciplines with the majority of psychiatrists. The main projects include annual academic meeting, publication of the quarterly journal (Japanese Bulletin for Social Psychiatry), and provision of up-to-date information on social psychiatry through its web. The 32nd annual academic meeting was held on March 7-8, 2013 in Kumamoto organized by Professor Manabu Ikeda of the University of Kumamoto with more than 400 delegates. As usual, its program included keynote speeches, symposia, oral/poster sessions and some educational sessions. The main theme was entitled as "Mental health in the confused society: from new born to aged generation". The symposia were as follows; Depression and suicide-comparison north and south, Supporting patients with cancer, Social psychiatric issues on sleep and related disorders, Community lives of people with schizophrenia, Psychiatric approaches to the children damaged by the Great East Japan Earthquake.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Impacts of aspects of society/economy on mental health in Asia Pacific			
Speaker	Mohan Isaac MD (Psy), DPM, FRCPsych, FRANZCP, Professor of Psychiatry			
Abstract	Most countries in the Asia pacific region are currently going through a period of unprecedented and rapid social, political and economic change. Although a broad range of literature across different disciplines dwells on possible impact of such change on health and mental health, there is little direct research on the effects of such changes on population mental health. While it is widely recognized that political and economic factors outside the world of academic and clinical psychiatry influence mental health, mechanisms of how societal change affects mental health is under researched due to a variety of methodological problems and is poorly understood. The brief presentation will highlight the widening income inequality, rising mental health inequity and growing prevalence of common mental disorders, sub-threshold and adjustment disorders, alcohol use related problems and suicidal behaviour. Socio economic issues related to globalization and the problem of suicides by large number of farmers in India during the past decade (as a case study example) will be raised for discussion.			
References				

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Symposia

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	HARM REDUCTION IN PSYCHIATRY			
Chairperson	Michael Krausz, University of British Columbia (UBC), Vancouver, Canada			
Co-chairperson	Michaela Amering, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria			
Abstract	Harm reduction is an interventional approach, a political concept and a medical principle. While it has polarized the discussion in the addiction field for years, harm reduction has also gained interest in the wider field of mental health care. A recovery approach with a focus on consumer choice and individual support requires a balanced approach to risk and harm reduction. Globally, the existing scarcity, inequity and inefficiency of mental health resources as well as the enormous treatment gap underscore the significance of harm reduction policies. This symposium will inform about history and current developments of the harm reduction concept and will present examples of its relevance. Michael Krausz from the University of Vancouver/Canada will set the scene by presenting the case for following the basic paradigm of harm reduction with examples from addiction medicine and the challenge of an integrated approach to health and mental health care. Jonathan Burns from the University of KwaZulu-Natal in Durban/South Africa will discuss policy chances and challenges for the South African situation with its various areas of necessary harm reduction. Ingrid Sibitz from the Department of Psychiatry and Psychotherapy at the Medical University of Vienna/Austria will present on stigma resistance and will argue for novel approaches to combat stigma and discrimination on the societal as well as on the individual level in order to reduce the harmful impact on peoples' living and treatment situations. Finally, Richard Warner from the University of Boulder in Colorado/USA will introduce a community treatment program of collaboration between the mental health and substance abuse treatment services, the sheriff's and the probation departments, and the courts, to prevent relapse and recidivism among clients with coexisting mental disorder and substance use problems. He will present data on the impressive harm and cost saving capacity of this approach.			
References				
Speakers	1. Michael Krausz, University of British Columbia (UBC), Vancouver, Canada mkrausz@mail.ubc.ca Harm reduction a basic paradigm for mental health care – lessons learned from addiction medicine 2. Jonathan Burns, Department of Psychiatry, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban, South Africa, burns@ukzn.ac.za Harm reduction in psychiatry - the South African situation 3. Ingrid Sibitz, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria, ingrid.sibitz@meduniwien.ac.at Stigma Resistance – combating stigma and discrimination on a societal as well as on an individual level 4. Richard Warner, Colorado Recovery, Inc. and University of Colorado, Boulder, USA, rwarner@coloradorecovery.com Keeping People with Mental Illness out of Jail and Prison			
Contact:	Michaela Amering Department of Psychiatry and Psychotherapy Medical University of Vienna Waehringer Guertel 18-20 1090 Vienna Austria Tel +43 699 11991030 Fax + 43 1 40400 3605 michaela.amering@meduniwien.ac.at			

Session:	Symposium	SPEAKER 1	Code	
Title:	Harm reduction a basic paradigm for mental health care – lessons learned from addiction medicine			
Speaker	Michael Krausz, University of British Columbia (UBC), Vancouver, Canada mkrausz@mail.ubc.ca			
Abstract	Mental health care is guided by explicit and implicit values and paradigms. Although we are only able to serve about 1 third of people in need according to the US National Comorbidity Survey and only a small minority is seeing a specialist for care, the mental health system is focussing on the concept of treatment and cure. Mental health care is normally not organized on a population level. Addiction medicine adopted the political and therapeutic concept of harm reduction as key of clinical pathways. It resulted in better access to care, prevention of infectious disease like HIV and HCV and methadone being the most effective measure against the spread of HIV. What does that teaches us for the future of mental health care?			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Harm reduction in psychiatry - the south african situation			
Speaker	J.K. Burns Nelson R Mandela School of Medicine, University of KwaZulu-Natal Durban, KwaZulu-Natal South Africa			
Abstract	Nearly 10 years ago, new mental health legislation was enacted in South Africa. The Mental Health Care Act (2004) was based on a number of important human rights principles including: integration of mental health into primary health care, decentralisation of services, minimum level of coercion possible, user empowerment and access to representation, promotion of community based mental health care and equality of mental health within the health care system. While the principles of this legislation aimed to improve care and reduce harm, the lack of funding for mental health and the absence of a strategy to implement change has resulted in a system that perpetuates multiple forms of harm experienced by users. These include: grossly inadequate community mental health facilities; minimal psychosocial rehabilitation and the continued long-term institutionalisation of many users; poor funding and maintenance of mental health facilities; inadequate training and support at district level with resulting poor quality of decentralised care; and continued stigmatisation of users and their families both within the health service and in the general community. A lack of political commitment to ensuring effective functioning of regional review boards has meant that users continue to have little recourse to legal representation. Thus this attempt to institutionalise a legislated vehicle for harm reduction, has largely failed in implementation; and users remain largely unprotected and voiceless. This presentation will review the above issues and challenges and will suggest practical steps that could be taken to reduce harm in current mental health practice in South Africa. These steps are relatively simple and inexpensive and are based on the principle of strengthening community empowerment, participation and collaboration in mental health planning and provision. The major barriers are political commitment and competence to implement commitments to change; as well as public prejudice, ignorance and apathy regarding mental health. The presenter will conclude by proposing a strategy aimed at breaking down these harmful political and social barriers within this middle-income context.			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Focusing on stigma resistance as a new approach to combat stigma and discrimination in people with schizophrenia			
Speaker	Ingrid Sibitz, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria			
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should be able to define			

	stigma resistance and give recommendations about how to build up stigma resistance both on an individual level as well as in society. Purpose: The aim of the study was to shed more light on the new concept of stigma resistance, i.e. the capacity to counteract the stigma of mental illness. Methods: Transcripts of recorded interviews with 32 people with schizophrenia were coded and analysed thematically using a modified grounded theory approach. The analyses were conducted with the help of NVivo 7 (QSR International). Results: Stigma resistance is referred to being immune to stigma, being able to counteract it and being open about the mental illness. Developing stigma resistance is a life-long process and the use of various strategies is essential. The processes of development of stigma resistance described by our interview partners do refer to both common generic topics regarding the development of a mature personality (e.g. self-esteem, self-efficacy, confidence, social competence, resilience) and specific topics such as dealing with the illness and the stigma associated to it. Positive and encouraging relationships, the possibility to work, enough money, high quality integrated person directed care and specific anti-stigma therapies are suggested to further stigma resistance on the individual level. On the societal level stigma resistance can be fostered through building resilience in kindergarten and school and educating people about mental illness. Information provided by people with experience in mental illness is regarded as especially important to counteract prejudices and negative attitudes among family, friends and special groups such as the police or scholars. Conclusions: Interventions to increase stigma resistance should consider the multifocal general and specific aspects. Societal support of self-help groups and movement may be a crucial step to promote stigma resistance.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	Keeping people with mental illness out of jail and prison.			
Speaker	R. Warner 1,2 1 Colorado Recovery, Boulder, Colorado USA 2 University of Colorado, Denver, USA			
Abstract	Educational Objectives: Participants will be able to describe two different programs which are effective in diverting offenders with mental illness and/or substance abuse problems from jail and prison incarceration into community-based treatment. Purpose: The programs, developed in the same county in Colorado, are run collaboratively by criminal justice system and the county mental health and substance abuse treatment services in an attempt to reduce the number of inmates of the county jail who suffer from mental illness or a substance abuse disorder. Methods: Involved in the selection of program candidates and the delivery of services are the sheriff's department (which operates the jail), the probation department, the district attorney, the public defender and the courts. One program uses the techniques of assertive community treatment to prevent relapse and recidivism among clients with coexisting mental disorder and substance use problems. The other program, the integrated treatment court, works with felons who are failing to comply with the requirements of probation because of substance abuse. In the latter program the judge employs the strategies of positive reinforcement and motivational interviewing. This program, like 3,000 similar courts across the US, is oriented towards rewarding and applauding progress rather than simply punishing failure. Results: These two programs use very different approaches to successfully divert two different populations of offenders with mental health or substance abuse problems from repeated or long-term incarceration and, as a result, they reduce the overall costs to government by considerable amounts. Conclusions: Both diversion models are effective with different offender populations, are complimentary and, overall, save considerable funding resources			
References				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	IMPLEMENTING FAMILY WORK IN SEVERE MENTAL ILLNESS: PEARLS, MYSTERIES AND PITFALLS		
Chairperson	Manuel Gonçalves-Pereira (Faculdade de Ciências Médicas, Universidade Nova de Lisboa)		
Co-chairperson	Julian Leff (Emeritus Professor of the Institute of Psychiatry, King's College London)		
Abstract	Family work, including so-called psychoeducational interventions, is highly effective in severe mental illness. Despite the evidence on benefits for patients and families, a large implementation gap remains. We aim to discuss the difficulties in implementing family approaches, particularly in schizophrenia. We will present suggestions on how to overcome barriers at the management and staff training level, and regarding practical family engagement. First, a review of the evidence on the effectiveness of family work will be presented. High-quality trials have been conducted within different theoretical frameworks but sharing common principles (improving knowledge on the disease and competence to deal with it, and building partnerships with families) Lack of implementation will be discussed and practical suggestions made (e.g. systemic changes at service level, active involvement of managers). Second, an example of a tentative implementation at national level will be described. In Portugal, following the guidelines of the National Mental Health Plan, a family psychoeducation staff training program was launched. The trainees' acquisition of competences was satisfactory. However, several difficulties emerged, including work overload and little time allowed for family approaches. Thirdly, a technical issue will be explored. Regardless of the focus of family work (e.g. lowering expressed emotion, problem-solving), there is a dearth of knowledge on the active ingredients of the process. The intervention by Kuipers, Leff & Lam (1992) will be broadly described, along with preliminary results of a qualitative study on its key-components. Finally, recent Portuguese data on family intervention studies (groups for relatives, behavioural family therapy) will be discussed in the light of international literature. Determinants of acceptance and adherence to family work will be specifically addressed. These topics may be of high importance for the congress participants. Family work remains a core component of global investment in mental health, although implementation issues are still somehow neglected.		
References	□ Gonçalves-Pereira M, Xavier M, van Wijngaarden B, Papoila AL, Schene AH, Caldas de Almeida JM (2012). Impact of psychosis on Portuguese caregivers: A cross-cultural exploration of burden, distress, positive aspects and clinical-functional correlates. <i>Social Psychiatry and Psychiatric Epidemiology</i> [epub ahead of print]. doi: 10.1007/s00127-012-0516-7 □ Leff, J. (2000). Family work for schizophrenia: Practical application. <i>Acta Psychiatrica Scandinavica</i>. Supplementum, (407, 78-82. □ Magliano, L., Fiorillo, A., Fadden, G., Gair, F., Economou, M., Kallert, T., et al. (2005). Effectiveness of a psychoeducational intervention for families of patients with schizophrenia: Preliminary results of a study funded by the European commission. <i>World Psychiatry: Official Journal of the WPA</i>, 4(1), 45-49.		
Speakers	1. Julian Leff (Institute of Psychiatry, King's College London; London, United Kingdom) 2. Miguel Xavier (Faculdade de Ciências Médicas, Universidade Nova de Lisboa; Lisboa, Portugal) 3. Jaime Grácio (Clínica Psiquiátrica de S. José, Irmãs Hospitaleiras; Lisboa, Portugal) 4. Manuel Gonçalves-Pereira (Faculdade de Ciências Médicas, Universidade Nova de Lisboa; Lisboa, Portugal)		

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Session:	Symposium	SPEAKER 1	Code	
Title:	Family work in schizophrenia: revisiting the issues on practical application			
Speaker	Julian Leff. Emeritus Professor of the Institute of Psychiatry, King's College London, United Kingdom			
Abstract	Family work for schizophrenia developed in the 1980s simultaneously in the UK and US. The early studies indicated that this was an effective intervention in reducing the relapse rate of schizophrenia. A number of international replications followed, creating a convincing body of evidence which will be reviewed. Despite this there were considerable barriers to implementing family work in routine clinical practice. The reasons for this and ways of overcoming the barriers will be discussed. The extension of family work to other psychiatric conditions will be presented and the possibility of adapting this approach to physical diseases will be explored.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Barriers to the implementation: lessons from a staff training program in Portugal			
Speaker	Miguel Xavier (Faculdade de Ciências Médicas, Universidade Nova de Lisboa; Lisboa, Portugal)			
Abstract	Introduction: Notwithstanding of mounting confirmation of their effectiveness, psychoeducational family interventions for schizophrenia and other non-organic psychotic disorders are still not consistently applied in clinical routine. In Portugal, the scarcity of original studies in family interventions is bewildering. After the launching of the Portuguese National Mental Health Plan, a psychoeducational training program has been prepared by the Ministry of Health. Objectives: a) to implement a psychoeducational training program on a national basis and b) to identify barriers to implementation in routine work. Methods: Professionals from public mental health services across the Country attended a 3 days full-time program in which they were trained in the psychoeducational intervention through presentation of guidelines, demonstrative audios and role-playing. Results: The trainees' acquisition of competences was found rather satisfactory. The most frequent obstacles in the enactment of the intervention included work overburden, the difficulty to integrate family work with other duties, and the poor allowance of time from the service to run the intervention. Conclusions: Arrangements need to be conceived in order to deal with obstacles limiting the accomplishment of family interventions in clinical practice. These should include changes in the services governance, like liveness of timetable and career incentives for professionals involved in the implementation process			
References	WHO Mental Health Improvements for Nations Development - -- Report from Portugal. Mateus P & Xavier M. WHO, 2009. Available at: http://www.acs.min-saude.pt/cnsm/2010/03/17/countrysummary/			

Session:	Symposium	SPEAKER 3	Code	
Title:	Searching for the active ingredients of effective family work in schizophrenia			
Speaker	Jaime Grácio (Clínica Psiquiátrica de S. José, Irmãs Hospitaleiras; Lisboa, Portugal)			
Abstract	Despite their proven efficacy, little is known about the process of family interventions in schizophrenia (FIS). So far we have detailed descriptions of the elements, structure and some process issues of the most important models. However, this information is still not enough for one to grasp the active ingredients that actually make FIS work. In this presentation, we will describe a systematic literature review regarding the process of FIS. Major findings of this work will be discussed, namely the need to conduct comprehensive qualitative research in the field, and the further development of a new generation of studies controlling process related variables. In this regard, a qualitative analysis of the five-year (1977-82) clinical trial of Julian Leff and his collaborators will be outlined.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Family work: focusing on engagement and adherence			
Speaker	Manuel Gonçalves-Pereira (Faculdade de Ciências Médicas, Universidade Nova de Lisboa; Lisboa, Portugal)			
Abstract	Family work is highly effective in severe mental illness. Despite the evidence on benefits for patients and families, an implementation gap remains. We revisit Portuguese data on family intervention trials, aiming to discuss the difficulties around initial engagement and adherence to family work. The FAPS study (a quasi-experimental study of families of people with psychosis) included a family intervention in the format of groups for relatives. At baseline, carers who accepted to participate tended to report more consequences of caregiving, albeit only in specific domains. In the 'Psychoeducational' study (a European trial which involved the training of staff in the implementation of behavioural family therapy) family engagement was indirectly analysed in therapists' reports, through qualitative analyses. There are multiple determinants of acceptability and engagement, the same applying to what retains the family in the intervention. Carers' variables are involved, but acknowledging their needs by means of empathetic approaches is also an issue. This is a matter of ongoing debate for researchers and therapists involved			
References	☐ Gonçalves-Pereira M et al. Impact of psychosis on Portuguese caregivers: A cross-cultural exploration of burden, distress, positive aspects and clinical-functional correlates. Soc Psychiatry Psychiatr Epidemiol, 2013; 48: 325-335. ☐ Gonçalves-Pereira M, Papoila A, Xavier M. The FAPS study on severe mental illness: views on the implementation of psychoeducational family work in Portuguese settings. Eur Psychiatry, 2009; 24(1): S232. ☐ Magliano L et al. Effectiveness of a psychoeducational intervention for families of patients with schizophrenia: Preliminary results of a study funded by the European commission. World Psychiatry, 2005; 4(1): 45-49.			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	FAST PROGRAMME: DEVELOPING ACCESS TO MENTAL HEALTH CARE IN LOW AND MIDDLE INCOME COUNTRIES			
Chairperson	Prof. Driss Moussaoui, Ibn Rochd University Hospital, Casablanca, Morocco Prof. Thomas Craig, King's College, London, United Kingdom			
Co-chairperson				
Abstract	In most countries, mental health services are inadequate. It is estimated that in Low and Middle Income Countries (LAMIC) 80% of people with mental disorders do not receive treatment¹. This has severe consequences for the patients and their families, including suffering, exclusion, precariousness... The World Association for Social Psychiatry (WASP) and the Access to Medicines department of Sanofi have joined forces to develop better access to mental health care in LAMIC, and in 2009 they launched the Fight Against Stigma (FAST) programme. The FAST programme is implemented through local partnerships, which involve local key stakeholders, including the Ministry of Health, NGOs, and other associations depending on the local situation. The programmes are articulated around a comprehensive set of initiatives including: ☐ Awareness / education programmes for communities, to address the stigma faced by people with mental disorders ☐ Supporting patients and families' associations ☐ Psycho-education of patients and their families ☐ Training of primary Healthcare professionals (GPs, nurses...) ☐ Supply of adapted and affordable The programme has demonstrated its efficacy in two pilot regions where it has been implemented, in Morocco and in Mauritania. In Nouadhibou (Mauritania), at baseline (May 2009), only 7% of people with schizophrenia were treated. As a result of the programme implemented, it is now estimated that over 50% of people with schizophrenia have access to care. Similar programmes are now rolled-out in several countries in Africa and in Latin America (Guatemala in particular). During this symposium, the WASP and the Access to Medicines Department of Sanofi will present their shared vision of the FAST programme, while a representative from the MoH of Mauritania will discuss the impact of the Nouadhibou pilot, and a Psychiatrist from Guatemala will present his perspective as he is involved in the local implementation in his country.			
References				
Speakers	1. Prof. Driss Moussaoui, Ibn Rochd University Hospital, Casablanca, Morocco - Why WASP is committed to FAST 2. Dr Robert Sebbag, Access to Medicines, Sanofi, Paris, France - Sanofi: its role in the FAST Programme 3. Mr Sidi Aly Ould Sidi Boubacar & Mr Youssef Ould Limane, Ministry of Health, Nouakchott, Mauritania - What has FAST brought to Mental Health in Mauritania? Views from the MoH. 4. Dr Alejandro Paiz, Ministry of Public Health and Social Welfare, Sololá, Guatemala - Improving access to mental health care in Guatemala: main challenges.			
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Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	PEER SUPPORT IN MENTAL HEALTH CARE			
Chairperson	Richard Warner, Colorado Recovery, Inc. and University of Colorado, Boulder, USA			
Co-chairperson	Michaela Amering, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria			
Abstract	Recovery orientation is guiding mental health policy in the English speaking world with growing interest internationally. Peer support is an essential ingredient of recovery oriented mental health care. Experiential and scientific evidence for its feasibility and specific effects is growing. This symposium will present examples of projects that support and evaluate peer work in mental health and provide insight into current developments and discussions of the concept and its practice. Jörg Utschakowski from Bremen/Germany will introduce the multi-national European Leonardo da Vinci project of Experience Involvement (www.ex-in.info) and its training programmes for people with experience of using mental health services to work as trainers and peer supports and will report on the resulting developments in different European countries. Candelaria Mahlke from the University of Hamburg will present on a randomized controlled trial of peer to peer – support in severe mental disorders in Germany. Richard Warner from Boulder/Colorado/USA will highlight the importance of service-user communities with successful examples from different parts of the world and the US that build on the value of the mutual support available in a community of people with psychiatric disabilities. From Portugal, the Advisory Committee for User and Carer Participation (Maria Neves) will present the working group composed of users, informal and formal carer representatives created in 2010 within the National Mental Health Program with the aim to provide support and advice in the field of user, carer and community participation, self-help networks and advocacy in the current Portuguese mental health reform (Marta Ferraz).			
References	1. Jörg Utschakowski, FOKUS - Initiative zur sozialen Rehabilitation, Bremen, Germany, 2. Candelaria I. Mahlke, Department of Psychiatry and Psychotherapy, University of Hamburg, disorder – a randomized controlled Trial 3. Richard Warner, Colorado Recovery, Boulder, Colorado, and University of Colorado, USA, 4. Marta Ferraz, Programa Nacional para a Saúde Mental, Direção-Geral da Saúde, Lisboa,			
Speakers				
Contact:	Michaela Amering Department of Psychiatry and Psychotherapy Medical University of Vienna Währinger Gürtel 18-20 1090 Vienna Austria Tel +43 699 11991030 Fax + 43 1 40400 3605 michaela.amering@meduniwien.ac.at			

Session:	Symposium	SPEAKER 1	Code	
Title:	Peer to peer - Support in severe mental disorders: experience involvement (EX-IN)			
Speaker	Jörg Utschakowski, social worker, Initiative for social rehabilitation, Bremen/Germany Coordinator EX-IN Europe			
Abstract	Educational Objectives: The participants will learn about the concept and the value of We- Knowledge arising from the individual and collective experiences of mental distress. Purpose: The purpose of the so called EX-IN training is, to qualify people who have experienced severe mental disorders on base of their experiences as peer-experts who work in all fields of mental health Methods: The main method of the project is the use of we-knowledge of people who have experienced			

	severe mental disorders as a new source in mental health in the fields of support, treatment, rehabilitation, research and training. As support workers the peer-experts have a strong impact in their function as role model, bilingual interpreter, recovery guide, peer, trusted person... Results: The concept of training experts by experienced has been developed in the frame of an European project and is still spreading further in Europe. The strength of concept lies in the production and application of we-knowledge Conclusions: ☐ The training and employment of experts by experience in the field of mental health supports more effective, more recovery orientated and more satisfying mental health services. It also gives people who are usually excluded from the labour market due to their experience with severe mental disorders the chance to earn money with a job which values their experiences. This supports also the recovery process of the peer workers. ☐ The EX-IN project has been a success story. It improves the support of clients of mental health services, it develops new concepts of understanding mental distress and it supports the recovery process of the peer workers themselves. The EX-IN training is implemented in a growing number of countries in Europe on different educational levels (as vocational training or as university course) ☐ The knowledge of people experienced in severe mental disorders has been ignored or underestimated in the history of psychiatry. The project has shown how strong the the values of experiences are if the are structured on an individual and collective level. The we-knowledge is an important source to improve mental health practice, research and theory. ☐ The results of the project and the collateral research leads to the need of more and wider research about the impact of peer work, but it leads also to the need of defining the role of experts by experience properly and to the question of an appropriate salary.
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Peer to peer - Support in severe mental illness: affective disorders, schizophrenic spectrum disorders and personality disorder – A randomized controlled trial			
Speaker	Candelaria I. Mahlke, Department of Psychiatry and Psychotherapy, University of Hamburg, disorder – a randomized controlled Trial			
Abstract	Introduction Severe mental illness like affective disorders, schizophrenic spectrum disorders and personality disorders generate the highest cost in mental health system. The phenomenon of cyclic hospital re-admission is well known and along with heavy losses in quality of life and high suicidal rates in these diagnoses a refinement of intervention is still required. In mental health Services (MHS) there is an international trend toward recovery-orientated interventions, like Peer-support^{1,2}. For Germany this is the first try to implement peer-support area wide in a metropolis expecting to increase self-efficacy, global functioning and health status. Former studies revealed that mental health customers had higher adherence in medical use and service engagement by receiving additional Peer-Support¹. This project forms a part of “psychnet – Hamburger Netz psychische Gesundheit“, supported by the Federal Ministry of Education and Research during 2011 - 2014. Educational Objectives: Like former mentioned there is a trend toward recovery-orientated interventions, like Peer-support^{1,2}. In this project people with own experiences of mental disorders support after a one-year-qualification at “Experienced Involvement” others with affective disorders, psychoses and personality disorders additional to their “treatment as usual”, supplying individual self-help on eye-level leaning on reciprocity. At the conclusion of this presentation we want to give an understanding of the broad potential of peer counselling for patients with severe mental illness and share experiences of implementing peers in psychiatry. The particular approach of peer-support will be revealed during the symposia. Purpose: The purpose of the Peer to Peer-Project is to prove the effectiveness of Peer-counselling for patients with severe mental illness, with the further aim to implement it as a regular part of mental health system in Germany. Methods: Presented are results of a randomized controlled trial: • Multi-centre: involving 8 psychiatry's • Sample: N=200, in- and out-patients with affective disorders, schizophrenic spectrum disorders and personality disorders • Intervention: up to 6 months of peer-counselling; Control: Treatment as usual			

	• Intention to treat analysis • 3 observation points: pre-, post-intervention, six-month follow up • Questionnaires and rating scales for: Quality of life, self efficacy, illness management, social functioning, severity of illness and days of hospitalization Results: Until now the study isn't concluded, but first extrapolations support most of the expected findings - the results will be presented. Also a high level of acceptance and service satisfaction is observed. Conclusion: Preliminary findings support that the project achieved its objectives. Controversial results will be discussed
References	1 Doughty C, Tse S. Can Consumer-Led Mental Health Services be Equally Effective? An Integrative Review of CLMH Services in High-Income Countries. <i>Community Ment Health J.</i> 2011; 47:252–266.; 2 Davidson L, Chinman M, Sells D, Rowe M. Peer support among adults with serious mental illness: a report from the field. <i>Schizophr Bull.</i> 2006; 32:443-450.

Session:	Symposium	SPEAKER 3	Code	
Title:	The importance of service user communities. Is mainstreaming always the answer?			
Speaker	Richard Warner, Colorado Recovery, Boulder, Colorado, and University of Colorado, USA			
Abstract	Educational Objectives: Participants will be able to name and describe programs which illustrate the benefits of service-user mutual support. Purpose: Drawing an analogy with immigrant and ethnic minority communities, the presenter will argue that there is a value in the mutual support found in identity communities of people who have experienced mental illness and that mainstreaming is not always the best solution for these clients. Methods: Ethnic minorities have multiple successful pathways towards community. They can choose to live, work and socialize in the dominant community, they can remain in their sub-communities, or they can move back and forth, choosing some activities in each. The presenter will suggest that people with psychiatric disabilities should be allowed these same choices and that we should not assume that integration into the broader community must always be the ultimate goal. Results: The presentation will cite successful models such as social firms and the psychosocial clubhouse model that build on the value of the mutual support available in a community of people with psychiatric disabilities. These include business incubators that help community members develop micro-businesses and a user-friendly bank to assist in capitalizing such ventures. The presenter will describe an economic development approach which points the way to enterprises that can advance the economic circumstances of the service-user community and offer members of the group work opportunities and leadership roles. Conclusions: Service-users should be given the opportunity to appreciate the mutual support which comes from those with whom they share experiences, concerns, needs and goals, and not feel they should abandon this resource in order to integrate themselves into the broader community.			
References	Mandiberg, J.M. Warner, R. (in press) Is Mainstreaming Always the Answer? The Social and Economic Development of Service User Communities, <i>The Psychiatrist</i> .			

Session:	Symposium	SPEAKER 4	Code	
Title:	Effective collaboration between mental health stakeholders in Portugal			
Speaker	Marta Ferraz, Programa Nacional para a Saúde Mental, Direção-Geral da Saúde, Lisboa,			
Abstract	Educational Objectives: At the end of this presentation participants should be able to identify what the Advisory Commission for User and Carer Participation (CCPUC) is and its role in the current mental health reform in Portugal. Participants ought to be able to recognize guiding principles and work methodologies that allow for an effective collaboration between mental health stakeholders. Purpose: This presentation aims to share with participants the experience of the CCPUC as an example of			

	the much desired and effectively possible collaboration between users, family members and mental health professionals at a governmental level. Since 1998, the Portuguese government, through the Ministry of Health, seeks to promote the participation of professionals, family members and users of mental health services in advisory bodies. This right is enshrined in the Mental Health Act and subsequent Decree-Law n. ° 35/1999 which regulates it. The need to ensure the citizens' participation in the effective operation and management of these services, more specifically, that of family and user associations is again asserted in the amendment and republication of 2009. Community participation is part of the values and principles advocated by the National Mental Health Plan 2007-2016 (approved by the Ministers Council in March 2008) which states that "people with mental illness should be involved and participate in the planning and development of the services they benefit from. Family members of people with mental illness should be considered key partners, encouraged to participate in the provision of mental health care and receive the necessary training and education to do so." In this context, in October 2010, the Advisory Committee for User and Carer Participation was created within the National Coordination for Mental Health (currently the National Program for Mental Health/Directorate-General of Health). The ultimate goal of this committee is to identify and disseminate a model for the involvement of users and caregivers in mental health services nationally, and to inform and evaluate its implementation. Composed by users, formal and informal caregivers and/or their representatives, the CCPUC operates according to a model that aims for the involvement, empowerment, recovery and empowerment of stakeholders, increased awareness by civil society and promotion of advocacy. Conclusions: As far as we are concerned CCPUC has successfully achieved its objectives through the promotion of and participation in various capacity building initiatives (workshops, conferences, publications, etc.) that have allowed, not only for stakeholders to come together and share their opinions and concerns in a positive and collaborative manner, but also to gain more significant power and influence over the current mental health reform in Portugal.
References	

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	CHALLENGES TO PRACTISING SOCIAL PSYCHIATRY IN SOUTH AFRICA			
Chairperson	Prof Jonathan Burns Department of Psychiatry, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban, South Africa			
Co-chairperson				
Abstract	One of the Grand Challenges in Mental Health is to promote the development and implementation of progressive mental health legislation and policy in low- and middle-income countries. Ten years ago, a new Mental Health Care Act (MHCA) (2002) was passed in South Africa, prioritising decentralisation of mental health care, integration of mental health into primary care, improved access to care, and human rights for users. In this symposium four clinician/researchers with extensive experience in mental health policy and health services development, and representing various regions and contexts in South Africa, will present their work guided by this legislative framework. Dr Grobler will provide an overview of the process of implementation of the MHCA (2002), highlighting challenges encountered over the last decade in attempting to translate policy into practice. Prof Janse Van Rensburg will review 7 years of experience and data from his direct involvement in establishing and running an acute district level mental health service in an urban context. Dr Sukeri will present data on the development of a mental health programme within the low-resourced, mainly rural Eastern Cape Province. Dr Nassen will present a programme based in urban townships around Cape Town that integrates public health, NGO and community-based groups focused on improving access to care for children and adolescents affected by HIV, sexual violence, substance abuse and mental health disorders. This symposium aims to provide a broad case study of efforts to implement good mental health legislation within a middle-income country where multiple political, social and economic factors create barriers to successful implementation. The central focus will be a discussion of innovative methods of overcoming these seemingly insoluble barriers that may be useful models for similar global contexts			
References				
Speakers	1. Dr Gerhard Grobler, President of the South African Society of Psychiatrists, Johannesburg, South Africa; email: gpgrobler@sasop.co.za; "The implementation of the South African Mental Health Care Act (2002)" 2. Prof Bernard Janse Van Rensburg, Department of Psychiatry, University of Witwatersrand, Johannesburg, South Africa; email: bernardj@gpg.gov.za; "Social psychiatric practice in an urban South African acute public care setting." 3. Dr Kiran Sukeri, Department of Psychiatry, Walter Sisulu University, East London, South Africa; email: ksukeri@telkomsa.net; "Developing a mental health programme for a low middle-income region of South Africa." 4. Dr Rene Nassen, Department of Psychiatry, Stellenbosch University, Tygerberg, South Africa; email: rnassen@sun.ac.za; "An integrated programme for child and adolescent mental health in peri-urban Cape Town townships."			
Contact:	Professor Jonathan K Burns Department of Psychiatry Nelson R Mandela School of Medicine University of KwaZulu-Natal Durban 4000 South Africa Tel: +27 31 2604321 Fax: +27 31 2604322 Email: burns@ukzn.ac.za			

Session:	Symposium	SPEAKER 1	Code	
Title:	An overview of the process of the implementation of the south african mental health care act (Act No 17 of 2002)			
Speaker	Dr Gerhard Grobler, President of the South African Society of Psychiatrists, Johannesburg, South Africa; email: gpgrobler@sasop.co.za; “The implementation of the South African Mental Health Care Act (2002)”			
Abstract	Educational Objectives: This presentation will examine the implementation of the South African Mental Health Care Act in the context of a post-liberation, democratic South Africa. It will engage in a critical discussion of the progress made by the Act as well as barriers to and limitation of implementation. Purpose: The Mental Health Care Act replaced the Mental Health Act (Act No 18 of 1973) and improved it in several significant ways. The Mental Health Care Act aims to protect the person and dignity of mental health care users. Methods: The paper will examine and contrast the Mental Health Act and Mental Health Care Act with particular reference to the democratic Constitution of the Republic of South Africa. Empirical research on the implementation of the Mental Health Care Act will reviewed. Conclusions will be drawn from both the conceptual – philosophical analysis as well as empirical findings. Results: The Mental Health Care Act espoused the values of the Constitution but also infringes on basic human rights of mental health care users. It differs significantly in approach and design from the previous Mental Health Act. The implementation of the Mental Health Care Act is hampered by infrastructural and resource related problems. Conclusions: ☐ The Mental Health Care Act aligns closely with the Constitution of the Republic of South Africa and take the founding principles as well as the Bill of Rights into consideration ☐ The Mental Health Care Act varies markedly from the previous Mental Health Act. It moves from a community-centred custodial philosophy to an individually focused, community-based approach ☐ Despite its regards for basic human rights of mental health care users, the Mental Health Care Act does infringe on certain human rights. This infringement is balanced by oversight and appeal mechanisms ☐ There are several factors limiting the implementation of the Mental Health Care Act			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Social psychiatric practice in an urban south african acute public care setting			
Speaker	Prof Bernard Janse Van Rensburg, Department of Psychiatry, University of Witwatersrand, Johannesburg, South Africa; email: bernardj@gpg.gov.za; “Social psychiatric practice in an urban South African acute public care setting.”			
Abstract	Educational Objectives: During the past 10 years several clinical reviews of public sector psychiatric services at Helen Joseph Hospital (HJH) in Johannesburg, South Africa have been undertaken, including: (1) HIV-positive users; (2) inpatient services for schizophrenia; (3) morbidity, treatment outcome, cost and appropriate unit design for acute in-patient care; and (4) a 5-year comparative outcomes review of inpatient and outpatient services. Purpose: To present the most important trends of these reviews in terms of clinical profile, treatment outcome, cost and inpatient unit design at this regional general hospital, in the context of its role in the local urban referral system. Methods: These reviews were mainly retrospective, quantitative clinical reviews. The clinical records of users admitted to HJH for acute inpatient psychiatric care and who attended the outpatient clinic for follow-up were reviewed. Descriptive and comparative quantitative analyses were made.			

	Results: At the time, only 17.4% of the total number of service users' were tested for HIV status, either prior to, or during admission. In terms of inpatient care for schizophrenic users, four factors (age, gender, substance abuse and follow-up referral) had a significant association with longer and more costly admissions to this unit. At the time, the total cost of acute inpatient psychiatric care at this facility amounted to only 2.4% of the total hospital expenditure. Considering safety, as well as upholding patients' human rights, design solutions for this acute inpatients unit were developed and the projected capital cost was calculated. The subsequent review of services from 2008 to 2012 included a comparative review of all in and out-patient services, in the context of adherence to treatment, of the prevention of re-admissions and of psychosocial-rehabilitation in the region. Conclusions: ▪ These studies highlighted the importance of delineating catchment areas for regional referral specialist hospitals, and identified the significance for community programs to address adequate accommodation and co-morbid substance abuse of users with schizophrenia ▪ Managers were assisted to make evidence-based decisions regarding resource allocation, using an approach whereby clinicians were involved in a bottom-up approach to cost the activities of their department ▪ Appropriate structural adjustments to acute mental health care units should be implemented in order for facilities not to be in violation of the regulations of the mental health legislation on patients' basic human rights and safety ▪ The necessary resources, capacity and infrastructure must be provided to ensure the effective follow-up of patients through the referral system, by local mental health review boards.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Developing a mental health plan for the Eastern Cape Province, a low middle income region of South Africa			
Speaker	Dr Kiran Sukeri, Department of Psychiatry, Walter Sisulu University, East London, South Africa; email: ksukeri@telkomsa.net; "Developing a mental health programme for a low middle-income region of South Africa			
Abstract	The Eastern Cape Province is located on the south east coast of the Republic of South Africa. It has a population of 6.5 million. 72% of the population live below the poverty line. The unemployment rate is 28%. More than half of the population is dependent on social grants. The Eastern Cape is a resource limited province with a fragmented mental health service. The objectives of the study were to determine the status of public sector mental health service delivery and to develop an informed model of public mental health. METHODOLOGY The study design is a descriptive cross sectional study. The research tool was an audit questionnaire based on the Norms Manual for Severe Psychiatric Conditions and the World Health Organisations' Assessment Instrument for Mental Health Systems (WHO)AIMS). Data analysis followed WHO requirements and the Norms Manual for Severe Psychiatric Conditions. RESULTS The Eastern Cape Province does not have a provincial policy or plan for mental health. The Department of Health was unable to provide information on its budgeting for mental health, data on service utilisation, training of nurses at primary health care level and inter-sectoral collaboration. There is an inequitable distribution of resources between the eastern and western regions of the province. The poorer eastern region has limited access to mental health facilities, human resources and non-governmental organisations. CONCLUSIONS The Eastern Cape Department of Health faces a challenge in the development of a comprehensive mental health plan in the context of its limited human resources, public sector mental health facilities and absence of a mental health information system. A model of mental health service delivery has to be developed to address the distinct differences between the eastern and western regions.			

	A comprehensive mental health policy and plan is possible with the development of novel techniques that are evidence based.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	An integrated approach to the provision of services to hiv positive children and adolescents			
Speaker	Dr Rene Nassen, Department of Psychiatry, Stellenbosch University, Tygerberg, South Africa; email: rnassen@sun.ac.za;			
Abstract	Educational Objectives: This presentation will describe the establishment of group based interventions at a primary clinic servicing 95 HIV positive children and adolescents resident in Khayelitsha Township, a large peri-urban community on the outskirts of Cape Town. A collaboration was established between the local specialist child and adolescent mental health (CAMH) service, a primary care clinician at the HIV clinic, lay counsellors and allied professionals. This collaboration was extended to include clinicians from Medecins Sans Frontieres. Purpose: This initiative aimed to establish groups in order to improve adherence to antiretroviral treatment, particularly among adolescents, and to provide a confidential space for adolescents to engage about sensitive issues. Methods: The CAMH team and HIV clinicians met initially, after which a site visit was conducted to observe groups. Written inputs and recommendations were provided to documents describing group content, by the CAMH team. Training on group facilitation was provided by the CAMH occupational therapist and inputs provided about screening for psychiatric and neurocognitive problems. Results: Groups have been established but occur infrequently, due to limited human resources and large numbers of patients serviced at the clinic. The CAMH team is in the process of facilitating a formal link between the HIV clinic and mental health clinicians at primary level. The aim is to increase the frequency of the groups and strengthen a referral pathway to CAMH services. Following establishment of more regular caregiver and adolescent groups, mental health and cognitive screening will be established. Conclusions: ☐ Integrated models of care to HIV positive youth and their families demonstrate improved outcomes, both in terms of HIV disease but improved adherence and mental health outcomes. ☐ The proposed model is a more integrated method of assessment and intervention for a vulnerable group of patients, who are failing to access care at specialist level, but who present with a complex range of medical and psychosocial problems. ☐ Clinicians from disciplines such as medicine, child psychiatry, psychology and possibly social work, from primary, general and specialist level services will collaborate to provide both psychosocial as well as medical intervention. ☐ This model will cut across the current model of a division between specialist, district and primary healthcare services, in South Africa. It will require an interaction between facility managers as well as consent from senior management, in order to formalize an agreement between the various levels of service and the non- governmental sector (Medecins Sans Frontieres) ☐ This initiative will provide opportunities to research treatment outcomes of improved psychosocial interventions, screening and integrated models of care for children and adolescents living with HIV.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	TRIALOGUE – COMMUNICATION BETWEEN USERS, CARERS AND MENTAL HEALTH WORKERS BEYOND ROLE STEREOTYPES		
Chairperson	Michaela Amering, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria		
Co-chairperson	Thomas Bock, Department of Psychiatry and Psychotherapy, Medical University of Hamburg, Germany		
Abstract	The active involvement of users and relatives and friends is essential for the development of recovery-oriented mental health practice and research. However, accepting each other as equally entitled experts is still a challenge. In Trialogue-groups users, carers and friends and mental health workers meet regularly in an open forum, that is located on ‘neutral terrain’ - outside any therapeutic, familial or institutional context - with the aim of discussing the experiences and consequences of mental health problems and ways forward. Trialogues offer new possibilities for gaining knowledge and insights and developing new ways of communicating beyond role stereotypes. They also function as basis and starting point for trialogic activities on different levels - e.g. serving on quality control boards or teaching in trialogic teams - and different topics - e.g. a task force on stigma busting or a work group on trauma and psychosis. In German speaking countries well over hundred Trialogue groups are regularly attended by altogether ~ 5000 people. International interest and experiences are growing fast. The concept of Trialogue was first introduced internationally at the World Congress of Social Psychiatry 1994 in Hamburg/Germany. This symposium will present an update on Trialogue starting with co-founder Thomas Bock from Hamburg/Germany giving an overview of the concept and its roots and developments. Liam McGabhann and Patrick McGowan from Dublin City University in Ireland will introduce the Mental Health Trialogue Network Ireland and present experiences and data on a large implementation project in several Irish locations. Michaela Amering from the Medical University in Vienna/Austria will highlight the work of the first trialogic WPA Task Force on Best Practice in Working with Service Users and Carers and will use data from a qualitative research project in Berlin/Germany to argue that Trialogues facilitate a discrete and independent form of acquisition and production of knowledge. Finally, Friederike Ruppelt from the University of Hamburg/Germany will present a first empirical evaluation of German-speaking Trialogue groups with a focus on search of meaning, empowerment and recovery.		
References			
Speakers	1.Thomas Bock, Department of Psychiatry and Psychotherapy, Medical University of Hamburg, Germany, 2.Liam MacGabhann, Paddy McGowan, School of Nursing and Human Sciences Dublin City University, Ireland, I 3.Michaela Amering, Department of Psychiatry and Psychotherapy, Medical University of Vienna, 4.Friederike Ruppelt, Department of Psychiatry and Psychotherapy, Medical University of Hamburg, Germany,		
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Session:	Symposium	SPEAKER 1	Code	
Title:	Trialogue and psychosis seminars – concept, roots and developments			
Speaker	Thomas Bock, Department of Psychiatry and Psychotherapy, Medical University of Hamburg, Germany,			
Abstract	Educational Objectives: What is the meaning of trialogue on various levels – in psychiatric practice, education, research and public relations? What is already accomplished and what should be achieved? Is there a ‘philosophy of trialogue’? At the conclusion of this presentation participants shall be sensitized, how to promote recovery and participation in and throughout trialogue work. Purpose: Meeting as experts, mutual learning in trialogue is essential for the development of recovery-oriented mental health practice and research. The philosophy of trialogue, as an anthropological point of view, is necessary for reducing stigma and facilitating coherence. Methods: The “germ cell” of trialogue is the psychosis-seminar, an open forum on neutral terrain outside of institutional or familiar dependence, a place of mutual learning and meeting as experts. It creates a special “language area”, an “anarchistic” meeting of people, looking for new insights and new ways of communication beyond role stereotypes. – In the last years new steps of the trialogue movement can be observed including trialogue in education, research, public relations with books, newspapers, associations and campaigns. Clinical practice is evolving, e.g. open dialogue with first episode-patients. Important will be, how to counteract medical reductionism, which has proven unable to reduce fear in the community or to promote recovery. We have to look for alternative ways and peer-support of users and relatives are essential for change. Results: Trialogue is a precondition of recovery and should be a cachet of quality in psychiatry. Conclusions: ☐ No public relations work should be done without trialogue. ☐ The idea of open dialogue has to be transferred from first episode patients to overall psychiatry. ☐ Trialogue participation has to be a requirement for research – like ethical commissions. ☐ Trialogue can help to limit the normative powers of psychiatry: The anthropological point of view serves as a counterbalance to the pathological one. ☐ Peer-support of users and relatives will help to establish trialogue in daily psychiatry			
References	• Bock, Th., Priebe, St. (2005); Psychosis-seminars, an unconventional approach for how users, carers and professionals can learn from each other, psychiatric Services, Vol. 56, No. 11, 1441-1443. • Bock T, (2012); Partizipation in Klinischer und Sozial-Psychiatrie – Impulse aus dem Trialog, in: Rosenbrock R, Hartung S, Handbuch Partizipation im Gesundheitswesen, Vincentz-Verlag Berlin.			

Session:	Symposium	SPEAKER 2	Code	
Title:	Mental Health Trialogue Network Ireland (MHTNI) – Transforming Dialogue in Mental Health Communities			
Speaker	Liam MacGabhann, Paddy McGowan, School of Nursing and Human Sciences Dublin City University, Ireland, I			
Abstract	Educational Objectives Folowing this presentation participants will: know how the MHTNI evolved and Trialogue Meetings were established as a living tradition in Irish communities; recognise the benefits of Trialogue Meetings as a place of learning, emancipation and generation of collective expertise for mental health professionals, service users, families/friends and community members in relation to mental health and mental illness. Purpose of MHTNI The purpose of establishing this project was: to facilitate the establishment of community leaders in the area of mental health; to develop a community forum using the ‘Trialogue’ processes; to strengthen the voice of people with mental health problems & families/ carers regarding needs & supports in their communities; and to provide a focus for developing awareness and action around mental health within Irish communities Methods The MHTNI developed as a Participatory Action Research community development project. It evolved			

	from another project that also brought service users, family members and mental health professionals together as a leadership team with the task of initiating and completing a service improvement in their local mental health service (Mac Gabhann et al. 2010). Over several years participants had recognised the benefits of open dialogue communications through a Trialogue process in enabling significant changes within mental health services. Concurrently the authors had an ongoing research and practice interest in open dialogue processes and particularly Trialogue. Collectively there was an impetus to establish Trialogue Meetings outside of services in participating communities and the authors successfully bid for funding to establish the MHTNI. The initial timeframe for the project was eighteen months with the aim of establishing the network as a stand alone sustainable process within this period. Monthly Trialogue Meetings were established in seven participating sites with the plan to snowball from these sites over time. Local leaders were identified who were trained in open dialogue processes, had Trialogue experience and they formed the core co-ordinating team for each emerging Trialogue group. A core project team co-ordinated; training, advertisement, marketing, facilitation of initial meetings, development of guidelines and conducted the ongoing evaluation for all participating communities. This process was enabled through a national project co-ordinator and an interactive website www.trialogue.co. Quantitative and qualitative tools were utilised to evaluate the experience, knowledge generation, sustainability and extent of collective experience generated in Trialogue. Results The MHTNI has been established as a stand alone community network of Trialogue Meetings in Ireland, with almost half of initial participants continuing to participate on a monthly basis. The website continues to provide learning, information and a communication hub for people interested in Trialogue around the globe. Specific learning and engagement in the evolving process has been quantified and the qualitative results provide an inductive framework on how people change how they think about mental health/illness, engage with them, and develop new understandings and ways of relating to their community. Conclusions Objectives were achieved and the Trialogue Meetings as MHTNI established in Ireland. A wealth of knowledge and transformations occurred and the implications suggest that this process provides a forum for communities to embrace emancipatory change that goes towards enabling a genuine recovery for individuals and communities (Mac Gabhann et al. 2012).
References	Mac Gabhann, L., McGowan, P., Walsh, J. & O'Reilly, O. (2010) Leading change in public mental health services through collaboration, participative action, co-operative learning and open dialogue. The International Journal of Leadership in Public Services. Volume 6, (Supplement), September. Mac Gabhann, L., McGowan, P., Ni Cheirín, L., Spencer, A., Amering, M. (2012) Mental Health Trialogue Network Ireland: Transforming Dialogue in Mental Health Communities. Dublin City University

Session:	Symposium	SPEAKER 3	Code
Title:	this openness must continue' – changes through trialogue		
Speaker	Michaela Amering, Department of Psychiatry and Psychotherapy, Medical University of Vienna,		
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should have gained insight into how changes through Trialogue come about. Purpose: Trialogs are widely popular, but scarcely researched. Methods: Focusgroups as well as written narratives were qualitatively analysed. Results: Communication in trialogue groups is clearly different from clinical and other encounters. All three groups cherish and aspire to interest for each other, good will, openness and truthfulness. Clinical routine with role prescriptions, power balance and constant pressure to act is experienced as an impediment. Conclusions: Trialog facilitates a discrete and independent form of communication and acquisition and production of knowledge.		
References			

Session:	Symposium	SPEAKER 4	Code
Title:	Dialogue and Search of Meaning, Recovery and Empowerment. A first empirically evaluation of German-speaking psychosis seminars.		
Speaker	Friederike Ruppelt, Department of Psychiatry and Psychotherapy, Medical University of Hamburg, Germany,		
Abstract	Educational Objectives: The Hamburger SuSi-Project will be presented and especially one of the latest study in this project. At conclusion of this presentation, the participants shall be sensitized for subjective sense and meaning of psychoses and should be able to recognize that dialogue has effects on recovery, empowerment and search for meaning. Purpose: Psychosis seminars provide an innovative opportunity for consumers, family members, and mental health professionals to meet in a neutral forum and share their perspectives. They are hitherto a rare subject of scientific evaluations. This study explores positive effects of psychosis-seminars on their participants regarding changes in the understanding of the emergence, experience of symptoms and consequences of psychoses. Changes in recovery attitudes and empowerment are focussed as well. Methods: The survey uses a pre-post-design with a non-randomized control group in 16 German-speaking psychosis-seminars. Participants i.e. patients, relatives and mental health professionals, complete questionnaires at the start and the end of a psychosis-seminar cycle which include at least six seminars during a five-months-period. Besides sociodemographic data and qualitative questions the following instruments are used: (I) German Subjective Sense in Psychosis Questionnaire (SUSE), (II) Recovery Attitudes Questionnaire (RAQ 7) and (III) Making Decisions (Empowerment Scale). Outcomes are compared using t-tests. Analyses of qualitative questions follow Mayring's qualitative content analysis by building inductive categories. Data collection started in August 2011 and is continued until today. Results: Concerning the search for meaning, psychosis patients and relatives showed significantly more positive experiences of symptoms after participating at psychosis-seminars. In qualitative data categories like "experiences of sense and coherence" were derived. Regarding attitudes towards recovery, patients developed a significant more positive attitude towards recovery from severe mental illnesses. In qualitative data categories like "paths to recovery" or "recovery is possible" were found. Concerning perceived empowerment, patients were significantly more empowered after participating at dialogue. In qualitative data categories like "group affiliation" or "equality" were derived. Furthermore, qualitative data underline the improvement of psychoses comprehension. Conclusions: This study indicates a change in meaning and sense of psychoses in patients and relatives. Patients benefit concerning their attitudes towards recovery und empowerment. All three groups develop an anthropological understanding of psychoses and knowledge about how to deal with acute crises. These results support a further establishment of psychosis-seminars in the psychosocial healthcare system		
References			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	INTERNATIONAL PERSPECTIVES ON ASSERTIVE COMMUNITY TREATMENT			
Chairperson	Dr Helen Killaspy, University College London and Chair, Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists			
Co-chairperson	Professor Alan Rosen, Senior Consultant Psychiatrist, University of Newcastle, Professorial Fellow, University of Wollongong, Clinical Associate Professor, University of Sydney, Australia alanrosen@med.usyd.edu.au			
Abstract	Background - Assertive Community Treatment (ACT) is a form of intensive case management for people with serious mental health problems who are high users of inpatient care and have difficulties engaging with standard community case management. There international evidence base for ACT is strong, but in some European countries, notably the UK, studies have failed to replicate the international findings. Goals- This session will include presentations from experts in ACT from the UK, Australia and Spain who will describe the implementation of ACT in their country and give an interpretation of the international evidence for ACT from their perspective Importance – ACT is an international model of care that has been widely implemented but has inconsistent findings for its efficacy in different countries Interest to the congress participants – this session is likely to be of interest to most conference participants			
References				
Speakers	1.Dr Helen Killaspy, Reader and Honorary Consultant in Rehabilitation Psychiatry, University College London, Chair, Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists h.killaspy@ucl.ac.uk – 2.Associate Professor Carol Harvey, University of Melbourne, c.harvey@unimelb.edu.au - 3.Dr Juan Jose Martinez-Jambrina, Consultant Psychiatrist, Aviles, Spain jjmjambrina@gmail.com			
Contact:	Dr Helen Killaspy, Reader and Honorary Consultant in Rehabilitation Psychiatry, Mental Health Sciences Unit, University College London, 67-73 Riding House Street, London, W1W 7EJ, UK. Tel 0044 207 679 9710, email: h.killaspy@ucl.ac.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	Assertive Community Treatment - the UK perspective			
Speaker	Dr Helen Killaspy, Reader in Rehabilitation Psychiatry, University College London			
Abstract	Objective - Assertive Community Treatment (ACT) is an internationally recognised, well defined form of intensive case management for people with serious mental health problems who are high users of inpatient care and have difficulties engaging with standard community case management. The international evidence base for ACT is strong, but in some European countries, notably the UK, studies have failed to replicate the international findings. This presentation will provide an overview of the history of implementation of ACT in the UK and the evidence for its effectiveness. Methods – review of trials evaluating intensive case management and ACT in the UK. Results –trials of intensive case management and ACT carried out in the UK have not found it to be as clinically or cost-effective as those carried out in the US and Australia in terms of reducing the need for inpatient admission and improving other clinical outcomes. However, many ACT teams in the UK failed to deliver components of the model that were later found to be “critical ingredients”. In addition, unlike comparison services in some of the early US studies, the comparison services in the UK trials were provided by community mental health teams that already delivered some of these “critical ingredients”. Furthermore, the admission threshold in the cities where the UK trials were carried out was probably			

	considerably higher than in some of the US trials. For these reasons, interpretation and comparison of results from ACT studies internationally is complex. Conclusions – given the economic climate in the UK, the evidence has been interpreted to justify devolution of ACT teams. Some have closed, others have had their staff absorbed into community mental health teams, and others are attempting to deliver a more diluted version of the ACT model. The result is that many service users have no access to the components of ACT associated with better clinical outcomes. Researchers need to communicate to policy makers and service planners a more refined understanding of the evidence relating to ACT, taking into account the service context within which it is delivered. Further research on hybrid models of ACT that respond to different socioeconomic contexts is required.
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Assertive Community Treatment - the Australian perspective			
Speaker	Dr Carol Harvey, Associate Professor in Psychiatry, Psychosocial Research Centre, Department of Psychiatry, University of Melbourne, Melbourne			
Abstract	Objectives: Assertive Community Treatment (ACT) is an internationally recognised, well defined form of intensive case management for people with severe mental health problems who are high users of inpatient care and have difficulties engaging with standard community case management. The international evidence for the efficacy of ACT is strong. Early US trials of ACT were successfully replicated in Australia with good clinical outcomes. This presentation will provide an overview of the history of implementation of ACT in Australia, the evidence for its effectiveness and the current status of this model of service delivery in Australia. Methods: Review of trials evaluating ACT and intensive case management in Australia. Results: Fewer studies of ACT and intensive case management have been carried out in Australia than in the USA and Europe. However, the early Australian trial and subsequent evaluations of ACT reported a number of positive outcomes including reduced hospital admissions and length of stay as well as improved functioning. Less positive findings from recent ACT studies conducted in the UK have highlighted the complexities in interpreting the evolving international evidence. A comparison of ACT implementation between Melbourne, Australia and London, UK underscored this, suggesting that the London ACT teams failed to deliver “critical ingredients” of the ACT model. Recent trials of ACT within the Asia Pacific region have been conducted outside Australia. Conclusions: There was early implementation of ACT in many Australian states and territories from the mid-1980s which was supported by evidence-informed policy. Although Australia has been relatively unaffected by the global financial crisis, funding for mental health services has not kept pace with demand. ACT teams continue to be established and maintained in some states and territories. However elsewhere, in an attempt to respond to growing service demands and a perceived failure of standard community case management, well-established teams have been “integrated” with community mental health teams. Within these integrated teams, critical ACT ingredients have been replicated to varying extents resulting in “diluted” versions of the ACT model which have not been rigorously evaluated. Drawing on Australian experience, ACT is being introduced in the Asia Pacific region in standard and hybrid forms, the latter for complex economic and socio-cultural reasons. Further research on hybrid models of ACT that respond to different socioeconomic and cultural contexts is urgently required			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Assertive Community Treatment - the Spanish model			
Speaker	Dr Juan José Martínez Jambrina. Psychiatrist. Director of Mental Health Service. San Agustín Hospital, Avilés, Asturias. Spain			
Abstract	Objectives: Assertive Community Treatment (ACT) is an internationally recognised, well defined form of intensive outreach for people with the most severe mental health problems who are high users of inpatient care and have difficulties engaging with standard community care. The international evidence for the efficacy of ACT is strong. Early US trials of ACT were successfully replicated in Spain with good results. This presentation will provide an overview of the history of implementation of ACT in Spain, the evidence for its effectiveness and the current status of this model of service delivery in our country. Methods: Review of trials evaluating ACT in Spain. Results: Fewer studies of ACT and intensive case management have been carried out in Spain than in the USA and Europe. However, the early Spanish trial developed in Avilés and subsequent evaluations of ACT teams reported an important number of positive outcomes including reduced hospital admissions and length of stay as well as improved functioning. Less positive findings from recent ACT studies conducted in the UK have highlighted the complexities in interpreting the evolving international evidence. A comparison of ACT implementation between Spanish, British and Dutch models is made, suggesting that the London ACT teams failed to deliver “critical ingredients” of the ACT model and that Spanish and Dutch models have interesting points of view. Conclusions: The Avilés ACT team was the first one developed in Spain (1999). Spain has been severely affected by the global financial crisis and funding for mental health services has not kept pace with demand. Surprisingly, ACT teams continue to be established and maintained in some communities. There are 30 ACT teams working in Spain currently. Most of them have integrated critical ACT ingredients resulting in “diluted” versions of the ACT model which have not been rigorously evaluated. Further research on hybrid models of ACT that respond to different socioeconomic and cultural contexts is urgently required. The Dutch model may be a good proposal to discuss			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	MENTAL HEALTH CARE IN DEVELOPING COUNTRIES - PERSPECTIVE FROM INDIA			
Chairperson	R.K.Chadda, Professor of Psychiatry All India Institute of Medical Sciences New Delhi 110029, India			
Co-chairperson				
Abstract	Mental disorders impose a massive burden in the society. Most of the developing countries face huge burden of the mental health problems with limited resources. India has taken a number of initiatives in this direction, which will be discussed in the symposium. Prevalence estimates for mental disorders in India range between 5.82 to 7.3%, translating to a population of about 70 million. There is a gross deficiency of the manpower. Number of psychiatrists, psychologists, psychiatric social workers and psychiatric nurses is estimated at 2, 0.03, 0.03 and 0.05 per 100,000 of the population respectively. The Indian Government has taken a number of initiatives in the last 30 years. The National Mental Health Programme (NMHP) was initiated in India in 1982, aimed at ensuring availability and accessibility of minimum mental health care for all, integration of mental health into general health care and community participation. Its extension, the District Mental Health Programme (DMHP), initiated in 1996 currently covers about one fifth of the country. The Government has also recently initiated dedicated manpower development schemes, aiming at increasing the training capacity in psychiatry, clinical psychology, psychiatric social work and psychiatric nursing. Centers of excellence in mental health have also been set up in the field of mental health by upgrading and strengthening identified existing mental health hospitals/institutes. There are also initiatives taken by the Non-Government Organisations, but still much needs to be achieved. Further initiatives need to be initiated which is not only community based, but also run by community participation			
References	• Chadda RK (2012) Six decades of community psychiatry in India. International Psychiatry, 9, 45-47 • Murthy RS (2011) Mental health initiatives in India (1947–2010). National Medical Journal of India, 24: 98-107.			
Speakers	Prof SK Khandelwal Prof Rakesh Chadda Prof Pratap Sharan Prof BS Chavan Prof JK Trivedi			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Current mental health needs			
Speaker	SK Khandelwal, Professor of Psychiatry, All India Institute of Medical Sciences, New Delhi 110029, India			
Abstract	Some important research studies, Global Burden of Diseases, World Mental Health Atlas, World Health Report 2001 and others, in last two decades have brought a few important messages regarding mental health development, including services, policies, and investments, for all developed and developing countries. The burden of diseases experienced globally on account of mental and neurological disorders has been huge, and is second only to the cardiovascular disorders. This burden is likely to increase in each successive decade, and by 2025 is likely to be around 15 percent. The consequences of this burden is going to be felt more acutely in developing countries as these are least prepared to handle it. The mental health professionals and facilities to provide mental health care is woefully inadequate in most of the developing world. Unfortunately, there are no adequate mental health programmes or policies in developing countries to prepare themselves with the impending increase burden. Severe mental illnesses cause irreparable damage to the intrinsic abilities of human mind causing severe impairment of all functions. The health budget and mental health budget in particular of most of the countries are grossly inadequate. For example, India spends only 1 percent of its GDP on health, and the share of mental			

	health is 0.06. Most of the expenses on health care is born by people, to the tune of 80 percent, out of their pockets, pushing people in to further poverty. If the governments in developing countries wish to look after the health and mental health of their citizens, they should make adequate provisions for development of mental health services, infrastructure, policies and programmes. It makes a huge sense in investing in mental health.
References	

Session:	Symposium	SPEAKER 2	Code
Title:	Existing Mental Health Resources in India		
Speaker	R.K.Chadda, Professor of Psychiatry All India Institute of Medical Sciences New Delhi 110029, India		
Abstract	Mental health resources in India are grossly inadequate in comparison to the needs. India has a vast population about 1.21 billion. As per the World Mental Health Atlas, 2011, India has about 0.301 psychiatrists, 0.047 clinical psychologists, 0.166 psychiatric nurses and 0.033 social workers per 100,000 of the population. There are about 10, 000 psychiatric beds available in general hospitals and 17, 835 beds in for mental health services, about 20,000 in psychiatric hospitals. Facilities of office based psychiatric practice are also available, largely in private sector, with roughly 2000-2500 psychiatrists providing the services. A number of non-governmental organisations (NGOs) are also providing mental health care services in form of community clinics, crisis intervention services, suicide prevention services, and rehabilitation services. However, one of the limitation is concentration of the mental health resources in and around the big cities. Some of the Indian states especially the hill states of Uttarakhand, Jammu & Kashmir, Himachal Pradesh, North Eastern India. The National Mental Health programme has been conducting short term sensitisation programmes for the primary care physicians for more than 2 decades, who also form an important resource for providing mental health care services in the primary care settings. Practitioners from the alternative systems of medicine like Ayurveda, Homeopathy, Unani system of medicine and Siddha, and indigenous and religious healers are also accessed by the patients with mental health problems. Studies have shown 60-75% of the patients with mental health problems access these sources of help at different times during the course of their illness. The facilities are, however, grossly inadequate considering the enormous population with mental health problems.		
References	• Chadda RK (2012) Six decades of community psychiatry in India. International Psychiatry, 9, 45-47 • Mishra N, Nagpal SS, Chadda RK, Sood M (2011). Help-seeking behavior of patients with mental health problems visiting a tertiary care center in North India. Indian Journal of Psychiatry; 53: 234-8 • Mental Health Atlas 2011 - Department of Mental Health and Substance Abuse, World Health Organization		

Session:	Symposium	SPEAKER 3	Code
Title:	National Mental Health Programme		
Speaker	Pratap Sharan, Professor, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi		
Abstract	The National Mental Health Programme was launched in 1982 with the objectives of: ensuring the availability and accessibility of minimum mental healthcare for all, particularly to the most vulnerable and underprivileged sections of the population, in the foreseeable future; (ii) encouraging the application of mental health knowledge in general healthcare and in social development; and (iii) promoting community participation in the development of mental health services and to stimulate efforts towards self-help in the community. The approaches advocated were: diffusion of mental health skills to general health care system; appropriate apportionment of tasks in mental healthcare; and integration of basic mental healthcare into general health services and linkage to community development and mental healthcare. Progress occurred in terms of integration of mental health care with primary healthcare through the district mental health programme (DMHP) that now covers about one fifth of districts in India. Other developments included strengthening of general psychiatry units and human resources and reorientation of mental hospitals.		

	A re-strategized NMHP was launched in 2003. The programme comprised 5 strategic components that included redesigning the DMHP around nodal institutions; strengthening medical colleges with a view to develop psychiatric manpower and general hospital psychiatry; transforming mental hospitals into becoming leaders for community mental health; strengthening central and state mental health governance; and research and training to support public mental health. During the plan period 2007-2013, there was a substantial increase in the funding support for the NMHP especially for the manpower development. Also, efforts at integrating the NMHP with the National Rural Health Mission (NRHM) were initiated. The NMHP has made some progress but has been criticized for lacking effectiveness, for having a top-down approach; for apparently being disconnected with cultural realities of India; and for inadequate involvement of the community. There is clearly a need for much progress in widening the scope and cultural specificity of mental health interventions, and increasing the involvement of all available community stakeholders
References	

Session:	Symposium	SPEAKER 4	Code
Title:	Mental Health Care from Developing Countries: Perspective from India		
Speaker	BS Chavan. Professor and Head of Psychiatry. Govt Medical College Chandigarh, India		
Abstract	Prior to formulation of National Mental Health Programme (1982), major focus of Govt of India (GOI) was setting up mental hospitals in 1950's and 1960's and little later promoting general hospital psychiatry units in 1960's and 1970's. The next big and laudable initiative was to integrate mental health into General health by enacting NMHP (1982) with the objectives of ensuring availability and accessibility of minimum mental health care for all , particularly to the most vulnerable and underprivileged sections of population and for promoting community participation in the mental health services development and to stimulate efforts towards self-help in the community. During last two decades, GOI re- strategised its initiatives and focused on reaching out larger number of patients in far flung rural areas through launch of District Mental Health Programme (DMHP). The DMHP components include early detection and treatment of patients within the community, reduction of stigma attached towards mental illness through change of attitude and public education, to treat and rehabilitate mental patients discharged from the mental hospital within the community , shifting focus and take off burden from Mental Hospitals, and training in basic mental health care of all the personnel at primary health care. Another major initiative by the GOI has been to accord high priority to manpower development in mental health through strengthening the department of psychiatry in medical colleges, setting up centres of excellence (COE) for developing manpower in psychiatry, clinical psychology, psychiatry social work and psychiatry nursing, and upgradation of mental hospitals. GOI is providing funding for building infrastructure , purchase of equipment and hiring faculty. For the first time GOI has come up with Mental Health Policy for the country which is expected to give direction to future development and implementation of comprehensive facilities in mental health. The Mental Health Act (1987) is being replaced with Mental Health Care Bill (2012) with a focus on protection of human rights of persons with mental illness, rehabilitation and commitment to provide mental health facilities to everybody through public health facilities. The GOI has also initiated efforts to design community based mental health model and MOU has been signed with Melbourne University for field testing four different mental health models. These bold initiatives by GOI are expected to bring out a perceptible change in the care of persons with mental disorders.		
References			

Session:	Symposium	SPEAKER 5	Code	
Title:	Challenges ahead and proposed strategies			
Speaker	J.K Trivedi. Professor, 2. Assistant Professor, Department of Psychiatry, King George's Medical University, Lucknow, UP, India			
Abstract	It is widely identified that the high burden of mental disorders, shortage of trained mental health professionals and need to integrate mental health care through the primary health care system are key impact areas acknowledged in mental health care delivery by all national/international programs. Several cost-effective and evidence based strategies have been shown to improve outcome and reduce the disability associated with mental disorders and substance abuse. However, delivery of mental health services in resource poor settings lags unacceptably and unjustly behind services for many other non-communicable diseases. The fraction of those affected who receive appropriate treatment remains alarmingly low. Community psychiatry, empowerment of primary health care centers, involvement of nonmedical community health workers in delivery of mental health care and enhanced training and teaching of the medical graduates are commonly voiced strategies to deal with such wide treatment gap. However, lot of the limitations have been identified and experienced during implementation at ground level. Leadership from politicians, administrators, health and mental health professionals is crucial. Educating the population about mental illness using the mass media will reduce the stigma and increase the demand for services. Users, families, interest groups, health professionals and scientists should come together with the single aim of improved service provision for future transformation. Improving primary health care system in general, restructuring medical and nursing education and simplifying psychiatric training for non-specialist are urgently needed.			
References	WHO World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. JAMA 2004; 291: 2581–90 2. Jacob K S. Repackaging mental health programs in low- and middle-income countries. Indian J Psychiatry, 2011;53:195-8 3. Patel V, Goel DS and Desai R. Scaling up services for mental and neurological disorders in low-resource settings. Int Health. 2009; 1(1): 37–44.			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	WPA CROSS-SECTIONAL SYMPOSIUM MENTAL HEALTH AND WORK ENVIRONMENT			
Chairperson	M. Sadre-Chirazi-Stark, Asklepios Westklinikum			
Co-chairperson	M. Amering, Chairwomen of the WPA section			
Abstract	In industrial countries the burn-out wave is sweeping through the media. Also the health insurance companies report a dramatic rise of call of illness because of depression and anxiety which might be the psychiatric diagnostic equivalent of the burn-out syndrome. This symposium will raise awareness on this problem. It will discuss various objectives such as diagnostic definitions of burnout, socioeconomic pressures, and the role of workplace hierarchical structures			
References				
Speakers	Prof. Rataemane; Prof. Amaddeo, Dr. Rossouw, Dr. Ebert, Prof. Kallivayallil, Prof. Amering			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Managing workplace stress in the south african context: application of conflict management strategies			
Speaker	S. Rataemane, University of Limpopo (MEDUNSA) Pretoria, South Africa			
Abstract				
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	The prevalence of burnout and depression among medical doctors working in the cape town metropole community health care clinics and district hospitals of the provincial government of the western cape: a cross-sectional study			
Speaker	L. Rossouw ¹ , & S. Seedat ² , ¹ Division Family Medicine & Primary Care, University of Stellenbosch ² Department Psychiatry, University of Stellenbosch, South Africa			
Abstract				
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services			
Speaker	G. Cetrano, & F. Amaddeo, Department of Public Health and Community Medicine, Section of Psychiatry, University of Verona, Verona, Italy			
Abstract				
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	INTERNET-BASED PREVENTION OF MENTAL HEALTH DISORDERS IN EMPLOYEES - RESULTS FROM A RANDOMIZED CONTROLLED TRIAL			
Speaker	D.D: Ebert, Leuphana University Lueneburg, Germany			
Abstract				
References				

Session:	Symposium	SPEAKER 5	Code	
Title:	Mental Health and Work Environment: Preventive Aspects			
Speaker	R. Kallivayalil, Chairman of the WPA section			
Abstract	It is very important that the work environment fosters mental health. It leads to increased productivity, job satisfaction, contentment and peace and collegiality at the work place. Psychological support, civility and respect, recognition and reward, psychological and physical protection are essential. An efficient and caring leadership will be most helpful. It is also worthwhile to find the 'psychological fitness' of employees before employment. Some other issues which affect mental health at workplace are stigma and discrimination, job burnout, harassment, bullying or violence, or substance use. These issues should be addressed to prevent mental ill health.			
References				

Session:	Symposium	SPEAKER 5	Code	
Title:	COMMENTS OF THE WPA SECTION OF PREVENTIVE PSYCHIATRY			
Speaker	M. Amering, Chairwomen of the WPA section			
Abstract				
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	MENTAL HEALTH CARE THE WEB AND SOCIAL MEDIA - FACING A PUBLIC HEALTH THREAT			
Chairperson	R.M.Krausz, University of British Columbia (UBC), Vancouver, Canada			
Co-chairperson	M. Schaub, University Zurich, Institute of Addiction and Public Health Research			
Abstract	Background: Only every 10th mental health client is seeing a specialist for treatment, only a third of all mental health clients were getting basic care according to the national comorbidity survey in the US. The gap between necessary capacities in mental health care and available services is one of the biggest international public health threats. It will be impossible to address this with the current structures and resources. Over the last years more websites and programs came up with solutions for mentally ill especially offering information and access to communication. Objectives: We want to present upcoming solutions in the web and the necessary paradigm shift for the structure of Mental Health services integrating online opportunities. We want to start the dialogue in Socialpsychiatry about future solutions to build necessary capacities. Goals: The web and social media provide the opportunity of a paradigm shift and new opportunities to serve mentally challenged individuals. We want to raise awareness about this opportunity to shape the future of Psychiatry. Special opportunity: To learn about an upcoming area of health care delivery and communication and its role in future Psychiatry.			
References				
Speakers	1. Reinhard Michael Krausz (Vancouver, Canada, M.Krausz@mac.com) 2. Christian Schuetz (Vancouver, Canada, schutzc@mail.ubc.ca) 3. Michael Schaub (Zurich, Switzerland, michael.schaub@isgf.uzh.ch) 4. Majid Aldesouki (Riyadh, maldesouki@ksu.edu.sa)			
Contact:	Michael Krausz MD, PhD, FRCPC UBC-Providence Leadership Chair for Addiction Research Director Addiction Psychiatry Institute of Mental Health at UBC David Strangway Building 5950 University Boulevard Vancouver, BC V6T 1Z3 mkrausz@mail.ubc.ca			

Session:	Symposium	SPEAKER 1	Code	
Title:	Health care of the future – ready for a paradigm shift in Mental Health?			
Speaker	Reinhard Michael Krausz (Vancouver, Canada, M.Krausz@mac.com)			
Abstract	Background: The web and social media are changing our communication. Especially young people are networking through changing social platform, contact peers or acquire information and resources. From a mental health perspective young people are a very important target group, which are complicated to reach. For any effective approach in the future the development of effective programs using the possibilities of the web is key. Only 10% of challenged kids ever see a specialist. In rural areas and even a lot of cities it's extremely complicated to access any support. Web based health care: Already today Internet based solutions contribute to mental health care. Everybody is using the web as information hub. We will present examples, which are showing possible directions in the coming years. Paradigm shift in mental health: Mental health care is the area in medicine, which could benefit the most from web based services, social media and new communication. Initiating a dynamic of dialogue about possible, feasible and available solutions, more inclusive and user driven than ever before and building on the dialogue between people with lived experiences, families as well as peers and professionals. That could trigger a reorganization based on empowerment and create more capacity and access to care.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Online interventions for tobacco cessation			
Speaker	Christian Schuetz (Vancouver, Canada, schutzc@mail.ubc.ca)			
Abstract	Smoking continues to be the psychiatric disorder with the highest prevalence and the highest public health impact. Tobacco is responsible for almost 20% of all deaths and it is preventable. Tobacco users have the highest risk to develop dependence among users and it has the youngest age of onset among all substances of abuse. It thus constitutes possible more of a gateway drug than other substances. The Internet is becoming increasingly the main vehicle for spread of information and it increasingly discussed as a vehicle for interventions and web-based treatments can deliver broad reaching, relatively inexpensive, and clinically tested methods for smoking cessation The presentation will focus on various online tools and emerging possibilities. While Internet based interventions may assist online users with methods and strategies to quit smoking, there are some limitations in the efficacy of the currently available interventions			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Internet based therapies for drug addiction			
Speaker	Michael P. Schaub, Swiss Research Institute for Public Health and Addiction, Zurich, Switzerland, michael.schaub@isgf.uzh.ch			
Abstract	Objective: To provide an update on Internet based therapies for drug addiction conducted, identify its strengths, limitations, and to define the next steps for further improvement for such interventions. Methods: The detailed results and limitations of the currently available online intervention studies aiming at the reduction and/or cessation of problematic cannabis or cocaine use will be presented and compared to Internet based therapy studies for tobacco smoking cessation and controlled drinking. Results: The current available data among randomized controlled online intervention studies provides mixed results on the effectiveness of the reduction of substance use in problematic drug users. So far, the more interactive interventions based on motivational interviewing, cognitive-behavioral therapy approaches, and principles of self control seem most promising for the reduction of substance use in problematic drug users. Those drug users with higher depression symptoms and less pronounced severity of addiction symptoms can profit most of such interventions. Chat counseling sessions based on motivational interviewing have not yet been integrated to online self-help interventions for problematic drug users, a method that has been demonstrated to be promising in studies for controlled drinking in problematic alcohol users. There are currently no studies on the integration of Internet based therapy approaches to conventional face-to-face addiction therapies. Conclusion: Future studies should try to integrate anonymous chat sessions based on motivational interviewing and include at least some therapy modules for the reduction of depression symptoms to improve retention and potentially also study effectiveness. There is a strong need for studies investigating the integration of Internet based therapy interventions into face-to-face addiction therapies.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Implementing E-Health initiatives, “why things may go wrong”			
Speaker	Majid Aldesouki (Riyadh, maldesouki@ksu.edu.sa)			
Abstract	The use of information technology has become essential for the practice of medicine. Implementation of such technologies is not always so simple, as is the case for E-Health strategies. A major concern is developing a service, which facilitates sustained adoption by consumers, and this is where many initiatives fail. This talk will brush upon the challenges and obstacles that face E-Health initiatives, and try to shed some light on why many times they cannot even demonstrate their proposed benefits			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	I FIGHT DEPRESSION – USING THE INTERNET TO ENHANCE AWARENESS AND SELF-MANAGEMENT CAPACITY FOR DEPRESSION			
Chairperson	Ricardo Gusmão Universidade Nova de Lisboa, Portugal			
Co-chairperson				
Abstract	By the year 2020, depression is set to take 2nd place in the ranking of Disability Adjusted Life Years (DALYs) for all ages and both sexes. Already unipolar depression ranks first when considering the index “years lived with disability” (YLD) in high income countries (Collins et al., 2011). At the same time for various reasons only a minority of patients receive treatment according to established guidelines. Internet-based interventions could be a cost-effective approach to reduce therapeutic deficits. The internet and modern information and communication technologies offer new ways in targeting mental health. Millions of people access the internet each year for health-related information and more users search for information on depression than any other condition. However, despite growing evidence endorsing the effectiveness of online interventions such as self-help programs based on cognitive-behavioural therapy techniques, a major challenge is participants’ adherence to these interventions. Also, the adoption of internet-based interventions targeting depression is still limited in many countries. The symposium aims to give an overview about internet-based self-management of depression and to introduce the iFightDepression online intervention and awareness website developed in the current EC funded project Preventing Depression and Improving Awareness through Networking in the EU (PREDI-NU). After outlining the state of the art regarding world-wide efforts on internet-based self-management of depression and one successful example from Germany, the comprehensive literature review that delivered the evidence base for the iFightDepression – tool, the programme itself and the multilingual and multifaceted website in which it is embedded will be presented. Both components form part of the European collaborative effort to examine the acceptability and			
References				
Speakers	1. S. Kutcher Dalhousie University and the IWK Health Center, Halifax, Canada 2. C. Rummel-Kluge. University of Leipzig,, Leipzig, Germany 3. M. Maxwell University of Stirling, Stirling, UK 4. N. Koburger. University of Leipzig , Department of Psychiatry and Psychotherapy , Leipzig , Germany 5. R.Gusmão CEDOC Universidade Nova de Lisboa, Lisbon, Portugal			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	On-line based self-management of depression in young people: state of the art			
Speaker	Educational Objectives: Based on the Wagner Chronic Disease Care Model, participants will learn about various approaches and various tools available to address self-management of Depression in youth. Purpose: To provide attendees with an over-view of current concepts pertaining to on-line self-management of Depression in youth. To provide attendees with an over-view of on-line tools pertaining to Depression in youth. Methods: We searched literature and electronic databases to identify various approaches and tools pertaining to on line self-management of Depression in youth. Results: These clustered into the following categories: General self-help and wellness enhancement; Psychological interventions for treatment; Self-monitoring of symptoms and outcomes; Self-monitoring			

	of medications. In each category we identified key tools and have created synthesis of information about each tool identified. We will present these syntheses. Conclusions: A number of potentially useful on-line self-management tools for Depression in youth exist. They all have various strengths and weaknesses. Overall, some are ready for wider clinical application but much more research and development is yet needed
Abstract	
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Results from a German online forum for depression			
Speaker	Educational Objectives: At the conclusion of this presentation, the participants should be able to see that using the moderated online discussion forum for depression can contribute to coping with the illness. Purpose: To evaluate if a moderated online discussion forum for depression is used by people with depression and if this forum can contribute to dealing with depression. Methods: The discussion forum depression for patients and relatives was developed in 2002 within the 'Kompetenznetz Depression, Suizidalität' and is now being operated by its successor, the 'Stiftung Deutsche Depressionshilfe'. Since the opening of the forum more than 300.000 postings from more than 14 000 registered users were written. Diagnosis and treatment status were analyzed within a subgroup of users. Results: The vast majority of participants received the diagnosis depression, and more then 1/3 of the respondents suffered currently from a depressive episode. Frequent comorbid disorders were phobic disorders and somatoform disorders. Within the analyzed subgroup, over 90% had been treated as outpatients, and over 60% as inpatients. The respondents stated that their trust in medical treatment was raised and that they were encouraged to seek professional help. Furthermore, about one third of the interviewed participants rated their attitudes towards the treatment with medication more positive than before being a member in the discussion forum. Conclusions: The online depression forum is reaching the intended group, namely people with depression and their relatives, and is being used in addition to professional psychiatric care. Taking part in the forum is positively influencing the acceptance of and the coping with the illness. Future analyses will include specific subgroups such as high/low-users, different age groups and gender differences as well as linguistic analyses			
Abstract				
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	A realist synthesis for evidence based implementation of internet based self help interventions			
Speaker	M. Maxwell. University of Stirling, Stirling, UK			
Abstract	Educational Objectives: Evidence from meta and systematic reviews has demonstrated that computerised cognitive behavioural therapy (cCBT) interventions are effective treatments for anxiety and depression. However, besides			

	evidence of effectiveness, there is little knowledge to guide the development and delivery (implementation) of such interventions. This presentation will inform on best practice for implementation. Purpose: The aim of the study was to identify best practice recommendations for the implementation of self-management e-health technologies, and key processes involved in implementing these interventions in terms of what works, for whom and in what circumstances. Methods: Informed by the Realist approach (Pawson, 2002), the realist review is a technique for synthesising data on complex interventions that situates questions of ‘effectiveness’ within broader literature in order to answer the question: ‘What works, for whom and in what context’. Steps included: specifying PICOs, inclusion/exclusion criteria; developing search strategies, systematic searching; screening, selection and critical appraisal of literature; and data extraction & synthesis of literature produced between January 1990-December 2011. Results: There were 58 included papers ranging from systematic reviews to guidelines and qualitative studies. What works?: purely self-guided cCBT only works if individuals are self-motivated; interventions with some level of support are more effective; there is no clear evidence on guidance (optimal length, content, type of guidance, or type of professional required). For whom does cCBT work better?: women; mild to moderate depression; self-selecting/media-recruited people; existing depressive symptoms; well-educated, and computer literate. Under what circumstances does cCBT work better?: more engagement with the material & tasks; prior belief/expectancy that it will reduce depression. Further recommendations for improving implementation and adherence will also be presented. Conclusions: A realist synthesis of the literature has revealed some evidence for what works in cCBT implementation but greater attention should be paid to reporting implementation issues when reporting clinical trials.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	The predi-nu online intervention: a self-management program based on best practice and expert consensus for adolescents and adults with mild to moderate depression			
Speaker	N. Koburger. University of Leipzig , Department of Psychiatry and Psychotherapy , Leipzig , Germany			
Abstract	Educational Objectives: At the conclusion of this presentation the participants should have a basic understanding of the aims and structure of 1) the Predi-Nu project and 2) the iFightDepression internet-based self-management tool and its implementation as a guided online self-help intervention. Purpose: The purpose of the iFightDepression self management tool is to offer a free, guided self-help intervention in multiple languages for patients with milder forms of depression. Methods: The iFightDepression self-management tool was developed based on a literature review and best practice examples as well as expert advice. In a first step, 58 papers were examined in relation to existing evidence concerning best practice for the development and implementation of computerised cognitive behavioural therapy interventions. At the same time, existing interventions and websites were explored systematically to assess core components and implementation guidance. Then, a first outline for the iFightDepression – Tool was prepared in two versions: for adolescents and younger adults (15-24 years) and adults (25 years and older). The tool contents are consecutively improved and consented by the Predi-Nu project consortium and a broader group of external experts, including representatives from patient and family organisations. The iFightDepression – Tool is available in five European languages and tested for acceptability and feasibility in a pilot study. Results: The iFightDepression self-management tool comprises six core modules as well as target group specific additional modules, printable worksheets, help addresses and a mood rating. The patients using the tool			

	are to determine their personal pace and the order of the modules. For maximising their benefit from the tool, they are provided with recommendations for using it and guided by trained general practitioners, psychotherapists and other mental health professionals. Conclusions: Within the Predi-Nu project, an evidence-based, internationally consented self-management tool (iFightDepression) for patients with milder forms of depression was developed. A pilot study is exploring the acceptability and feasibility of the tool, which will be optimised and further implemented in a second study phase of the Predi-Nu project
References	

Session:	Symposium	SPEAKER 5	Code	
Title:	Ifightdepression.com – an international awareness website for depression			
Speaker	R.Gusmão CEDOC Universidade Nova de Lisboa, Lisbon, Portugal			
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should be able to acknowledge the importance of e-health in improving awareness of depression and suicidal behaviours, reducing stigma, empowering people and improving access to effective care. Purpose: The iFightDepression.com website was setup to become a developable, flexible and sustainable ICT platform in order to meet the needs of average internet users for depression information, the needs of other target audiences, and the needs for light and moderate depression self-management, in eight different languages. Methods: A collaborative work was organized to address the major components within the 3 years of the project: conceptualization and website design, building the self-help tool, developing contents, and programming. To review depression focused websites and CBT interventions through the internet were key steps in the process. Results: A brand – the iFightDepression.com domain and logo – with which the general public could identify in a very genuine and spontaneous manner, a visible, accessible, highly-usable and attractive website, with evidence-based and best practise contents supported by written, graphic and video materials were important deliverables. An information architecture and awareness website structure were developed targeting to capture the attention of the general public but with a communication potential for the several profiles that the consortium deemed necessary to reach through five main tabs/profiles: “For All” includes general information about depression, “For Young People” takes in account teen behaviour and youth specificities, “For Families & Friends” informs family and informal carers on the best identification and management strategies, “For Community Professionals” includes information for gatekeepers such as teachers, pharmacists, police forces, religious agents, media, social workers, etc., and “For Health Professionals” displaying case studies and support materials and a restricted area with clinical tools and training materials. Cross-contents are always present, such as FAQ or the “Self-management programme” including psychoeducational materials and the self-management tool. Conclusions: The website seems to address the needs for E-Awareness and E-Self-management and to reach the audiences set by the consortium. In the future, an E-Learning and E-Referral modules can be developed as well as interactive tools both for patients and family, through monitored chat and blog, and health and community professionals through a forum where to leave questions and obtain specialized answers. This will reinforce sustainability, which along with making available financing to maintain and actualize contents, will be the future challenges for this project after its end, in August 2014			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	ADDICTION AMONG VULNERABLE URBAN POPULATIONS			
Chairperson	R.M.Krausz, University of British Columbia (UBC), Vancouver			
Co-chairperson	Andrej Kastelic, National Center for the Treatment of Drug Addiction, Ljubljana			
Abstract	Background: The prevalence of addiction, physical challenges, trauma and mental illness are not equally distributed. Especially in our growing cities worldwide vulnerable individuals are marginalized and shift to specific neighbourhoods, with high morbidity and mortality rates and little access to care. The use of psychotropic substances is of special importance to these vulnerable urban populations like homeless, women in survival sex trade and prisoners. Together with partners in other services Psychiatry needs to play a proactive role to address those downward spirals. Goals: We want to present and discuss this critical challenge for our mental health system and propose to develop a strategy to reposition Psychiatry especially in the areas of Addiction and Social Psychiatry Objectives: What are specific needs of vulnerable urban populations and who is looking after them today? How to improve care for marginalized mentally ill in the community? Special opportunity: This symposium will offer an opportunity to overcome the existing fragmentation between service and research areas addressing the most vulnerable and most neglected populations in the system.			
References				
Speakers	1. Andrej Kastelic, Nusa Segrec (Ljubljana, Slovenia, andrej.kastelic@psih-klinika.si) 2. Franceso Bartoli, Ester di Giacomo, Paola Sciarini, Giuseppe Carra M. Clerici (Milan, Italia, maxcin@libero.it) 3. Christian Schuetz (Vancouver, Canada, schutzc@mail.ubc.ca) 4. Reinhard Michael Krausz (Vancouver, Canada, M.Krausz@mac.com)			
Contact:	Michael Krausz MD, PhD, FRCPC UBC-Providence Leadership Chair for Addiction Research Director Addiction Psychiatry Institute of Mental Health at UBC David Strangway Building 5950 University Boulevard Vancouver, BC V6T 1Z3 mkrausz@mail.ubc.ca			

Session:	Symposium	SPEAKER 1	Code	
Title:	Addiction, comorbidities and imprisonment			
Speaker	Andrej Kastelic, Nusa Segrec (Ljubljana, Slovenia, andrej.kastelic@psih-klinika.si)			
Abstract				
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Deprivation in comorbid patients: results of a cross-sectional study in Italian Mental Health Care Trusts			
Speaker	Francesco Bartoli, Ester di Giacomo, Paola Sciarini, Giuseppe Carra M. Clerici (Milan, Italia, maxcin@libero.it)			
Abstract				
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Childhood traumatization, addiction and concurrent disorders among homeless in Canada and a possible therapeutic response			
Speaker	C.G. Schütz MD PhD MPH University of British Columbia, Vancouver, BC, Canada			
Abstract	Aims: Studies have found that the homeless population suffer from high rates of mental disorders and substance use disorders. However, few studies have included psychiatric assessments to elucidate the prevalence and the association of mental disorders with substance use disorders, potential risk factors and its impact on health care utilization in this marginalized population. With individuals suffering from concurrent disorder individuals regularly reporting the highest level of unmet needs the Province of British Columbia responded by opening a 100 bed unit to specifically target this population. Methods: A total of 500 individuals living on the street, or in shelters were recruited from the cities of Vancouver, Victoria and Prince George BC. Standardized assessment instruments, such as the Mini International Neuropsychiatric Interview (M.I.N.I), the Maudsley Addiction Profile (MAP) and childhood trauma questionnaire (CTQ) were employed. Results: Overall mean age was 37.9 (SD: 11.0); 39.2% were female; and 39.8% of aboriginal descent. The lifetime prevalence of mental disorders in this population was extremely high. Only 7.2% reported no current disorders, while a total of 53.8% fulfilled criteria for current concurrent disorders. Concurrent disorders were associated with specific risk factors e.g. childhood traumata. The program targeted to the specific needs of this population will be presented. Conclusions: High levels of childhood traumatisations are associated with high levels of substance use disorders and concurrent psychiatric disorders. A specific approach based on the specific need to treat this population within the context of a 100 bed recovery centre will be delineated.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Psychiatry and the most vulnerable – innovative ways of service integration in the community addressing client needs			
Speaker	Reinhard Michael Krausz (Vancouver, Canada, M.Krausz@mac.com)			
Abstract	Background: The prevalence of addiction is high, its beside mood disorders and anxiety the most common mental illness. The majority of chronic clients and high need patients suffer from addiction and concurrent disorders. But it is not on the agenda of Social Psychiatry. Substance use is stigmatized or ignored in the mental health field, which contributes to ineffective services, lack of training and research. Goals: We want to present and discuss this critical challenge for our mental health system and propose to develop a strategy to reposition Psychiatry especially in the areas of Addiction and Social Psychiatry Objectives: To raise awareness on the importance of an integration of efforts. What are specific needs of vulnerable urban populations and who is looking after them today? How to improve care for marginalized mentally ill in the community? How to shift paradigms in Social Psychiatry? Special opportunity: This symposium will offer an opportunity to overcome the existing fragmentation between service and research areas addressing the most vulnerable and most neglected populations in the system.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	COERCION IN PSYCHIATRY- INTERNATIONAL PERSPECTIVES			
Chairperson	Andrew Molodynski, Oxford Health NHS Trust and Oxford University Department of Psychiatry, Oxford, UK.			
Co-chairperson				
Abstract	Coercion in psychiatry has always been a hotly debated yet poorly understood area. With the progressive deinstitutionalisation of psychiatric care in High Income Group countries and the increasing provision of care in Low and Middle Income Group countries the issues are changing and also becoming of wider relevance. In recent years there has been increasing focus on the issue of coercion from various perspectives. This symposium draws together empirical evidence, ethical principles and realities, and the emerging work of the WASP international task force on coercion in an attempt to bring some clarity in this complex area to the audience.			
References				
Speakers	1. George Szmukler, professor of psychiatry and society, Institute of Psychiatry, London, UK. 2. Daniel Maughan, Oxford Health NHS Trust and Oxford University Department of Psychiatry, UK. 3. Andrew Molodynski, Oxford Health NHS Trust and Oxford University Department of Psychiatry.			
Contact:	Andrew Molodynski, Consultant Psychiatrist and Honorary Senior Lecturer, Oxford Health NHS Trust and Oxford University Department of Psychiatry. Social Psychiatry Group, Warneford Hospital, Headington, Oxford, United Kingdom, OX3 7JX. +441235 799800 Andrew.molodynski@oxfordhealth.nhs.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	‘Article 2 ‘Right to Life’ under the ECHR and its implications for the patient at risk of suicide.			
Speaker	George Szmukler, professor of psychiatry and society, Institute of Psychiatry			
Abstract	Article 2 of the European Convention on Human Rights (ECHR) states that “Everyone’s right to life shall be protected by law”. It imposes an obligation on the state to take reasonable measures when there is a “real and immediate risk to life” to an identified person, aimed at avoiding that risk materialising. In a landmark decision the Supreme Court of the UK ruled that Art. 2 applied to voluntary as well as detained psychiatric inpatients (Rabone v Pennine Care NHS Foundation Trust. The case concerned a young woman admitted to a psychiatric hospital following a number of suicide attempts. After being granted leave for two days to stay with her parents, she committed suicide. Key to the Supreme Court’s decision were the answers to the following questions: is the position of the informal psychiatric patient the same as or different to a medical or surgical patient; or is it closer to the position of an involuntary psychiatric patient? Was there a “real and immediate” risk that should have been known, and reasonable measures that could have been taken to avoid it? I will argue that this judgment is another example of legal discrimination against persons with a mental illness.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Daniel Maughan, Oxford Health NHS Trust and Oxford University Department of Psychiatry, UK.			
Speaker	Coercion and compulsion in community psychiatry- where are we now?			
Abstract	Objectives; Review the historical contexts of coercion and compulsion. Summarise the current evidence on different forms of coercion and compulsion. Results; The literature on coercion has been divided along clinical, legal and ethical lines. The former has examined the effects upon clinical outcomes whereas the others have focused on civil liberties, the role of the state and arguments for and against coercive intervention. There is consensus that many experience their community treatment as coercive and that this varies between communities and mental health systems. There has been difficulty in establishing an evidence base for CTOs. Conclusion; There remains a dearth of research on many aspects of coercion. Sources of coercion vary between high and low income countries and more evidence is needed in low and middle-income countries. There is currently not sufficient evidence to determine the specific clinical, ethical, or service use outcomes of CTOs			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Andrew Molodynski, Oxford Health NHS Trust and Oxford University Department of Psychiatry			
Speaker	Coercion in psychiatry- the work of the WASP international working group			
Abstract	Issues of coercion and compulsion remain central in the care of the severely mentally ill, both in hospital and in the community. The source of coercion appears to vary depending on a number of service and social factors but good quality evidence regarding the experience of the mentally ill and those around them is very scarce outside a small group of wealthy nations (and absent in most). This presentation will focus on what we know regarding these complex issues, what we don't know, and how we may be able to move forwards our understanding, both empirically and in a wider sense over the coming few years.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	FROM RECOVERY TO WELL-BEING AND BACK			
Chairperson	Dr. Mary Leamy, Institute of Psychiatry, King's College London			
Co-chairperson	Dr. Beate Schrank, Institute of Psychiatry, King's College London			
Abstract				
References				
Speakers	1. Dr Mary Leamy, Institute of Psychiatry, King's College London, United Kingdom, mary.leafy@kcl.ac.uk. 'The REFOCUS intervention: the reality of implementing and evaluating recovery-oriented practice'. 2. Ms. Victoria Bird, Institute of Psychiatry, King's College London, United Kingdom, victoria.bird@kcl.ac.uk. 'What recovery means to me? Perspectives on the meaning of recovery for individuals from BAME communities'. 3. Dr. Simon Riches, Institute of Psychiatry, King's College London, United Kingdom, simon.j.riches@kcl.ac.uk. 'The WELLFOCUS study: development and evaluation of an intervention to increase well-being in people with psychosis'. 4. Dr. Beate Shrank, Institute of Psychiatry, King's College London, United Kingdom, beate.schrank@kcl.ac.uk. 'Recovery and well-being: comparing concepts and interventions'.			
Contact:	Dr. Mary Leamy, Institute of Psychiatry, King's College London Programme Co-ordinator and Trial Manager, REFOCUS Programme, Section for Recovery Health Service and Population Research Department, Institute of Psychiatry, King's College London De Crespigny Park, Denmark Hill, London SE5 8AF. Tel: 020 7848 5095 Fax: 027 848 5056 mary.leafy@kcl.ac.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	The REFOCUS intervention: the reality of implementing and evaluating recovery-oriented practice'			
Speaker	1. Dr Mary Leamy, Institute of Psychiatry, King's College London, United Kingdom			
Abstract	- to describe the REFOCUS intervention to promote recovery - to outline preliminary findings from the process evaluation embedded within the cluster randomised controlled trial to validate of the REFOCUS model, underlying the intervention and its implementation			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	What recovery means to me? Perspectives on the meaning of recovery for individuals from BAME communities'			
Speaker	2. Ms. Victoria Bird, Institute of Psychiatry, King's College London, United Kingdom			
Abstract	- to summarise findings from a systematic review and narrative synthesis of the recovery literature to develop a conceptual framework of personal recovery - to present qualitative research findings undertaken to validate the conceptual framework with current service users, including the perspectives of individuals from Black Asian Minority Ethnic communities			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	The WELLFOCUS study: development and evaluation of an intervention to increase well-being in people with psychosis'			
Speaker	Dr. Simon Riches, Institute of Psychiatry, King's College London, United Kingdom			
Abstract	- to describe how Positive Psychotherapy has been adapted specifically for people with psychosis - to present initial findings from the process evaluation on the feasibility and potential usefulness of the adapted intervention, currently being evaluated in a pilot randomised controlled trial			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Recovery and well-being: comparing concepts and interventions'			
Speaker	Dr. Beate Shrank, Institute of Psychiatry, King's College London, United Kingdom			
Abstract	- to outline the concept of well-being and compare it to that of recovery - to address the question of what an intervention to increase well-being can add to a recovery oriented service			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	INTERNATIONAL EXAMPLES OF COMMUNITY REHABILITATION PSYCHIATRY SERVICES			
Chairperson	Dr Sridevi Kalidindi, Consultant Rehabilitation Psychiatrist, Complex Care, Psychosis CAG, South London & Maudsley NHS Foundation Trust; Honorary Clinical Lecturer, Institute of Psychiatry, UK.			
Co-chairperson				
Abstract	Across the world, deinstitutionalisation of large mental health asylums/hospitals has been underway for several decades. The process is at different stages in different countries, but some have now moved on to fully integrated community rehabilitation services and are involved in fine-tuning such services to improve their effectiveness and their outcomes for both service users and commissioners. Three systems, each from a different country, from world-renowned psychiatrists, will be presented to the delegates to increase their knowledge of the possibilities and to consider which aspects may be most relevant to their own practise and services. Three speakers as outlined below will present a picture of the services and skills necessary to achieve good results in community rehabilitation psychiatry for complex service users followed by time for questions and discussions from the attendees. The speakers are experienced in this specialist field. Objectives To consider effective approaches to community rehabilitation psychiatry in three different European countries, whose success has led to duplication in other countries. To identify which components are similar between these approaches and can be potentially generalised to set up services / support similar services, globally. Goals It would be expected that the delegates attending would increase their knowledge of the important similarities and differences in such services across different European countries. This knowledge can potentially be applied to the delegates' own practice and services to work towards different ways of working, which in turn may lead to improvements in outcomes for service users and commissioners of services			
References				
Speakers	1. Dr Sridevi Kalidindi, Consultant Rehabilitation Psychiatrist, Complex Care, Psychosis CAG, South London & Maudsley NHS Foundation Trust; Honorary Clinical Lecturer, Institute of Psychiatry, UK. E-mail: 2. Dr. J. R. van Veldhuizen, psychiatrist, The Netherlands Chairman of the Certification Centre for Act and Fact (CCAF) First Author of the Dutch FACT manual Former Inspector of Mental Health Care 3. Professor Roberto Mezzina, Director of Mental Health Services in Trieste, Italy			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	The case for community rehabilitation teams from a UK perspective			
Speaker	Dr Sridevi Kalidindi, Consultant Rehabilitation Psychiatrist, Complex Care, Psychosis CAG, South London & Maudsley NHS Foundation Trust; Honorary Clinical Lecturer, Institute of Psychiatry			
Abstract	Dr Kalidindi, the Vice Chair of the Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists, UK, will focus on recent National commissioning guidelines for rehabilitation psychiatry services(1) and a paper published by the Rehab Faculty on the skills necessary to run such services effectively(2) both of which she co-authored			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	FACT, FLEXIBLE ACT, A Dutch Version of ACT			
Speaker	Dr. J. R. van Veldhuizen, psychiatrist, The Netherlands Chairman of the Certification Centre for Act and Fact (CCAF) First Author of the Dutch FACT manual Former Inspector of Mental Health Care			
Abstract	FACT (Flexible ACT) teams are clinical case management teams with partly an individual approach with home visits and partly (if needed) a shared caseload approach withy assertive outreach , similar to ACT. The model aims to combine treatment, support and rehabilitation to serve all SMI in a certain region with good continuity of care. Compared with ACT, the innovation in FACT teams is the choice to work with two procedures in one team: “low scale” (for the more stable patients) and “high scale” (for the most unstable, hard to engage patients at risk for admission: with full ACT). The FACT team can move flexibly between the two procedures, working with the Digital FACT board in the daily team meetings. FACT teams are serving in a defined region or area of + 50.000 inhabitants all SMI. Certification started by the Centre for Certification ACT and FACT (see www.ccaf.nl) In the Netherlands at this moment 150 teams are implemented. FACT has some interesting opportunities for rehabilitation and recovery support: it’s working in a small region, with optimal continuity of care and with inclusion of IPS and peer specialist. Remmers van Veldhuizen is psychiatrist and developed together with Michiel Bähler the FACT model at the Mental Health Care Services ‘GGZ Noord Holland Noord’. He is the chairman of the Dutch Certification Centre for ACT and FACT (CCAF).			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	The Trieste Approach To Community Rehabilitation Psychiatry			
Speaker	Professor Roberto Mezzina, Director of Mental Health Services in Trieste, Italy			
Abstract	Professor Roberto Mezzina will draw on his experience as a psychiatrist and the Director of a comprehensive, 24-hour Community Mental Health Centre, Department of Mental Health in Trieste, Italy. He has taken a key role in the mental health reforms in Trieste, begun by Franco Basaglia. Roberto is currently Head of the WHO Collaborating Centre for Research and Training, Department of Mental Health, Trieste, focussing on deinstitutionalisation and community-based service development.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	AUTISM SPECTRUM DISORDERS: CHALLENGES IN ADULTHOOD		
Chairperson	Doutor Bernardo Barahona Corrêa. Faculty of Medical Sciences, New University of Lisbon, Portugal CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal		
Co-chairperson	Dra. Sandra Pinho. CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal		
Abstract	Autism is a pervasive neuropsychiatric developmental disorder with a multifactorial, polygenic aetiology. Autism affects about 10-60 individuals per 10 000 people with a marked male predominance of 4,5:1. Although the prevalence of Autism appears to have increased over the last 30 years, it remains unsettled whether this is due to more inclusive diagnostic criteria or to truly biological factors. Autism is probably best conceived of as a spectrum disorder, since it may manifest in various degrees of severity, from the classical non-verbal Kanner syndrome to the so-called higher functioning Autism Spectrum Disorders (ASD). Regardless of their degree of severity, all ASD individuals present pervasive deficits in three core areas of functioning: 1. social interaction; 2. verbal and non-verbal communication; 3. cognitive and behavioural flexibility. Deficits in all three of these areas are often - but not always - accompanied by behavioural and sensory peculiarities such as sensory hypersensitivity, motor clumsiness, psychomotor slowness or, more rarely, some particular, unusually developed psychomotor skill. The deficits of individuals with ASD have a deep impact on their ability to interact with others and with the world around them, as well as on their ability to cope with the simplest challenges of daily life. Moreover, individuals with ASD are at greater risk of developing significant psychiatric co-morbidity, specially mood and anxiety disorders. The best treatment strategies for ASD combine tailored psychosocial interventions with biological interventions for selected psychiatric co-morbidities, in a genuinely bio-psychosocial, multidisciplinary approach involving doctors, psychologists, various therapists and coaches, and family members. ASD are chronic, life-long irreversible conditions that, nevertheless, evolve with age. On the most subtle end of the spectrum, Asperger syndrome patients usually present with an average to above-average intellectual ability and well developed language, but with significant deficits in social interaction, non-verbal communication and behavioural and cognitive flexibility. Although many Asperger syndrome patients manage to finish school successfully, difficulties invariably arise in early adulthood with the need to adapt to university or to the demands and challenges of the work market. Even the most able and qualified individuals with high-functioning ASDs usually face formidable difficulties at this stage of their lives, when, often unexpectedly to themselves and to their families, new needs for treatment become painfully evident. The combination of above-average intellectual ability, high qualification and ASD poses particularly difficult challenges to therapists and all those specialized in treating this population. This is especially the case where it comes to social integration in unpredictable, non-structured settings or to obtaining and keeping a job. In this symposium we propose to review the clinical features and treatment difficulties of high-functioning adults with ASDs. We will present and discuss two different psychosocial interventions specifically aimed at this particular subgroup of patients, one of them developed at the University of Salamanca, and the other one at the Centro de Apoio ao Desenvolvimento Infantil in Lisbon. Finally, we will also present the results of a recent research project on semantic memory deficits on Asperger syndrome patients, and their consequences to therapeutic interventions in this population.		
References			
Speakers	1. Doutor Bernardo Corrêa. Faculty of Medical Sciences, New University of Lisbon, Portugal CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal 2. Prof. Doutor Carlos Filipe & Doutora Joana Carmo 1 Faculty of Psychology, University of Lisbon, Lisbon, Portugal. 2 CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal. 3 Faculty of Medical Sciences, New University of Lisbon, Portugal 3. Dra. Zoila Guisuraga. University of Salamanca, Spain 4. Dra. Sandra Pinho CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal		
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Session:	Symposium	SPEAKER 1	Code	
Title:	Wanderers in No-man's Land: Asperger Syndrome in Young Adults			
Speaker	Bernardo Barahona Corrêa, MD, PhD. Centro de Apoio ao Desenvolvimento Infantil; Champalimaud Foundation; CEDOC - NOVA University of Lisbon			
Abstract	Asperger Syndrome (AS) is an autism spectrum disorder with unique clinical features. Similarly to other autism spectrum disorders, AS presents with prominent dysfunction of social interaction and non-verbal communication, a typically narrow pattern of interests, and a rigid adhesion to routines. Unlike classical autism, however, AS patients usually have a normal or even precocious development of speech, as well as normal, or often superior, intelligence. AS is a life-long condition. It is usually diagnosed in infancy or adolescence, although occasional cases may go on undiagnosed until adulthood. AS patients suffer prominent psychosocial dysfunction from an early age, and although in many cases both symptoms and the resulting incapacity tend to attenuate with age – mainly as a consequence of imitation learning of conventional social behavior – in most instances transition into adult life poses as formidable challenge for patients, relatives and health care professionals. For patients, entering university or a first-time job will often overwhelm an already limited ability to flexibly adapt to new challenges and rules. Occasionally, it will bring to light AS symptoms that had gone undiagnosed during infancy and adolescence. For more disabled AS patients in particular, leaving the relative safety and predictability of school life often constitutes a catastrophic event, resulting in absolute social isolation and total inactivity. Unsurprisingly, significant psychiatric comorbidity is the rule in young adults with AS, especially affective and anxiety disorders, substance use disorders, and deliberate self-harm. Addressing the special needs of young adults with AS may prove particularly challenging: most adult psychiatry professionals are not familiar with AS and its features; most general psychiatry services do not offer specialized programs for this special population; and most conventional psycho-social rehabilitation programs directed at severe mental disorders – mainly schizophrenia and other chronic psychoses – are certainly not adequate or acceptable for most young adults with AS. Helping young adults with AS to come to terms with their unique disorder implies a tailored, integrated multidisciplinary approach that flexibly addresses such varied needs as psychiatric morbidity, social skills learning, autonomous living skills learning or vocational and professional orientation and advice.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Categorization processing of natural categories in Autism Spectrum Disorder: The effect of typicality.			
Speaker	Prof. Doutor Carlos Filipe & Doutora Joana Carmo 1 Faculty of Psychology, University of Lisbon, Lisbon, Portugal. 2 CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal. 3 Faculty of Medical Sciences, New University of Lisbon, Portugal			
Abstract	Recently, several studies (e.g. Bowler, Graigg & Gardiner, 2008; Bowler, Limoges & Mottron, 2009; Sumiyoshi et al., 2011) show that semantic memory processes differ in key aspects from those of neurotypical individuals and cast some doubt on whether semantic memory and categorization processes are truly intact in individuals with Autism Spectrum Disorder (ASD). In this study we aim at understanding if deficits in semantic processing regarding memory tasks are due to an impairment of semantic processing per se, or due to the use of atypical conceptual categories. For that purpose we have tested a sample of high-functioning adults with ASD (n=22) and a sample of control participants (n=22) matched for age, IQ and education level on several tasks. First, in order to evaluate the content and composition of conceptual categories we adapted a task from Lambon-Ralph (2010) where errors on typical, atypical and pseudo-typical items can be observed. Additionally, in an implicit categorization task (Release from Proactive Interference paradigm) we have assessed whether recollection from memory can be aided by the activation of typical or atypical semantic categories. We have also introduced a task that tackles the executive functioning, as the ability to strategically search in memory, and have cluster-analyzed this data regarding the typicality of produced items. Differences found between processing of typical and atypical items from a conceptual category			

	are discussed, taking into account the implicit and explicit nature of the different tasks used.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Psychosocial intervention in college students with ASD			
Speaker	Dra. Zoila Guisuraga. University of Salamanca, Spain			
Abstract				
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Pilot projects on psychosocial intervention in young adults with autism spectrum disorders.			
Speaker	S. Pinho. CADIn – Centre for Child Development, Cascais, Portugal			
Abstract	At the conclusion of this presentation, the participants should be able to recognize behavioural and cognitive strategies for developing adaptive behaviour and employability in young adults and adults with Autism Spectrum Disorders (ASD) Purpose: To develop adaptive behaviour, employability and quality of life of young adults and adults with ASD Methods: In project “Enabling to work”, we used group training of beneficiaries, group training of co-workers in job places and supported work placement to promote 9 months work experiences to 7 adults with ASD. In project “Active Net”, we used group activities of: 1) social skills training; 2) tai chi practice; 3) arts; 4) cooking course; 5) outdoor activities; and 6) volunteering activities of beneficiaries, to promote adaptive behaviour in 10 young adults with ASD. In both projects, the intervention model was adapted from “Access Course” and “Work Preparation Programme”, from Prospects, National Autistic Society (UK). Results: Quality of life, as measured by Self Evaluation of Well Being Questionnaire (European Platform for Rehabilitation) showed an increase in 6 out of 7 beneficiaries. Group training of co-workers in Autism Awareness involved around 100 participants. Monthly job evaluations of the beneficiaries are showing results around 4 in 5 point scale and some companies are showing interest in employing the beneficiaries after project end. A measure of adaptive behaviour was applied in the beginning of “Active Net” project. Though the final evaluation is only programmed for the end of July, beneficiaries show high participation rates and evaluated very positively the social skills training (with 4 in a 5 point scale). Conclusions: Through these projects, we expect the following results ☐ Enhancement in perceived Well Being of the beneficiaries ☐ Increase in Autism awareness of the co-workers in job places ☐ Increase in employability of beneficiaries in the open labour market (three beneficiaries to be employed by the companies were they have been working during project period) ☐ Development in adaptive behaviour of beneficiaries, especially in the areas of daily leaving activities and social skills			
References				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	BURDENS OF MENTAL DISORDERS: RESULTS FROM THE WHO WORLD MENTAL HEALTH SURVEYS INITIATIVE		
Chairperson	Jordi Alonso, Institut Hospital del Mar d'Investigacions Mèdiques, Barcelona, Spain		
Co-chairperson			
Abstract	The goal of this symposium is to discuss the individual and societal costs of mental disorders, based on the last results from WHO World Mental Health (WMH) Surveys Initiative. The speakers will specifically address individual and social disadvantages associated with mental disorders, disability impacts of mental disorders, and implications of these data for mental health policy development. The main objective of the WHO World Mental Health Surveys Initiative was to carry out rigorously implemented general population—surveys in order to: (1) estimate the prevalence of mental disorders, (2) evaluate risk and protective factors for purposes of targeting interventions, (3) study patterns of and barriers to service use, and (4) validate estimates of disease burden world-wide. The WHO World Mental Health surveys, carried out in 24 countries studying more than 120,000 respondents, used the most up-to-date measures, field procedures and analysis methodology. Presentations will focus on the consequences associated with mental disorders across the life course of the individuals with particular attention to productivity losses, disability and worsened perceived health. The results reported and discussed in the symposium represent an important advance in understanding of the societal costs of mental disorders and make a compelling case for the value of expanding treatment resources for people with mental disorders throughout the world. They also provide new knowledge with important implications for the development of mental health policy across the world.		
References	Kessler, R. C, Haro, J. M., Heeringa, S. G., Pennell, Beth-Ellen & Üstün, B. T. (2006). The World Health Organization World Mental Health Survey Initiative. <i>Epidemiologia e Psichiatria Sociale</i>, 15, 161-166. J. Alonso, S. Chatterji, & Y He (2012) (Eds.) <i>The Burdens of Mental Disorders in the WHO World Mental Health Surveys</i>. WHO WMH Surveys Series Volume IV. New York: Cambridge University Press (In Press).		
Speakers	1. Jordi Alonso (Institut Hospital del Mar d'Investigacions Mèdiques, Barcelona, Spain, jalonso@imim.es): 2. Ronny Bruffaerts (Katholieke Universiteit Leuven, Belgium, ronny.bruffaerts@uzleuven.be): “ 3. Maria do Carmen Viana (Universidade Federal do Espírito Santo, Vitória, Brasil, mcviana@intervip.com.br 4. JM Caldas de Almeida (Faculdade de Ciências Médicas, Universidade Nova de Lisboa, Portugal, jcaldasalmeida@gmail.com		
Contact:	Prof. Jordi Alonso, Institut Hospital del Mar d'Investigacions Mèdiques, Barcelona, Spain, jalonso@imim.es		

Session:	Symposium	SPEAKER 1	Code
Title:	Burdens of the Mental Disorders: Contributions of the WMH Surveys		
Speaker	Jordi Alonso, Institut Hospital del Mar d'Investigacions Mèdiques, Barcelona, Spain		
Abstract	The Global Burden of Disease (GBD) study put mental disorder in the map of the burden of diseases. In its 2010 replication, Mental Disorders in developed countries are the second cause of disability and the third cause of combined disability adjusted premature mortality. In developing countries mental disorders are very rapidly catching up as major cause of DALYs. The WHO World Mental Health (WMH) surveys, with over 121,000 respondents surveyed across 24 different countries, is the largest on-going cross-national series of community epidemiological surveys of mental disorders ever carried out. The surveys are multipurpose studies of descriptive epidemiology of mental disorders worldwide: the frequency of mental disorders, their age of onset, and their associated disability and use of services have been assessed. Particular strengths of the WMH surveys include the large size and geographical representativeness of their samples, the exhaustive and well-standardized evaluation of mental disorders (with the WHO Composite International Diagnostic Interview, (CIDI) and		

	health outcomes, and the use of sophisticated analytical approaches capable of accurately estimating the population distribution of the consequences of disease. In addition, while the GBD study focuses on decrements in current health and mortality associated with the health conditions, the WMH data allow for the consideration of a much wider range of adverse outcomes. Very recently, a specific WMH book has been published focusing on a particular way to assess the several burdens associated with the mental disorders across the life course of the individuals: personal disadvantages, productivity losses, disability, and worsened perceived health (Figure). The figure includes both the outcomes and some of the possible intermediate variables that the vast body of literature suggests may play a role in the association between the two. Data in that WMH book show how parental psychopathology is related to mental disorders in offspring are indeed associated with an increased risk for every class of offspring mental disorder, even after controlling for the presence of comorbid parental disorders, as well as for number of parent disorders. Also early-onset mental disorders are associated with a decreased likelihood of satisfactory educational attainment at each of the educational periods (primary, secondary, and college entry and termination). These results suggest that some of the later life effects attributed to lower educational attainment should be considered, at least in part, consequences of early-onset mental disorders. Early-onset mental disorders reduce the amount of time people spend in marital relationships both by reducing the likelihood that they will marry and, more importantly, by increasing the likelihood that they will divorce or separate after marrying. Mental disorders developed prior to marriage are associated with a significantly elevated risk of marital violence in most of the countries studied. Frequently under-evaluated, productivity loss is a major disease burden, which, from a purely economic point of view, might justify intense investments in health restoration. WMH data show that individuals with serious mental illness earn, on average, almost one-third less than others in the population (29% in high income countries to 31% in low and lower-middle income countries). Also, our data show a strong association of common early-onset mental disorders (in this particular case defined as disorders present before completion of educational attainment) with current household income after adjusting for education. This association is considerably stronger in high income than upper-middle income countries and not significant at all in low and lower-middle income countries. After discussing some limitations of the study, conclusions are made about the need to further explore the spectrum of the burdens of mental disorders worldwide and the urgency of designing policies which facilitate addressing these burdens.
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Disability and Treatment of Mental and Physical Disorders: Results from the World Mental Health (WMH) Surveys			
Speaker	Ronny Bruffaerts Universitair Psychiatrisch Centrum – KU Leuven. Herestraat 49. B-3000 Leuven, Belgium			
Abstract	Objective: To present and discuss findings from the World Mental Health Surveys in terms of disability and treatment of mental disorders and common physical conditions around the globe. Methods: We report findings from the World Mental Health Surveys carried out in general population surveys worldwide. Findings will be presented on (a) full and partial disability associated with mental disorders and physical conditions and (b) treatment patterns for these disorders. The CIDI-3.0 version of the WHO-DAS-2 was used to assess partial (i.e. days in which some people are partially unable to perform as usual) and full disability (i.e. days in which people are completely unable to perform as usual). Results: Common mental and physical disorders are consistently associated with both partial and full disability, both at the individual and societal level. At the individual level, these disorders are associated with 31 and 25 of full disability days per year, respectively, and 41 and 28 days with partial disability. At the societal level, population attributable risk proportions were systematically higher for physical conditions (47.6-49.2% on average) than for mental disorders (14.7-16.5% on average). Especially depression and back pain are disabling conditions because of their high prevalence, their association with both partial and full disability, and their mutual comorbidity. Physical conditions were more likely to be treated than mental disorders (47.6-65.3% vs. 5.7-23.7%). In addition, people with mental disorders reported dramatic long delays in seeking professional help.			

	Discussion: Disability of mental disorders and physical conditions may be higher than reported so far because these conditions are not only associated with full disability but also with partial disability, over and above full disability. Especially depression and back pain may be disorders that could be priorities from a public health perspective.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Family burden related to common mental and physical disorders in the world: results from the WHO World Mental Health (WMH) Surveys			
Speaker	Maria Carmen Viana. Department of Social Medicine Federal University of Espírito Santo, Vitoria, Brazil			
Abstract	Objectives: Family caregivers shoulder the vast majority of long-term care responsibilities worldwide. Widespread health trends, such as greater life expectancy and prolonged survival with severely disabling conditions, are steadily increasing the demand for informal care. This study aimed to assess the prevalence and correlates of family caregiver burdens associated with common mental and physical conditions worldwide. Methods: Cross-sectional community surveys interviewed 43,732 adults residing in 19 countries of the WHO World Mental Health (WMH) Surveys, inquiring about chronic physical and mental health conditions of first-degree relatives. Among those reporting affected family members who were directly involved in their care, the associated objective (time, financial) and subjective (distress, embarrassment) burdens were assessed. Magnitudes and associations of burden are examined by kinship status and family health problem; and population-level estimates are calculated. Results: Among the 18.9-40.3% of respondents in high, upper-middle, and low/lower-middle income countries with first-degree relatives having serious health problems, 39.0-39.6% reported burden. Among those, 22.9-31.1% devoted time, 10.6-18.8% had financial burden, 23.3-27.1% reported psychological distress, and 6.0-17.2% embarrassment. Mean caregiving hours/week was 12.9-16.5 (83.7-147.9 hours/week/100 people aged 18+). Mean financial burden was 15.1% of median family income in high, 32.2% in upper-middle, and 44.1% in low/lower-middle income countries. Higher burden was reported by women than men, and for care of parents, spouses, and children than siblings. Conclusions: The uncompensated labour of family caregivers is associated with substantial objective and subjective burden worldwide. Given the growing public health importance of the family caregiving system, it is vital to develop effective interventions that support family caregivers.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Results from the WHO World Mental Health Surveys Initiative: Implications for mental health policy development			
Speaker	JM Caldas de Almeida, Universidade Nova de Lisboa, Portugal			
Abstract	Objectives: 1.- To analyse key findings from the World Mental Health (WMH) Surveys that are relevant for public policy needed to promote better health and well being of persons with mental illness; 2 - To discuss policy implications relevant to both developed and developing countries as they grapple with the challenges of the burden of mental disorders in their populations. Methods: Using population-based, cross-national epidemiological data from both developed as well as developing countries included in the World Mental Health (WMH) Surveys Initiative, we will analyse the data on the burden of mental illness that are relevant for policy development. Results: The results of the WMH surveys reinforce the need to invest on the development and improvement of mental health systems worldwide. Secondly, they show why it is so important to integrate mental health policy into general health policy, as well as into social policies. Finally, they provide a new understanding of associated factors, course, comorbidity, impact and treatment of mental disorders that is relevant for action in several areas of mental health policy (e.g., organization, financing and delivery of services, prevention, psychosocial rehabilitation, child mental health services and interventions, inter-sectoral collaboration, workforce development and training, etc.). Conclusions: The results of the surveys strongly encourage governments to revise, update and develop			

	mental health policies and plans, based on the existing knowledge on the burden of mental disorders, and taking into consideration the available evidence on the cost-effectiveness of services and interventions. They also call the attention of policy makers for the need to improve the provision of integrated mental health care, through strategies contributing to the development and delivery of community-based services, integration of mental health treatment and care into primary care and general hospitals, strengthening of psychosocial rehabilitation programmes, promotion of collaborative care models with task-shifting components, and the use of e-mental health programmes. The surveys findings also reinforce the need to further coordinate efforts at the global level to reduce the global burden of mental disorders and promote mental health of the populations.
References	

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	SOCIAL DETERMINANTS AND MENTAL HEALTH			
Chairperson	Sabine Bährer-Kohler, Dr. Bährer-Kohler& Partners, Switzerland			
Co-chairperson				
Abstract	Social determinants affect mental health directly and indirectly in various life span perspectives. These determinants are diverse and complex, and include social inequalities, social networks, and environmental factors as well as, for example, gender- and stress-related factors. At the beginning of the symposium there will be a presentation on the subject of Mental Health, Socioeconomic Inequalities and Children in Brazil. The data presented relate to various determinants of internalizing behavior problems in children as well as to the potential contribution of socioeconomic inequalities (gender and mothers' education) and community violence in order to show the necessity of social and economic investments in the members of families with children as well in communities. It relates to the intimate realm of the family vis-à-vis the broader socioeconomic context shaped by governments, international agencies and civil society. The data presented also reveals potential key targets for early intervention, especially for children from highly vulnerable families. The second presentation will discuss the interrelationship between social networks and mental health. Individuals have been recognized as social beings living in ecological environments. The level of social integration in communities and the available resources influence the mental health of those individuals. It will be documented that social networks have the potential to provide individuals with protection and support. The construction of social networks can prevent negative mental health conditions and change unhealthy life styles, directly or indirectly. Prevention mechanisms aim at universal (general), selective (at-risk) or indicated (mental disorders) target groups to provide a supportive environment for coping with social stress. The third presentation will discuss the impact of the occupational stress syndrome of burnout on mental health worldwide. Burnout may be result of a complex interaction between workplace-related, social and individual factors. Several epidemiological studies have found a high prevalence of burnout in developed and developing countries. Burnout may affect almost anybody, employees in various occupations as well as caregiving relations. The presenter will underline that preventive approaches are needed, including modifying the work environment and improving the individual's ability to cope with stress.			
References				
Speakers	1. Simone Gonçalves de Assis, Socioeconomic Inequalities, Violence and Internalizing Problems in Brazilian school-children 2. Hui-ching Wu, National Taiwan University, Taiwan 3. Francisco Javier Carod-Artal, Institut Universitaire En Santé Mentale Douglas, Canada			
Contact:	Sabine Bährer-Kohler, Dr. Bährer-Kohler& Partners, Switzerland			

Session:	Symposium	SPEAKER 1	Code	
Title:	Socioeconomic Inequalities, Violence and Internalizing Problems in Brazilian school-children			
Speaker	Simone Gonçalves de Assis, Socioeconomic Inequalities, Violence and Internalizing Problems in Brazilian school-children			
Abstract	Objectives The study aims to investigate the association of internalizing problems in Brazilian school children with the following variables: socioeconomic inequalities, family and community violence. Methods The research is based on a cross-sectional analysis of schoolchildren aged between 6 and 10 years-old, selected by random sampling from a city in the state of Rio de Janeiro, Brazil. Socio-economic variables, violence and internalizing problems were investigated by caregivers' information and organized in blocks for analysis. A binary logistic regression model was applied, according to hierarchical blocks. Results The resulting model indicates that girls developed more internalizing problems than boys (OR=2,56). Children of mothers with low education have more emotional problems than those with more years of schooling. Also, children who suffered community violence have more the studied behavior problem than those who do not suffer it. No family violence variables are associated with internalizing problems. Conclusion The study points to multiple determinants of internalizing behavior problem in children, as well as the potential contribution of socioeconomic inequalities (gender and mother's scholarship) and community violence. It reveals the necessity of social and economic investments in the members of family with children as well in context of the community. It involves the intimate realm of the family towards the broader socioeconomic context shaped by the governments, international agencies and civil society. The study also reveals potential key targets for early intervention, especially for children from highly vulnerable families			
References	The research had the support of the National Council of Scientific and Technological Development (CNPq) and the Carlos Chagas Filho Research Support Foundation of the State of Rio de Janeiro (Faperj), Brazil. 2 All the authors are from "Jorge Careli Latin American Centre for Studies on Violence and Health" (CLAVES), Oswaldo Cruz Foundation/ Brazil.			

Session:	Symposium	SPEAKER 2	Code	
Title:	Social Networks and Mental Health			
Speaker	Hui-ching Wu, National Taiwan University, Taiwan			
Abstract	Objectives: The purpose of the study was to discuss the inter-relationship between social networks and mental health. Multiple social, psychological, and biological factors were found to determine the level of mental health of a person at any point of time. Individuals have been recognized as social beings living in the ecological environments. The level of social integration in the communities and the resources influence the mental health of those individuals. Methods: The study employed literature review to examine the function of social networks on the wellness of mental health and in further to explore how it was affected by a collective culture. Results: The findings suggested that the networks of social integration and interaction provide opportunities through which social support is made available. Networks were viewed as one dynamic element in the process of support and that comprise the properties of social composition, structure and relations. Social networks tend to have a protective effect on mental health by buffering individuals from the ill effects of stressful events or support treatment for the psychological discomfort. When this buffering is absent or withdrawn due to a fragmented or dysfunctional social network, an individual's vulnerability to mental disorder may increase. The social networks and social support are reciprocity. Social networks involve the quantity and structure of a person's relationships, the social support provided by those relationships, and their impact on that person's well-being. Social support was one of the functions provided by a social network, and can be viewed as the comfort and support received from other people through various types of relationship. Culture was an important determinant of mental health for its size, density, ties, and			

	multiplicity of social networks. Conclusion: Social networks have the potential to provide individuals with protection and support. The construct of social networks would prevent the negative mental health condition and change unhealthy life style, directly or indirectly. The preventive mechanism aimed at universal (general), selective (at risky) or indicated (mental disorder) population to provide a supportive environment while they encounter the social stress.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Burnout syndrome and mental health in an international setting			
Speaker	Francisco Javier Carod-Artal, Institut Universitaire En Santé Mentale Douglas			
Abstract	Objective: The impact of the professional stress syndrome of burnout on mental health worldwide will be reviewed. Methods: A systematic review of the literature in search of epidemiological articles was done. Results: Several epidemiological studies have found a high prevalence of burnout in developed and developing countries. Burnout may affect almost anybody, employees in various occupations and caregiving relations. Nevertheless, this specific work-related syndrome may occur more frequently among people who work with human recipients of services. Burnout rates among the society range from 2.4% to 72%, whereas depressive symptoms may affect between 3% and one third of workers. Burnout may be result of complex interaction of workplace and social and individuals factors. The Karasek's job demand-control-social support model predicts that workers with high-strain jobs and low social support in the workplace are at high risk of disease. Common factors that may have an adverse effect on mental health and influence the risk of suffering depression in the workplace include: 1) specific stressful events (interpersonal conflicts, bullying by supervisors; sexual harassment); 2) organizational workload (long hours of work); 3) high job strain, organizational injustice and effort-reward imbalance; 4) low social support at work and outside; 5) personality traits and workaholism. Gender inequalities, poor paths of participation, a lack of occupational health services coverage, poor nutrition and hygiene, illiteracy and general poverty are some additional factors that can aggravate burnout and work-related stress in developing countries, outside the work environment. In Africa, the debilitation of health systems has provoked a heavy workload in health carers and teachers and an increased workforce burnout. Excessive work stress and burnout have negative consequences for the health, safety and well-being of workers, and the productivity and cost-effectiveness of the industries and services. People at risk for burnout and work-related depression can contribute to worsening job performance, and increase absenteeism, job turnover, and decrease productivity. Conclusions: Preventive approaches are needed and include both modification in the work environment and also improvement in the individual's ability to cope with stress. Nevertheless, in developing countries workers may not be familiar with burnout and job-stress prevention strategies.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	RECENT DEVELOPMENTS IN BRITISH THERAPEUTIC COMMUNITIES			
Chairperson	Dr Rex Haigh, Inaugural Committee, The Consortium of Therapeutic Communities. Consultant Psychiatrist, Berkshire Healthcare NHS Foundation Trust			
Co-chairperson				
Abstract	British Therapeutic Communities, originally based on the Social Psychiatry Movement in the 1950s - 1960s and based on the work of Maxwell Jones and others, have undergone a renaissance in recent years. Although many older communities have closed, others have developed and thrived in different sectors – particularly for troubled children, mentally disordered offenders and mental health patients diagnosed with personality disorders. This symposium will bring together four contributions to illustrate this work.			
References				
Speakers	1. Dr Rex Haigh, Slough Therapeutic Community, Berkshire, UK rexhaigh@nhs.net The New Non-Residential Therapeutic Communities for Personality Disorder. 2. Professor Michael Brookes, Grendon Prison, Buckinghamshire, UK. 3. Caryn Onions and Jennifer Browner, Mulberry Bush School, Oxfordshire, UK. 4. Sarah Paget, Programme Manager, Royal College of Psychiatrists, London, UK.			
Contact:	Dr Rex Haigh, Inaugural Committee, The Consortium of Therapeutic Communities. Consultant Psychiatrist, Berkshire Healthcare NHS Foundation Trust. Address: 1 St Marys Rd, Mortimer, Berkshire RG7 3UE UK Phone: +44 (0) 7768 546963 Email: rexhaigh@nhs.net			

Session:	Symposium	SPEAKER 1	Code	
Title:	The New Non-Residential Therapeutic Communities for Personality Disorder			
Speaker	Rex Haigh, Slough Therapeutic Community, Berkshire, UK			
Abstract	OBJECTIVE To demonstrate the change, development and growth of new British Therapeutic Community Practice since 2000. METHOD Analysis of policy, through case description - of quality, training and research projects. RESULTS The English Government's 'National Personality Disorder Programme' was launched in 2002 and saw the end of much 'traditional' therapeutic community practice. However, new forms and approaches to therapeutic community working have emerged, with government sponsorship, in the National Health Service (NHS) and Criminal Justice System (MoJ and NOMS). The main characteristics of the innovations are a focus on (1) quality of therapeutic relationships (2) minimisation of exclusion and (3) coherent working across sectors, organisations and professions. Suitable training programmes have been developed, and new research strategies to evaluate them. CONCLUSIONS Although residential Therapeutic Communities are in decline as part of social psychiatry practice, the radical ideas at their core are surviving and thriving in new formats. The same is true in prisons and elsewhere.			

References				
Session:	Symposium	SPEAKER 2	Code	
Title:	Recent Developments in Therapeutic Community work in Grendon Prison			
Speaker	Michael Brookes, Director of Therapy, HMP Grendon, UK			
Abstract	OBJECTIVES For the past fifty years Grendon prison has pioneered a unique, therapeutic community, approach to the management and treatment of severely personality disordered offenders. The offences committed by prisoners at Grendon include murder, manslaughter, grievous bodily harm, rape and sexual abuse of children and young people. Recently, externally imposed directives combined with internal management changes have altered the structures which surround how the therapeutic communities operate. This paper will explain how Grendon has adjusted to these developments whilst still maintaining the integrity of therapy delivered. METHODS Described will be Grendon's treatment regime and the various government, national and local initiatives that prison managers have had to navigate and respond to over the past five years. These include an offender personality disorder strategy, market testing policy, healthcare and substance misuse funding arrangements, the accreditation of each therapeutic community, prison service audits and, revised management and grading arrangements. RESULTS Outcome data will be presented to demonstrate Grendon's efficacy as a treatment intervention along with the views of Her Majesty's Inspector of Prison and findings from Community of Communities/HM Prison Service therapeutic community accreditation reports. CONCLUSION Grendon prison has been able to successfully operate as a series of therapeutic communities adjusting and adapting to an ever changing external world while maintaining the core and core and essential elements of its internationally recognised treatment programme.			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Bringing the Family into Focus: New Work at a Therapeutic Community for Primary School Aged Children			
Speaker	Caryn Onions and Jennifer Browner Mulberry Bush School & Organisation, Oxfordshire, UK			
Abstract	OBJECTIVES When children are sent away from home or taken into care, the burden of responsibility for change can sometimes lie too heavily and somewhat unfairly on their shoulders. This paper will use two case studies to describe the work of the new Therapies and Networks Team at the Mulberry Bush School in Oxfordshire and how this work is integrated into the therapeutic milieu of the school. METHOD Qualitative: case studies RESULTS The work of the team aims to bring the focus for change more firmly onto the family as a whole in order to share with the child the responsibility for change and emotional development. The case studies will look at how we assess children and their families, whether birth, adoptive, or fostered, and how these assessments inform the range of interventions we offer alongside the milieu therapy in which the children are immersed.			

	CONCLUSIONS Through these case studies, the paper will briefly describe these interventions which include a range of individual therapies, family work or therapy, foster care support, and Family Weekends, in which the whole family is given an experience of the therapeutic milieu.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	Enabling Environments': Healthy Organisations and Relationship-Based Practice.			
Speaker	Sarah Paget ,Programme Manager, Royal College of Psychiatrists, London, UK.			
Abstract	OBJECTIVES The Enabling Environments Project has developed to reflect the importance and impact of the social environment on well being and personal development. The aims and objectives of any organisation will be impacted by the qualities of the social environment. This is more than just focusing on individual well being or promoting healthy lifestyles. The social environment, or culture, is the product of all the relationships and activities and central to enabling all participants to grow, develop and flourish. The result will be happier and healthier staff and improved outcomes for service users. This paper will describe the development of an Enabling Environment Quality Mark and explore the impact on member services. METHOD Qualitative: case studies RESULTS The Enabling Environment project promotes ten simple standards that help us think about the environment in which we live, work or play. The standards relate equally to those who provide a service (staff) as to those who receive it (patients, prisoners, customers etc). The standards apply to a range of settings and break the environment down into specific elements that have been identified as factors critical to a healthy social environment. We will follow the experiences of those applying for the award, identifying specific differences across a range of different environments. CONCLUSIONS Through these case studies, the paper will briefly describe the experiences of a range of services in developing and demonstrating their practice in relation to the qualities of their environment and report on the effect on overall outcomes.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	THE EFFECTIVENESS OF MENTAL HEALTH REHABILITATION SERVICES FOR PEOPLE WITH LONGER TERM AND COMPLEX NEEDS			
Chairperson	Dr Helen Killaspy, University College London and Chair, Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists			
Co-chairperson	Professor Jose Miguel Caldas de Almeida, New University of Lisbon, Portugal			
Abstract	Background – Mental health rehabilitation services focus on people with longer term and complex needs. The majority of this group have a diagnosis of schizophrenia with severe negative symptoms and other problems that have complicated their recovery, such as treatment refractory symptoms, cognitive impairment and comorbidities such as substance misuse. These problems often impact on day to day function and necessitate lengthy admissions to hospital. Highly supported community facilities are often required on discharge to support individuals, through a graduated care pathway of supported accommodation, to achieve their maximum level of independence in the community. For these reasons, this relatively small group absorb a large proportion of mental health and social care resources but, until recently there was little research into the aspects of care that were most beneficial for them and little evidence to guide practitioners and service planners. Goals - This symposium will describe major programmes of research from the UK and Portugal that focus on mental health rehabilitation services and aim to provide evidence for their effectiveness. Importance – The research programmes described in this symposium aim to identify the components of care that are incorporated into the complex intervention of mental health rehabilitation that most help people with complex mental health problems to achieve and sustain successful community living. Details of the development of an enhanced rehabilitation intervention that aims to improve people's engagement in meaningful activities will be described. Variations on this intervention are being evaluated through randomised controlled trials as part of the research programmes in the UK and Portugal and, if found to be effective, have potential for international roll-out. Interest to the congress participants – this session is likely to be of interest to most conference participants but especially those who work with people with longer term and complex mental health problems			
References				
Speakers	1. Dr Helen Killaspy, Reader and Honorary Consultant in Rehabilitation Psychiatry, University College London, Chair, Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists 2. Dr Sarah Cook, Reader in Mental Health occupational Therapy, Sheffield Hallam University, 3. Associate Professor Graca Cardoso, New University of Lisbon, Portugal			
Contact:	Dr Helen Killaspy, Reader and Honorary Consultant in Rehabilitation Psychiatry, Mental Health Sciences Unit, University College London, 67-73 Riding House Street, London, W1W 7EJ, UK. Tel 0044 207 679 9710, email: h.killaspy@ucl.ac.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	The effectiveness of mental health rehabilitation services for people with longer term and complex needs			
Speaker	Dr Helen Killaspy, Reader in Rehabilitation Psychiatry, University College London			
Abstract	Objective – The REAL study is a five year programme of research into mental health rehabilitation services across England, funded by the National Institute for Health Research. These services provide care for people with severe and complex mental health problems such as schizophrenia or schizoaffective disorder, where recovery is complicated by severe negative symptoms, non-response to medication, substance misuse and challenging behaviours. Rehabilitation provide multidisciplinary interventions to help the person gain/regain skills that they have lost through their illness, cope better with their			

	symptoms and gain the confidence and ability to leave hospital. Because of the severity of their problems, this group often require lengthy admissions and therefore absorb a large proportion of resources. Despite this, very little research has been carried out to help understand which aspects of rehabilitation work best and which patients benefit most from these services. Methods Phase 1: National survey of all NHS mental health rehabilitation services in England. Phase 2: Development of a training programme for nursing and other ward staff to improve service user engagement in activities on the ward and in the community. Phase 3: Cluster randomised controlled trial involving 40 inpatient mental health rehabilitation services to investigate the clinical and cost-effectiveness of the staff training intervention developed in Phase 2. Phase 4: Naturalistic cohort study investigating 12 month outcomes for patients of 50 inpatient mental health rehabilitation services. Results Phases 1 and 2 have been completed. Phase 1 has provided a detailed description of inpatient mental health rehabilitation services and those who use them. Results of multilevel models will be presented showing the associations between different components of care and service user outcomes. Progress with Phases 3 and 4 will be reported. Phase 2 will be presented by another speaker (Dr Sarah Cook). Conclusions The results of the REAL research programme will allow us to identify the service and service user characteristics that result in improved clinical outcomes associated with successful discharge from hospital and reduced service costs. This will inform future development and investment in services for people with complex mental health needs.
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	The Rehabilitation Effectiveness for Activities for Life (REAL) study: Phase 2. Development of GetREAL, a training programme for nursing and other ward staff to improve service user engagement in activities on the ward and in the community			
Speaker	Sarah Cook, Reader in Occupational Therapy, Sheffield Hallam University			
Abstract	Objectives 1) To develop GetREAL, a staff training programme aimed at equipping mostly unqualified nursing and other ward staff with the understanding, skills and behaviours to improve service user engagement in activities both on rehabilitation wards and in their local community. 2) To prepare an intervention manual and induction programme for the staff teams employed to deliver this training intervention to 20 psychiatric rehabilitation wards across England within the study. 3) To prepare a fidelity measure to assess the delivery of the training intervention during the study. Methods The development process involved building on existing evidence and theory, consulting with clinical experts and service users, and piloting the intervention in practice. Consultation events were held with service users, practicing occupational therapists, members of the REAL study Steering Group, and staff teams in 5 rehabilitation units. The draft intervention manual was further refined and training materials created by the new intervention teams during their induction week and by piloting the GetREAL intervention in two NHS units. Fidelity criteria were developed by the authors and the REAL study steering group and GetREAL was formally endorsed by The College of Occupational Therapists. Results The GetREAL training was underpinned by theories from organisational change and from occupational therapy including a three-stage model of change. Senior psychiatrists visited senior staff in each health care service provider during the 'Predisposing stage' to engage their commitment to change. A senior occupational therapist and activity worker, with input from a service user consultant, worked alongside ward staff for five weeks during the 'Enabling phase'. This included two training events with all ward staff, goal setting and action planning and intensive, hands on support for staff to gain confidence in the implementation of the specific techniques learned to engage seemingly unmotivated service users in			

	activities of their choice. An appreciative enquiry approach was taken which focuses on good practice. The 'Reinforcing stage' involved long term action plans and continued offers of support in order to maintain sustainable change. Conclusion The GetREAL manual, training materials, induction programme and fidelity criteria were developed through successive phases that consulted many different people with a variety of expertise. The novel features of GetREAL are that it targeted management and senior staff as well as the staff working on the ground and that the trainers worked closely together with ward staff teams for a full five weeks to bring about change in practice.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	The PromQual study: a national study of mental health rehabilitation services in Portugal			
Speaker	Associate Professor Graca Cardoso, New University of Lisbon, Portugal			
Abstract	1. Objectives a. Assessing the quality of care, living conditions, and rehabilitation of people in long-term psychiatric and social institutions; b. Developing a new training intervention for professionals working in these institutions, designed to improve the quality of care and rehabilitation of its users; c. Evaluating the effectiveness of the intervention. 2. Methods A randomized controlled trial is being carried out. All the existing units in Portugal were assessed at baseline with the Quality Instrument for Rehabilitative Care (QuIRC) filled online by the manager, and face-to-face interviews with the Service User Interview Schedule with a random sample of service users. The intervention consisted of workshops attended by the managers and the staff of the residential units in the intervention arm; and of a 4-week local intervention delivered by one occupational therapist and one activity worker to help local professionals integrate the knowledge and skills gained from the workshops into their everyday work with residents. Units will be reassessed at 4 and 8-months after training is completed using the baseline instruments. All managers and users gave their informed consent. 3. Results The majority of the residential units assessed (n=42) were in Lisbon and surrounding districts (59.5%), 50% were in hospital surroundings and 50% in the community, and had a mean number of 11.5±6.9 beds [5-31]. The QuIRC mean score was 52.5% [26.6-78.8%]. The units interviewed users (n=278) were mainly men (66.2%), had a mean age of 49.4±10.6 years [23-83], and had on average studied for 9.1±4.9 years [0-30]. 4. Conclusions The baseline assessment showed significant problems in several areas of the quality of care provided by the residential units. The training intervention was already carried out in half of the units without major problems, proving its feasibility			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	CO-MORBIDITY OF DEPRESSION AND DIABETES: PROBLEMS FOR SCIENCE AND CONSEQUENCES FOR PATIENTS AND PRACTICE			
Chairperson	Norman Sartorius, MD, PhD: Dialogue on Diabetes and Depression			
Co-chairperson	Driss Moussaoui, MD: World Association of Social Psychiatry			
Abstract	Description of the symposium: The psychiatrist should play a central role among the health care providers involved in collaborative care of patients with serious chronic diseases complicated by a co-morbid depression. Depressive disorders are frequently co-morbid with diabetes. Depression can lead to poor self-care, affect glycaemic control and compromise quality of life in patients with diabetes. The prognosis of both diabetes and depression – in terms of severity of disease, complications, treatment resistance and mortality – as well as the costs to both the individual and society is worse for either disease when they are co-morbid than it is when they occur separately. The introduction to the symposium will review epidemiological findings about co-morbidity of depression and diabetes and the public issues related to it. This will be followed by a presentation of the views of professions that are most directly concerned with the management of comorbidity: including the family physicians, nurses, the psychiatrists and the diabetologists. The views of patients with comorbidity will also be presented. The symposium will also describe a major international programme launched to address the problem.			
References				
Speakers	1. Henk Parmentier, M.D., World Association of Family Doctors (WONCA), London, U.K. henk.parmentier@gmail.com “The management of co-morbid depression and diabetes: “views of the family physicians” 2. Seyda Ozcan, RN, MSN, PhD; Associate Professor, Istanbul University; Florence Nightingale Nursing Faculty; Federation of European Nurses in Diabetes (FEND), Istanbul, Turkey. seyda_ozcan@hotmail.com “The management of co-morbid depression and diabetes: “views of the nurses” 3. Driss Moussaoui, MD: World Association of Social Psychiatry (WASP); Casablanca, Morocco. drissm49@gmail.com “The management of co-morbid depression and diabetes: “views of the psychiatrists” 4. Joao Manuel Valente Nabais, President, International Diabetes Federation (IDF), European Region; Lisbon, Portugal; joao@idf-europe.org “The management of co-morbid depression and diabetes”: views of diabetologists and consumers”.			
Contact:	Larry C. Cimino Global Programme Director, Dialogue on Diabetes and Depression 3693 Power Place Carmel, IN 46033 USA Phone: +1 (317) 846-5760 Fax: +1 (317) 846-5760 Email: CiminoLC@Gmail.com			

Session:	Symposium	SPEAKER 1	Code	
Title:	Management of Co-morbid Depression and Diabetes: Views of the Psychiatrists			
Speaker	Driss Moussaoui President, World Association for Social Psychiatry Ibn Rushd University Psychiatric Centre, Casablanca, Morocco			
Abstract	There is ample evidence that there are strong links between diabetes (especially type 2) and depression. As a matter of fact, patients with type 2 diabetes present an increased risk of depression, and depressed patients are at increased risk of developing type 2 diabetes in a 3 year-period. One of the links between the two is the high plasma level of cortisol, which loses its diurnal rhythm. It constitutes a toxic factor for the central nervous system, and explains why there is atrophy in the hippocampus often seen in depressed patients. Cortisol secretion is the indicator of a chronic stress which leads to a decrease in the volume of neurones, in the number of their synapses, and in apoptosis of astrocytes in some regions of the brain. A well-known clinical link between depression and diabetes is the triggering effect on the latter of major negative life events, which in turn can aggravate an emerging depressive episode, which will worsen the diabetic illness. Complications, of course, worsen both clinical pictures. This is why it is essential to introduce in the psycho-education of diabetics notions of management of stress, depression and their interaction with diabetes. The problem is that psychiatrists rarely consider the importance of the somatic component introduced by the discovery of diabetes in a depressed patient, because of depression itself, or because of the prescription of novel antipsychotics in bipolar patients, which aggravate the diabetic illness, among other “metabolic syndrome” components.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	MENTAL HEALTH AND THE MIDDLE EAST CONFLICTS			
Chairperson	Prof. Federico Allodi, Chair, WPA Section on Psychological Consequences of Torture and Persecution. Psychiatrist Member, Consent and Capacity Board of Ontario, Ministry of Health, Toronto, Ontario, Canada.			
Co-chairperson				
Abstract	This symposium includes papers on the social and consequent mental health changes observed in persons directly involved or affected by the violent conflicts in the Middle East and Islamic countries in the last few years. They describe the demographic and clinical characteristics of samples of Libyan adults and women refugees living in Tunisian camps, former members of the police forces in Tunisia after the popular uprising finding their roles converted from oppressors into the oppressed, and Middle Eastern and Muslim exiles and immigrants attending social and mental services in California, USA, and in Uppsala, Sweden. Three papers describe specifically the mental health consequences and professional ethical responsibilities in the Israeli Palestinian conflict. One paper reports on the rates of PTSD rates and the resilience as a protective factor in children subject to the Israeli invasion of Gaza in December 2008-January 2009, another paper describes the stresses suffered by Palestinian children in Israeli detention centres and the factors associated with false or innocent confessions under interrogation. The papers have plentiful numerical data, relevant statistical analysis in graphic, tablets and histograms and conclusions which would be helpful to mental health workers, psychiatric clinicians and future researchers.			
References				
Speakers	1. Nahla El Sayed Nagy, Professor of Psychiatry, Ain Shams University, Cairo, Egypt. 2. Sami Ouanes, Anissa Bouasker, Rym Ghachem. Razi Hospital - La Manouba, Tunis, Tunisia.. 3. Mohammed Belaizi *, Yassine Otheman, Mohammed Zakaria Bichra. * Psychiatrist. My Ismail Military Hospital. Meknes. Med-V-Souissi University. Rabat. 4. Derek Summerfield, Honorary Senior Lecturer, Institute of Psychiatry, King's College, University of London. 5. Graciela Karmon, Psychiatrist, Chairperson, Physicians for Human Rights-Israel, Tel Aviv, Israel. 6. Maria Jose Lera, Professor, Department of Psychology University of Seville, Spain, and Ahmed Abu Tawahina, Clinical Director, Gaza Community Mental Health Program, Gaza, Palestine.			
Contact:				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	THE RELATIONSHIP BETWEEN MENTAL HEALTH, PSYCHOSOCIAL FACTORS AND CHRONIC DISEASE IN CHILDREN AND ADOLESCENTS IN LATIN AMERICA.		
Chairperson	Darci Neves Santos, Psychiatrist. PhD in Psychiatric Epidemiology, University of London. Institute of Collective Health, Federal University of Bahia, ISC/UFBA.		
Co-chairperson	Leticia Marques dos Santos, Psychologist. MSc Psychology, PhD in Public Health. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Caroline Feitosa, Psychologist, MSc Epidemiology, London School of Hygiene and Tropical Medicine (LSHTM). Institute of Collective Health, Federal University of Bahia, ISC/UFBA.		
Abstract	Background In recent years, there has been an increase in the awareness of the role of mental health and psychosocial factors in the aetiology and symptomatology of several diseases. There is evidence that the co-morbidity between mental health problems with chronic illness leads to a worse prognosis, higher burden of symptoms, and more costs for the health system. Furthermore, apart from the individual mental health, the mental health status of the family and other psychosocial factors also account for determining the illness process. However, in Latin America, there is a visible gap in the knowledge concerning the relationship between mental and physical illnesses, particularly for respiratory problems and obesity. Objectives This symposium aims to gather knowledge seeking to: (1) present evidence of the relationship between mental health, psychosocial factors and physical illness from different populations in Latin America, at different stages of development (childhood and adolescence); (2) discuss the appropriate conceptual framework, studies limitations and the guidelines for further research in this topic; Importance Approximately 35 million overweight children live in developing countries and asthma is the most common chronic illness in childhood. Both obesity and respiratory problems account for a major burden of disease in this stage of development. Despite the high prevalence and severe consequences throughout the life course, there is no clear policy for prevention and treatment in Brazil. Understanding this complex relationship can contribute for introducing mental health care for prevention and improvement of the chronic illness prognosis. This work comes from an interdisciplinary group involved in epidemiological research on mental health for many years, which confronts the conceptual and analytical challenges on investigating of mental health, psychosocial factors and chronic illness in two cohorts of children/adolescents living in different low-income settings in Brazil.		
References			
Speakers	Dr. Darci Neves Santos, Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA - Brazil. 2. Dr. Leticia Marques dos Santos. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA - Brazil.”. 3. Caroline Feitosa. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA – Brazil. 4. Dr. Ney Boa-Sorte. State University of Bahia, UNEB. Salvador – BA – Brazil.		
Contact:	Darci Neves Santos Psychiatrist. PhD in Psychiatric Epidemiology, University of London. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Rua Basílio da Gama, s/n - Campus Universitário Canela. Cep: 40.110-040- Salvador – BA. Phone: +55 71 32837453 Fax: +55 71 3336 0695		

Session:	Symposium	SPEAKER 1	Code
Title:	Understanding the complex relationship between mental health, psychosocial factors and chronic disease: a conceptual framework		
Speaker	Dr. Darci Neves Santos, Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA - Brazil		
Abstract	Background: In recent years, there has been an increase in the awareness of the role of mental health and psychosocial factors in the aetiology and symptomatology of several diseases. There is evidence that the co-morbidity between mental health problems and chronic illness leads to a worse prognosis, higher burden of symptoms, and more costs for the health system. Furthermore, apart from the individual mental health, the mental health status of the family and other psychosocial factors also account for determining the illness process. However, in Latin America, there is a visible gap in the knowledge concerning the relationship between mental and physical illnesses, particularly for respiratory problems and obesity. Approximately 35 million overweight children live in developing countries and asthma is the most common chronic illness in childhood. Both obesity and respiratory problems account for a major burden of disease in this stage of development. Despite the high prevalence and severe consequences throughout the life course, there is no clear policy for prevention and treatment for both conditions in Brazil. Understanding this complex relationship in early stages of development can contribute for introducing mental health care to improve the prognosis of chronic illness. Objective: This work aim to gather information from studies in Latin America, presenting the conceptual and analytical challenges on investigating mental health, psychosocial factors and chronic illness in low-income settings in Brazil and to discuss an appropriate conceptual framework, studies limitations, and guidelines for further research in this topic.		
References			

Session:	Symposium	SPEAKER 2	Code
Title:	Maternal mental health and social support: effect on childhood asthma symptoms		
Speaker	Dr. Leticia Marques dos Santos. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA - Brazil.”.		
Abstract	Background: Despite of efforts to identify different risk factors for childhood asthma, the literature didn't establish the etiology for this syndrome, and there is an increasing debate about the psychosocial contribution for this phenomenon. We investigated the effects of family social support and maternal mental health on childhood asthma prevalence, considering differences between asthma phenotypes and the inter-relationship between these factors to explain asthma morbidity. Methods: This is a cross-sectional study of 1013 children participating in the Social Change Allergy and Asthma in Latin America project. Psychosocial data were collected through a household survey utilizing Self Reporting Questionnaire and Medical Outcome Study Social Support Scale. Socio-economic and wheezing information was obtained through the questionnaire of the International Study of Allergy and Asthma in Childhood and level of allergen-specific IgE was measured to identify atopy. Polytomous logistic regression was used to estimate the association between maternal mental health, social support and atopic and non-atopic wheezing. Effect modification was evaluated through stratified polytomous regression according to social support level. Results: Maternal mental disorder had the same impact on atopic (AOR: 1.74, 95% CI 1.12-2.71) and non-atopic (AOR: 1.73, 95%CI 1.17-2.55) wheezing, even after adjusting for confounding variables. Material (AOR: 0.63, 95%CI 0.42-0.95) and informational supports (AOR: 0.60, 0.40-0.90) had protective effects on non-atopic asthma and there is some evidence that social supports may act as a buffer for the impact of maternal mental disorder on non-atopic wheezing. Conclusion: Poor maternal mental health is positively associated with wheezing, independent of whether asthma is atopic or non-atopic, but perception of high levels of social support appears to buffer this relationship in non-atopic wheezers only.		
References			

Session:	Symposium	SPEAKER 3	Code	
Title:	Behaviour problems and asthma: The effect of internalizing symptoms on the onset and course of childhood asthma symptoms			
Speaker	Caroline Feitosa. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA – Brazil.			
Abstract	Background: In recent decades, there has been an increase in asthma prevalence in Latin America. There is evidence that the psychological characteristics of the child are associated with greater asthma incidence and morbidity. In this presentation we will address the results of two studies, with three aims: 1. to investigate the role of behaviour problems in the incidence of asthma symptoms; 2. to investigate whether the presence of behaviour problems decreases the chance of remission of wheezing; and 3. to investigate how these behavioural factors affect the acquisition of severe symptoms. Methods: These were two cohort prospective studies: the first with 907 healthy children and the other with 371 asthmatic children living in a poor urban area in Salvador, Brazil. The psychological characteristics of the child were assessed using the Child Behaviour Checklist (CBCL) and wheezing was defined using the ISAAC questionnaire at the start and end of follow-up. A multiple logistic regression model with random effects was used to examine the association between the psychological components and both outcomes. Results: Children with internalizing problems had an increased chance of developing wheezing (AOR: 2.46, 95% CI 1.40-4.32, p:0.002). The association of internalizing problems with the onset of wheeze was present among atopic and non-atopic children. The remission of symptoms of wheeze was much lower in those children with internalizing problems (AOR: 0.54, 0.33-0.87, p:0.01). Furthermore, internalizing problems increased almost five times the chance of acquiring severe symptoms during follow-up (AOR: 4.03, 95%CI: 1.39-11.70, p:0.01). Conclusion: Children with internalizing problems had a higher chance of developing wheeze and a lower chance of remission, with also an increased risk of acquiring severe symptoms. These results highlight the importance of psychological care for children with asthma, in order to improve the prognosis of this condition.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Emotional and behavioural problems and overweight in adolescents: The role of gender and resilience.			
Speaker	Dr. Ney Boa-Sorte. State University of Bahia, UNEB. Salvador – BA – Brazil.			
Abstract	Background: Overweight and obesity represents a significant and growing public health problem. Recent data in Brazil revealed patterns of rapid growth in the prevalence of obesity amongst adolescents. Experimental and epidemiological studies consider the effect of psycho-emotional factors on an individual's biological system. Despite recent advances, there are still many gaps in this area, with few works addressing protective aspects, such as resilience against disadvantaged environments. This study aims to evaluate the association between emotional and behavioural problems and excess weight in adolescents living in a poor and semi-rural area and to verify the role of gender and resilience in this relationship. Methods: Cross-sectional study including 951 adolescents aged between 11 and 18 years in the district of Monte Gordo, Camaçari, Bahia, Brazil. The Youth Self Report/11-18 was used to assess behaviour problems. Excess weight was diagnosed using the body mass index indicator (BMI) for age +1 standard deviation (SD) from the standard curve recommended by the World Health Organization (WHO). Resilience was measured using the Resilience Scale. Prevalence ratios were estimated using Poisson regression with robust error. Results: We found a positive association between behavioural problems and excess weight (APR: 1.86, CI95% 1.27- 2.73). This association was only observed amongst girls (PR: 1.90, CI95% 1.27-2.83). This finding was also observed for internalizing (PR: 1.63, CI95% 1.12-2.35) and externalizing problems (PR: 1.64, CI95% 1.04-2.58). The magnitude of the association between behavioural problems and excess weight was 1,6 times stronger among adolescents with low resilience. Moreover, we only found evidence of an association between externalizing problems and excess weight amongst adolescents with low resilience. Conclusion: The association observed reinforces theoretical and empirical evidence of a relationship between behavioural problems and overweight/obesity. Special attention should be paid to gender and resilience in respect of treatment and prevention programs for overweight.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	TRANSCULTURAL PSYCHIATRY: WHAT REALLY MATTERS			
Chairperson	John M. de Figueiredo, MD, ScD Department of Psychiatry Yale University School of Medicine. WPA-TPS Treasurer			
Co-chairperson	Joseba Achotegui MD. Psychiatrist. Professor of University of Barcelona.WPA-TPS Secretary			
Abstract	The field of transcultural psychiatry must broaden to social psychiatry. Several aspects will be discussed in this symposium open to epistemological aspects of demoralisation that has to be understood in the context of the patient's individual, social and cultural background, and patients unfamiliar with western-type psychotherapies have to be oriented to guide their expectations before they are treated Chronic and multiple stress in the Ulysses syndrom show the importance to avoid the misdiagnosis and medicalization of stress reaction in the immigrants. The paradigm that underlie transcultural psychiatry in different european countries will be discussed. The objective is to demonstrate that it is necessary to leave the anthropological dogma and take into account the ethical and sociological problems.			
References				
Speakers	1 John M. de Figueiredo, MD, ScD Department of Psychiatry Yale University School of Medicine Tel:+ 203-272-9628 : Fax: 203-272-5124 2. Joseba Achotegui MD. Psychiatrist. Professor of University of Barcelon SAPPRI. Hospital de Sant Pere Claver. Vila I Vila 16. Barcelona 08004, Spain Telephone; 0034- 3. José López Rodas Instituto Nacional de Salud Mental "Honorio Delgado, Perú 4. Rachid BENNEGADI MD Minkowska Center Paris Honorary Member of the World Psychiatric Association. Chair "Medical Anthropology and Psychiatry" Section of the W.A.S.P 00-33-1-53 06 84 84 00-33-1-53 06 84 85 :			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Culture and demoralization in psychotherapy			
Speaker	John M. de Figueiredo, MD, ScD Department of Psychiatry Yale University School of Medicine Tel:+ 203-272-9628 : Fax: 203-272-5124			
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should be able to recognize how to identify demoralization across cultures, the limitations of our current diagnostic systems, and new approaches to arrive at a diagnosis and select the appropriate intervention. Purpose: The purpose of this presentation is to review the theoretical background and the methodological challenges faced in the cross-cultural study of demoralization and psychotherapy and to describe the clinical applications and research prospects of this area of inquiry. Method: A critical review of recent literature on distress and demoralization was conducted with a focus on the application of psychotherapy across cultures. Results: In most societies, members of a culture have attempted to help each other in times of trouble with various types of healing methods. Demoralization - an individual experience related to a group phenomenon - responds to certain elements shared by all psychotherapies. Demoralization follows a shattering of the assumptive world and it is different from homeostatic response to a stressful situation or from depressive disorders. Only a few comparative studies of this construct across cultures have been undertaken. The presentation of distress may vary widely from culture to culture and even within the same culture. To avoid "category fallacy" it is important to understand the idioms of distress peculiar to a cultural group. A cultural psychiatrist or psychotherapist would have to identify patient's values and			

	sentiments, reconstruct his/her personal and collective ambient worlds, and only then study demoralization. The presenting problem has to be understood in the context of the patient's individual, social and cultural background, and patients unfamiliar with western-type psychotherapies have to be prepared to guide their expectations before they are used. Conclusions: Cultural clinicians should consider using a combination of both “clinimetric” and “perspectival” approaches in order to arrive at a diagnosis and identify the appropriate intervention. Future research should identify the gaps in knowledge on the effectiveness of cultural psychotherapy at reversing or preventing demoralization.
References	de Figueiredo JM, Gostoli S: Culture and demoralization in psychotherapy. In press, Advances in Psychosomatic Medicine (invited article). Volume on “Cultural Psychiatry” edited by Renato Alarcon, MD.

Session:	Symposium	SPEAKER 2	Code	
Title:	Immigrant living in extreme situation. New data about “the Ulysses syndrome” among immigrants in Spain			
Speaker	Joseba Achotegui MD. Psychiatrist. Professor of University of Barcelona			
Abstract	I present/ the data of studies conducted in the Public Health Network of Mental Health in Barcelona that shows that the percentage of immigrants who experience the characteristic symptoms of The Ulysses Syndrome is 14,4% . The sample was of 1042 immigrants visited in SAPPRI (Servicio de Atención Psicopatológica y Psicosocial a Inmigrantes y Refugiados). These data are comparable of the data of other studies conducted in the region of Valencia (Spain) that show that the percentage of immigrants who experience the defining symptoms the Ulysses Syndrome is 17.02%. These data show the importance of using this diagnosis to avoid the misdiagnosis and medicalization and psychiatrization of stress reaction in the immigrants. Because the Ulysses Syndrome is not a mental disorder, when in fact what they suffer is a reactive crisis in response to extreme stress directly related to the process of migration (forced solitude, helplessness, persecution...)			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Mental health in Peruvians returnees			
Speaker	José López Rodas. Psychiatrist. Instituto Nacional de Salud Mental Honorio Delgado - Hideyo Noguchi . Universidad Paruana Cayetano Heredia. . Soc. Renato Lopez Guevara. Universidad Paruana Cayetano Heredia			
Abstract	I would like to present a research about the return of immigrants to Peru. In March this year, 12,000 high school students from public schools answered three questions of the MINI MENTAL DEPRESSION, as one of the 0 Suicide Program – 2012. They were also asked if at least one parent had been living abroad. At least 3% of students said that one parent was living abroad. We report only the information of 48 students from four schools. To them was applied the questionnaire allows us to identify indicators of Ulysses Syndrome in their parents.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Challenges for transcultural psychiatry in the new european society			
Speaker	Rachid BENNEGADI MD Minkowska Center Paris			
Abstract	Transcultural psychiatry in European countries today has many faces and is based on different paradigms. It would appear that the European construction requires inevitably a consistent policy of care for migrants and refugees throughout Europe. The Schengen Protocol regulates the immigration process. What about the harmonization of the provision of mental healthcare regarding the language barrier, the cultural representations of mental illness, posing a diagnosis and therapeutic orientation? Also, what is the focus placed on social determinants of mental illness in migratory process and burden of exile. This presentation will focus on the tools needed to enable mental healthcare professionals to develop cultural competence in clinical practice and social practices.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	PARTNERS FOR WELLNESS: THE FOUNTAIN HOUSE MODEL AND INTEGRATED HEALTHCARE		
Chairperson	Alan Doyle EdD, Fountain House, New York		
Co-chairperson	Ralph Aquila MD, Sidney R. Baer Center, New York		
Abstract	In 2011, Fountain House following a long partnership with Dr. Ralph Aquila of Roosevelt Hospital opened the Sidney R. Baer Center, integrating medical and rehabilitative care for people with serious mental illness. With nearly two decades of experience and the recent emergence of a public interest in integrated health care, Fountain House proposes a Symposium on the topic, Partners for Wellness, that focuses on a collaboration of medical and rehabilitative services in psychiatric care. Working communities modeled after Fountain House in association with an integrated medical health facility offer comprehensive, cost-effective community psychiatric recovery centers. As such, Fountain House and those throughout the globe that adhere to its model deliver daily on the goal of deinstitutionalization and demonstrate that people with severe mental illness can live and thrive in our society. Partners for Wellness goes well beyond coordinated medical care, establishing an “alliance” among patients, their clubhouses, psychiatrists, general practitioners, family members, and even friends all in the concerted pursuit of a patient's recovery and wellness. The following issues will direct our discussion: 1. The adequacy of available health and wellness services—including access to both medical care and recovery resources in the community (i.e. employment, housing, friends, etc.). 2. Whether these services are being offered by practitioners who understand that recovery in mental illness means more than symptom relief and community tenure, and who welcome the opportunity to collaborate with community agents in pursuit of quality of life goals. 3. Thinking beyond the clinical management of the disease that instills hope, a sense of self-efficacy, and self-esteem. 4. Reducing stigma and discrimination in our societies with available results from current research including: • Tod Mijanovich PhD (New York University): assessment on hospitalization and service utilization for recipients of Medicaid. • Michael O'Loughlin PhD (Adelphi University): qualitative study of clients' internal life, psychological stress, and trauma		
References			
Speakers	1. Alan Doyle EdD (Moderator), Fountain House, New York, USA, adoyle@fountainhouse.org, Director of Education. 2. Ralph Aquila MD, Sidney R. Baer Center, New York, USA, raquilamd@gmail.com, Director. 3. John Rivera, Fountain House, New York, USA, sunsetlotus@gmail.com, Consumer. 4. Juan Pedro Sapène MD, La Casa del Paraná, Rosario, Argentina, juanpedrosap@gmail.com, Psychiatrist. 5. • Bertil hartoch, Clubhouse de Waterheuvel, Amsterdam, Holland, Director.		
Contact:	Alan Doyle EdD, Fountain House, 425 West 47th Street, New York NY 10036, USA, 1212 482 0340, 212 582-6971 (fax), adoyle@fountainhouse.org .		

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	PROGRESS IN THE STUDY OF DEMORALIZATION			
Chairperson	John M. de Figueiredo, MD, ScD. Department of Psychiatry. Yale University School of Medicine New Haven, CT			
Co-chairperson				
Abstract	Demoralization is the clinical presentation of many, but not all, individuals who seek psychotherapy, many patients with medical illnesses (“giving up-given up complex”), many patients in the emergency departments (“crisis”) and even some patients with chronic mental illness (“social breakdown syndrome”). Demoralization follows the shattering of the assumptive world and it is different from homeostatic response to stressful situation and from depressive disorders. Although originally recognized in psychiatric outpatients and medical settings, it is estimated that the prevalence of demoralization in general populations is quite high and intimately associated with adversity. Research on demoralization has expanded significantly since Jerome D. Frank introduced this clinical construct in the early 1960s. For example, research diagnostic criteria for demoralization have been proposed and several scales have been developed for its assessment. Sub-types of demoralization have been characterized. Demoralization has been documented among immigrants and refugee and has been shown to be a risk factor for certain mental disorders, including major depressive disorder and post-traumatic stress disorder. This symposium will review and discuss recent advances in the study of demoralization and its position in the spectrum of psychopathology. Demoralization may be conceptualized as involving two components, distress and subjective incompetence. As the stressful situation increases in duration or severity, some people with subjective incompetence experience helplessness, and some with helplessness become hopeless, and, at times, suicidal. The relationship of demoralization to the diagnostic categories of DSM-IV will be discussed. The presentation of demoralization in one particular group of subjects, refugee women, will be reported. The challenges presented by the recognition of demoralization in various social and cultural contexts will be examined. Together, these presentations are designed to stimulate our thinking about an important clinical construct that emerges at the boundaries between person and environment, past and future, “normal” and “abnormal”.			
References				
Speakers	1. John M. de Figueiredo, M.D., ScD. Department of Psychiatry, Yale University School of Medicine, New Haven, CT, U.S.A. 2. Chiara Rafanelli, M.D. Department of Psychology, University of Bologna, Bologna, Italy 3. Lynne Briggs, Ph.D. School of Human Services and Social Work Griffith University, Gold Coast Campus, Australia 4. Renato Alarcón, M.D., M.P.H. Department of Psychiatry, Mayo Clinic, Rochester, MN, U.S.A.			
Contact:	John M. de Figueiredo, MD, ScD P.O. Box 573 Cheshire, CT 06410-0573, U.S.A. Tel: 203-272-9628 Fax: 203-2725124 e-mail: johndefig@sbcglobal.net			

Session:	Symposium	SPEAKER 1	Code	
Title:	Demoralization: criteria, assessment and relevance			
Speaker	J. M. de Figueiredo. Yale University School of Medicine, New Haven, CT, U.S.A.			
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should be able to recognize the criteria for demoralization, methods for its assessment and its central role in the spectrum of psychopathology. Purpose: The purpose of this symposium is to present current, state-of-the art information on the recognition of demoralization in medical, social and cultural contexts, and its implications for research and clinical practice. Methods: Theoretical and empirical studies of demoralization were reviewed using both computerized databases and manual searches of the relevant peer-reviewed literature. Results: Demoralization is a spectrum or a gradient that starts with non-pathological distress, increases in complexity with the overlapping of subjective incompetence, moves on to take the form of helplessness, sometimes grows into hopelessness as negative outcome expectations make their appearance, and becomes pathological when it is enduring and causes significant impairment in social, occupational, or other important areas of functioning. In its most severe form, demoralization can be recognized as a syndrome (i.e., an enduring or persistent constellation of symptoms), including helplessness and distress that may be non-specific or specific (i.e., part of a physical illness or another mental disorder). Conclusions: Demoralization meets a clinical need not currently addressed by our existing diagnostic categories and plays a central role in both adaptation to stress and the natural histories of mental disorders.			
References	de Figueiredo J.M.: Deconstructing demoralization: Distress and subjective incompetence in the face of adversity. In: The Psychotherapy of Hope: The Legacy of Persuasion and Healing, eds. Julia Frank MD and Renato Alarcon MD, The Johns Hopkins University Press, 2012 pp. 107-124 de Figueiredo JM: Distress, demoralization, and psychopathology: Diagnostic boundaries. The European Journal of Psychiatry 27(1): 61-73			

Session:	Symposium	SPEAKER 2	Code	
Title:	Characterization of demoralization in the medically ill			
Speaker	C. Rafanelli, University of Bologna, Bologna, Italy			
Abstract	Purpose: There is increasing interest in the issue of demoralization in the setting of medical disease. The aim of this investigation was to use both DSM-IV comorbidity and the Diagnostic Criteria for Psychosomatic Research (DCPR) for characterizing demoralization in the medically ill. Methods. 1700 patients were recruited from 8 medical centers in the Italian Health System and 1560 agreed to participate. They all underwent a cross-sectional assessment with DSM-IV and DCPR structured interviews. 373 patients (23.9%) received a diagnosis of demoralization. Data were submitted to cluster analysis. Results. Four clusters were identified: demoralization and comorbid depression (27.6% of the cases); demoralization and comorbid somatoform/adjustment disorders (18.2%); demoralization and comorbid anxiety (24.7%); demoralization without any comorbid DSM disorder (29.5%). Conclusions. The findings indicate the need of expanding clinical assessment in the medically ill to include the various manifestations of demoralization as encompassed by the DCPR. Subtyping demoralization may yield improved targets for psychiatric research and treatment trials.			

References	Fava GA, Freyberger HJ, Bech P, Christodoulou G, Sensky T, Theorell T, et al. Diagnostic criteria for use in psychosomatic research. <i>Psychother Psychosom.</i> 1995;63(1):1-8.

Session:	Symposium	SPEAKER 3	Code	
Title:	Demoralization—psychological distress among refugee women			
Speaker	Dr Lynne Briggs, Griffith University			
Abstract	Background The international literature on refugees generally focuses on political, economic, and social issues. There is little reference specifically to refugee women's experiences and the resultant mental health implications. These women suffer a variety of human rights violations, but although they are sometimes subjected to similar abuses as men, such as political repression, women are often invisible victims because the dominant image of the political actor in our world is male. Goal The aim of this paper is to highlight the plight of refugee women. In doing so resettlement issues and their impact on mental health are identified. A discussion of the findings of a three-year study that self-report scales to examine the degree of demoralisation and psychological distress among a sample of seventy refugee and migrant women living in Australasia are presented. Results Major findings included a comparison of the mean total scores between the women and men in the study. Scores on the BDI-II that showed that the women were more depressed (mean=22, SD=13.85), than the men (mean=18.83, SD=11.94). Overall, scores from the BHS demonstrated that the women felt slightly more hopeless (mean=7.37, SD=5.31) than the men (mean=5.77, SD=5.02), had more abnormal hedonic tone (mean=2.90, SD=3.66) in comparison to the men (mean=1.53, SD=2.67), and were generally more demoralized (mean=41.99, SD=20.05) than the men (mean=33.73 SD=17.02). Of interest for participants There is a pressing need for services to ensure the mental health and well-being of refugee women and their families are met in a timely and appropriate way that will allow them to adjust more rapidly, to make full use of their skills and knowledge, and begin to rebuild their lives successfully in their new country			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Demoralization: cultural perspectives and their clinical implications			
Speaker	Renato D. Alarcón, MD, MPH. • Emeritus Professor of Psychiatry, Mayo Clinic College of Medicine, Rochester, MN, USA; Honorio Delgado Chair, Universidad Peruana Cayetano Heredia, Lima, Perú.			
Abstract	Demoralization is a term that seems to describe concepts and kinds of phenomena that differ more or less significantly according to the cultural context in which it occurs. These cultural variants are examined in the presentation, with descriptions that undoubtedly reflect contexts and meanings from a diversity of cultural perspectives, also influenced by individual personality traits and idiosyncratic management approaches. After discussing the role of demoralization in the dynamics of the clinical-psychotherapeutic encounter, a clinical assessment of the concept is attempted, emphasizing its characteristics as a cognitive-emotional product, an eventual, ubiquitous symptom, a pre-syndromic state or an improbable clinical entity in a diagnostic/nosological frame of reference. The cultural nature of demoralization makes it possible, in turn, the formulation of a variety of research projects in clinical and psychotherapy areas.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	SUBSTANCE USE COMORBIDITY IN EARLY-PHASE PSYCHOTIC DISORDERS			
Chairperson	Carol L.M. Caton, Ph.D., Department of Psychiatry and Mailman School of Public Health, Columbia University, New York, New York, USA; and Robert E. Drake, M.D., Ph.D., Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA.			
Co-chairperson				
Abstract	Description and justification of the symposium: Substances with psychotomimetic properties, such as alcohol, cannabis, cocaine, and amphetamine, are widely used internationally, particularly by adolescents and young adults. Their use or abuse can provoke psychotic reactions requiring treatment in people otherwise free of serious mental illness. Moreover, concurrent drug and alcohol use by patients with schizophrenia and other primary psychotic disorders is well documented. Substance use and psychosis comorbidity has been associated with a host of negative outcomes, such as re-hospitalization, treatment non-compliance, and homelessness. The diagnostic distinction between a psychotic disorder that is substance-induced and a primary psychotic disorder that co-occurs with alcohol or other drugs is critical for understanding illness course and planning for appropriate treatment. This symposium focuses on clinical and psycho-social similarities and differences between primary psychotic disorders and those that are substance-induced, drawing heavily on the Columbia University Study of Psychosis and Substance Use Comorbidity carried out in New York City. The overall objective is to share with congress participants what is currently known about this important and under-investigated topic, and initiate a dialogue on appropriate treatment interventions and future research initiatives. It is anticipated that interest in this topic will be high, given that substance use and abuse are increasingly common among patients presenting for treatment in psychiatric settings across the globe.			
References				
Speakers	1. Leanne Hides, BBehSc(Hons), Ph.D (Clin), Institute of Health and Biomedical Innovation, Queensland University of Technology, Brisbane, Australia, 2. Deborah R. Becker, M.Ed., CRC, Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA. 3. Carol L.M. Caton, Ph.D., Department of Psychiatry and Mailman School of Public Health, Columbia University, New York, New York, USA, 4. Robert E. Drake, M.D., Ph.D., Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA,			
Contact:	Carol L.M. Caton, Ph.D., Department of Psychiatry, Columbia University, Unit 56, 1051 Riverside Drive, New York, N.Y. 10032, 212-305-3503, clc3@columbia.edu			

Session:	Symposium	SPEAKER 1	Code	
Title:	Differences between first episode psychosis (FEP) patients with cannabis dependence diagnosed with DSM-IV primary and substance-induced psychotic disorders			
Speaker	Leanne Hides, BBehSc(Hons), Ph.D (Clin), Institute of Health and Biomedical Innovation, Queensland University of Technology, Brisbane, Australia,			
Abstract	Objective: To compare the demographic, family, clinical and substance use characteristics of patients with first episode psychosis (FEP) and cannabis dependence diagnosed with DSM-IV primary and substance-induced psychotic disorders. Methods: A subsample of 119 FEP patients with current cannabis dependence were identified from a larger sample of 386 FEP patients (169 (44%) with substance-induced psychosis (SIP; cannabis, alcohol and cocaine induced psychosis were the most common) and 219 (46%) with primary psychosis (PP)) recruited from 5 psychiatric emergency departments in New York city. Sixty of the FEP patients with cannabis dependence had PP and 59 had SIP on the DSM-IV Psychiatric Rating Interview for Substance and Mental Disorders (PRISM). Almost all of the SIPs (N=46, 88%) were cannabis induced. Baseline data on demographic, family, clinical and substance use variables were compared by diagnostic category using t-tests for continuous data and Chi square analysis for			

	dichotomous data. Results: There were no significant differences between the SIP and PP groups with cannabis dependence on demographic variables, the age of onset of drug use or the rates of borderline or antisocial personality disorders, post traumatic stress disorder (PTSD) or substance use disorders. The SIP group with cannabis dependence had significantly higher levels of premorbid adjustment, higher rates of poly-substance dependence, less severe positive, negative and general psychopathology symptoms and higher levels of insight than those in the PP with cannabis dependence group. Conclusions: Current results indicating patients with SIP with cannabis dependence had less severe levels of psychopathology and higher levels of insight than those with PP and cannabis dependence, parallel those found in the original study comparing SIP and PP across all substance types. However, unlike the original study, which found significant between group differences on all types of concurrent substance use disorders except cannabis abuse/dependence, no differences in diagnostic comorbidity on substance use disorders were found, except the SIP with cannabis dependence group had higher rates of poly-substance dependence. Whether the differences between the SIP and PP groups found in the current study are attributable to the presence of concurrent cannabis or poly substance dependence requires further exploration. The clinical implications of these findings will be discussed.
References	

Session:	Symposium	SPEAKER 2	Code
Title:	Early Psychosis and Employment		
Speaker	Deborah R. Becker, M.Ed.,CRC, Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA.		
Abstract	Objective: Employment may be an important factor in helping patients with early psychosis to recover rapidly and to avoid involvement in disability and welfare programs. Methods: This study followed 351 patients with early psychoses, either primary psychoses or substance-induced psychoses, for two years to examine their patterns of competitive employment in relation to service use, psychosocial outcomes, and disability and welfare payments. Results: Workers differed from non-workers at baseline and over two years. At baseline, they had better educational and employment histories, were more likely to have substance-induced psychoses rather than primary psychoses, were less likely to have drug dependence, had fewer negative symptoms, and had better psychosocial adjustment. Over two years, baseline psychosocial differences persisted, and the workers used fewer medications, mental health services, and disability or welfare payments. Conclusions: Employment predicts less service use and fewer disability claims among early psychosis patients. As supported by initial randomized controlled trials, supported employment may be a mechanism to reduce federal insurance costs and disability payments		
References			

Session:	Symposium	SPEAKER 3	Code
Title:	Gender Differences in Patients with Primary and Substance-Induced Psychotic Disorders		
Speaker	Carol L.M. Caton, Ph.D., Department of Psychiatry and Mailman School of Public Health, Columbia University, New York, New York, USA,		
Abstract	Objective: We present comparative data on gender differences in people with primary psychotic disorders (PP) with concurrent substance use and those with substance-induced psychoses(SIP). Gender differences have been observed in studies of schizophrenia with important implications for treatment. Surprisingly, gender differences in psychotic disorders that are substance-induced have not been reported. Gender differences are essential to understanding the onset, course, and treatment of all types of psychotic disorders, including those that are substance-induced. Methods: This report is based on 385 subjects identified during a crisis admission to psychiatric emergency departments in New York City. Study subjects were between the ages of 17 and 45 years, had at least on psychotic symptom identified by the clinical staff, had used alcohol and/or street drugs within the 30 days prior to admission, and had no psychiatric inpatient history prior to the last six months. DSM-IV research diagnoses were made using the Psychiatric Research Interview for Substance and Mental Disorders (PRISM), which was developed to assess psychiatric and substance use comorbidity. In addition to demographic and family characteristics, assessments included the Positive and Negative Syndrome Scale (PANSS), the Premorbid		

	Adjustment Scale (PAS), the Scale to Assess Unawareness of Mental Disorders (SUMD), and the Sexual Abuse Exposure Questionnaire. The study was approved by the Institutional Review Boards of Columbia University and participating hospitals. Results: 217 subjects had PP (affective or non-affective psychoses), while 168 had a SIP (alcohol, cannabis, and cocaine were the most common). Some of the study's findings parallel those from studies of schizophrenia. For example, men in the PP group were younger at illness onset, had more impaired premorbid adjustment, and were less likely to be married or have children compared to PP women. Men in both diagnostic groups had more arrests compared to women. In contrast, women in both diagnostic groups had greater histories of childhood sexual abuse compared to men, and women with SIP had greater recent partner abuse. Post-traumatic stress disorder was higher among women in both diagnostic groups compared to men. Conclusion: Findings confirm the clinical and social impact of substance use disorders in both psychosis groups. Findings underscore the need for treatment interventions that address substance abuse from the beginning stages of a psychotic illness, which for some may involve the criminal justice system. Gender-specific trauma informed services are needed for women in both diagnostic groups that also address the mothering role and care of children.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	Clinical Approaches with Patients who have Early Psychosis and Substance Use			
Speaker	Robert E. Drake, M.D., Ph.D., Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA,			
Abstract	Objective: When patients present with early psychosis and substance use, immediate diagnostic distinctions, medication treatment, and psychosocial interventions are needed, but guidelines are unclear. This paper attempts to provide a structure for thinking about these issues clinically. Method: A review of clinical issues based on the Columbia Study of Early Psychosis and Substance Use and the author's clinical experience working for several years in a clinic for young patients with co-occurring serious mental illness and substance use disorders. Results: The author reviews diagnostic criteria, findings on which patients are likely to convert to primary psychosis from substance-induced psychosis, protocols for medication treatment and suggestions regarding when and how rapidly to taper antipsychotic medications, the need for residential stabilization, family support and education, supported education/employment, cognitive-behavioral treatments, and peer support interventions. Conclusions: Initial treatment should be comprehensive, balancing the need for safety and psychosocial interventions as well as for medications to control psychotic symptoms, but clinicians must explain the potential risks and benefits of on-going treatment			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	THE PARADIGM BETWEEN PSYCHOTHERAPY AND SOCIAL PSYCHIATRY			
Chairperson	Dr. Rachid BENNEGADI: Director of the Research Pole, Sigmund Freud University Paris, France			
Co-chairperson				
Abstract	The Symposium entitled "The paradigm between psychotherapy and social psychiatry" is presented by Sigmund Freud University Paris and the French Association for Social Psychiatry. This symposium focuses on key issues arising in the field of psychotherapy and social psychiatry, such as the impact of psychotherapy on the social organization of a group, a society, or the importance of acknowledging social determinants in mental health care. Exploring such issues would lead to further important research in the field of social psychiatry and mental health care.			
References				
Speakers	1. Dr. Hervé HUBERT: L'Elan Retrouvé, Paris, France. herve_hubert@hotmail.fr "A new concept to be worked on in psychiatry: social transference" 2. Dr. Jalil BENNANI: Psychiatrist / Psychoanalyst - Rabat, Morocco bennani.jalil@gmail.com "How does psychoanalysis participate in social changes in a society?" 3. Dr. Rachid BENNEGADI: Director of the Teaching, Studies and Research Department at the Centre Françoise Minkowska, Psychiatrist, Anthropologist, Paris, France. bennegadi@minkowska.com "The impact of sickness and the elaboration of diagnosis of migrant patients"			
Contact:	Dr Rachid BENNEGADI: Director of the Teaching, Studies and Research Department at the Minkowska Centre, Psychiatrist, Anthropologist, Paris, France, bennegadi@minkowska.com +33153068484.			

Session:	Symposium	SPEAKER 1	Code	
Title:	A new concept to be worked on in psychiatry: social transference			
Speaker	Dr. Hervé HUBERT: L'Elan Retrouvé, Paris, France			
Abstract	The issue of social integration and its success is a fundamental one for persons with mental health problems. There is a new concept that may help us in addition to the tools that we use, a concept which I will define as "social transferences". The word "transference" in psychiatry is historically linked to psychoanalysis and I propose to extend it from the works of Freud, Lacan and others to social relationships and social relations. The beginning of this presentation will focus on the definition of social transference from Freud's study on "Group Psychology and the Analysis of the Ego." This study leads us to two geometric axes to define the problem of transference: a vertical axis that is directed by the One, and a horizontal axis that is oriented towards the equality between people. The aim of the presentation is to extend this approach to the fact that a human being is a social being, a being constituted by social relations. This will allow us to analyze the phenomena of violence and segregation in both the individual and the collective.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	The impact of sickness in the development of diagnosis among migrant patients			
Speaker	Dr. Rachid BENNEGADI: Director of the Teaching, Studies and Research Department at the Centre Françoise Minkowska, Psychiatrist, Anthropologist, Paris, France.			
Abstract	The approach of Clinical Medical Anthropology developed by Françoise Minkowska Centre, a Medical Psycho-Social Centre for migrants and refugees throughout the Paris area, has put the focus on social determinants, which Clinical Medical Anthropology distinguishes as “sickness”. It is frequent in migrant and refugee mental healthcare to include the impact of sickness within the expression of the patient's pathology. The author illustrates his remarks with the case of a patient presenting PTSD given by his own account of his psychological disorders as well as that of his family and environment. However, after taking into account his migratory path and his coping process, it turns out that it is more likely a Ulysses syndrome than a PTSD since fairly quickly, a number of symptoms related to chronic and multiple stress were reversible after a few interviews.			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	How does psychoanalysis participate in social changes in a society?			
Speaker	Dr Jalil BENNANI: Psychiatrist / Psychoanalyst - Rabat, Morocco			
Abstract	Because the symptom belongs to all social classes and that suffering is universal, psychoanalysis concerns all social backgrounds. Even in traditional societies in which there is a predominance of group, psychoanalysis allows individuals to express themselves and to exist. By the changes taking place in them, it can have an influence on their group, their family or friends. Psychoanalysis follows social changes by integrating them into universal values. Issues of identity, culture, language and religion occupy an essential place today. Examine the individual and sociocultural context as part of a universal symbolic field: these are some of the onerous tasks of psychoanalysis.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	SOCIAL, CULTURAL, AND ECONOMIC INFLUENCES ON POST PARTUM DEPRESSION: THE CASE OF ETHIOPIAN WOMEN IN ISRAEL AND ETHIOPIA.			
Chairperson	Rafi Youngmann, Ruppin Academic Center			
Co-chairperson	Ada H. Zohar, Ruppin Academic Center			
Abstract	Objectives: To present cultural and social influences on post partum depression (PPD) by presenting the symptomatology and prevalence of PDD in Ethiopian women in Ethiopia and Israel, and to put it in the context of rural women in developed and developing countries, as well as in the context of world poverty. Methods: A brief overview will precede the four main presentations, followed by comments by the discussant. Results and Conclusions: While PDD is best understood in the context of MDD, the social, cultural, and personal context in which it appears and the way in which it is labeled affect the symptomatology, prevalence, and outcome. The intersection of being poor, living in a rural area, being a member of a minority group, and in stress as a result of childbirth, puts women at considerable risk for PDD. The idiom of distress is affected by cultural, social and economic forces, and needs elaboration if women at risk are to be identified and helped.			
References				
Speakers	1. Dr. Rafi Youngmann, Ruppin Academic Center, Emek Hefer, Israel, 2. Prof. Charlotte Hanlon, Kings College London, London, England 3. Dr. Glasser, The Gertner Institute for Epidemiology and Health Policy Research, Tel-Hashomer, Israel 4. Prof. Coast, London School of Economics, London, England 5. Prof. Ada Zohar, Ruppin Academic Center, Emek Hefer, Israel			
Contact:	Prof. Ada H. Zohar, Ruppin Academic Center, Emek Hefer Israel, 40250. Phone 972-98983013; Fax: 972-98981062			

Session:	Symposium	SPEAKER 1	Code	
Title:	Opening remarks			
Speaker	Rafi Youngmann, Senior Lecturer, Ruppin Academic Center, Israel			
Abstract	In my opening remarks I will briefly address the following issues: • Why study post-partum depression? • What is the validity of this diagnosis and how does it relate to major affective disorder? • What is the prevalence of the disorder and what are generally known to be risk and protective factors? • Why are social, cultural and economic influences of particular interest re post-partum depression?			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	On affective disorders in Ethiopia with special reference to perinatal maternal mental health			
Speaker	Lars Jacobsson, Professor Emeritus, Psychiatric Department, University of Umea, Sweden.			
Abstract	Background: There is a growing body of research on women's health in developing countries, and			

	particularly in African countries. Objectives: In my presentation I will review the research of the last decade in Ethiopia on peri- and post-natal affective disorders in women, with special emphasis on the most recent population study of post-partum depression. Methods: The Perinatal Mental Disorder in Ethiopia study by Dr Charlotte Hanlon and coworkers. The study ascertained a population based sample of 1065 pregnant women and followed then to and after delivery, using culturally appropriate measures and approaches, as well as the EPDS. In addition, qualitative methods were employed for describing the peri- and post-natal local practices. Findings: Self-reported mental disorders in pregnancy had a prevalence of 12%, and postpartum around 5 %. These prevalence estimates are lower than those found in studies in other African settings. Discussion: The lower rates of mental disorders may be a reflection of a high level of adherence to socio-cultural perinatal practices, which were studied in the very interesting qualitative study. Some methodological issues will be discussed, as well as implications for preventive work.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	A Review of Perinatal Depression among Arab women in Israel			
Speaker	Nabil N. Geraisy M.D, M.P.A.H- Deputy of District Psychiatrist- Northern District Health Office- Ministry of Health			
Abstract	Background: The epidemiological data regarding mental health problems in the Arab countries, and regarding Arab women among the Arab minority in Israel are scanty, although the last decade has seen a growth of relevant research. Goals: This report will review the mental health of Arab women in Israel, with a special emphasis on perinatal depression. Results: There is a strong relationship between perinatal depressive symptoms, socio-demographic traits, various risk factors, and interethnic differences among Arab women attending Mother- Child Health Care clinics within the Arab minority in Northern Israel. Recent research shows a high level of emotional distress among the elderly Arab female population, In adolescent Arab girls there is research on eating related attitudes, psychological traits, suicidal behaviors, and treatment lag among first time female patients attending out- patient mental health clinics. Discussion: There is an elevated level of emotional distress among Israeli Arab women, starting with adolescence and culminating in elderly women. In this context the elevation of perinatal emotional difficulties and post-partum depression is easily understood. The implications for clinical care will be discussed. Health policy authorities should be informed regarding the needs of the various sub-populations.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Diagnosis and treatment of postpartum depression in Australian Aboriginal and Torres Island women: Barriers, challenges, and emerging therapeutic interventions			
Speaker	Rachel Bachner-Melman. Social and Community Sciences and Clinical MA Program, Ruppin Academic Center, Emek Hefer, Israel. 2 Psychology, Hebrew University of Jerusalem, Jerusalem, Israel			
Abstract	Objectives: Elevated rates of postpartum depression relative to those of the white Australian population have consistently been reported among Aboriginal women, as well as Torres Strait Island women, whose culture and history are inseparable from the broader indigenous story, yet distinctive from it. There is a significant lack of understanding of the mental health needs of these women during and after pregnancy, and a lack of culturally appropriate clinical tools to help women experiencing postpartum depression and offer them appropriate support. The aim of this presentation is to discuss the unique problems experienced by Aboriginal and Torres Strait women when they give birth, and describe promising, preliminary, culturally sensitive interventions that have been designed and implemented. Methods: A brief overview of some relevant cultural features of Australian Aborigines and Torres Strait Islanders			

	will be given, as well as their unique perspectives towards mental health. The literature on postpartum depression in Australian Aboriginal and Torres Island women will be reviewed, and Australian government initiatives for perinatal care presented. Several initiatives that have been launched throughout Australia to recognize and manage peri- and postnatal distress and depression in indigenous populations will be described. Results: Programs targeting perinatal health in Aboriginal and Torres Strait Islander women via culturally sensitive postnatal services appear to have been successfully implemented. The development of collaborative partnerships between the local community and teams of clinicians and researchers may be cause for cautious optimism. Various cultural considerations in diagnosing and treating peri- and postnatal disorders in Aboriginal and Torres Strait Islander contexts will be highlighted, alongside strengths that exist within the culture that potentially promote postnatal wellness. Results of research evaluating these interventions will be presented, and observations will be offered on the efficacy of existing interventions, problems that have arisen and recommendations for improvements. Conclusion: Evaluations have suggested that a collaborative model of care utilizing cultural consultants or health workers improves the access to and efficacy of the services. Yet postnatal depression still remains a severe problem for a disproportionate number of Aboriginal mothers. Despite encouraging beginnings of collaborative interventions and culturally appropriate services, the need for improved detection and treatment of postnatal depression within Aboriginal and Torres Strait Islander communities remains urgent.
References	

Session:	Symposium	SPEAKER 5	Code	
Title:	Concluding Remarks and Discussion			
Speaker	Ada H. Zohar, Professor, Ruppiner Academic Center, Israel			
Abstract	Objectives: To tie together the diverse findings presented by the three speakers, describing the situation on three continents: Asia, Africa and Australia, by integrating common risk and resilience factors, as well as pointing out differences owing to particular social, cultural or economic factors.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	SERVICE USER AND FAMILY PERSPECTIVES ON COERCION IN PSYCHIATRY			
Chairperson	Andrew Molodynski, consultant psychiatrist, Oxford Health NHS Trust and honorary senior lecturer, Oxford University, Oxford, UK. George Szumukler, professor of psychiatry and society, Institute of Psychiatry, London, UK			
Co-chairperson				
Abstract				
References				
Speakers	1. Dr Jorun Rugkåsa, Senior Researcher, Health Services Research Unit, Akershus University Hospital, Norway 2. Dr Krysia Canvin, Research Fellow, Oxford University Department of Psychiatry, Oxford UK 3. Dr Yasser Khazaal, Geneva University Hospitals and Swiss Society For Social Psychiatry			
Contact:	Andrew Molodynski Oxford health NHS Trust and Oxford University department of Psychiatry Social Psychiatry Group, Warneford Hospital, Headington, Oxford OX3 7JX, UK. +441235799800 andrew.molodynski@oxfordhealth.nhs.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	Family experiences of community coercion			
Speaker	1. Dr Jorun Rugkåsa, Senior Researcher, Health Services Research Unit, Akershus University Hospital, Norway. jorun.rugkasa@ahus.no			
Abstract	Since 2008, mental health professionals in England and Wales have had the option of using Community Treatment Orders (CTO) to oblige patients (who meet the legal criteria) to adhere to treatment while living in the community. As part of a general deinstitutionalisation of care, it is acknowledged that the introduction of CTOs is likely to have impact on patients' families. Little research has been conducted, however, to elucidate exactly what these impacts may be and how they are experienced. As a result, the implications of CTOs on family life are currently poorly understood. Based on a series of qualitative interviews, this presentation will begin to address this knowledge gap by providing an outline of family carers' experiences and opinions of CTOs as currently used in England. Particular attention will be directed towards views about interactions between families and health services.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Pressures in community psychiatric services: Service user perspectives			
Speaker	2. Dr Krysia Canvin, Research Fellow, Oxford University Department of Psychiatry, Oxford UK. Krysia.canvin@psych.ox.ac.uk			
Abstract	Deinstitutionalisation and the shift in the delivery of the majority of psychiatric services to the community setting has led to new demands on the practices, policies and legislation for managing individuals with mental illness. There exist numerous informal and formal pressures aimed at managing service users in the community setting. Informal pressures are those that fall outside legal and policy provision or guidance, such as the practice of 'leverage' (also known as 'informal coercion'), while formal pressures include the use of the Mental Health Act and, more recently in England and Wales, the Community Treatment Order (CTO). Little is known about how these pressures are experienced by			

	service users in the England, especially since the introduction of CTOs. This presentation will discuss the findings of an extensive qualitative study of service users' experiences and perceptions of formal and informal pressures in community psychiatric services. A model depicting the type and range of pressures that service users perceive will be introduced with a view to shedding some light on the mechanisms that impact upon their effectiveness.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Advance directives based on cognitive therapy: a way to overcome coercion?			
Speaker	3. Dr Yasser Khazaal, Geneva University Hospitals and Swiss Society For Social Psychiatry yasser.khazaal@hcuge.ch			
Abstract	Mental health advance directives (ADs) are potentially useful for patients with bipolar disorder. Advance directives based on cognitive therapy (ADBCT) is a cognitive intervention aiming to help the patients during the ADs creation process The aim of the present preliminary study is to evaluate the impact of ADBCT on the number and duration of hospitalizations as well as compulsory admissions and seclusion procedures. Number and duration of psychiatric hospitalizations and number of compulsory admissions and seclusion procedures were recorded for a sample of non-adherent and committed patient 2 years before ADBCT and during a 2 year follow-up period. The number and the duration of hospitalizations as well as the number of compulsory admission procedures reduced significantly after ADCBT in comparison to the 2 years who preceded this intervention. The preliminary study at hand suggests that ADBCT is effective for patients with compliance and coercion problems. These results need to be confirmed in further randomized controlled trials.			
References				

Symposium:**MENTAL HEALTH CARE, MIGRATION AND SOCIETY**

Principal Organizer – Medical Anthropology and Psychiatry Section of the World Psychiatric Association

Co-organizers – Association Française et Eugène Minkowski (AFEM) & Centre Française Minkowska (CFM)

The symposium entitled “Mental health care, migration and society” focuses on the challenges met in the field of mental health care, including the articulation between health services and the need for treatment. The impact of such reflections and expertise are enlightening in terms of mental health spending and public health concerns. The consequences are obvious in terms of best practices and training professionals in the field of mental health. It is important to improve migrants and refugees’ access to mental health care as well as services while taking into account simultaneously social, cultural and psychological elements.

Speakers (Names, affiliations, city, country, email and tentative titles)

1. Mr. Christophe PARIS, Managing Director of the Française Minkowska Centre, Paris, France (paris@minkowska.com):

“Public health approach in offering mental health care for migrants and refugees in France”

2. Stéphanie LARCHANCHE, Medical Anthropologist and Coordinator in the Department of Teaching and Research at the Française Minkowska Centre, Paris, France (larchanche@minkowska.com)

“The role of the Anthropologist in a mediation consultation at the Française Minkowska Centre”

3. Marie Jo BOURDIN, Social worker and Director of the Training Department at the Française Minkowska Centre, Paris, France bourdin@minkowska.com : “Sickness and mental distress”

4. Dr Rachid BENNEGADI, Psychiatrist, Anthropologist and Director of the Teaching, Studies and Research Department at the Française Minkowska Centre, Paris, France bennegadi@minkowska.com

“Psycho-anthropological aspects of acculturation”

Full information of the proposal contact person

Dr. Rachid BENNEGADI, Honorary Member of the World Psychiatric Association. Vice -President of the French League for Mental Health ; Director of the Research Department, Sigmund Freud University ,Paris ; Chair "Medical Anthropology and Psychiatry" Section of the W.A.S.P; Director of the Teaching, Studies and Research Department, CFM, Paris, France ; Co-editor in chief of the Journal "TranSfaire et Cultures" ; Editor in chief of the French Version of the World Psychiatry Journal.

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Other considerations that you would like the Scientific Program Committee to know

Thank you very much

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	IMPROVING ACCESS TO PRIMARY CARE MENTAL HEALTH IN OLDER PEOPLE AND ETHNIC MINORITIES: DESIGN AND EVALUATION OF THE AMP MODEL			
Chairperson	Linda Gask: Professor of Primary Care Psychiatry, University of Manchester, United Kingdom			
Co-chairperson	Carolyn Chew-Graham, Professor of General Practice Research, Research Institute, Primary Care and Health Sciences, Keele University, United Kingdom			
Abstract	Evidence-based interventions exist for common mental health problems. However many people are unable to access effective care, because it is not available to them or because interactions with care-givers do not address their needs. We have developed and evaluated a new multifaceted model for increasing equity of access to high quality primary mental health care for under-served groups (www.amproject.org.uk). There are three components: Community engagement involves information gathering, working with community champions and focus groups and a task oriented community working group to work on identified problems. There is strong engagement with non-governmental organizations and an emphasis on improving health literacy. Primary Care: provision of an interactive needs-led training package to family practice including knowledge transfer, systems review and active linking to other domains of the model. The third element is delivery of culturally sensitive psychosocial Wellbeing Interventions to people with mental health problems (we focused on older people and those from ethnic minority South Asian communities, as these were priorities for the primary care organization with whom we worked in partnership), with individual, group and sign-posting options. This symposium will address important challenges for delivering psychosocial interventions at the interface of primary care, public health and mental health. We will share our experiences of implementing and evaluating this new approach in two deprived communities in the North West of England.			
References				
Speakers	1 Prof Linda Gask, Professor of Primary Care, University of Manchester, UK 2 Prof. Carolyn Chew-Graham, General Practice Research, Research Institute, Primary Care and Health Sciences, Keele University. UK. 3 Dr. Susan Beatty, Research Associate, University of Manchester. UK 4 Ms Saadia Aseem. Research Assistant, University of Manchester, UK			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Improving access to primary care mental health in older people and ethnic minorities: design and evaluation of the amp model			
Speaker	L Gask, University of Manchester, UK			
Abstract	Educational Objectives: At the end of this session, participants will be able to understand: a). Barriers for patients from under-served groups in accessing primary care b). The development of the AMP (Access to Mental Health in Primary Care) model and its three components c). How to specifically implement the community engagement intervention Purpose: Our aim was to increase equity of access to high quality primary mental health care for under-served groups.			

	Methods: Examination of evidence from seven sources brought forward a better understanding of dimensions of access, including how people from under-served groups formulate (mental) health problems and the factors limiting access to existing psycho-social interventions. This informed a multi-faceted model to improve access with three elements: community engagement, primary care quality and tailored psychosocial interventions. Using a quasi-experimental design with a no-intervention comparator for each element, we tested the model in four disadvantaged localities, focusing on older people and minority ethnic populations. Community engagement which we will focus on in this presentation, involved information gathering, community champions and focus groups and a community working group. Results: For Community Engagement, there was strong engagement with third sector organisations, and variable engagement with health practitioners and commissioners. Outputs included innovative ways to improve health literacy. Results from other parts of the intervention will be described in the following presentations. Conclusions: Mental health expertise exists in communities, but needs to be nurtured. Primary care is one point of access to high quality mental health care. Psychosocial interventions can be adapted to meet the needs of under-served groups. A multi-level intervention to increase access to high quality mental health in primary care can be greater than the sum of its parts. Further research is needed to test the generalisability of our model.
References	Dowrick C, Gask L, Edwards S, , et al. Researching the mental health needs of hard-to-reach groups: managing multiple sources of evidence. BMC Health Serv Res. 2009;9:226. Gask L, Bower P, Lamb L, et al. Improving access to psychosocial interventions for common mental health problems in the United Kingdom: narrative review and development of a conceptual model for complex interventions. BMC Health Services Research. 2012; 12(1):249

Session:	Symposium	SPEAKER 2	Code	
Title:	Improving access to primary care mental health in older people and ethnic minorities: design and evaluation of the amp model – primary care quality			
Speaker	C.A. Chew-Graham, University of Keele, UK			
Abstract	Educational Objectives: At the end of this session participants will: Understand a model used to improve Primary Care Quality Appreciate lessons learned from working with practices Purpose: To understand development and evaluation of the Primary Care Quality component of the AMP model to improve access to mental health services in under-served groups. Methods: The process of developing the practice intervention will be described. The aim of the training was to work with whole practices, not just clinicians, and to embed ‘access-friendly’ systems in the practice. The training model included three components: knowledge transfer (sharing information and expertise), systems review (facilitating change within practices) and active linking (with community resources). The model was designed to be relevant to the practice’s everyday work, and flexible enough to respond to the challenges posed by the needs of an individual practice. A process evaluation, using qualitative methods, was conducted. Results: Some practices engaged with the AMP study team more than others, and numbers of workshops held with practices varied from one to 7. Topics covered in workshops included consultation skills training, working with asylum seekers, older people’s mental health, triage. Qualitative data suggests that the training intervention was well received and changes to practice systems were made. Conclusions: ☐ It is possible to develop and offer (and deliver) a flexible package of training to a whole practice			

	☐ Factors influencing engagement are important to consider ☐ A 'Practice champion' is crucial ☐ Practice has to be understood as an organization ☐ Role of research team must be considered ☐ Tensions between research and service ☐ Primary care is necessary but not sufficient
References	Grol R. Knowledge transfer in mental health care: How do we bring evidence into day-to-day practice? Can J Psychiatry 2008;53:275-6.

Session:	Symposium	SPEAKER 3	Code	
Title:	Delivering a tailored psychosocial intervention to older people with depression: patients' and therapists' perspectives			
Speaker	S. Beatty, University of Manchester, Manchester, UK			
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should be able to understand the barriers and enablers to recruiting older people with depression and engaging them in treatment for common mental health problems, and to appreciate older people's and therapists' perspectives on the tailored psychosocial intervention that was delivered. Purpose: To evaluate the accessibility and acceptability of a tailored psychosocial intervention for older people with depression as part of a research programme to improve access to mental health services in primary care for people from under-served groups. Methods: The third element of the AMP model comprised a feasibility study to test the effectiveness and acceptability of a tailored psychosocial intervention for people from under-served groups. As part of the evaluation process, we conducted semi-structured interviews with 14 patients aged 51 to 85 in South Manchester to elicit their views on being referred into the study and receiving the psychosocial intervention. Therapists who delivered the psychosocial intervention were also interviewed. All interviews were audio-recorded, transcribed, and analysed using Framework analysis. Results: Housebound patients appreciated the option of receiving one-to-one sessions at home. Patients who joined a group reported benefit from the mutual support and activities provided. Some patients felt that an age difference between therapist and patient was difficult. Patients reported that they continued to use the behavioural activation techniques to motivate themselves, and some had developed links with organisations where they could then work as volunteers. Therapists commented on the particular challenges in working with older patients: the need to be proactive in encouraging participation, the impact of complex physical health problems on patients' mental health, and how issues from the past impinged on patients' current wellbeing. Conclusions: Accessibility was enhanced by having multiple referral routes. The intervention was generally acceptable in that it met patient need in a timely way, offered choice, and enabled patients to develop strategies to prevent relapse and to make links with organisations to maintain wellbeing.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Delivering a tailored psychosocial intervention to south asians with common mental disorders: balancing choice and necessity			
Speaker	S. Aseem. University of Manchester, UK.			
Abstract	Educational Objectives: At the conclusion of this presentation participants will have an appreciation of the views and experiences of South Asian women in receipt of a culturally sensitive psychosocial intervention for depression in the United Kingdom. They will also understand the importance of balancing choice and necessity in delivering a culturally sensitive intervention.			

	Purpose: To evaluate the delivery, acceptability and cultural appropriateness of a tailored well-being intervention for the South Asians with common mental disorders. Methods: Semi-structured interviews were conducted with 14 South Asian patients in Longsight, Manchester to share their views and experiences about referral, engagement and delivery of the well-being intervention. Additional questions were added to obtain information on the acceptability and cultural appropriateness of the well-being intervention. Three therapists and one supervisor who delivered the psychosocial intervention were also interviewed. All the interviews were transcribed, and data was analysed using computer software MaxQDA and Framework analysis. Results: Being able to experience a sense of empathic connection with the therapist was valued to be as important as cultural matching with and cultural or linguistic competence of the therapist. Some participants preferred to see a therapist who could understand their culture and/or speak their language, but for others the key to satisfaction was feeling that their problems could be understood by the therapist, regardless of their race or ethnicity. Conclusions: When designing interventions to improve access to therapy, it is important that assumptions are not made about requirements based on expectation about desire for cultural matching and language skills. Client choice may vary with time, nature and urgency of presenting problem and specific needs at the time of presentation.
References	

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	NARRATIVE APPROACH TO TREATING OBSESSIONAL DOUBTS AND DELUSIONAL BELIEFS			
Chairperson	Kieron O'Connor. Fernand-Seguin Research Center, Louis-H. Lafontaine Hospital, Montreal (Quebec) Canada			
Co-chairperson				
Abstract	Background information. Obsessional doubt forms a part of obsessional thinking, where the person doubts actions, information, or the self, and ruminates excessively that harm or error 'may' have occurred. Obsessional doubts can become overvalued ideas and form a dimension with delusional beliefs. Such obsessional doubts, overvalued and delusion ideas, are justified by the person through idiosyncratic narratives. These narratives are often overlooked by a symptom based approach but are essential to understanding the personal sense of the beliefs. The person considers the narrative based on authority, prior personal experience, hearsay, facts and logical calculation. But the personal stories contain rhetorical devices and reasoning fallacies which convincingly lead the person into a possible and imaginary world. Hence, restorying the person is a non-confrontational option to modifying beliefs. Goals. This workshop presents a novel narrative approach to evaluating and treating obsessions and delusions. The workshop describes a narrative treatment explicitly targeting obsessional doubt and delusional beliefs. Objectives. The first part of the workshop discusses: the conceptual underpinning of the narrative approach and in particular its grounding within both narrative and reasoning theory; and how the self stories become invested in the obsessional/delusional narrative so making any cognitive challenge extremely menacing to the person. The program is illustrated with clinical case illustrations and audience interaction step by step, soliciting the background narrative, the accompanying reasoning processes, and replacing remote narratives with other more relevant narratives. Distinctions between the current approach and the current cognitive therapy focus are outlined. Interest to the congress participants. The participants will learn how narrative techniques can aid understanding of abnormal beliefs. They will become familiar with narrative case formulation of belief maintenance as the rehearsal of personal stories. They will acquire information on the empirical base of the narrative approach.			
References				
Speakers	1. Kieron O'Connor. Fernand-Seguin Research Center, Louis-H. Lafontaine Hospital, Montreal (Quebec) Canada			
Contact:	Kieron O'Connor, Ph.D. Fernand-Seguin Research Center Louis-H. Lafontaine Hospital 7331 Hochelaga Street Montreal (Quebec) H1N 3V2 Canada Tel: 514-251-4015 x2343 Fax: 513-251-2617 e-mail: kieron.oconnor@umontreal.ca			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	CHALLENGES FOR A FUTURE PSYCHIATRY AND PSYCHOTHERAPY			
Chairperson	Ammon, Maria (Berlin/Munich), Burbiel, Ilse (Munich), German Academy for Psychoanalysis			
Co-chairperson				
Abstract	The objective of this symposium is to present holistic treatment methods for psychotherapy and new approaches of psychosomatic medicine. The authors describe the challenges for a future psychiatry and psychotherapy in a globalized “postmodern” society including the developmental task for the formation of identity as individuals and in groups. Classical contributions of the identity theory in psychoanalysis are reviewed and the consequences of the “intersubjective turn” in psychoanalysis for the definition of self and identity are considered. Guenter Ammon’s interpersonal theory of identity and his concept of social energy are described. Consequences from Guenter Ammon’s theory for the functioning and development of society are drawn. Günter Ammon’s health concept of Dynamic Psychiatry is presented including the conditions necessary to enable groups to facilitate an identity development for their members, virtual their mental-psychological-social health. The authors thus emphasise in particular the promotion of efforts of groups and their members to undertake for autonomy and emancipation as a forceful constructive potential against conformance, resignation and powerlessness in an increasingly unmanageable, bureaucratic, power-focussed and capital-controlled world, estranged from the human being. In addition a survey of the schools of learning in the field of modern psychosomatic medicine is included and the results of special psychosomatic field with the causes of specific psychosomatic illnesses.			
References				
Speakers	1. Maria Ammon, German Academy for Psychoanalysis, Berlin, Germany, DAPBerlin@aol.com The importance of personality as a challenge in our society 2. Ilse Burbiel, German Academy for Psychoanalysis, Munich, Germany info.kalb@psychoanalysebayern.de, Mental health, emancipation and group 3. Bast, Sieglinde, German Academy for Psychoanalysis, Berlin, Germany, bast_sieglinde@gmx.de Psychosomatic Crises or the loss of the human being and modern psychosomatic medicine			
Contact:	Maria Ammon, German Academy for Psychoanalysis, Kantstraße 120, 10625 Berlin, Germany, phone: +4930 3132698, fax: +49303136959, DAPBerlin@aol.com			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	MENTAL HEALTH CONSEQUENCES OF CONFLICT AND DISPLACEMENT: RESEARCH CHALLENGES (PART 1)			
Chairperson	Namrita S. Singh, Johns Hopkins Bloomberg School of Public Health			
Co-chairperson				
Abstract	This symposium, comprising two panels, will examine various aspects of mental health consequences of conflict and displacement. Mental illness contributes significantly to the global burden of disease. Communities affected by conflict and displacement experience unique stressors and barriers to mental health and psychosocial services. Additional research is needed to identify levels of illness across displacement contexts, the relationship between particular stressors and mental health outcomes, and the particular coping mechanisms of groups affected by conflict. Evaluation studies are also needed to assess the efficacy of interventions. The goal of the first panel is to elaborate research methodologies, challenges, and innovations in measuring mental illness among conflict-affected groups. Prevalence levels of disorders and psychosocial problems across conflict-affected groups; measurement of the impact of displacement on mental health; and methods for evaluating the efficacy of mental health and psychosocial interventions will be discussed. What are strategies for accessing 'hidden' displaced populations? What are specific cross-cultural research challenges in defining mental health and illness? What are methods for eliciting local terminology and mental illness constructs? This panel will emphasize psychometric challenges and strategies in the development of mental health instruments in conflict settings, as well as approaches for integrating ethnographic and epidemiological methods. Presentations by panelists will include discussions of: a randomized controlled trial of mental health interventions with torture survivors on the Thailand-Burma border; applying a bio-psycho-social-spiritual theoretical approach to mental health interventions; measuring idioms of distress and well-being among Iraqi refugees in Syria; the development of an integrated mental health diagnostic interview protocol for conflict-affected populations; validation of a symptom measure of psychological distress among Somali refugees in Ethiopia; and validation of a set of mental health measures, as well as the ethnographic assessment of local mental illness constructs, among elderly internally displaced persons in the Republic of Georgia.			
References				
Speakers	1. Courtland Robinson, PhD Johns Hopkins Bloomberg School of Public Health Center for Refugee and Disaster Response, Assistant Professor, Baltimore, USA crobinso@jhsph.edu 2. Constanze Quosh, MA United Nations High Commission for Refugees (UNHCR) Syria, Psychosocial Advisor, Damascus-Kafarsouseh, Syria, and University of New South Wales, PhD Candidate, Sydney, Australia quosh@unhcr.org 3. Brian Hall, PhD Johns Hopkins Bloomberg School of Public Health Department of Mental Health, Baltimore, USA, NIMH Postdoctoral Fellow in Psychiatric Epidemiology bhall@jhsph.edu 4. Alvin Tay, MSc World Health Organization (WHO), Research Assistant, Geneva, Switzerland and University of New South Wales, PhD Candidate, Sydney, Australia alvin.tay@unsw.edu.au 5. Namrita S. Singh, MSc Johns Hopkins Bloomberg School of Public Health Center for Refugee and Disaster Response, NIH Predoctoral Fellow and PhD Candidate, and Behavioral Health Leadership Institute Project Connections community mental health program, Research Associate, Baltimore, USA nasingh@jhsph.edu			

Contact:	Namrita S. Singh, MSc NIH Predoctoral Fellow and PhD Candidate Department of International Health, Social & Behavioral Interventions Center for Refugee and Disaster Response Johns Hopkins Bloomberg School of Public Health 615 N. Wolfe St., Room E5527 Baltimore, MD, 21205, USA nasingh@Jhsph.edu (m) 1-719-339-3327

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	DEPRESSION AND PSYCHOLOGICAL TRAUMA: AN OVERVIEW FOR INTEGRATING EPIDEMIOLOGICAL, NEUROBIOLOGICAL AND CLINICAL ASPECTS IN THE TREATMENT OF DEPRESSION.		
Chairperson	Veronica Vitriol MD, Psychiatrist, Professor of Psychiatry, Medical School of Universidad de Talca, Chile		
Co-chairperson	Alfredo Cancino MD, Family Physician, Psychoterapist, Chief of the Mental Health Unit Cesfam Curico, Chile Carolina Salgado MD, Psychiatrist, Mental Unit Health Talca Hospital, Chile, Professor Psychology Universidad Católica del Maule, Talca, Chile Soledad Potthoff MD, Psychiatrist, Chief of the Mental Unit Health, Talca Hospital, Chile. Kristina Weil MD, Psychiatrist, Associate Professor of Psychiatry, Chief of the Department of Psychiatry, Medical School of Universidad de los Andes, Santiago de Chile		
Abstract	Background information, goals, objectives, importance, and interest to the congress participants, better within 200-300 words. Depression is a major cause of morbidity worldwide. In most countries the number of people who would suffer from depression during their lives falls within an 8–12% range. According to the World Health Organization, unipolar depressive disorders were ranked as the third leading cause of the global burden of disease in 2004 and will move into the first place by 2030. Among the factors that are associated with its development and its increased clinical severity, is the exposure to traumatic events, such as childhood abuse, either sexual or physical, domestic violence, natural disasters, and others. The discussion of the differentiation of depression as "neurotic" or "biological", or the existence of a single depression postulated by DSM classifications has not been elucidated. However clinical experience and evidence have corroborated many decades the effect of certain biographical facts about the psychic apparatus and the appearance of adult disease. Most of the approaches related to trauma have considered PTSD as the main diagnosis. However, depression is a disorder two times more prevalent than PTSD in the general population. The goal of this symposium is to integrate the epidemiological and clinical findings in patients with depression and trauma history, and then to discuss how relevant these findings are for treatment of depression. The objectives will be to review the epidemiological, neurobiological, clinical, therapeutic, and gender related findings that are present in depression associated with psychological trauma. The importance and interest to the participants will be in the possibility to discuss from a bio-psychosocial model the impact of a traumatic event during the life cycle for the development of depressive disorders, and how important it is to deal with such an impact during the treatment of depression.		
References	--Vitriol V, Ballesteros S, Florenzano R, Weil K, Benadof D. Evaluation of an outpatient intervention for women with severe depression and a history of childhood trauma. Psychiatr. Serv. 2009; 60: 636-942. -Cancino A, Asenjo A, Jofre C, History of childhood trauma in women with depression attending in to the Depression Program in 2006, Cegis,año3 no7 ,2007 Weil K , Florenzano R, Vitriol V et al Child battering and adult psychopathology :an empiric study. Rev Med Chile 2004; 132: 1499-1504 Salgado C, Potthoff M.S., Vitriol V. The prevalence of early trauma in 590 outpatients with different diagnoses of complex problems of mental health, in Ambulatory Psychiatric Service of Hospital Regional Talca, Chile 2012, preliminary data		
Speakers	1.- Alfredo Cancino, MD, Family Physician, Psychotherapist, Chief of the Mental Health Unit Cesfam Curico, aecancino@gmail.com, 2.- Carolina Salgado and Soledad Potthoff, Psychiatrist, Hospital de Talca, Chile, carolslg@hotmail.com, 3.- Kristina Weil, MD, psychiatrist, Associate Professor of Psychiatry, Chief of the Department of Psychiatry, Medical School of Universidad de los Andes, Santiago, Chile, kweil@uandes.cl, 4. - Veronica Vitriol, Psychiatrist, Professor of Psychiatry Medical School Universidad de Talca, Chile		
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Session:	Symposium	SPEAKER 1	Code	
Title:	Depression and psychological trauma: epidemiological aspects			
Speaker	Dr. Alfredo Cancino Arce, Ps. María Andrea Asenjo Ramírez			
Abstract	During the past decade, international studies showed that 50% of general population is exposed to potentially traumatic events. Risk factors associated with the further development of psychopathology are female gender, interpersonal trauma and childhood trauma. A series of epidemiological studies has demonstrated that childhood sexual abuse is associated with a range of psychiatric disorders in adulthood that includes mood, anxiety, and substance use disorders. Post-traumatic stress disorder (PTSD) is the most studied diagnosis as a result of trauma. However, depression is a disorder that happens very often after a trauma and it is two times more prevalent than PTSD in general population. Depression is a major cause of morbidity worldwide. In most countries, the number of people who would suffer from depression during their lives falls within an 8–12% range. According to the World Health Organization, unipolar depressive disorders were ranked as the third leading cause of the global burden of disease in 2004 and will move to the first place by 2030. In Chile, the prevalence of depressive symptoms in the last year is 17.7% in general population, with a 25.5% in women. Since 2006, this disease is incorporated to the Explicit Health Guarantees (GES). Since 2002, we have developed research on the prevalence of childhood traumatic antecedents in adults who consult for depression in primary and secondary care in the Public Health Service of Región del Maule, Chile. All these studies have used the Marshall Scale. This scale asks whether an individual has memories of having one or more of the following traumatic experiences before the age of 15 years: traumatic separation from a parent or caregiver, alcohol or drug abuse of a family member, physical injury associated with punishment, and forced sexual contact with a relative or a non relative. Results have shown that between 55% and 82% of depressed patients recall at least one childhood traumatic event, of which 35 to 42% include sexual abuse, in both men and women. In women, the abuse is most frequently perpetrated by family member and in men by non family member. One of these studies demonstrated that traumatic history in women was associated to severe depression with greater symptomatic intensity, suicidal behavior and 49% in prevalence of PTSD. These findings were independent of severity of depression in primary care. These results evidence the high prevalence of childhood trauma, including sexual abuse, in patients who consult for depression in the Mental Health System in Chile. These records are associated to greater severity and comorbidity. According these findings, it requires to ask actively for childhood trauma history, to determine comorbidity and to design specific treatment strategies in patients with depression.			
References	-Caron Zlotnick, Jennifer Johnson, Robert Kohn, Benjamin Vicente, Pedro Rioseco, Sandra Saldivia. Childhood trauma, trauma in adulthood and psychiatric diagnoses: results from a community sample. Compr Psychiatry. 2008; 49(2) 163-169. -Cancino A., Asenjo M. Antecedentes traumáticos infantiles en personas ingresadas al programa de depresión en el CES Curicó-Centro durante el año 2006. FACE- ESGS, año 3, n° 7. Universidad de Talca, noviembre de 2007			

Session:	Symposium	SPEAKER 2	Code	
Title:	Depression and psychological trauma, gender differences and their neurobiological aspects.			
Speaker	Carolina Salgado and Soledad Potthoff, Psychiatrist, Hospital de Talca, Chile,			
Abstract	The clinical considerations in relation to how women respond to experiencing illness in a distinctly different way than men, has only been evaluated in the last decade. Previous to the year 2000 only male study groups were considered for research and the conclusions from those studies were extrapolated to the female gender. However, sexual dimorphism does exist and it is expressed in cerebral functions also and thus in the way illness is manifested and in mental health. Researchers, such as Mary C. Blehar and Miranda Olff, have focused their work on trying to understand the many differences of gender in the rate of prevalence, etiopathogeny, social-cultural factors, and in the response to treatment in different psychiatric disorders, especially PTSD and depression. Hence, different explanations have emerged that concern the exposure of particular types of traumatic experiences which have greater risk in the development of PTSD. Those explanations also include			

	specific gender differences and genetic vulnerability in both psychological and biological response to trauma. Social cultural factors, such as the early exposure to trauma, the role of gender, social position, legal rights, access to education and healthcare, gender violence, previous history of childhood negligence and early attachments problems during infancy, are seen as determining different manifestations and effects of psychological trauma in both sexes. These factors, together with others, can influence an increased frequency of depression and PTSD in women. These social cultural factors are equally as important as considering the intergenerational perspective of the repetition of certain extremely dysfunctional relationship patterns (ex. Domestic violence, sexual abuse, adolescent pregnancy) and also as important as considering the perspective of individual vulnerability. It has been determined that from the occurrence of a traumatic event progressing to the generation of a psychiatric disorder, a cascade of psychological and neurobiological events exist (exposure to trauma, subjective assessment of the event, emotional and behavioral response, neuroendocrine response, coping mechanism, defense mechanism, existence and search of social support). These play an important role in the development of the disorder like depression, PTSD, other anxiety disorders, addictions, etc. It is proposed that there could be a major gender difference in each of the steps of such a cascade of events. It is known that after a traumatic event a neuroendocrine system response is produced, specifically by the SAM axis and HPA axis, and that the principal hormones adrenalin and cortisol are released by each axis and have complementary roles. To reference Miranda Olff's work: Males could be more likely to have sensitized physiological hyper arousal systems (resembling the classical fight or flight paradigm) with relates symptoms such as poor impulsive control, aggression, and hyper vigilance. Women are said to more often have sensitized dissociative systems (resembling more passive defense mechanism) and to be more likely to exhibit corresponding symptoms like anxiety disorders, mayor depression and dissociative disorders. The subjective interpretation of the trauma is as important as the event for the generation of distress and, it has been seen that women tend to subjectively characterize an event in a very threatening way. This is crucial in starting the cascade of psychobiological responses to trauma and could be associated with increased neuroendocrine reactivity. Women and men tend to apply different mechanisms of stress reduction. Women are socialized to use more passive and emotion-focused coping behaviors (dissociation, avoidance) and men are socialized to use more active, instrumental behaviors (hyper vigilance, fight and flight). The lack of social support after a traumatic event plays an important role in how the event is resolved and in the development of psychiatric disorders. It is evident that women are particularly more affected by the availability of social support networks and/or the lack of them. In summary, all these interrelated factors in and of themselves could greatly explain the differences in the prevalence of depressive and anxiety disorders that are found to be more frequent in women.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Clinical Aspects of Trauma			
Speaker	Kristina Weil Parodi. Associate Professor of Psychiatry – Medical School – Universidad de los Andes – Santiago / Chile			
Abstract	Several studies demonstrate the relationship between traumatic experiences and psychopathology. Psychological trauma increases the risk for somatization disorder, personality disorder, depression, alcohol and drugs abuse, eating disorders and others. The relationship between psychological trauma and Post-traumatic Stress Disorder (PTSD) is well known, and the risk of developing the illness is higher if child abuse is given. Certain authors report that PTSD is superimposed with Borderline Personality Disorder, and define a “complex PTSD”. Politraumatized patients should receive a special category, joining axe I and II of DSM classification and should be seen as different as borderline patients. Women with early sexual abuse reported higher rates of complex PTSD and Borderline Personality Disorder, than those with delayed abuse. Sexual abused or victims of parents’ negligence have 4 more possibilities to be diagnosed as Personality Disorder in the adulthood than control subjects. Sexual abuse is related to several diagnoses, with the higher odds ratio with bulimia, alcohol and drugs abuse. Our studies in 4 general hospitals in Chile, recluding 505 patients, revealed high exposure to child			

	trauma, and high association with PTSD, somatization disorder, affective disorder, depression and personality disorder. The transgenerational transmission of trauma and child mistreat was often, expressed by autodestructive behaviours and actual exposure to psychological trauma.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	Depression and Psychological Trauma, Therapeutic Approaches			
Speaker	Veronica Vitriol, Psychiatrist, Professor of Psychiatry Medical School Universidad de Talca, Chile			
Abstract	Depression is a significant public health problem. Risk factors involved in its development and clinical course include a history of childhood trauma. Patients with depression and early trauma often present a more severe and complex psychopathology including posttraumatic chronic symptoms of anxiety and depression, emotional dysregulation and interpersonal impulsiveness, and interpersonal difficulties. The complex clinical picture observed among adults who have a history of childhood trauma has been explained as a process of neurobiological and psychological vulnerability. Patients with depression and early trauma needs multimodal treatment including psychotherapy, pharmacotherapy that will be effective in quieting the body's hyper responsiveness to stress and reverse epigenetic modifications induced by trauma and stress and environmental interventions that provide a support network . According the above in 2000 at Curicó Hospital, located 180 km south of Santiago, In view of such evidence, we developed an intervention for this patient group. In addition to standard pharmacological treatment, the model incorporated a three-month structured intervention by a multidisciplinary team. Its objectives were to actively explore early traumatic experiences among women with depression, determine PTSD comorbidity and to focus psychological treatment on interpersonal difficulties in the present understanding them as repetition of the traumatic past. . The goal of the intervention is to discriminate the present from the past, avoid the re-victimization and promote the desvictimization. This interview was evaluated in a randomized clinical trial in 2002. 44 women with severe depression were treated with the proposed intervention and compared with 43 women who followed the usual treatment. The patients were evaluated at the start, at three and six months with the Hamilton scale, Lambert's Outcome Questionnaire (OQ-45.2), and the posttraumatic eight item treatment outcome (PTO8) After three months there were significant differences in favor of the experimental group in the Hamilton 22.1 versus 27.5 ($p < 0.01$) and in Lambert's OQ45 92.7 versus 105.4 t ($p < 0.05$). At six months there were significant differences in favor of the experimental group in the number of patients with recuperating indicators in the OQ45: 39% versus 14% ($p < 0.05$) and remission in Hamilton scale: 22% versus 5% ($p < 0,05$) We demonstrated that the proposed intervention was more effective than the usual treatment. However, the intervention group persists with symptomatic and dysfunctional indicators at the end of the observation. It must continue to validate long term treatment in these patients.			
References	Saveneau RV, Nemeroff CB. Etiology of depression: genetic and environmental factors. Psychaitry Clinics North Am 2012 35 51-71 Vitriol V, Ballesteros S, Florenzano R, Weil K, Benadof D. Evaluation of an outpatient intervention for women with severe depression and a history of childhood trauma. Psychiatr. Serv. 2009; 60: 636-942.			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	PROBLEMS ON CLASSIFICATION AND LINGUISTIC DISSEMINATION			
Chairperson	Toshimasa Maruta, Department of Psychiatry, Tokyo Medical University, Tokyo, Japan			
Co-chairperson	Norman Sartorius, Association for the Improvement of Mental Health Programmes, Geneva, Switzerland			
Abstract	The publications of the ICD-11 and the DSM-5 are rapidly approaching. In particular, the DSM-5 will be published in May, 2013. Both systems will give huge impact not only to mental health professionals and researchers and but also lay peoples. In this circumstance, it is very valuable to reconsider them from many fields. Firstly, Dr Sartorius will introduce and discuss about the processes of the two systems entitled as “Present challenges facing those proposing of mental disorders” Secondary, Dr. Craig will present and discuss useful classification relevance to rehabilitation entitled as “Diagnostic classification: relevance to rehabilitation psychiatry” Thirdly, Dr. Maruta will present and discuss about linguistic translation problems entitled as “Linguistic translation problems in the Japanese version of the ICD-11 and the DSM-5”.			
References				
Speakers	1. Norman Sartorius, Association for the Improvement of Mental Health Programmes, Geneva, Switzerland, sartorius@normansartorius.com, “Present challenges facing those proposing of mental disorders” 2. Tom K J Craig, Kings College, London, UK, thomas.craig@kcl.ac.uk, “Diagnostic classification: relevance to rehabilitation psychiatry” 3. Toshimasa Maruta, Department of Psychiatry, Tokyo medical University, Tokyo, Japan, maruta@tokyo-med.ac.jp, “Linguistic translation problems in the Japanese version of the ICD-11 and the DSM-5”			
Contact:	Toshimasa Maruta M.D., Ph.D, Department of Psychiatry, Tokyo medical University, 6-7-1, Nishi-shinjuku, Shinjuku-ku, Tokyo 160-0023, Japan, Tel: +81-3-3342-6111(ext. 5754), Fax: +81-3-3340-4499, E-mail: maruta@tokyo-med.ac.jp			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	INCENTIVES & OBSTACLES TO DEINSTITUTIONALISATION IN 21ST CENTURY EUROPE			
Chairperson	Justine Schneider, University of Nottingham, UK			
Co-chairperson	Chiara Samele, Informed Thinking Consultancy, London, UK			
Abstract	The closure of large psychiatric hospitals has been a policy objective for half a century yet they remain the main form of provision in a number of European countries, including Malta, Hungary, Croatia, Bulgaria, Lithuania, Latvia, Romania, Greece, Hungary, Portugal, Slovenia and the Czech Republic. Speakers representing 3-4 of these countries will present the obstacles and incentives to deinstitutionalisation in their particular context, to explore the factors that appear to promote it and those that impede it. The symposium will be steered by the convenors to generate discussion about the most promising 'pressure points' for improving inpatient psychiatric services.			
References				
Speakers	1. Justine Schneider – Introduction to the symposium 2. Ray Xerri, Malta: Fostering de-institutionalisation through legislation in Malta 3. Tomas Petr, Martin Holly, Petr Winkler, Czech Republic: Psychiatric reforms in the Czech Republic. 4. Chiara Samele (UK), Overview of psychiatric inpatient provision in Europe and description of EuroPOPP study. Chair: Justine Schneider, Professor of mental health and social care, University of Nottingham, UK			
Contact:	Justine Schneider, Institute of Mental Health, University of Nottingham, Triumph Road, Nottingham, UK NG7 2TU. Tel: 44 (0)115 846 7307/(0)7843607085. Justine.Schneider@nottingham.ac.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	Introduction to the symposium			
Speaker	Justine Schneider, Professor of mental health and social care, University of Nottingham			
Abstract	"The mental health care field needs both a debate on the values of care and good research on the effects of different forms of institutionalized care" wrote Priebe et al. in 2008, and they also reminded us that "Institutions as such are neither good nor bad, but they always absorb funding" (Psychiatric Services 59, 5 570-3). This symposium will look at hospital care for mental health problems across Europe. Its purpose is to stimulate debate and attention to a topic which has largely disappeared from the research agenda, but which has huge implications for the lives of people affected. The negative impact of deinstitutionalisation on community-based mental health services is debated – what factors mitigate against this? Negative impact on service users may also be relevant - for instance, in England, one of the first countries to embrace deinstitutionalisation, Keown et al. (2011) have demonstrated an association between bed closures and rates of compulsory admissions to the beds remaining in psychiatric hospitals. Contextual factors appear to influence successful deinstitutionalisation – a buoyant labour market and effective social security safety net are likely to promote successful bed closures. European hospitals contain many thousands of psychiatric inpatients. Publicly-available data collated for a recent survey of mental health policy in European Member States and other countries will be used to explore the variations in bed ratios and taking account of different country contexts, to look at the feasibility of deinstitutionalisation, the desirability of implementing alternatives to hospital care, and the factors that promote optimal outcomes for service users.			

References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Fostering de-institutionalisation through legislation in Malta			
Speaker	Ray Xerri, Malta			
Abstract	The new Maltese Mental Health Act was ratified by Parliament in December 2013. De-institutionalisation is one of the main trusts of the new law. Contrary to other countries' policies, the Maltese Ministry of Health has no intention of closing down its main psychiatric hospital though it has been downsized it over the years through a process of integrating previous inmates in the community after a programme of intense rehabilitation. Buildings and healthcare settings do not cause institutionalisation. It is the processes and the professional culture within such institutions that give rise to clients' dependency on the service and facilitates their institutionalisation. The new Act puts the patient at the focus of the service and makes it mandatory that the services provided must cater for the holistic needs of the patient and his social network to foster their effective socio-economic integration. Inter-alia the Act: • Promotes and safeguards the human rights of such a client group • Introduces checks & balances to safeguard patients' welfare and wellbeing through the establishment of the "Office of the Commissioner for the Promotion of Rights for Persons with Mental Disorders". The role of the Commissioner is not solely that of a patient's advocate but also has executive and monitoring roles to ensure that the length of a patient's stay in institutions is appropriate to one's needs. • Ensures that all healthcare professionals are accountable for their interventions in terms of patients' holistic wellbeing. • Specifies that all clients must have a multidisciplinary care plan with clear outcomes within specified timeframes. Health professionals will be constantly audited to ascertain that targets set in the care plans are attained within the shortest possible time. • Any interaction between clients and the service, of what ever nature, must be regulated by standardised patient management protocols which are legally binding to ascertain that the risk of service dependency and institutionalisation is minimised whilst promoting the concept of value for money in service provision			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Psychiatric reforms in the Czech Republic.			
Speaker	Tomas Petr, MSc, Chairman at Psychiatric Section of Czech National Nurses Association Martin Holly, MD, Chairman at Committee of Czech Psychiatric Society of Czech Medical Association of Jan Evangelista Purkyně			
Abstract	The system of mental health care in the Czech Republic is based on the existence of large psychiatric hospitals. A large proportion of these hospitals were built in the early 20th Century. Another important feature of the present system is very sparse network of community services and unequal distribution of outpatient psychiatric care. At the end of 2012, the Ministry of Health decided to transform current system of care for the mentally ill. Main reasons for transformation: - Increase of number of people with mental health problems - compared to 2000 there is the increase in the number of patients, who seek help of psychiatrist by 54% - Mental disorders represent a very significant burden for society - the share of neuropsychiatric disorders in the total amount of years lost to premature mortality and morbidity was 22%, which is the first place before cardiac disease (20.4%) and cancer (13.7%). - the existing system of care based on the existence of large psychiatric hospitals with inadequate levels of hotel services is outdated and rigid and does not effectively provide services and support to the patients			

	- Czech Republic is criticized by European Institutions because not fulfil a human rights of patients. - Psychiatry is underfunded - for mental health care in the Czech Republic goes around 3.5% of the health care budget, while the average in developed European countries is about 8% - stigmatization of people with mental illness is a major problem that can result in delaying the help of professional services and present the negative social consequences following the provided psychiatric care These are the most commonly cited reasons for reform, but there are many others such as the aging population and related problems with dementia, underdeveloped area of child psychiatry, etc. In the symposium we shortly describe the current system of mental health care in Czech Republic, its strengths and weaknesses. We, as members of working group of Ministry of Health, will present the vision of a new structure of psychiatric services and describe the process to achieve a vision step by step. We will share and discuss the main challenges and obstacles, which we experience during the process of transformation
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	Overview of psychiatric inpatient provision in Europe			
Speaker	Chiara Samele (UK), Overview of psychiatric inpatient provision in Europe and description of EuroPOPP study			
Abstract	The latter part of the last century saw the closure of many large mental hospitals across Europe. Some European Union Member States continue to have a predominance of psychiatric hospitals with few mental health services based in the community. While inpatient psychiatric beds form an important part of any mental health service more recent debates have discussed the issue of striking the right balance between psychiatric hospital and community based care. Despite a general decline in the number of inpatient psychiatric care beds over the past decade several European countries have increased their bed numbers in recent years; with growing concerns about the 'new institutions' with the rise in long-stay supported residential accommodation. Inpatient psychiatric care can consume large proportions of expenditure allocated to mental health services, leaving little scope for investing in community based care. Using data from EUROSTAT and the recent literature we show how the rates for inpatient psychiatric care beds in Europe since 2001 have both declined and increased for some countries. These data also reveal the countries with the highest and lowest rates. We also describe the EuroPoPP-MH (European Profile of Prevention and Promotion of Mental Health) project which includes an overview of mental health systems across European Member States and other countries.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	GENDER VIOLENCE: MUTILATED MIND, BEATEN BODY			
Chairperson	Luísa Branco Vicente, Faculty of Medicine, University of Lisbon			
Co-chairperson	Elza Pais, National Parliament Gabriela Moita, Superior Institute of Social Work of Porto Manuel Lisboa, Faculty of Social and Human Sciences, New University of Lisbon			
Abstract	Violence is a social and historical problem which does not obey to any economical, religious or cultural specific levels. Gender Violence remains a multicomplex and controversial problem, even though there were redefinitions to every social levels, namely on its illegitimacy and criminality. The consequences of these violent acts had become a global problem, overcoming cultural and political aspects. Their resolution comes as an emergency when facing repercussions in terms of health, both physical and psychological, given its deconstructing power and its worrying impact above every women life's levels. All over the world, statistics show an increase of Domestic Violence's levels. On the whole, these values are a positive side of the problem, as showing a greater social openness to the approach of this theme and the consequent emancipation of the violated woman. In several of the most developed countries, we are now noting alerts and commitments to pursue policies intending to minimize or eliminate these forms of Violence. Not only prevention, but also victim's assistance comes now as a priority, allowing women to access different support structures, such as mutual support groups and other therapeutic specific projects. Attending to the fact that the fight against Violence has been considered by the World Health Organization as one of the greatest current challenges to Public Health Worldwide, this symposium emerges as a way to actively combat gender violence by sensitizing the participants for this phenomena's complexity, attending to its several cultural, social and psychological meanings and specific dynamics.			
References				
Speakers	1. Luísa Branco Vicente, Faculty of Medicine – University of Lisbon, Lisbon, Portugal, luisabrancovicente@gmail.com, Psychiatrist, Paedopsychiatrist, President of the Portuguese Society of Group Psychoanalytic Psychodrama, Didactic Psychoanalyst. 2. Elza Pais, Parliament, Lisbon, Portugal, elzapais@ps.parlamento.pt, Sociologist, Chairwoman of the Equality Subcommittee of the Committee on Constitutional Affairs, Rights, Freedoms and Guarantees, Researcher of the CESNOVA (Sociology Studies Center -New University of Lisbon). 3. Gabriela Moita, Superior Institute of Social Work of Porto, Porto, Portugal, gabnobmoita@gmail.com, Psychologist, President of the Federation of European Psychodrama Training Organizations. 4. Manuel Lisboa, CESNOVA (Sociology Studies Center - New University of Lisbon), Lisbon, Portugal, m.lisboa@fesh.unl.pt, Sociologist, Director of the National Observatory of Gender and Violence, International expert on gender-based violence for the European Institute for Gender Equality.			
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Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	MENTAL HEALTH CONSEQUENCES OF CONFLICT AND DISPLACEMENT: SERVICE NEEDS (PART 2)			
Chairperson	Namrita S. Singh, Johns Hopkins Bloomberg School of Public Health			
Co-chairperson				
Abstract	This symposium, comprising two panels, will examine various aspects of mental health consequences of conflict and displacement. Mental illness contributes significantly to the global burden of disease. Communities affected by conflict and displacement experience unique stressors and barriers to mental health and psychosocial services. Additional research is needed to identify levels of illness across displacement contexts, the relationship between particular stressors and mental health outcomes, and the particular coping mechanisms of groups affected by conflict. Evaluation studies are also needed to assess the efficacy of interventions. The goal of the second panel is to examine the particular mental health service needs of conflict-affected groups and displaced persons. The panel will discuss different types of mental health and psychosocial interventions with conflict-affected and displaced groups, as well as panelists' direct experiences with service provision. What is the evidence for the effectiveness of different intervention models? What new intervention ideas are emerging? Challenges in service delivery in emergency and humanitarian contexts will be considered, as well as innovations, strategies, and guidelines. Differences in intervention models and service structures with displaced persons in low and middle income countries versus high income countries will also be discussed. The panel will also consider some of the more practical aspects of service delivery, including the hiring, training, supervision, and retention of mental health staff, and strategies for increasing service utilization. Panelists' presentations will include discussions of: best practices in training mental health professionals for work with displaced persons; implementation of community mental health programs in urban contexts, using Cairo as a case study; experiences with mental health service delivery and telemental health for refugees in the West Bank and Gaza Strip; training and retention of community mental health workers on the Thailand-Burma border; and a review of intervention and service models across emergency and resettlement contexts.			
References				
Speakers	1. Nancy Baron, EdD Psycho-Social Services and Training Institute in Cairo (PSTIC), Director; Global Psycho-Social Initiatives (GPSI), Director; and International Trauma Studies Program, International Training Director, Cairo, Egypt drnancyl@gmail.com 2. Bassam Saeed Madi, MD United Nations Relief and Works Agency (UNRWA), Community Mental Health Program, Manager and Public Health Advisor, West Bank, Palestine b.madi@unrwa.org 3. Catherine Lee, PhD Mental Health Assessment Project (MHAP), Program Director, Thai-Burma Border, and Johns Hopkins Bloomberg School of Public Health Center for Refugee and Disaster Response, Postdoctoral Fellow, Baltimore, USA cilee@jhsph.edu 4. Sarah Meyer, MPhil United Nations High Commission for Refugees (UNHCR) Consultant and Johns Hopkins Bloomberg School of Public Health Center for Refugee and Disaster Response, PhD Candidate, Baltimore, USA smeyer@jhsph.edu			
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Session:	Symposium	SPEAKER 1	Code	
Title:				
Speaker				
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Session:	Symposium	SPEAKER 2	Code	
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Speaker				
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Session:	Symposium	SPEAKER 4	Code	
Title:				
Speaker				
Abstract				
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Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	ACHIEVEMENTS, BARRIERS AND FACILITATING FACTORS IN THE IMPLEMENTATION OF NEW COMPREHENSIVE SERVICES FOR PEOPLE WITH SEVERE MENTAL DISORDERS IN PORTUGAL			
Chairperson	José Miguel Caldas de Almeida, Faculdade de Ciências Médicas, Universidade Nova de Lisboa (FCM/UNL).			
Co-chairperson				
Abstract	In the last decade significant strides have been made in many countries in implementing services and programs designed to improve comprehensive mental health care for people with severe mental disorders. The goal of this symposium is to analyze the achievements, barriers and facilitating factors found in this process in Portugal. The members of the panel will discuss the results of studies developed in the country at three different levels – services, programs and interventions. The first study evaluated the implementation of a new psychiatric service in a general hospital responsible for the provision of comprehensive mental health care in a large catchment area of the Region of Lisbon. The second study evaluated the outcomes of an innovative integrated program for people with schizophrenia and schizoaffective disorders in another catchment area of Lisbon. The last study had as its main objective to increase the knowledge on the barriers and facilitating factors found in the implementation of an evidence-based model of case management for people with severe mental disorders at the national level. The symposium will contribute to the discussion of the specific problems found in the implementation, with the resources usually available in the real world, of innovative evidence based practices for the treatment of people with severe mental disorders. A special attention will be dedicated to the identification of the ingredients that proved to have a key role in the successful implementation of those best practices. All these issues are especially important in a time of significant financial constraints, when people with severe mental disorders are particularly vulnerable and the use of existing resources must be based on solid evidence.			
References	Caldas de Almeida JM, Killaspy H (2011). Long-term mental health care for people with mental disorders. European Union, Luxembourg.			
Speakers	1. Graça Cardoso (FCM, Universidade Nova de Lisboa, Portugal, Gracacardoso@gmail.com) & Teresa Maia Correia (Hospital Fernando da Fonseca, Amadora, Portugal): “Implementing a new psychiatric service in a general hospital responsible for the provision of comprehensive mental health care in a large catchment area” 2. Joaquim Gago (Faculdade de Ciências Médicas, Lisboa, Portugal, joaquimgago@me.com): “Outcome study of an integrated program for the treatment of people with schizophrenia and schizoaffective disorders” 3. Pedro Mateus (Programa Nacional para a Saúde Mental, Lisboa, Portugal, pedromateus@mac.com): “Barriers and facilitating factors in the implementation of an evidence-based model of case management for people with severe mental disorders” 4. JM Caldas de Almeida (FCM, Universidade Nova de Lisboa, Portugal, jcaldasalmeida@gmail.com): “Policy implications”.			
Contact:	Prof. José Miguel Caldas de Almeida, Faculdade de Ciências Médicas, Universidade Nova de Lisboa, Campo dos Mártires da Pátria 130, 1169-056 Lisboa, Portugal, jcaldasalmeida@gmail.com.			

Session:	Symposium	SPEAKER 1	Code	
Title:	Implementing a new psychiatric service in a general hospital responsible for the provision of comprehensive mental health care in a large catchment area			
Speaker	Graça Cardoso (FCM, Universidade Nova de Lisboa, Portugal,			
Abstract	1. Objectives			

	To create and run a department of Psychiatry providing comprehensive mental health care in the general hospital and in the community, meeting the WHO and the National Mental Health Direction principles. The main objectives of the new department were to address the mental health care needs including: mental health promotion; prevention and treatment with special focus on severe mental disorders; rehabilitation and social inclusion of people with mental health problems in the catchment area of the district of Amadora and of part of the district of Sintra. 2. Methods Presentation and discussion with the hospital managers of the department plan, main structure, objectives and professional resources, before the department's opening. Regular team discussion of the patients followed, and a weekly meeting of the whole department to insure information updating and continuity of care. Taking in account the opinions of patients and their families, and working with them to meet their needs. Collaboration with the primary care centers, the municipalities and NGOs in the community. Creation of residential facilities and rehabilitation programmes in the community. Annual assessment of the achievements and planning of next year's activities. 3. Results The department comprises the following units working in close articulation: acute inpatient unit, day hospital and consultation-liaison psychiatry in the general hospital, and a community intervention unit. The later comprises four community teams functioning in the primary care and mental health centers, with an assertive outreach intervention. Along with general outpatient mental health care they also provide home visits, psychoeducation, social support, rehabilitation programmes, and an early intervention for psychosis. Two day centers complete the community intervention for severe mental disorders. 4. Conclusion This model of mental health service, including an inpatient unit in the general hospital e multidisciplinary teams in the community, in articulation with primary care and with rehabilitative and residential structures, has proven to be feasible and to respond adequately to the challenges of a large catchment area in Portugal.
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Barriers and facilitating factors in the implementation of an evidence-based model of case management for people with severe mental disorders			
Speaker	Pedro Mateus (Programa Nacional para a Saúde Mental, Lisboa,			
Abstract	1. Introduction Implementation science considers the steps that influence the translation of evidence-based treatments into routine use. The implementation of a new Portuguese National Mental Health Plan started in 2007. In order to improve the way services are delivered, an implementation process for an evidence-based case-management (CM) model was initiated by the National Programme for Mental Health. 2. Objectives To assess the results of a national implementation programme, considering the following dimensions: a) mental health services main characteristics, b) leadership profile, c) main barriers and facilitators to implementation, d) implementation fidelity. 3. Methods 40 public and private mental health services were included in a cross-sectional evaluation. Implementation activities included a CM training programme. Implementation degree, main barriers and facilitators to implementation were rated by: Barriers and Facilitators Assessment Instrument (Peters, 2001) and Illness Management Fidelity Scale (Mueser, 2009). 4. Results Assessment of services showed: liaison with PHC (50%), guidelines use (57%), single clinical record			

	(50%), in service continuing professional education plan (85%), research practice (21%). Regarding professionals profile, 70% used case management in practice, only 20% with previous formal training. After the implementation programme full CM implementation occurred in 36,3% of services, fair implementation in 45,4%, but still not enough implementation fidelity in 18,3%. Main barriers were lack of time (61%), lack of dedicated facilities (59%), low motivation (38%) and absence of financial incentives (36%). 5. Conclusion Despite the efforts to implement evidence-based practices in Portuguese mental health services and a good degree of implementation fidelity, there are still several obstacles that undermine full implementation. Structured implementation programmes may constitute coadjutants to ameliorate the delivery of effective practices.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Outcome study of an integrated program for the treatment of people with schizophrenia and schizoaffective disorders			
Speaker	Joaquim Gago (Faculdade de Ciências Médicas, Lisboa, Portugal)			
Abstract	1. Introduction There are psychological and psychosocial interventions well supported by scientific evidence, which show benefit in conjunction with psychopharmacological treatments. Although this evidence we know that a significant number of people with severe mental illness do not receive the care mentioned. This reality led to the development of integrated programs. 2. Objectives 1) Assessment the feasibility and implementation of an integrated care program, for people with schizophrenia or schizoaffective disorder; 2) Impact evaluation of the program, for these patients and their mental health care delivery. 3. Methods We drew up an integrated care program based on the clinical case management model. Were selected the appropriated interventions: psycho-educative, family-based interventions, strategies for dealing with the symptoms and the disorder, relapse prevention and interventions to improve social and occupational functioning. We did a prospective study with two assessments (one year follow-up). 4. Results Of the 146 patients who started the study, 116(79,4%) were diagnosed with schizophrenia and 30(20,6%) with schizoaffective disorder. After one year the program dropout rate was 18%. The individual care plan was done for 98% of patients. Regarding their employment status, in the first assessment 8(7,4%) were in full time employment and the number rise to 18 (16,7%). In relation to psychopathology, disability, social and occupational functioning, quality of life and patient satisfaction there was a significant improvement. This was not the case with attitudes towards medication and with insight. It happened a decreased in unmet needs and partially met needs and increased in the situations where relevant needs were no longer found. When we compared the year prior to this program and the year after, there were fewer hospitalizations (reduction of 64,1%). Regarding the length of hospitalization there was a reduction of 999 days (65,6%). There was also a 45,6% reduction of relapses. 5. Conclusions It was possible the feasibility of an innovative integrated care program and the implementation of it. In assessing the impact of the program, the results suggest potential application, to improve clinical state and psychosocial variables for these patients. The results obtained are promising for the development of similar programs at nationally and internationally level, that could benefit a wider group of patients.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Policy Implications of studies on the implementation of new comprehensive services for people with severe mental disorders in Portugal			
Speaker	JM Caldas de Almeida (FCM, Universidade Nova de Lisboa, Portugal)			
Abstract	1. Objectives 1- To analyse the impact of the national mental health policy and plan in Portugal in the last 15 years on the improvement of care provided to people with severe mental disorders; 2 - to discuss the policy implications of the results of the studies on the implementation of community-based services for people with severe mental disorders in Portugal. 2. Methods Methods will include the analysis of the results from the studies included in the symposium and of data related with mental health policy and services development in Portugal in the last 10 years. 3. Results The national mental health policy and plan in Portugal resulted in significant developments in community-based services for people with severe mental disorders. Main achievements include significant advances in the replacement of care provided by old institutions by care provided by general hospitals and new community facilities and programs. Several studies proved to be possible with the available resources to develop integrated programs with case management for people with severe mental disorders. Barriers found in this process include inadequate management and financing models as well as lack of trained human resources. 4. Conclusion Strategies to improve the implementation of the national mental health plan in Portugal should include the development of a new financing model, training of mental health professionals in integrated community-based care and continued support to psychosocial rehabilitation programs.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	DISASTER PSYCHIATRY AND PTSD: LESSONS FROM THE PAST AND HOPE FOR THE FUTURE			
Chairperson	Pr Raymond TEMPIER, University of Ottawa & Montfort Hospital, Ottawa, Canada			
Co-chairperson				
Abstract	Goal : to give participants an update on disaster psychiatry and recognition and management of psychological traumas. Background Information: Natural and human disasters can have extensive immediate and long-lasting psychosocial effects. Psychosocial interventions need to be planned and implemented as soon as possible. Traumas can be extended by fears of recurrence. Unique aspects of psychosocial reactions to earthquakes and disasters alike will be addressed and draw on recent experiences of intervention programmes. Objectives: Inform on psycho-therapeutic and pharmacologic treatment of victims and survivors of psychological trauma. Identify factors of severity and long term effects of disasters. Importance & Interest: Disasters can occur anywhere and disaster psychiatry is becoming a major topic for clinicians as any population could be exposed to natural or man-made disasters and bear chronic memories, suffering and bereavement. Immediate response in a form of a tool kit as well as long term treatments will be addressed in this symposium. This symposium will also provide an update on disaster psychiatry and PTSD in light of future developments regarding PTSD diagnoses and treatments.			
References				
Speakers	1. Pr Issack Biyong, University of Ottawa, Ottawa, Canada 2. Pr William Yule, King's College London, London, UK 3. Pr Ka Sunbaunat, University of Cambodia, Pnomh Penh, Cambodia 4. Pr Louis Jehel, University of Antilles Guyane, Fort de France, Martinique, French West Indies 5. Pr Raymond Tempier, University of Ottawa & Montfort Hospital, Ottawa, Canada			
Contact:	Raymond Tempier, Montfort Hospital, 713 Montreal Rd, Ottawa, On, Canada 16137644621 ext 3982, Fax 16137484938 e mail: raymondtempier@montfort.on.ca			

Session:	Symposium	SPEAKER 1	Code	
Title:	Post Traumatic Stress: Update and future developments			
Speaker	Pr Raymond Tempier MD, MSc, FRCPC, DFCPA CES Psy. (France) Professor of Psychiatry, University of Ottawa & Department Chief, Montfort Hospital, Ottawa			
Abstract	-Remind participants that post-traumatic stress focuses on trauma psychological consequences - Appraise the extent of PTSD in various populations, clinical features, new therapeutic approaches and models - Learn about a possible reclassification of the syndrome in light of the DSM V			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Social Psychiatry and primary health care for migrants in the developed countries			
Speaker	: Issack Biyong ¹ , Raymond Tempier ² , B. Kounou ² 1) Department of psychiatry, University of Ottawa, Canada 2) Pr of psychiatry, University of Ottawa, Canada Head Department, Montfort Hospital, Ottawa, Canada 3) Laboratoire du Stress Traumatique (EA 4560), Toulouse, France			

Abstract	1. Show the inventory of primary health problems among migrants in developed countries 2. Highlight mental health as part of overall health problems of migrants. 3. Show the importance of integrating mental health care into primary health care to demystify psychiatric disorders educate and make prevention among these most vulnerable populations. 4. Demonstrate that this approach can overcome the lack of mental health specialists and psychiatrists to better promote social psychiatry for the right for mental care for everybody.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Psychosocial responses to earthquakes			
Speaker	Pr William Yule, Emeritus Professor of Applied Child Psychology, Institute of Psychiatry King's College London			
Abstract	It is now recognised that natural disasters can have extensive and long-lasting psychosocial effects. It is understandable that until now, most effort of emergency services has been aimed at meeting immediate needs for safety, shelter, and physical injuries. However, psychosocial intervention needs to be planned and implemented from the beginning. Not all disasters have the same consequences. It is sometimes said that earthquakes do not cause deaths but that bad buildings do. In other words, earthquakes are natural disasters with a man-made dimension. The trauma can be extended by the fears of recurrence and the presence of aftershocks. Buildings are seen as unsafe – but when is it safe to return to them? Sudden bereavement impacts on the survivors. Trapped and decomposing bodies are difficult for survivors and rescuers alike. Spinal injuries may be common among survivors and greatly complicate the long term psychosocial needs. This paper explores some of the unique aspects of psychosocial reactions to earthquakes and draws on recent experiences of intervention programs.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	The France's National Psychological Response System to Disasters			
Speaker	Pr Louis Jehel (1)(2)(3), F Ducrocq (4), Aforcump-SFP (1) University Antilles Guyane (French West-Indies), (2) University Center Hospital of Martinique, France (3) Research Unit INSERM U669 (4) University Center Hospital of Lille, France			
Abstract	Objective: The organization and implementation of France's national system to respond to terrorism and other catastrophes is described. Method: Following a series of terrorist bombings, France's President established a task force to develop a centralized national system in 1997 to respond to the psychological needs of victims. This network was reinforced in January 2013. As a result, multidisciplinary regional response teams were implemented throughout France. Systematic training was provided these response teams. Response teams were made part of France's national emergency medical system. Results: Since the system's inception, the teams have been activated systematically, responding to several needs of psychological distress after a traumatic event. Victims and professional rescuers reported high satisfaction with these specific psychological services. Conclusion: Discussion will include establishing cooperation between Emergency Medical Service & and the Medico-Psychological teams appropriate protocols, and the advantages and disadvantages of a centralized national response system			
References				

Session:	Symposium	SPEAKER 5	Code	
Title:	Trauma treatment or prevention			
Speaker	Pr Ka Sunbaumat, Dean & Consultant psychiatrist, Faculty of Medicine, University of Cambodia, Phnomh Penh, Cambodia			
Abstract	So far, since the WWI, a lot of man-made disasters, in addition to natural disasters, have caused a lot of victimizations to billions people of many generation. Since “ Société des Nations” has been created nothing changed. Now UN has replaced this first world organization, since then still manmade disasters still continued to occur; traumas existed and continue from individual to individual, from group of persons to groups of persons, communities even nation and from nation to nation and worldwide. A lot of regulation and rules convention have been developed and signed between many countries especially convention for peace. Physicians treated physically damaged people from trauma, psychiatrist, and allied professional tried to operate and build mental health care systems and policy to help those survivors; but still traumas repeated again and again, from generation s to generations traumas continued to cause tremendous psychiatric disorders especially PTSD. Not only the victims but the killers, including militaries themselves, suffered from many kind of psychiatric illness, such as post Vietnam war. Prevention of trauma is not the task of health professionals, but the responsibility of politicians, warriors, weapon producers, and all peace keepers. Traumatization of new generations of victims appears increasing too much faster and greater then what health professional tried to build network, technology to help trauma survivors. To help people in the world to suffer less and less from trauma and to reduce manmade traumas, human being should have a real attitude and ethic as what has been described what human being is different for other being/animals in the world such as wild animal, that they never expand disasters as men.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	PSYCHOSOCIAL BURDEN AMONG THE MARCH 11, 2011 GREAT EAST JAPAN EARTHQUAKE AND FUKUSHIMA DAIICHI NUCLEAR PLANT ACCIDENT VICTIMS			
Chairperson	Jun Shigemura (Department of Psychiatry, National Defense Medical College)			
Co-chairperson				
Abstract	On March 11, 2011, Great East Japan Earthquake and subsequent tsunami struck the northeast coast of Japan. The damage was devastating, with nearly 19,000 people dead or missing. The Fukushima Daiichi Nuclear Power Plant accident subsequently followed, and had caused complexity to this already tragic disaster. Mandatory evacuation measure has been in effect in the neighboring region; the displaced residents are uncertain of if they will ever be able to go back to their hometown. The invisible nature of radiological contamination provokes immense fear and uncertainty; health concerns are prominent, younger people are moving out, and there have been reports of discrimination and stigma to the affected people. A large number of nuclear plant workers are also local victims, and they not only experience the clean-up responsibility but also strong guilt for the outcome of their workplace. The decommissioning process is expected to take decades, but such struggle makes it challenging for these workers to maintain their mental health. This symposium will have talks from three Japanese professionals that have been providing care to the victims of this complex disaster.			
References	1. Shigemura J et al: Psychological distress in workers at the Fukushima nuclear power plants. JAMA 308:667-9, 2012. 2. Shigemura J et al: Launch of mental health support to the Fukushima Daiichi Nuclear Power Plant workers. Am J Psychiatry 169:784, 2012			
Speakers	1. Yuriko Suzuki, MD, PhD National Institute of Mental Health, National Center of Neurology and Psychiatry yrsuzuki@ncnp.go.jp “Psychological distress of the residents in Fukushima” 2. Jun Shigemura, MD, PhD National Defense Medical College Tokorozawa, Japan shige@ndmc.ac.jp “Mental health consequences of the Fukushima nuclear plant workers following the Fukushima Daiichi Nuclear Power Plant accident” 3. Kazuma Yonekura Director Soma Wide Area Mental Health Care Center Nagomi yonekura-k@soso-cocoro.jp “Activity Report concerning the Great East Japan Earthquake: What happened then? What should be done next?”			
Contact:	Jun Shigemura, MD PhD Department of Psychiatry National Defense Medical College 3-2 Namiki, Tokorozawa, Saitama 359-8513 Japan Tel +81-4-2995-1619 Fax +81-4-2996-5203 Email shige@ndmc.ac.jp			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	NONCOMMERCIAL ALCOHOL			
Chairperson	Matthew Testa, International Center for Alcohol Policies (ICAP)			
Co-chairperson	Andrey Soloviev (Deputy Director, Institute of Psychology and Psychiatry, Northern State Medical University; Arkhangelsk, Russia; ASoloviev@nsmu.ru)			
Abstract	The World Health Organization estimates that nearly 30% of all alcohol produced, sold, and consumed around the world is not reflected in official statistics. These beverages, which can be called “noncommercial alcohol,” include traditional drinks produced for home consumption or limited local trade, unregistered and counterfeit products, and nonpotable surrogate alcohol. The products are generally not taxed or regulated, and their sale and purchase cannot be easily monitored or quantified. Because they are usually significantly cheaper than commercial products, noncommercial beverages tend to be favoured by poor and marginalized populations, and are often the beverage choice of many individuals who drink excessively. In addition, since they are not subject to formal quality checks, they may pose health risks due to adulteration or unsanitary production and storage. This symposium is focused on understanding the informal alcohol market as well as its public health implications in various low- and middle-income countries, including Russia, China, Brazil, Kenya, and India. Speakers will share the results of recent surveys in these countries addressing noncommercial alcohol consumption patterns, socioeconomic status, and mental and physical health outcomes. Speakers will also discuss possible treatment, intervention, and prevention strategies to reach groups that are most at risk of consuming noncommercial products harmfully, as well as policy considerations for reducing harm			
References				
Speakers	1. Andrey Soloviev (Deputy Director, Institute of Psychology and Psychiatry, Northern State Medical University; Arkhangelsk, Russia; ASoloviev@nsmu.ru) – chair 2. Ian Newman (Director, Nebraska Prevention Center for Alcohol and Drug Abuse, University of Nebraska–Lincoln; Lincoln, Nebraska, USA; ian@buffalobeach.com) 3. Elisaldo A. Carlini (Director, Brazilian Centre for Information on Psychotropic Drugs [CEBRID]; Professor, Universidade Federal de São Paulo, Departamento de Medicina Preventiva; São Paulo, Brazil; eacarlini@gmail.com) 4. David Ndeti (Professor, University of Nairobi and Africa Mental Health Foundation; Nairobi, Kenya; dmndeti@amhf.or.ke) 5. Amit Chakrabarti (Professor of Pharmacology, Sikkim Manipal Institute of Medical Sciences; Sikkim, India; amitchakrabarti@hotmail.com)			
Contact:	Mr. Matthew Testa, International Center for Alcohol Policies, 1519 New Hampshire Avenue NW, Washington, DC 20036, USA; tel: +1 202 986 1159, fax: + 1 202 986 2080, mtesta@icap.org			

Session:	Symposium	SPEAKER 1	Code	
Title:	Official bans and hidden opportunities— Unregistered alcohol consumption in the European North of Russia			
Speaker	Andrey Soloviev Northern State Medical University, Arkhangelsk, Russia			
Abstract	The European North of Russia is historically a mostly “alcohol” but not “drug” territory due to its remoteness from major drug trafficking, the “dead-end” nature of its location, its low rankings on social and economic indicators, its adverse climate for producing plant-based drugs, and its lack of factories producing legal drugs. Drinking patterns in the European North of Russia are characterized by the northern style of alcohol consumption, involving mainly strong spirits consumed in large doses and with great frequency.			

	Despite the local administration's attempts to reduce official rates of alcohol abuse, legislative initiatives have sometimes had unexpected consequences, including a rise in the consumption of noncommercial alcohol. There are several features of the hidden marketing and illegal distribution methods of noncommercial alcohol: advertisement on the street; sale after 10:00 p.m.; services for the home delivery of alcohol with food, including at night; sale of alcoholic beverages in addition to other goods; promotions in shops, such as "3 bottles for the price of 2" and "additional bottle with discount"; the sale of alcohol in shops without a receipt at night; the sale of alcohol in taxis; advertisements in the free newspapers about technical fluids at a discount; and sale of industrial alcohol at home. At a broader level, other characteristics of the noncommercial alcohol market have been observed: a decline of home-produced alcohol for sale; mass consumption of beverages that are legal but not good quality; and high consumption of technical ethanol (hydrolysis, sulfite). In this situation the following opportunities for intervention may be suggested: continuing analysis of the features of cheap alcohol sales; ongoing checking of poisoning by alcohol surrogates, taking into account local climate conditions; improving toxicological techniques to identify poisonings by technical alcohol and technical fluids; evaluating of the impact of noncommercial alcohol on the overall dynamics of population alcohol consumption; and evidence-based proposals to support local legislative initiatives.
References	

Session:	Symposium	SPEAKER 2	Code
Title:	Summary of a three-year study of noncommercial alcohol production, sale, and consumption in China		
Speaker	Ian M. Newman , PhD Director, Nebraska Prevention Center for Alcohol and Drug Abuse University of Nebraska-Lincoln		
Abstract	OBJECTIVES: This presentation summarizes the results of a three-year study of family- or village-produced alcohol in rural China. The context of China's alcohol culture and the local environments of noncommercial alcohol production are also discussed. METHODS: The first phase focused on describing the methods used to manufacture distilled spirits. The second phase involved interviews with 259 village residents, including alcohol makers, sellers, and village leaders. The third phase involved chemical analysis of samples of the noncommercial alcohols sold in the villages where the interviews were conducted, in rural Hubei Province. The fourth phase involved interviews with a random sample of approximately 1,000 rural residents in each of three different provinces in China: Anhui, Hebei, and Hubei. RESULTS: Noncommercial alcohol producers were found to distill spirits from grain using simple and traditional methods. Producers and sellers expressed pride in their reputation, which they sought to protect by making or selling only quality products. Chemical analysis of 36 samples of spirits indicated alcohol content of 38.7% to 56.2% by volume and no evidence of extreme measures of harmful substances. All 3,268 persons surveyed in phase four had consumed alcohol in the last year. Among males, 35.1% reported drinking daily; among females, 11.8%. Consumers in Anhui and Hebei preferred commercial spirits; in Hubei, noncommercial beverages. Reasons cited for choosing noncommercial alcohol included cost (35.9%) and taste (27.1%). Males reported consuming 2.5–3.1 liangs per drinking occasion, while females reported 1.3–2.2 liangs per occasion (1 liang = approx. 50 g or 1 jigger). CONCLUSION: In China, informal alcohol production is not illegal, and the product and the makers are respected members of their communities. Making, selling, buying, or drinking noncommercial alcohol are considered normal, unremarkable behaviors. In rural communities alcohol production is part of a social network that ensures the safety of the product. Consuming indigenous alcohol is preferred by older rural men. As this population declines it is possible that noncommercial alcohol production will also decline, negating the need for additional regulations. If indigenous alcohol were taxed, it would be a source of revenue for the government, but demand would fall, as price advantage is one of the major reasons for purchase cited by consumers. This study suggests that the strategies promoted in the West to reduce alcohol-related problems may not be as effective in societies where commercial and noncommercial alcohol play a different role in family and community life.		
References			

Session:	Symposium	SPEAKER 3	Code
Title:	Study of noncommercial alcohol in the states of São Paulo and Minas Gerais, Brazil		
Speaker	Elisaldo A. Carlini Centro Brasileiro de Informações sobre Drogas Psicotrópicas (CEBRID), Departamento de Medicina Preventiva, Universidade Federal de São Paulo (UNIFESP).		
Abstract	INTRODUCTION: Commercial beverages, especially beer, account for most of the alcohol beverages consumed in Brazil. However, the formal beverage alcohol market coexists with an increasingly important noncommercial market. According to estimates by the Ministry of Agriculture, 95% of cachaça stills are thought to be clandestine, contributing 10% to 20% of total production. There has thus far been only limited research on the subject, especially on related aspects such as counterfeiting, tax evasion, and methanol poisoning. METHODS: Our research on unregistered alcohol beverages was divided into two stages: a study in two municipalities of the state of São Paulo (SP) in 2010, followed by a study in five municipalities in the state of Minas Gerais (MG), in 2011 and 2012. These studies utilized methods and techniques that included semi-structured interviews with consumers and producers, chemical analysis of alcohol beverages, and requests for institutional data. Interviewees were adults selected at random in public places. We also analyzed 2,808 news items that dealt with alcohol, drugs, or related policies in Brazil. RESULTS: Most participants (77.7% in MG, 96.5% in SP) stated that they were familiar with unregistered alcohol beverages. A high proportion of respondents (66.5% in MG, 80.5% in SP) stated they have consumed unregistered beverages, mostly cachaça; among this group, 19.8% in MG and 26.8% in SP stated they know they have consumed counterfeit beverages. Respondents cited the low price of unregistered beverages, the availability of such beverages, and cultural tradition (for homemade beverages) as factors in their consumption. A large majority of participants also stated that the effects of these beverages on health are negative. Chemical analysis of noncommercial beverages (mostly cachaça) revealed the presence of methanol and higher-chain alcohols in many samples but mostly in concentrations below the legal limit. Hydrocyanic acid, precursor of ethyl carbamate, was found in 85 of 87 samples from MG and 24 of 65 from SP. Data from three institutions indicated three distinct types of problems associated with production and sale of unregistered beverages: crimes against the economic system, crimes against public health, and subsistence production. Of the 2,808 media news items, only nine dealt with unrecorded alcohol. CONCLUSIONS: Further interdisciplinary studies on unregistered alcohol in Brazil are needed. Although many people perceive there are various health and socioeconomic disadvantages associated with unregistered beverages, consumption of these beverages is prevalent nonetheless. Future actions to promote public health in relation to registered and unregistered alcohol beverages should consider primarily access to information, cultural values, and income level.		
References			

Session:	Symposium	SPEAKER 4	Code
Title:	Noncommercial alcohol consumption patterns in Kenya		
Speaker	David Ndeti, University of Nairobi and Africa Mental Health Foundation		
Abstract	OBJECTIVES: Traditional noncommercial alcohol drinks, which include homebrews and home-distilled beverages, account for an estimated 74% of the total alcohol consumption in Kenya. Since these products are untaxed and can use low-cost ingredients and production methods, they tend to be cheaper (volume for volume) than their commercial counterparts. The consumption of noncommercial alcohol is highest among the poor, who cannot afford commercially produced beer or spirits. Because some of these beverages are produced illegally in hidden, unhygienic conditions, they are not always inspected for consumer safety. This study had the following objectives: to examine the patterns of production, sale, and consumption of noncommercial alcohol; to analyze the composition of noncommercial alcohol products; to examine the views and attitudes of stakeholders regarding the production, sale, and consumption of noncommercial alcohol; and to establish whether the people who consume noncommercial alcohol suffer from any mental or physical alcohol-related problems. METHODS: Consumers in a rural location (Kibwezi) and urban location (Kangemi) answered survey questions and kept diaries of their consumption for 30 days. Interviews were conducted with consumers, producers, and sellers of noncommercial beverages. RESULTS: Men made up 81% of the 320 consumers interviewed in the initial phase of the study. Most consumers were casual laborers, have only a primary-school education, and very low income. In the sample of consumers from across the Kibwezi District, two-thirds reported earning less than KES 4,000		

	shillings (USD \$47.60) per month. Among the positive effects reported were reduction of stress, ease in talking with others, meeting and making new friends, sleeping well, getting the energy to work, reducing pain, relaxing after a hard day's work, finding happiness, getting a good feeling, and providing a way of socializing and forgetting one's problems. However, half of all consumers showed signs of a major depressive disorder, according to the MINI Plus neuropsychiatric interview. Only 22.8% of consumers from the initial phase said that the alcohol they consumed had negative effects, such as family problems and medical problems. CONCLUSIONS: The study confirmed that poverty is a significant factor in the noncommercial alcohol market in Kenya. Most consumers have very low income and choose noncommercial beverages because they cannot afford commercial ones. These consumers face numerous physical and mental health risks from the daily consumption of beverages often produced in unsanitary conditions as well as from using other substances and having poor access to healthcare.
References	

Session:	Symposium	SPEAKER 5	Code	
Title:	Noncommercial alcohol consumption in three Indian states			
Speaker	Amit Chakrabarti, Sikkim Manipal Institute of Medical Sciences, Sikkim, India Currently: Regional Occupational Health Centre (ROHC), Eastern National Institute of Occupational Health (NIOH), Indian Council of Medical Research (ICMR)			
Abstract	INTRODUCTION: India has a rich tradition of noncommercial alcohol consumption and production. Because licensed alcohol beverages are considerably more expensive, home-brewed and illicit liquor are popular among people at lower socioeconomic levels. Such liquor is mostly produced in small batches by distillation or fermentation commonly using cereals as raw materials. However, with no legal quality-control checks in place, noncommercial alcoholic beverages can have alcohol content as high as 56% and may be adulterated. OBJECTIVES: A study to assess the nature and patterns of noncommercial alcohol consumption and production in India was conducted in two rural and two urban sites in Sikkim, two rural sites in Assam, and two urban areas in West Bengal. These states have distinct cultural characteristics as well as their own traditional alcohol beverages. METHODS: Across all sites, 1,207 subjects responded to a generic questionnaire to measure sociodemographics and alcohol consumption, the CAGE questionnaire to assess alcohol dependence, and the SF-36 questionnaire to measure quality of life; 1,137 participants kept a 30-day diary to record alcohol consumption and contexts of drinking. RESULTS: Differences in alcohol beverage preferences were observed among the study sites and among socioeconomic groups within some study sites. Participants had low socioeconomic status, with average monthly earnings ranging from 3,578 rupees (USD \$65) to 6,041 rupees (\$109). Average monthly expenditure on alcohol ranged from 436 to 976 rupees (\$7.87–\$17.62). A high percentage (66%–99%) had scores of 2 or more on the CAGE questionnaire. Most consumers drank daily, starting early in the day. Location of consumption (bars, homes, production facilities) varied by study site. Almost all study participants indicated that they felt no adverse effects of noncommercial alcohol; many reported some beneficial effects. Although 85% of all participants said that their current overall health was good, 26% said that their overall health was worse than it had been during the previous year. Chemical analysis was performed on 35 samples of noncommercial alcohol beverages collected from study sites in Sikkim and West Bengal. The samples contained moderate ethanol content ranging from 20% to 27% by volume. Methanol concentrations in all samples—even for distilled beverages known sometimes to be adulterated—ranged from 0.32% to 0.57% v/v.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	PSIQUIATRIA SOCIAL E REABILITAÇÃO PSICOSSOCIAL NO SÉCULO 21: MUDANÇAS DE PRÁTICAS, MUDANÇAS DE SISTEMAS E MUDANÇAS DE PARADIGMAS E FORMAS DE PENSAR A ATENÇÃO A CRIANÇAS E JOVENS NO BRASIL			
Chairperson	Ligia Costa Leite, PhD em comunicação, Professora do Instituto de Psiquiatria/ Universidade Federal do Rio de Janeiro (IPUB/UFRJ)			
Co-chairperson	Ana Maria Fernandes Pitta, MD, PhD, Universidade de São Paulo (USP), Universidade Católica de Salvador (UCSAL), World Association for Psychosocial Rehabilitation (WAPR) and Izabel Christina Friche Passos, PhD em psicologia Universidade Federal de Minas Gerais (UFMG), Associação Brasileira de Saúde Mental (ABRASME)			
Abstract	A proposta para este simpósio visa discutir as mudanças e transformações, que vêm sendo realizadas no Brasil, em três aspectos: (1) rede de cuidados em saúde mental; (2) práticas institucionais; e (3) ideias e conceitos. Estes aspectos estão presentes na atenção e reabilitação psicossocial para adolescentes sem privilégios, em quatro diferentes contextos e cidades brasileiras: Rio de Janeiro (Rio de Janeiro), Salvador (Bahia), Belo Horizonte (Minas Gerais) e Itapecuru-mirim (Maranhão). O intuito é partilhar estas experiências com outros países que vivenciam as mesmas questões de abandono e desesperança da juventude que encontra nas drogas, no abandono das famílias, nas escolas e políticas públicas negligentes, o estímulo para uma marginalidade/ criminalidade crescente. Estes trabalhos têm demonstrado uma evidência fundamental: a necessidade urgente de implantar políticas públicas de prevenção e proteção à saúde mental para essa juventude, uma precondição para o desenvolvimento da nação. Este é um tema de crescente importância para a saúde psíquica de adolescentes no mundo globalizado e individualizado atual, onde o sujeito jovem está cada vez fragmentado entre desejos e possibilidades. Os cinco apresentadores estão desenvolvendo ações e criando metodologias inovadoras ao longo dos últimos anos, que incorporam os adolescentes como protagonistas dessas ações, dando-lhes voz, para conhecer seu mundo e poder mediá-lo com o resto da sociedade e têm influído em mudanças significativas em algumas políticas públicas			
References				
Speakers	1. Ligia Costa Leite, PhD em comunicação Professora do Instituto de Psiquiatria/ Universidade Federal do Rio de Janeiro (IPUB/UFRJ), Brazil 2. Ana Maria Fernandes Pitta, MD, PhD Universidade de São Paulo (USP), Universidade Católica de Salvador (UCSAL) Brasil, World Association for Psychosocial Rehabilitation (WAPR) 3. Carlos Augusto de Araújo Jorge. Médico psiquiatra. Ex-diretor do Centro Psiquiatrico Pedro II, Secretário Municipal de Desenvolvimento Social e Sub-Secretário de Proteção Especial da Secretaria Municipal de Assistência Social do Rio de Janeiro, Brasil			
Contact:	Ligia Costa Leite, PhD em comunicação Professora do Instituto de Psiquiatria/ Universidade Federal do Rio de Janeiro (IPUB/UFRJ), Av. São Sebastião, 241, Urca, Rio de Janeiro, Brazil, 22291-070 Phone: 55 21 93220531 or 55 21 38735567 Fax: 55 21 25433101 ligia.cleite@gmail			

Session:	Symposium	SPEAKER 1	Code	
Title:	A abordagem da reabilitação psicossocial em grupos terapêuticos para jovens que acolhidos na rede de abrigos da municipalidade			
Speaker	Ligia Costa Leite, PhD em comunicação Professora do Instituto de Psiquiatria/ Universidade Federal do Rio de Janeiro (IPUB/UFRJ)			
Abstract	Esta apresentação objetiva descrever como a abordagem da reabilitação psicossocial é importante e válida no trabalho terapêutico com jovens que se encontram abrigados na rede de acolhimento municipal, em função de medidas de proteção especial determinadas pela lei brasileira. A falta de políticas públicas inclusivas e preventivas produz riscos psicossociais e sofrimento psíquico e gera diferentes formas de violência, em particular a silenciosa, esta expressa pela ausência de direitos civis e de cobertura em saúde mental para essa juventude. O trabalho reabilitativo, feito em grupos de jovens e seus cuidadores, provou ser um instrumento capaz de gerar mudanças no comportamento dos jovens, atuando em sua autoestima e autoconhecimento, de modo a que eles pudessem pensar em um projeto de vida para conviver em sociedade. Esta abordagem pode ajudar mediar conflitos e criar vínculos mais sustentáveis entre adolescentes, cuidadores sociais e a equipe terapêutica do IPUB. Ela também possibilita a perspectiva de um destino diferente para suas vidas. A experiência será ilustrada, neste simpósio, pela apresentação de um grupo clínico com nove meses de duração. Suas narrativas e avaliações finais do trabalho confirmam por suas próprias vozes, a transformação neles vivenciadas. Enfim este trabalho pode ser considerado uma evidência da necessidade urgente de implantar políticas públicas nesta área, de modo a fortalecer a saúde mental dessa juventude, uma pré-condição para o desenvolvimento da nação.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Projeto Capitães de Areia: Trabalhando em rede de cuidados para crianças e adolescentes no Centro Histórico de Salvador, Bahia			
Speaker	Ana Maria Fernandes Pitta, MD, PhD em Saúde coletiva Universidade de São Paulo (USP), Universidade Católica de Salvador (UCSAL), World Association for Psychosocial Rehabilitation (WAPR)			
Abstract	A equipe do Projeto Capitães de Areia iniciou suas atividades em 2008 e trabalhando no Centro Histórico de Salvador, Bahia com o objetivo de oferecer cuidados abrangentes para crianças e adolescentes que vivem em situação pessoal e social de vulnerabilidade (estão nas ruas e geralmente envolvidos com o uso e abuso de substâncias psicoativas, em especial o crack), através de ações de promoção, prevenção no processo de recuperação de sua saúde, assim como para sua reabilitação psicossocial. A parceria com o Projeto Axé, que vem atuando há vários anos nesse local, possibilitou mapear o território, identificar e abordar o grupo de usuários. Usamos a técnica de “pedagogia do encontro” como um recurso de aproximação e vinculação. Esta técnica consiste em ter sempre presente no território dois ou três profissionais da equipe, junto a educadores de rua já conhecidos pelo grupo-alvo, de modo que as crianças e adolescentes se acostumem com esta presença e gradualmente permitam uma aproximação. Depois desses contatos iniciais, adotaram-se estratégias de fortalecer os vínculos, buscando identificar as demandas emergenciais, facilitar o acesso aos serviços de saúde e, em uma abordagem intersetorial, estimular este público ao autocuidado e empoderamento para sua cidadania.			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Embaixada de Liberdade: um verdadeiro acolher, Rio de Janeiro			
Speaker	Carlos Augusto de Araújo Jorge. MD Foi Secretário Municipal de Desenvolvimento Social e sub Secretário de Proteção Especial da Secretaria Municipal de Assistência Social do Rio de Janeiro			
Abstract	O objetivos desta apresentação é relatar uma experiência, desenvolvida entre 2008-2010, de acolhimento, a crianças e adolescentes que permaneciam, dias a fio, na chamada cracolândia nas ruas de Manguinhos/Jacarezinho, considerada a maior existente na cidade do Rio de Janeiro, em condições de extrema vulnerabilidade. Trabalho foi inspirado na compreensão de princípios das embaixadas: “Um território livre em outro território”. A liberdade, a aceitação do outro em sua própria condição, o respeito e o afeto constituíram suas principais matrizes, com embasamento técnico nos trabalhos e premissas de Nise da Silveira e Franco Basaglia. A Embaixada da Liberdade era um espaço de acolhimento, aberto, situado a poucos metros da chamada cracolândia. Seu funcionamento foi aos poucos sendo determinado pelos próprios usuários e, segundo narrativas dos próprios jovens, possibilitava mudanças em seus hábitos e maior segurança nas suas vidas (redução de riscos e danos). A experiência piloto foi pensada para atender diariamente vinte e cinco crianças e adolescentes, porém não demorou a passar a atender diariamente a uma média entre cinquenta a setenta pessoas. Funcionou por aproximadamente um ano e meio, sendo desativada, após mudança de gestores, para dar lugar a uma política de “recolhimento, internação ou abrigamento compulsório”.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	FROM THE PAST TO THE FUTURE: WHAT WE HAVE LEARNT FROM THE ITALIAN EXPERIENCE ON SOCIAL PSYCHIATRY			
Chairperson	A. Bellomo, Department of Medical science, Psychiatric Unit, University of Foggia			
Co-chairperson	Co-organizers: S. Rullo, Therapeutic community, Rome			
Abstract	Description and justification of the symposium or workshop: The Italian Law 180 determined the shift from an hospital-centred service to a model of community psychiatry, and thirty-four years have elapsed. The main principle stated by the Law 180 is patients' right to be treated in the same way as patients with other diseases. Moreover, according to the reform law, only voluntary treatments are allowed while compulsory treatments are strictly regulated. The main features and consequences of the Italian reform are discussed, national and local experiences are analysed in order to describe main objectives achieved by the Italian experience. In many parts of the country the implementation of community-oriented models of mental health care has been successful. In fact, mental health care has been made accessible to many people with mental needs who would have refrained in the past from any contact with old-fashioned system based on the asylums. The quality of care delivered is, however, still questionable in several areas of the country, and there is the room for improvement. Moreover, it is still difficult to provide an evidence-based reply to the question if the Italian model can be exported elsewhere. In particular, it will be discussed the effects of Italian reforms on specific topics such as early intervention services, addiction disorders, trauma-related disorders, migration.			
References				
Speakers				
Contact:	A. Fiorillo, Department of Psychiatry, University of Naples, SUN, Largo Madonna delle Grazie, Naples, Italy, telephone:0039 0815666531, fax: 0039 0815666523 anfiioril@tin.it			

Session:	Symposium	SPEAKER 1	Code	
Title:	Community residential services without mental hospitals: the Italian Utopia			
Speaker	Santo Rullo. Therapeutic community, Rome			
Abstract	Italy was the first country 35 years ago which stopped psychiatric hospitals to focus on local services. The culture of the country was not ready for a so epoch-making step. Despite this, psychiatric revolution went forward resulting in a very uneven diffusion of good and bad practices. In particular the residential structures had to invent a new way to offer psychiatric assistance, doing care not to become new small asylums. This great change has been supported by a culture of social psychiatry clinical oriented and together by a very ideological attitude. This ambiguity has never completely resolved: today no one questions the closure of mental asylums, but social integration has not yet become collective heritage. Residential programs are far from being considered anything other than houses for social exclusion. Psychosocial interventions are the basis for a modern residential approach based on recovery and social integration.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Cultural adaptation and mental illness: language- proficiency among hospitalized immigrant psychiatric patients in Italy			
Speaker	A. Bellomo, A. Ventriglio			
Abstract	Lack of cultural adaptation may risk or worsen mental illness among immigrants, and interfere with			

	assessment and treatment. Language-proficiency (LP) seems essential for access to foreign environments, but the limited research concerning its effects on mental-health care encouraged this preliminary study. We reviewed clinical records of all immigrant psychiatric patients hospitalized at the University of Foggia in 2004–2009 (N=85), and compared characteristics of patients with adequate versus inadequate language proficiency (LP). Subjects (44 men, 41 women; aged 35.7±10.0 years) represented 3.62±0.94% of all hospitalizations (2004–2009). Most (60.0%) had emigrated from other European countries. Many were diagnosed with a DSM-IV unspecified psychosis (40.0%) or adjustment disorder (18.8%), and 45.9% were in first-lifetime episodes. Average comprehension and spoken language-proficiency (LP) was considered adequate in 62.4% and inadequate in 37.6%. In multivariate modeling, adequate-LP was more prevalent among women, emigration from another European country, receiving more psychotropic drugs at hospitalization, and having entered Italy legally. Findings support an expected importance of LP among immigrant psychiatric inpatients, and encourage language-assessment and training as part of comprehensive support of such patients, especially men.
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Session:	Symposium	SPEAKER 3	Code	
Title:	Bio-psychosocial models: the self-help approach beyond addictions.			
Speaker	L. Janiri, G. Camardese. Catholic University, Rome, Italy			
Abstract	The role of the empowerment of personal resources in cooperative processes is becoming increasingly important in bio-psychosocial models. Particularly rooted in rehabilitation settings, self help activities include all initiatives an individual autonomously promotes to search for any external support (1). Alcoholics Anonymous groups were historically the first self help groups, early followed by other self help approaches to various forms of both chemical and behavioral addictions. In the last 20 years many thematic groups have been proposed to patients with somatic diseases, distress situations or psychiatric disorders, and yet to family members of problem subjects. In spite of such widespread variety of applications of the model, some common characteristics may be recognized: mutual support, empathetic links, sharing emotions and experiences, information, communication (2). Programs inspired to the social model of recovery involve non-professional figures and treatment sites other than hospitals or mental health facilities, thus providing not expensive therapeutic tools (3). Also in Italy this promising approach to mental disorders and distress, based upon practice and experience more than technical training or education, represents a sort of “from bottom” revolutionary turning in treatment philosophy. Data coming from a national survey on self help-based rehabilitative experiences in psychiatry will be presented.			
References	1) G. Camardese, L. Janiri (Eds.) (2012) Manuale di riabilitazione per i disturbi dell’umore. Alpes, Roma, pp. 161-167 2) L.H. Levy (2000) Self-help groups. In: J. Rappaport & E. Seidman (Eds.) Handbook of community psychology. Kluwer, New York, pp. 591-613 3) D. Barrows (1998) An historical and developmental analysis of social model programs. J. Subst. Abuse Treat. 15: 7-17			

Session:	Symposium	SPEAKER 4	Code	
Title:	New challenges in social psychiatry in Italy			
Speaker	A. Fiorillo. Department of Psychiatry, University of Naples SUN			
Abstract	The radical changes occurred to the Italian mental health care after the promulgation of the psychiatric reform law in 1978 caused the shift from a predominantly hospital to a predominantly community-based model of care, making psychiatry more social. Many challenges have been faced by social psychiatrists in the last 30 years, and some of them are still on the agenda of mental health professionals. One of these challenges is to fight stigma against mental disorders and to reduce social disadvantages of the mentally ill. In fact, despite anti-stigma campaigns have been conducted for more than 30 years, they seemed to be ineffective so far, as the public image of psychiatry is still detrimental. Sensitization campaigns are highly needed, but they should be targeted where stigma arises, i.e. in the school, the workplace, the media. One further challenge is to provide evidence-based psychosocial interventions in routine care. In recent multicentric Italian studies, the main obstacles to perform routinely psychosocial interventions in mental health centres were organizational difficulties, such as work overload and lack of time from professionals. Modern national policies should consider this when dealing with new guidelines and treatment plans in mental health care. Finally, the impact of migration cannot be ignored by Italian social psychiatrists. New users and new diagnoses are often coming to psychiatric consultation, but psychiatrists are not yet adequately equipped to treat them. Training on how to manage emerging psychiatric syndromes has to become a priority. Other challenges will arise in the years to come. This means that social psychiatry in Italy is still alive, and will continue to be.			
References				

Session:	Symposium	SPEAKER 5	Code	
Title:	Early intervention in the real world, between clinical and social needs: one five years Italian experience.			
Speaker	R. Pollice. University of L'Aquila, Italy			
Abstract	In recent years, enthusiasm has grown for the need to rapidly identify and treat patients at risk to develop psychiatric disorders in the earliest stages of the illness.^{1,2} The advantages of early intervention in any illness are well known, with additional benefits to be gained in severe and long-standing psychiatric conditions such as schizophrenia. It is known that people with an at-risk mental state are typically unwell for a considerable time before accessing effective treatment. In this regard, early recognition and initiation of treatment in its broadest sense is crucial in improving clinical outcome not only in subjects at increased risk for psychosis but also for those at risk of mood and anxiety disorders. Notably, early identification of people at risk to develop severe psychiatric conditions is paramount especially in young people.⁸ It is the mission of our experience to reduce the burden of mental suffering in young people by means of an earlier recognition of signs and symptoms, systematic evaluation of psychological distress and promotion of attitudes that encourage young people to seek care. We also aim to reduce the delays that young people at incipient risk of severe psychiatric illness experience in accessing appropriate psychiatric care. Our first five years experience at our service for Early Interventions in Psychiatry, clearly suggests that early recognition and treatment is feasible across of a wide range of psychiatric diagnoses and is not limited to psychosis. Moreover, our approaches for destigmatizing mental illness might enable better management in symptom control. Of interest is also the observation that considerable effort has been expended to ensure an adequate continuity of care by networking between our staff, hospital psychiatrists and primary care providers. In conclusion, our little experience has established a comprehensive early intervention service providing most of the mental health service requirements for young people, across a broad range of mental suffering states and overt psychiatric symptoms. Notably, it is a significant advance over what was provided before in Italy. Hopefully, the development of early intervention programmes for mental suffering will result in better linkages between child and adult psychiatry services and also with those involved in long-term care to ensure treatment of psychiatric disorders throughout the life cycle.			

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Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	THE EVOLUTION OF SOCIAL PSYCHIATRY IN THE MEDITERRANEAN REGION IN THE XX AND XXI CENTURIES			
Chairperson	A. Guilherme Ferreira, President Mediterranean Sociopsychiatric Association			
Co-chairperson	Ramón Blasi i Ras, Me.Sp.A.			
Abstract	Social psychiatry appeared as an answer to the crisis of the Psychiatric Hospital, in the aftermath of World War II. Developed initially in anglo-saxonic countries, it spread, in a second step, precisely in the Mediterranean Region, before it reached practically all the World. It led to the construction of a preventive psychiatry which principal aim is naturally Mental Health Prevention The evolution of this approach in the Mediterranean Region is described and an example is given through the description of an intervention in Catalonia Two important problems rise in this moment in the Mediterranean Region: a) An important crisis reached the Mediterranean Region, firstly, in its European Shore and, in second step, in the Arabic Countries, after the emergence of a political struggle. Different ways to overcome this situation are analyzed. b) The problem of migration, very important in the European Countries, is studied as well as the development of an acculturation, which is the consequence of the individual trajectories of the migrants.			
References	A. Guilherme Ferreira, President Mediterranean Sociopsychiatry Association Av. Mouzinho de Albuquerque Lote B1 -7º - Lisboa, 1170-259 Portugal, Former Director and Chief of Service of Miguel Bombarda Hospital Tel. (+351) 218123438 Email: ag.ferreira@netcabo.pt			
Speakers	1. A. Guilherme Ferreira, President Mediterranean Sociopsychiatric Association, former Director and Chief of Service of Miguel Bombarda Hospital - Lisboa, Portugal, email: ag.ferreira@netcabo.pt - "Survey of social psychiatry evolution in the Mediterranean Region in the XXth and XXI centuries" 2. Ramón Blasi i Ras, Teaching and Research Centre C.D.D.R., ARAPDIS – Barcelona, Spain – email: rblasi@arapdis.org - "Social and Community psychiatric in Catalonia" 3. Rachid Bennegadi, chair of Network "Migration and Mental Health" – Paris, France - email: bennegadi@minkowska.com – "Why so much emphasis Odysseus to return to Ithaca" 4. A. Guilherme Ferreira, President Me.Sp.A. - "The socio-economical situation in the Mediterranean Region and its repercussion in Mental Health"			
Contact:	A. Guilherme Ferreira, President Mediterranean Sociopsychiatry Association Av. Mouzinho de Albuquerque Lote B1 -7º - Lisboa, 1170-259 Portugal, Former Director and Chief of Service of Miguel Bombarda Hospital Tel. (+351) 218123438 Email: ag.ferreira@netcabo.pt			

Session:	Symposium	SPEAKER 1	Code	
Title:	Survey of social psychiatry evolution in the Mediterranean Region in the XXth and XXI centuries			
Speaker	A. Guilherme Ferreira President Mediterranean Sociopsiquiatrie Association			
Abstract	After World War II there was a general contest to psychiatric hospital. Social Psychiatry movement appeared as a possibility to find new ways of psychiatric intervention. Born in Anglo-Saxon countries first as an intervention in hospitals and in patient units (therapeutic communities in Anglo-Saxon countries, institutional psychotherapy in France) and, in a second moment, in community itself through the support of out patients units and of self- help groups and networks that give support to individuals in risk. These kind of interventions were also developed in the Mediterranean Region, in a first step, in the Northern shore, composed by European and Christians countries and in Israel and in a second moment, in the Southern shore, constituted by African and Muslims countries. In consequence, a general movement developed conducting to a psychiatry centered in Mental Health promotion and, naturally, to Mental Illnesses prevention, in its three intervention areas. This evolution is analyzed and discussed and its results presented.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Social and community psychiatry in catalonia			
Speaker	Ramón Blasi, Teaching and Research Centre C.D.D. R. ARAPDIS			
Abstract	The evolution of "Social and Community Psychiatry" in Barcelona and Catalonia began 4 decades ago when a group of professional people formed a movement. This movement was in reply to the need to widen the field of work which up until then had been almost exclusively medical. It was also to serve as a union in the integration of the dynamic space with an open minded point of view, integral and integrating as regards the multi-disciplined concept of working in a team. All with the end in view of the future model "Psychosocial Comprehension of the Mentally Ill Patient and Community Intervention". More than 38 years ago, in 1971, the first "Day Centre (C.O.S.E.)" was set up. Then in 1973, with the first reform, some mental health clinics became "Mental Hygiene Centres". In 1981 the present day system with "Mental Health Centres" finalized the reform and settled the present day form with the "Psychiatric Reform in Catalonia" known as the "Catalan Model". 20 groups of postgraduates have obtained a "Master in Social Psychiatry" and we must look on the teaching of this subject as a valuable factor which is a basic and permanent support of our work. This work is continued and strengthened in our "Specialized Continued Training Programme" in "Integral Psychosocial Rehabilitation in the Community". It is organized by ARAPDIS "Document, Teaching and Research Centre". In 1982 an "Alternative Model of Postcure" was set up by Integral Reinsertion" (R.I). A combination of resources, techniques and interventions, created and interwinned progressively so as to be able to act on "deficits" at all "levels" as much as on the part of the "patient" as on the part of the "family" and also the "immediate environment". In "Catalonia the Psychiatric Reform" began officially in 1970 with a simple and futile sectorizing of the "Psychiatric Hospitals". In 1981 the "Real Reform" began with the development of a flexible, communicative, broad based and progressive model known as the "Catalan Model". In these almost 30 years of continuous evolution, we have undergone different stages with different policies from the varying political and administrative heads. As these varied, the course of these years has been unstable and variable. In some cases "Supply and Demand" has meant the collapse of the care system or fears of its disappearance. All this has meant that 1000 hospital beds are no longer necessary. The preset day budget is 450 million euros for "Psychiatric Health Care in Catalonia". In this exposition of past, present and future perspectives we present several works implemented at the CIS in SMC (Urban Therapeutic Community) in the district of Gràcia, with "24 hours Emergency Service, Sub-acute Admission, 2 Day Hospitals and Specialized Outpatient Consultation" with a multi-skilled team with 20 years of evolution (1994-2014).			

References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Why so much emphasis by ulysses to return to ithaca ?			
Speaker	R. Bennegadi Chair of Euromed Network "Migration and Mental Health"			
Abstract	The blind oracle, Tiresias, must have told him that apart from the pleasure of reuniting with his family, he would have a tragic destiny. Had Ulysses been practicing denial due to the fact that he knew he would perish by the hand of his own son? Obviously it is not Telemachus, the cherished son he had with Penelope, but rather Telegonus, the son he had with Circe, as she had never accepted that the Gods of Olympus, through Athena, separated her from the son of Laertes. Nostalgia is not what it once was, and Homer knew that we would be more interested in a heroic reunion rather than the miseries of reality. We will use the power of metaphor in order to discuss the work of acculturation and the changes it imposes, hence giving a less glamorous perception of migration trajectories.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	The socio-economic situation in the mediterranean region and its repercussion in mental health			
Speaker	A. Guilherme Ferreira President Mediterranean Sociopsychiatric Association			
Abstract	Since 2005, a severe economical crisis reached the Western World and, particularly, the Southern European Countries (In.E.U.) that constitute precisely the Northern Shore of the Mediterranean Sea. In these countries the GDP fall intensely (or at least rise very slowly) and, consequently, the personal income of their populations less also strongly. Similarly, in Arabic Countries of its Southern Shore, the so called Arabic Spring (as it is designated in Western Europe) developed and seems to lead to a similar situation. A research is proposed to be developed in all these countries (on at least in some of them, chosen aleatorilly) through structured clinical interviews in order to determine the repercussions this situation had on Mental Health and how it can be lessened through different preventive measures and which changes these facts should determine in the organization of Mental Health services and programs in order to answer to it.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	Healing through cathartic experiences. Analogy between religious rituals and psychotherapies			
Chairperson	MARCOS DE NORONHA BRAZILIAN ASSOCIATION OF CULTURAL PSYCHIATRY , BRAZIL			
Co-chairperson				
Abstract	1. Joseba Achotegui, University of Barcelona, Spain 2. António Pacheco-Palha, Lídia Gouveia, University of Porto, Portugal 3. José Lopez Rodas, Instituto Nacional de Salud Mental "Honorio Delgado, Perú 4. Marcos de Noronha, Brazilian Association Of Cultural Psychiatry , Brazil			
References				
Speakers				
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Stress Scale for Immigrants			
Speaker	Joseba Achotegui, University of Barcelona, Spain			
Abstract	This scale was designed as an instrument that structures information concerning migration related stress and mourning and facilitates welfare and psychosocial service provision as well as research. The scale can be used in the different social services that provide care to immigrants, not only in health services but also social and education services etc. The tale or narrative the immigrant brings us possesses an extraordinary phenomenological and anthropological value, but the provision of welfare and social services require trying to structure and make operative the information we possess such that it can be compared with that obtained by other professionals. The scale essentially serves a screening function; it evaluates the psychosocial situation of immigrants and measures risk factors. The approach would be similar to that of an insurance company: the scale evaluates the risk of problems. The scale is etic, that is to say it evaluates the facts from a conceptual framework external to an immigrant's own interpretation of his/her own experiences. The scale we present here applied to migration could be used in other situations of chronic stress, such as mobbing or bullying, etc., adapting the approach in relation to the types of stressors and mourning that is experienced in each situation.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Healing through cathartic experiences. Analogy between religious rituals and psychotherapies			
Speaker	Marcos de Noronha, Brazilian Association Of Cultural Psychiatry , Brazil			
Abstract	What societies, with their traditions that rely on rituals that come with catharsis. These practices, what kind of functions fulfilled in some societies? Catharsis has its importance to be used in a psychotherapy practice as a therapeutic resource? And in learning, even cathartic feature could make it easier? This presentation refers to the emotional aspects that make up the mental illness that could be considered for the treatment of the patient. The formula of emotion has a psychological basis and other physiological. But not just these two aspects. To understand its complexity also have to understand both the anatomical basis of brain function, such as the socio-cultural context in which this man entered.			

	Among these psychiatric treatments known some mobilize emotional aspects of the individual to try to cure him. Others do the same, but in a group. What are the advantages of individual treatment in relation to treatment group? Which type of treatment and how the resources of catharsis and appreciation of emotion can be used? As the affective and emotional appeal can be used by teachers who want to improve student learning? The author not only draws an analogy between the techniques of individual psychotherapy with the group, but also with both religious rituals. Even in the diversity of religious expression, which prevents us a generalization of the phenomenon, there is something in common, both in the formation of symptoms, and in manifestations of emotions. In this process comparing psychotherapeutic techniques and religious rituals the author walks a line of understanding that allows discriminatory actions less cooperative and more, integrating resources of mental health professionals and priests and shamans in the same population.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Aspects of the mechanism dissociative psychopathology in a population of young Mozambicans - the purpose of the School case Quisse Mavota "			
Speaker	António Pacheco-Palha, Lídia Gouveia, University of Porto, Portugal			
Abstract				
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Meaning of communication and relationship with fellow friends of adolescents with potential suicide			
Speaker	José Lopez Rodas, Instituto Nacional de Salud Mental "Honorio Delgado, Perú			
Abstract	Through qualitative study, conducted between January and May 2013, determining the meaning of communication and relationship with partner friend for adolescents with "potential suicide" some whose parents had been living abroad and returned to Peru in recent years. These young people were identified in the mental health examination-2012, corresponding to 0 Suicide Program in secondary school level in the district of Independencia, Lima, Peru (district with population of 220,000 inhabitants., mostly middle and poor middle class; their migration and return flows are similar to national migration flows; with community mental health services for 33 years). After processing of semi-structured questionnaire, interviews will be conducted by members of the mental health team. The analysis will be done with the program for Atlas-ti qualitative research. The findings, apart from pointing out the many aspects to research to expand knowledge, must offer positive aspects to incorporate and strengthen, as difficulties to be avoided and overcome in the support strategy considered for young potential suicide. It also pursues the purpose to incorporate these findings into national academic curriculum of secondary.			
References				

29 June - 3 July 2013
Lisbon, Portugal

Workshops

HOW TO IMPLEMENT CLINICAL GUIDELINES

Principal organizer: Lars Lien, National centre for dual diagnosis, Hospital Innlandet Trust, Norway

Co-organizer: Barbara Reeger, Athena Institute, VU University Amsterdam, the Netherlands

Description and justification of workshop:

Governments and regional and local health authorities establish numerous clinical guidelines and in Norway seven clinical guidelines for substance misuse services are planned, in process or finished in the past few year. There is, however, limited experience in implementing clinical guidelines and there is a need for developing new and systematic knowledge concerning implementation. Clinical guidelines are not a "magic bullet" to improve healthcare and there is a need for more research and practice on how guidelines are successfully implemented.

The objectives of this workshop is first to give an insight to why clinical guidelines need to be evidence based implemented and that without an implantation plan and process guidelines in itself will not change health worker attitude and praxis. Secondly, we will give at least to examples, one from Norway and one from the Netherlands on how guidelines might be implemented and which tools that is necessary to reach your goals.

We think this workshop will be of great interest to first of all clinical leaders on all levels and officials who work with changing health worker praxis's and patient organisations that is eager to get evidence based treatment for their diseases. But most all this workshop is important for all mental health workers who need to know why there are several obstacles to change in praxis and how they can be solved.

Speakers

1. Anne Landheim, National Center for dual diagnoses, Hamar, Norway, Title: Norwegian Guidelines for persons with concurrent mental disorders and substance use disorders: assessment, treatment and rehabilitation - How to identify gaps between current practice and clinical guidelines?
2. Lars Lien: National centre for dual diagnosis, Hamar, Norway. Title: - How to bridge gaps between current practice and clinical guidelines?
3. Lia van der Ham: Athena Institute, VU University Amsterdam, Amsterdam, The Netherlands. Title: Participation of patients in the development of guidelines
4. Janwillem Renes: Altrecht Institute for Mental Health Care, Amsterdam, The Netherlands: Title: Treatment of Bipolar Disorder in the Netherlands and concordance with treatment guidelines
5. Barbara Regeer: Athena Institute, VU University Amsterdam, Amsterdam, The Netherlands. Title: Support by a shared research agenda

Other considerations: We plan to have ample time for discussion and debate also opening for examples from the participants.

INTERSUBJECTIVE AND CULTURAL DATA IN PSYCHIATRY: THEORETICAL FOUNDATIONS OF CLINICAL PRACTICE

Principal organizer: Maria Luísa Figueira, Dept. of Psychiatry. (Faculty of Medicine of Lisbon. University Hospital of Santa Maria. Lisbon. Portugal)

Co-Organizers: Luís Madeira Dept. of Psychiatry. (Faculty of Medicine of Lisbon. University Hospital of Santa Maria. Lisbon. Portugal), Ana Neto, Dept. of Psychiatry. (Hospital of Fernando da Fonseca. Amadora. Portugal)

Background information:

While searching for reliability (and strict operative definitions) researchers have deliberately stripped psychopathology of subjective experiences (Andreasen 2007). There is criticism that diagnostic criteria have too long “*wear the trousers*” and entertained the notion of a descriptive glossary for psychopathological experiences that one must memorize (Parnas, Sass, Zahavi, 2008). The fact is that operational definitions we now hold as equivalents for disorders have not brought us any closer to a full representation of meaning of mental disorder. When leaving such superficial objectivity we are confronted with a load of behaviors and experiences that stand as possibly relevant to understandings of the disorder. Facing this overload of data, much of it impervious to natural sciences objectification is a petrifying experience for both doctors and researchers. In recent years there were those (e.g. Fuchs, Zahavi, Parnas, Stanghellini) who again defied such impediments and delved into the description and characterization subjective aspects of mental illness. Specific to these conceptualizations is the acceptance that part of the meaning of our experience is embodied and so pre-reflexive. The role of the ecological and intersubjective meaning of falling mentally ill has been reprocessed into concepts as empathy, mirror-neurons, theory of mind, appraisal and enactivism.

On the other hand, psychiatric anthropology illustrates how contemporary psychiatry faces superficial objectivity that has failed to grasp the diversity and complexity of subjective experiences (Kleinman, 1997, Obeyesekere, 1990). More importantly they alert for the consequences of such neglect (Daas, 2000; Kleinman, 1991) and how taking into account this dimension not only helps to understand how cultural and social aspects are meaningful but also reshape the meaning of mental disorders and therapeutic paths (Jenkins, 2003).

The discussion regarding a cultural dimension of experience is intuitive in practice. The dialogical dependence of recollection of data and stigma as anthropological and social consequence are key subjects that demand consideration. As a whole, a full picture of mental illness must represent its affective, biotic, aesthetic and social dimensions.

Goals: This workshop aims to present how the inter-subjective experience and cultural data is imbued in the phenomenology, ethics and epistemology of mental illness

Objectives: at the end of the workshop the audience should be acquainted with the concepts of primordial inter-subjectivity and a model of the self-experience (that includes pre-reflexive experience). Also they should be able to recognize the modulation, of what is taken as disordered, by cultural variances, through the glens of anthropological assistance. The presentation is divided in 3 parts: Theoretical ~25min + Small group discussion (2 groups ~30 min) + Joint group discussion (30 ~min)

Speakers

1. Luís Madeira Dept. of Psychiatry. Faculty of Medicine of Lisbon. University Hospital of Santa Maria. Lisbon. Portugal
2. Ana Neto, Dept. of Psychiatry. Hospital of Fernando da Fonseca. Amadora. Portugal

PSYCHIATRY, RELIGION AND SPIRITUALITY: IMPROVING SKILLS

Principal Organizer: Peter J. Verhagen, WPA Section on Religion, Spirituality and Psychiatry

Co-Organizers: Sameer Malhotra, WPA Section on Religion, Spirituality and psychiatry

An understanding of religion and spirituality and their relationship to the diagnosis, aetiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development.

The aim of this interactive workshop is to enlarge knowledge and to improve skills. Four topics will be covered: 1) research data and controversies, 2) assessment, 3) cultural dynamics and culture and 4) therapeutic concepts.

By attending this workshop participants will be able to update their knowledge and improve their skills in the following ways. 1) Despite the information available it is still difficult to interpret and evaluate research data in an appropriate way. There are still a lot of controversies. What are the points for attention? 2) Psychiatrist (and mental health workers) are still hesitating with regard to assessment and religious/spiritual history taking. How to proceed? What are the points of attention? 3) The term culture can be applied to an individual, to families, to whole communities and even nations. Culture refers to a way of life common to a group. What are cultural dynamics? How do these dynamics relate to spirituality and religion, and to mental health? What is the meaning of a cultural assessment and case formulation? 4) Different cultures have different views on handling stress, counteracting what may be conceived as mental illness, and promoting well-being, spiritual development and recovery from crises. In that sense the western biomedical model turned out not to be 'soul-saving'. What can be learned from other cultures concerning the maintenance of mental health and counteracting problems that are seen as mental illness?

Short presentations will be alternated with discussions and exercises.

Speakers

1. Peter J. Verhagen MD, GGZ Centraal, Harderwijk, Netherlands, verhagen.p@wxs.nl
2. Sameer Malhotra, PhD, Max Healthcare, India, sameersankalp2003@yahoo.com

Other considerations

Max. participants 25.

“MANAGING MENTAL HEALTH PROBLEMS DURING , AND IN THE AFTERMATH OF, DISASTERS”

Principal Organizer: Professor Scott Henderson, MD, DSc, Emeritus Professor, The Australian National University, Canberra.

Description and justification of the symposium or workshop: Natural and man-made disasters are ubiquitous and recurrent. The purposes of the Workshop will be:

- 1) how to identifying those individuals and families in need of intervention for their mental health;
- 2) to determine what interventions are needed;
- 3) training of personnel for meeting these needs; and
- 4) contributing to the prevention of mental disorders in the aftermath.

Moderators: (Names, affiliations, city, country, email and tentative titles)

1. Prof Scott Henderson.
2. Dr Jaya Reddy, MB, BS, PhD. Consultant Psychiatrist, The Canberra Hospital, Canberra, Australia.

Preparation: We seek support from the Conference Organisers on recruitment of participants. The numbers will need to be estimated beforehand to ensure adequate accommodation.

As an Introduction, Dr Reddy and I will brief participants on the Aims of the Workshop. They will then be divided into groups of about 6 persons to tackle the specified topics.

Requirements:

One room for the whole group.

One or more rooms for the small groups to assemble. (According to numbers, one large room may itself be sufficient.

Clusters of six or more chairs for each group.

Butcher paper, easel, coloured feltex pens.

A4 paper and pencils for each group.

GLOBALIZATION OF CULTURE AND ITS IMPACT ON NON-WESTERN PSYCHE

Principal Organizer: Rama Rao Gogineni

Co-organizers: Prof Roy Abraham Kallivayalil

United Nations reports Globalization opened international borders and has the potential for both positive and negative effects on development and health. Many countries have profited from globalization including China, India, Uganda and Vietnam. WHO reports that globalization of health is contributing to growing number of health problems including trafficking of women, increased drug abuse/trade, increase in juvenile delinquency, etc. Globalization raising ethical problems in relation to autonomy, sovereignty, toleration, multiculturalism. The difficulty increases largely when we think of countries like India, a country with vast population diversity, and having numerous traditions.

Globalization Is Changing the World's Cultures, contributing to changes in family structures, hierarchies, relational dynamics, ethnic/caste systems, gender roles. Globalization contributes to exchange/expansion of music (rock n roll, jazz, Indian/Arab classical music), language, food habits (chicken tikka, masala, hamburgers, French fries, tacos, kung pao chicken), festivals (valentines day), art, traditions (yoga, relaxation, dating, marriage, sexual practices) etc. and opportunities for growth. The Diaspora in countries of Immigration have been vital in promotion of such cultural expansion and changes.

Unfortunately there is a downside to this rapid globalization- increase in crime, delinquency, violence, anxiety and depressive disorders, addictive disorders. Many of the traditionalists as well as people that love traditions have been experiencing much anxiety about changes with grief reactions of "giving up" some of the valued traditions, at times contributing to ethnocentric reactions.

Another aspect of globalization of culture is its potential impact on changing of psychic structures particularly superego and individuation. Freud, Erikson, Horney, Kohut and cultural anthropologists contributed a great deal in explaining role of culture in formation of superego. Kakar, Roland, Ramanujam, Gringerg, Akhtar and others explained the differences between Eastern and Western cultures, family traditions in the formation of psyche. So, globalization can, probably be influencing psychic formation and superego formation. This workshop presents these aspects of globalization, globalization of culture and its impact on Psyche.

-Professor Kallivalil will present on Globalization and its effects on Social Psychiatry

-Dr. Pennoose will present on Globalization of culture and its vicissitudes on South Asian culture/social psychiatry

-Professor Rataemane will highlight application to Sub Saharan Africa

-Gogineni will discuss Globalization of culture's impact on non-western Psyche.

Educational/Learning Objectives

At the conclusion of the presentation participants will:

1. Learn the socio-cultural impact of globalization on various national/ethnic groups
2. Understand the pros and cons of globalization of culture on mental illness and its contributions anxiety, mood, substance abuse, women, children and others.
3. Explore the vicissitudes of globalization of culture on psychology and psychic structures of individual, group, and nations.

Speakers

1. Rama Rao Gogineni, MD
2. Roy Abraham Kallivalil, M.D.
3. Professor Pennoose
4. Professor Solomon Rataemane

INTEGRATIVE COMMUNITY THERAPY: a participatory response to respond social suffering and ‘psychic misery’.

Prof. Dr. Adalberto Barreto
Federal University of Ceara Brazil

Keywords: community therapy, local knowledge, social participation Brazil,

Over the last 26 years the Community Health Department of Federal University of Ceará has been implementing a supportive project for addressing psychological suffering and “Psychic misery” of families and individuals who live in the Pirambu’s slums at the community of 4 Varas in north east of Brazil and present in all Brazilian states, and others Country.

The big challenges are:

- How to move from a model which generates dependency to another that promotes autonomy?
- How to disperse the concentration among elite professionals allowing it to flow freely among all who need help?
- How to *rescue* the knowledge from African and Indian ancestors? - How to *rescue* the knowledge from people’s life experience?
- How to move from individual/pathology oriented approaches to community-health oriented practices?
- How to move from therapeutic practices limited to *clinical* interventions (micro) to larger scale, that is *community-based*.

This is therapy for BUILDING SOCIAL WEBS OF SOLIDARITY. It focuses on and brings out the individual’s competencies and positive values. It mobilizes the therapeutic dimension of the group/community itself.

Community Mental Health acts on the human relationships networks. It includes family, neighbours, friends and community in order to support the most vulnerable individuals and families who are living in critical life situation. Through with a preventive perspective, it identifies and mobilizes competencies and community resources.

The Project Goal : It works towards integrating the biological, sociocultural and political dimensions of the problems. Interaction starts from a “problem-situation” presented by a community member. The Community Therapist underlines the strategies used by other members in the group for resolving similar situations.

They ask reflective questions: to move the individual from a state of being overwhelmed by feelings (sensations) and be able to name and be cognizant of them (“when the mouth silences, the body talks”)

To move from an emotional state only to a reflective stance that brings a new understanding of themselves and experience and also individual and social change (*My husband continues being the same , but I’m not the same*”)

Emphasis is focused on group work for sharing problems and solutions. So it can serve as a shield for protecting the vulnerable ones. The group is also an important element for social insertion.

The intervention’s target is always the suffering of the people and not their pathologies/déficits.

We postulate that the solution must come from the group, through interactions, sharing of experiences, identification with one another, feeling of belonging, while respecting individual

diferences. The THERAPIST must be an integral part of this process of healing and social reconstruction. Both, THERAPIST and COMMUNITY benefit from each other. The community becomes more autonomous but also more integrated in the larger society, The THERAPIST is freed from his/her institutional and professional “autism” as well as from his/her alienating academic attitudes .

We believe that the best prevention is to link the individual to his/her cultural universe. It is by belonging to a group, to a set of cultural values that the individual nurtures him/herself and builds an identity. Culture for the individual is like a web for the spider.

We have helped the community rebuild its identity and renew its self-confidence; we have helped them to say ‘I can’.

TERAPIA COMUNITARIA INTEGRATIVA: Uma resposta participativa no acolhimento ao sofrimento e à miséria psíquica.

Palavras chave: Terapia Comunitaria, competencias e recursos culturais, participação comunitária Brasil

Nestes últimos 26 anos o Departamento de Saúde Comunitária da Universidade Federal do Ceara tem implementado um programa para acolher o sofrimento e tratar a miséria psíquica de indivíduos e famílias que vivem na favela do Pirambú na comunidade de 4 Varas no nordeste do Brasil, hoje presente em todos os estados do Brasil e em outros países. (www.abratecom.org.br - www.aetci-a4v.eu)

O grande desafio tem sido: Como passar de um modelo que gera dependência para um modelo que nutre autonomia e protagonismo?; Como romper com a concentração da informação e fazê-la circular numa linguagem acessível para que todos possam se beneficiar dela?; Como resgatar o saber dos antepassados indígenas, africanos, europeus, orientais e a competência adquirida por sua própria experiência de vida?; Como acolher o sofrimento sem ter que medicalizá-lo como se fosse patologia?; Como ultrapassar um modelo centrado na procura espontânea, na atenção individual, na cura medicamentosa, e possibilitar uma ação de promoção da saúde coletiva?

A Terapia Comunitária Sistêmica Integrativa é um ESPAÇO DE ESCUTA, PALAVRA E VÍNCULOS: uma prática sistêmica e integrativa de saúde e trabalho social comunitários, estruturado por regras precisas, permitindo a partir de uma situação problema, emergir um conjunto de estratégias de enfrentamento para as inquietações cotidianas devido a troca de experiências vivenciadas num clima de tolerância e liberdade, protegidos de projeções e desejos de manipulação.

Todos são convidados a serem corresponsáveis na busca de soluções e superação dos desafios do cotidiano saindo da posição de vítimas, objetos para corresponsáveis, parceiros, sujeitos. Atuamos numa perspectiva de promoção da saúde, que procura identificar e mobilizar as competências e recursos sócio culturais.

O ponto de partida é uma “situação-problema”, apresentada por alguém e escolhida pelo grupo. O animador procura estimular e favorecer a partilha de experiências possibilitando a construção de redes de apoio social. A pergunta que desencadeia a reflexão é:

« Quem já viveu algo parecido e o que fez para superar? »

A partilha de experiências mostra as possíveis estratégias de superação dos sofrimentos do cotidiano e permite a comunidade encontrar, nela mesma, as soluções aos seus problemas que a pessoa, a família e os serviços públicos não foram capazes de encontrar isoladamente.

Os objetivos da TCI são: Valorizar e reforçar o papel do indivíduo, da família e da rede de relações para que possam descobrir seus valores, suas potencialidades, tornando-se mais autônomos e menos dependentes; Favorecer o desenvolvimento comunitário, prevenindo e combatendo as situações de exclusão dos indivíduos e das famílias por meio da restauração e fortalecimento dos vínculos sociais e de encaminhamentos sócio econômico educacionais; Intervir nos determinantes sociais da saúde, em especial na redução do estresse e ampliação do apoio social.

Damos Ênfase no trabalho de grupo onde o foco da intervenção é o sofrimento jamais a patologia. Afirmamos que no lidar com o sofrimento, a solução está no compartilhar, no coletivo, nas identificações com o outro e no respeito às diferenças. Os profissionais são parte desta construção. Ambos tiram benefícios. A comunidade gerando autonomia e inserção social e nós profissionais nos curando de nosso autismo institucional e profissional bem como de nossa alienação universitária. “Ao cuidar do outro eu cuido também de mim”.

Nós acreditamos que a melhor maneira de promover a saúde, é ligar o indivíduo ao seu universo cultural. É pelo sentimento de pertença a um grupo e pela partilha dos valores culturais que o indivíduo nutre-se e constrói sua identidade. A cultura é para o indivíduo o que a teia é para a aranha. Temos ajudado a comunidade a reconstruir sua identidade e resgatar a confiança em si. Temos ajudado a comunidade a dizer : sim eu posso, eu sou capaz.

1. Prof. Dr. Adalberto Barreto

o papel do indivíduo, da família e da rede de relações para que possam descobrir seus valores, suas potencialidades, tornando-se mais autônomos e menos dependentes.

de redes de apoio social torna o indivíduo e a comunidade mais autônoma e menos dependente dos especialistas e instituições especializadas

BILINGUAL COMMUNICATION IN DIFFERENT SETTINGS: INCREASING PROVIDER-INTERPRETER COLLABORATION AND WORKING ALLIANCE

Principal Organizer: Betty Goguikian Ratcliff , University of Geneva

Co-organizers: Catarina Pereira, University of Geneva; F. Suardi, University of Geneva;
I. Fierro, Appartenances

Description and justification of the symposium or workshop:

In multicultural societies, with high rates of newcoming immigrants, it is of major importance that provider-migrant interactions are mediated by interpreters to facilitate communication in order to provide efficient and culturally sensitive assistance. However, the transition from a dyadic to a triadic encounter increases the complexity of the situation and leads to specific issues, not only in terms of roles, responsibility and power, but also in terms of interpersonal dynamics and processes.

Although interpreters' roles and functions in health care settings have been widely discussed, other areas such as school, social and legal contexts have received very scarce attention. Studies have actually underscored the importance of institutional norms and organisational structures on the dynamics of a bilingual encounter. Understanding providers' expectations and needs in different areas can provide important insight to interpreters' training, as the providers' preferences concerning the interpreters' degree of visibility (Invisible/interpreter-as-tool or conduit vs Visible/interpreter-as-mediator) may be very different. Therefore, the interpreters' ability to understand and adapt to provider's goals and expectations is essential to enhance the quality of provider-interpreter collaboration.

The three communications of the symposium will adopt a situational and interactional perspective, based on mixed-method studies. The first one will compare the views and practices of interpreters and providers collaborating in five different institutional contexts. The second one will analyse the impact of interpreters' training and providers experience in conducting bilingual interviews, on the quality of provider-interpreter collaboration. The last one will focus on the interpreters' contribution to therapeutic alliance in mental health setting.

Speakers (Names, affiliations, city, country, email and tentative titles)

1. Betty Goguikian Ratcliff
2. Catarina Pereira

Other considerations that you would like the Scientific Program Committee to know

TOBACCO SMOKING CESSATION/REDUCTION AND PERSONAL COMPETENCE IN PSYCHIATRIC PATIENTS: THE RECOVERY MODEL

Principal Organizer – Centro Hospitalar Psiquiátrico de Lisboa (Lisbon, Portugal). Tobacco smoking cessation/reduction program team.

Description and justification of the symposium or workshop:

Psychiatric and mental health services have evolved tremendously in the past few decades but much remains to be done to better the quality of care and quality of life for patients with psychiatric diagnosis. The tobacco smoking cessation/reduction program team, working in a large psychiatric hospital in Lisbon, Portugal, has had precisely this objective in mind and is now preparing multidisciplinary programs to address other health needs, like weight control and weight loss and exercise and physical activity, in this population of patients.

1. **Objectives:** to (1) Characterize tobacco smoking cessation/reduction interventions for psychiatric patients. (2) Discuss the recovery model in this context, focusing on the individual, competence, quality of life and a holistic view of human development. (3) Train active listening and counseling skills.
2. **Methods:** Based on a literature review, data analysis and clinical cases, the presentation will include models, concepts, practical interventions and clinical reasoning in clinical cases.
3. **Results:**(1) The majority of the participants in this program had diagnosis of anxiety and/or depressive disorders. However, many participants had substance abuse, bipolar or other psychotic disorders including several patients with residual schizophrenia.(2) Therapeutic effectiveness in this program was considered very significant.(3) The success of the program depends on the intervention model, dose-response relationship and communication and counseling skills.(4) The impact of these interventions can be extended to other risk behaviors and life objectives.(5) Strategies to minimize risks, low threshold interventions, relapse prevention and mobilizing social and caregiver support are fundamental.(6) Factors associated with positive outcomes are internal coherence, emotional and motivational stability, perception of control and differentiation of personal resources. Factors associated with negative outcomes are severity of illness, cognitive deficits, negative symptoms, co-morbid bio-psycho-social problems(ex. financial difficulties), cognitive biases and certain personality traits like impulsivity, low sociability and lack of flexibility.
4. **Conclusions:** Tobacco smoking cessation/reduction interventions for patients with psychiatric disorders should be considered an important opportunity to reduce a significant health risk and open the door to other initiatives in mental health settings like weight control and weight loss, exercise and increasing physical activity and self-regulation interventions. Effective management of motivational processes and harnessing personal competence are keys to change in lifestyle behaviors.

Speakers:

1. Miguel Trigo. Centro Hospitalar Psiquiátrico de Lisboa (CHPL). Tobacco smoking cessation/reduction program (CRRT). Lisbon, Portugal.. Clinical Psychologist
2. Isabel Ganhão. (CHPL). (CRRT). Lisbon. Portugal. Psychiatrist
3. Afonso Paixão. CHPL. CRRT. Lisboa. Portugal.. Clinical Psychologist
4. Noélia Canudo. CHPL. CRRT. Lisboa. Portugal. Clinical Psychologist

THE GENESIS OF PSYCHIC AND SOMATIC SYMPTOMS: PSYCHOSOCIAL PERSPECTIVE AND HOW TO IDENTIFY THESE PROBLEMS

Prof. Shridhar Sharma

MD, FRC Psy (Lond), DPM, FRANZCP (Australia), DFAPA (USA), FAMS;
Emeritus Professor, National Academy of Medical Sciences, and Institute of Human Behaviour & Allied Sciences, Delhi. Sr. Consultant & Head, Dept. of Psychiatry, PSRI Hospital & Research Centre, New Delhi.

The basic concept in a traditional illness is that the individual suffers from some pathology, which may be in an organ or a body system, which causes dysfunction, disability and pain to that individual. This basic premise is applicable both in the organic and psychiatric disorders. In psychosocial problems too the individual suffers from a disability, distress or pain but unlike the traditional illness, the primary pathology is outside the individual and due to this pathology, where one or the other organ or a system of a patient may be affected.

The symptoms originating from such psychosocial problems have certain basic characteristics. The physical symptoms in these cases are vague, ill-defined and often fleeting. They are changeable and present in one form or another for a short or long time. There is always an associated stressful precipitant factor. The symptoms become more marked with rising stress and are linked with continuation of stress. There is a clear time relationship between the initiation and continuation of the symptoms and the presence of psychosocial stress. The person suffering from these disorders may have an anxious, immature or a demanding personality. It is believed that behaviour resulting from such psychosocial problem can be differentiated from traditional illness behaviour. It is also known that all people with illness or illness feeling do not show same illness behaviour. Illness behaviour relates to those occasions or situations, where someone assumes that he is suffering from illness, adopts the role of a patient and thus seeks professional help. The workshop will discuss about these problems and also deal how these problems can be identified and managed in Primary health care setting.

SOCIAL PSYCHIATRY AND PRIMARY HEALTH CARE FOR MIGRANTS IN THE DEVELOPED COUNTRIES:

Auteurs: I. Biyong, R. Tempier, B. Kounou

Main objective: The promotion of mental health and prevention of mental disorders through promotion of primary health care according to WHO guidelines.

Specific objectives:

1. Show the inventory of primary health problems among the migrants in the developed countries.
2. To highlight mental health as part of overall health problems migrants.
3. Show the importance of integrating mental health care into primary health care to demystify psychiatric disorders educate and make prevention among these most vulnerable populations.
4. Demonstrate that this approach can overcome the lack of mental health specialists and psychiatrists to better promote social psychiatry for the right for mental care for everybody.

Affiliations of authors:

1. I. Biyong, Department of psychiatry, University of d'Ottawa, Canada
2. Dr. Raymond Tempier, B. Kounou, Processor of de psychiatry, University of Ottawa, Canada
3. Head Department of psychiatry/Mental health problem, Montfort Hospital, Ottawa, Canada
4. Laboratoire du Stress traumatique (EA 4560), Toulouse, France

SIGNIFICANCE AND TREATMENT OF BINGE EATING DISORDER IN OBESITY

Principal Organizer – Carlos M. Grilo, Ph.D. (Yale University School of Medicine)

Obesity is one of the world's leading health problems, and research has highlighted the clinical significance of a subgroup of obese persons with binge eating disorder (BED). BED is prevalent and is strongly associated with obesity and with increased psychiatric comorbidity and bio-psychosocial impairment. This presentation will provide an overview of controlled treatment research for obese persons with BED covering pharmacological, behavioral, psychological, and combined pharmacological-psychological interventions. A program of clinical research on the treatment of BED in obese patients across diverse clinical settings along with focused research on predictors and moderators of treatment outcomes will be also be presented. Recent studies have identified two reliable predictors of treatment outcomes for BED. One predictor is a patient characteristic reflecting body-image known as overvaluation of shape/weight and the second predictor is a treatment process known as rapid response. The significance of overvaluation of shape/weight has implications for refining and improved understanding of the BED diagnostic construct. Rapid response has clinical implications for informing stepped-care treatment approaches for BED and obesity. The broader implications of these findings for the dissemination of effective interventions and for informing social psychiatric and public health research will be presented.

Speakers

1. Carlos M. Grilo, Ph.D., Yale University School of Medicine, New Haven, USA,

AVATAR THERAPY: A NEW COMPUTER ASSISTED THERAPY FOR AUDITORY HALLUCINATIONS

Principal Organizer – Prof. Julian Leff (University College London, UK)

Objectives

To consider psychosocial processes that could explain the efficacy of a novel computer-based therapy for persecutory auditory hallucinations unresponsive to medication.

Methods

Patients were enabled to create a speaking image (avatar) of their supposed persecutor by means of a computerised system. They were encouraged to engage in a dialogue with the avatar which was controlled by the therapist. In the course of 6 sessions the avatar was altered by the therapist to come under the patient's control and to change its character from abusive to supportive and therapeutic. Each session was recorded and transferred to an MP3 for patients to use whenever they heard the persecutory voice. The efficacy of the therapy was evaluated in a randomised controlled trial.

Results

Assessment of patients before and after the therapy showed a significant reduction in the malevolence and omnipotence of the voices for the experimental patients, whereas there was virtually no change for the controls, who continued with treatment as usual. Three of the 16 patients who completed the therapy ceased to hear their voices altogether. A follow-up 3 months after the end of therapy showed that the experimental patients experienced a further significant reduction in the malevolence and omnipotence of the voices.

Psychosocial processes that could explain these results are: validation of the patients' experience by the therapist, increased control over the voices by the patients through creation of the avatar and its alteration to come under the patients' control, change in the nature of the avatar from persecutory to supportive and therapeutic. This could have enabled patients to reintegrate into their psyche the critical entity, formed from traumatic childhood experiences, that they could not tolerate and exteriorised as a persecutory voice.

Providing the patients with the recorded sessions on an MP3 probably explains the continued improvement in their hallucinations after the therapy ended.

Conclusion

The patients' experience in their dialogue with the avatar, which they had created, enabled them to oppose the actual persecutory voices vigorously and to take control of them. Some patients achieved an increase in insight during the therapy, recognising that the voices originated within their own mind.

This promising novel therapy is brief and efficacious. It needs to be evaluated in a large-scale replication trial.

Speakers

1. Prof. Julian Leff, University College London, UK

29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

29 June - 3 July 2013
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Oral Presentations

**Bio-psycho-social confluence
of psychiatric sciences**

NONSERIAL AND SERIAL SEXUAL HOMICIDE OFFENDERS IN CANADA: A COMPARISON OF TRAITS OF PERSONALITY DISORDERS AND PARAPHILIC BEHAVIOURS

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¹. City University of Hong Kong, Kowloon, Hong Kong, S.A.R.

². Simon Fraser University, Burnaby, British Columbia, Canada

³. Brown University, Providence, Rhode Island, U.S.A.

⁴. Rhode Island Hospital, Providence, Rhode Island, U.S.A.

Objectives: To explore the possible differences between nonserial and serial sexual homicide offenders (SHOs) in their manifestation of traits of personality disorders and paraphilic behaviours, and their potential influences in victim selection and perpetration.

Purpose: This paper aims to explore the possible differences between nonserial and serial SHOs in their manifestation of traits of DSM-IV-TR's ten (Cluster A, B, and C) personality disorders and paraphilic behaviours. In addition, the offending process by victim selection and perpetration methods of these two SHO groups is also examined.

Methods: Using a sample of incarcerated Canadian SHOs in a maximum correctional institution in the province of Quebec, between 1995 and 2005, 80 (73 nonserial and 13 serial) SHOs are examined.

Results: A number of important findings have emerged. Victims of serial SHOs ($M = 23.15$) are significantly younger than their nonserial counterparts ($M = 28.90$). In term of victim selection and perpetration methods, serial offenders are significantly more likely to engage in structured offense premeditation (62% versus 38%), to indulge in deviant sexual fantasies 48 hours prior to their offense (85% versus 48%), to hunt for strangers (69% versus 34%) with distinctive characteristics (46% versus 18%), and to verbally humiliate their victims during the offense than nonserial offenders. These differences may be partly due to the underlying manifestation of traits of personality disorders and paraphilic behaviours. Findings indicate that serial SHOs are significantly more likely to manifest traits of schizoid (62% versus 32%), narcissistic (69% versus 32%), and obsessive-compulsive (62% versus 32%) personality disorders than those who only sexually murdered one victim. Additionally, serial SHOs are also found to manifest significantly more paraphilic behaviours in the areas of exhibitionism (31% versus 8%), homosexual paedophilia (39% versus 16%), sexual masochism (62% versus 12%), voyeurism (23% versus 1%), and partialism (46% versus 19%) than their nonserial counterparts.

Conclusions: These findings underscore the potential influences of underlying manifestation of traits of personality disorders and paraphilic behaviours in victim selection and perpetration of nonserial and serial SHOs. Implications of the findings that may prove useful in criminal investigation are discussed.

Literature Reference

Chan, H. C., & Heide, K. M. (2009). Sexual homicide: A synthesis of the literature. *Trauma, Violence, and Abuse*, 10(1), 31-54.

RECENT DEVELOPMENTS IN THERAPEUTIC COMMUNITY WORK IN GRENDON PRISON

M. Brookes¹

¹. HMP Grendon, UK

Objectives: For the past fifty years Grendon prison has pioneered a unique, therapeutic community, approach to the management and treatment of severely personality disordered offenders. The offences committed by prisoners at Grendon include murder, manslaughter, grievous bodily harm, rape and sexual abuse of children and young people. Recently, externally imposed directives combined with internal management changes have altered the structures which surround how the therapeutic communities operate. This paper will explain how Grendon has adjusted to these developments whilst still maintaining the integrity of therapy delivered.

Methods: Described will be Grendon's treatment regime and the various government, national and local initiatives that prison managers have had to navigate and respond to over the past five years. These include an offender personality disorder strategy, market testing policy, healthcare and substance misuse funding arrangements, the accreditation of each therapeutic community, prison service audits and, revised management and grading arrangements.

Results: Outcome data will be presented to demonstrate Grendon's efficacy as a treatment intervention along with the views of Her Majesty's Inspector of Prison and findings from Community of Communities/HM Prison Service therapeutic community accreditation reports.

Conclusion: Grendon prison has been able to successfully operate as a series of therapeutic communities adjusting and adapting to an ever changing external world while maintaining the core and core and essential elements of its internationally recognised treatment programme.

ENHANCING CARE PROCESSES AND MANAGEMENT OF OMDs (OFFENDERS WITH MENTAL DISORDERS) UPON RELEASE FROM PRISONS – 1st YEAR OF SINGAPORE INITIATIVE.

B. Saluja¹, J. Goh¹, L. Lee¹, M. Gunasilan¹, R. Tan¹, C.H. Ang¹

¹Institute of Mental Health, Singapore

Objectives: Institute of Mental Health (IMH) is the only tertiary care psychiatric institute in Singapore. All the offenders with mental disorders (OMDs) when released from prison are given a follow-up appointment at IMH. Most of these OMDs don't turn up for their appointments and subsequently relapse and re-offend and end up in prison again – a typical revolving door phenomenon. Our data base (April 2010 to August 2011) indicates that 79% of the OMDs referred to IMH did not turn up for their scheduled first appointments. The average time to first appointment upon release during this period was 65 days. 70% of the remand admissions during this period consisted of OMDs who had re-offended and had been remanded at least once in the past.

Purpose: Establish a Specialist Forensic Community Services to support ex-offenders with mental disabilities (ex-OMDs) in their reintegration into the community, encompassing psychiatric treatment and social support in collaboration with partners.

Outcome Measures: 1) Default rate for the first visits, 2) Time to first psychiatric appointment and 3) Recidivism

Methods: A team consisting of psychiatrist, social workers and case coordinators was formed in 2011. A formal structured referral letter and triage process was put in place. Regular meetings were held with all the stakeholders including prisons, general psychiatric services, department of addictions services, after care services and voluntary work organizations. Pre-release assessment for risk and needs were done using CANFOR and HCR-20, and a multidisciplinary management plan formulated for each OMD. The family members of the OMDs were engaged in their management plan.

Our hospital IT system captured the data for the default rate for the first visits and time to first psychiatric appointment. Our case coordinators regularly contacted the prisons, remand wards, ex-OMDs and their family members to find out any recidivism. We were unable to obtain the data directly from criminal records office.

Results: 76 OMDs who fulfilled the inclusion criteria for our services were released from prison in Year 2012. 80% of OMDs engaged with mental health services upon release from prison within 14 days of their release. 5 (7.1%) ex-OMDs re-offended within 1 year of starting of the service.

Conclusion: Singapore model of care for ex-OMDs is in early stages of development. The initial data is encouraging and provides a good nidus for future development of the services.

EFFECT OF A LOW-IMPACT EXERCISE PROGRAM ON LEBANESE MARGINALIZED POSTMENOPAUSAL WOMAN WITH PSYCHOLOGICAL DISTRESS: A RANDOMIZES CONTROLLED TRIAL

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¹.American University Of Beirut (AUB)

Objectives: Although physical exercise is generally recommended by physicians to relieve Psychological distress (PD) among older adults, substantial evidence does not yet exist to fully support this recommendation. *Aim:* This study examines the effect of a low impact exercise program on marginalized postmenopausal Lebanese women with psychological distress.

Methods: Community-dwelling women with a mean age of 56 years were randomized to either a low impact exercise program for three times a week over 6 weeks or a control group who received daily calcium tablets. The 12-item General Health Questionnaire (GHQ-12) was used to assess PD, the main outcome measure, and intention-to-treat analysis was performed. A focus group discussion was then conducted with a group of women who completed the exercise program.

Results: Sixty nine women were enrolled. Psychological distress was significantly lower at the completion of the study when compared to baseline levels in both intervention and calcium groups. This decrease in the GHQ-12 was noted across all 69 women, but did not differ significantly between the two groups.

Conclusion: This study shows that light impact exercise does not result in significant improvement of PD though the postmenopausal women who participated in the exercise program reported improvement and asked to sustain this activity.

THE INTERVENTION OF CASE MANAGERS FOR PATIENTS WITH SEVERE MENTAL DISORDER IN *CENTRO HOSPITALAR DE SÃO JOÃO*

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Educational Objectives: The organization model of mental health services in Portugal includes strategies to promote integrated programs for patients with severe mental disorders. These programs are based on case management and its major goals are: assessment of individual problems and needs; definition of a care program approach; and monitoring progress.

Purpose: To characterize patients on Case Management Program in Psychiatry Department of Centro Hospitalar São João, Porto (CHSJ) and to evaluate the efficacy of this intervention.

Methods: Longitudinal retrospective study of patients included in the program more than 12 months before. We performed data analysis of socio-demographic and clinical variables and compared utilization of inpatient, day hospital, emergency and ambulatory services up to three years before and after the beginning of the intervention.

Results: We identified 40 patients. Most were included in the program following discharge from Day Hospital. Most patients were single (75%) and lived with parents (63%). Most patients were retired (49%) or unemployed (39%). Schizophrenia was the most common diagnosis (80%) followed by schizoaffective disorder (15%). Utilization of inpatient and day hospital services significantly decreased after entering the Program, both in number of days and number of admissions. Emergency department visits also significantly decreased. No significant differences were found between the ambulatory clinic visits and rate of attendance before and after starting the intervention.

Conclusions: Case Management Intervention was associated with decrease in the inpatient, emergency and day hospital service utilization but not outpatient clinic visits. More prolonged assessment of this intervention is required.

IMPACTS OF SOCIOECONOMIC, FAMILY, SCHOOL, BEHAVIORAL AND MENTAL DIFFICULTIES ON SUICIDE ATTEMPTS IN YOUTH

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² University of Luxembourg, Integrative research unit on Social and Individual Development (INSIDE), Walferdange

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⁴ INSERM, U669, University Paris-Sud, University Paris Descartes, UMR-S0669, Paris, France

Educational Objectives: This study may help participants to recognize factors influencing suicide attempt which have to be assessed/monitored in boys and girls.

Purpose: To assess the impacts of socioeconomic factors, alcohol/tobacco/cannabis/hard drugs uses, repeating a school-year, sustained physical/verbal violence, sexual abuse, depressive symptoms, and involvement in violence on suicide attempt among boys and girls in early adolescents.

Methods: The sample included 1,559 middle-school students from north-eastern France (778 boys and 781 girls, mean age 13.5, SD 1.3), who completed a self-administered questionnaire including gender, birth date, father's occupation, parents' education, nationality, income, social supports (9-item scale), and lifetime history reconstruction of parents' separation/divorce/death, alcohol/tobacco/cannabis/hard drugs uses, repeating a school-year, sustained physical/verbal violence (20-item scale), sexual abuse, depressive symptoms (Kandel scale), involvement in violence (11-item scale), and suicide attempts. Data were analyzed using Cox regression models.

Results: Lifetime suicide attempt affected 7.2% of boys and 12.5% of girls ($p < 0.001$). Among boys, the factors with significant crude hazard ratio cHR were: insufficient income (2.29), alcohol use (2.33), tobacco use (3.76), hard drugs use (4.48), depressive symptoms (3.60), sustained physical/verbal violence (2.72), sexual abuse (4.30), involvement in violence (3.16), and lack of social support (2.64 for score 1-2, 3.08 for score 3+, vs. score 0). Full model including all factors retained only insufficient income (adjusted hazard ratio aHR 2.11), alcohol use (1.99), depressive symptoms (3.29), and involvement in violence (2.64). Among girls, the factors with significant cHR were: parents' separation/divorce (2.44), insufficient income (2.23), low parents' education (1.86), repeating a school-year (2.56), alcohol use (2.04), tobacco use (5.19), cannabis use (3.72), hard drugs use (11.65), depressive symptoms (3.51), sustained physical/verbal violence (1.71), sexual abuse (8.09), involvement in violence (2.04), and lack of social support (3.46 for score 1-2, 6.92 for score 3+, vs. score 0). Full model retained only parents' separation/divorce (aHR 1.56), repeating a school-year (1.98), alcohol use (1.58), tobacco use (3.60), depressive symptoms (1.86), sexual abuse (6.60), and lack of social support (2.62 for score 1-2 and 4.38 for score 3+, vs. score 0). Compared with boys, girls had a significant cHR of 1.74 which decreased to 1.57 when controlling for all covariates (contribution 23%).

Conclusion: This study has achieved our objectives to identify a wide range of socioeconomic, family, school, behavioral and mental difficulties generating suicide attempt among boys and girls in early adolescence. Our findings are original. They reported their causal relationships, the knowledge of which may help public policy preventing suicide attempt.

Keywords: Adolescents, violence, socioeconomic factors, school/behavioral/mental difficulties, causal relationships.

CAN A BIO-PSYCHO-SOCIAL MODEL HELP IDENTIFY SELF-HARM REPEATERS IN ACUTE PSYCHIATRY?

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Educational Objectives: 1. Report findings from an investigation of a bio-psycho-social risk model for self-harm repeaters. 2. Focus on patients characterised by both suicide attempts and non-suicidal self-injury (SA+NSSI).

Purpose: To explore whether a biological marker could improve risk assessment of self-harm behaviour during the first year after discharge from an acute psychiatric department.

Methods: All (489) patients acutely admitted to a psychiatric ward during one year (2006-07) were asked to participate in this prospective observational study. Written consent was given by 254 patients. The following baseline variables were measured during hospital stay: lipid levels¹, the MINI suicidal scale² and psycho-social risk factors. Self-harming episodes were recorded at 3 and 12 months after discharge (n=199, dropouts=55) and compared with baseline measures.

Results: The SA+NSSI group (n=25) was characterised by triglyceride (TG) levels above mean (1.37, 1.28-1.47 mmol/litre). This group had more re-admissions and significantly more severe attempts compared to patients with only suicidal (n=36) or only NSSI (n=9) behaviours. TG remained a significant predictor of SA+NSSI in multivariate analyses at 3 and 12 months. The values of the area under the receiver operating characteristic curve (AUC) at 3-months were: MINI suicidal scale: 0.88, MINI suicidal scale + psycho-social factors: 0.93, MINI + psycho-social factors + TG: 0.94. AUC values after 12-months were 0.82, 0.83 and 0.86, respectively. The Odds ratio of TG for self-harm was significant for both men (OR=3.3, p=0.050) and women (OR=7.5, p=0.020), and significantly better for women than for men (p=0.037).

Conclusions: Triglyceride level above mean was a significant predictor of SA+NSSI behaviours in multivariate analysis at 3 and 12 months. Compared with a psycho-social model, the bio-psycho-social model increased the predictive effect sizes (AUCs) of post-discharge self-harm in this group. Limitations of the project were a small sample size and recruitment from only one hospital. Body mass index was not controlled for, but controlling for diabetes, alcohol abuse and medication did not change results. There were minor differences between the study group (199) and all target patients (489), and naturally other methodological problems pertaining to the observational study design may have biased the results. Still, even with these shortcomings results may be of significance.

One possible explanation of the results is that high triglyceride levels reflect increased nor-adrenergic activity caused by psychological distress. If confirmed by more extensive research our finding may open up for new treatment and management approaches.

¹ Roaldset, JO; Bakken, AM; Bjørkly, S. A prospective study of lipids and serotonin as risk markers of violence and self-harm in acute psychiatric patients. *Psychiatry Research* 2011; (186), 293-299

² Roaldset JO, Linaker OM, Bjørkly S: Predictive Validity of the MINI Suicidal Scale for Self-Harm in Acute Psychiatry: A Prospective Study of the First Year After Discharge *Archives of Suicide Research* 2012; (16), 1-15

DOES RELIGION STILL PROTECT AGAINST SUICIDE? A LONGITUDINAL STUDY OF 1 MILLION PEOPLE.

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Educational Objective/Purpose: This study addresses the question, why, given the increasing secularisation of society does the relationship between religion and suicide persist? If it is attributable to the increased social capital associated with church attendance, as suggested by Durkheim, then the risk should be lowest for Catholics, intermediate for Protestants and highest for those with no religious affiliation. If religiosity in terms of the relevance of religion in personal life is important, risk should be lowest for the more fundamental/Conservative Christian faiths.

Methods: This is a 9-year follow-up study of 1,106,104 people aged 16-74 enumerated in the 2001 census divided into four groups; Catholic, mainstream Protestant, Conservative Christians, and those with no religious affiliation, with Cox proportional hazards models adjusting for a wide array of cohort attributes identified at the census.

Results: The cohort experienced 1,119 suicides; 74.4% to males and 64.8% to people aged <45 years. The usual relationships between suicide risk and age, sex, marital status, social isolation and socio-economic standing were confirmed. In fully adjusted models there was no difference in risk between Catholics, and Protestants or those with no religion (HR 0.94; 95%CI 0.83, 1.08 and HR 1.00; 95%CI 0.84, 1.20 respectively); the risk for the Conservative Christians was about 30% lower than Catholics (HR 0.71; 95%CI 0.52, 0.97). Further analysis showed that the relationship between religious affiliation and mortality risk varied by age (Chi-sq 25.2; P = 0.047) but not by sex (Chi-sq 3.72; P = 0.294). Stratified analysis shows that between 16 and 34 suicide risk is about 25% highest for either Catholics or those with no religious affiliation than for Protestants or Conservative Christians. At 35-54 there is no appreciable difference between Catholics, Protestants and those with no religion, but lower for Conservative Christians (HR 0.50; 95%CI 0.29, 0.85 compared to Catholics). At 55-74 years, the absolute risk is low and there are no significant differences between the four groups.

Conclusions: The relationship, and suggested mechanisms, between religion and suicide risk established by Durkheim do not pertain in modern societies. The risk is similar for those with and without a religious affiliation and the higher Church attendance amongst Catholics does not protect against suicide risk. Religious affiliation is a poor measure of religiosity, except for a smaller group of Conservative Christians, though their lower risk may be attributed to factors other than religion such as lower risk behaviour and alcohol consumption.

THE EARLY INTERVENTION STRATEGIES (EIS) FOR THE SOCIAL INCLUSION OF CHILDREN WITH AUTISM SPECTRUM DISORDERS (ASDs)

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Objective: ASDs are characterized by impairments in social interaction, behavior, and communication and are often the cause of disability in children. So far there is no global consensus on what strategies of treatment, education, and social support are most effective for patients with ASDs [1-2].

Methods: We evaluated samples of 400 children with ASDs. We applied Autism Diagnostic Interview Revised, PEP-R, Ritw-Freeman and Vineland Adaptive Behavior Scales. The EIS included a consistent, if necessary, combined use of several rehabilitation trainings: of sensory stimulation and integration, special cognitive trainings (general perception, imitation, special school skills), behavioral trainings, trainings of social functioning (social perception, emotional cognition, basic social functioning skills (food intake, personal hygiene, peers communication, household appliance use, behavior in class, etc.), in case of need (expressive speech absence or on the first stage of speech development) the elements of methodology of alternative communication (facilitated communication, labels, icons). EIS comprised an average of 25 hours of therapy per week for 200 children of the main group. The rest of the children with ASDs were available chaotic aid correctional educators and speech therapists in special pre-schools.

Results: SEI in the study group has provided the best, compared with the control group, changes in cognitive function, speech formation, the formation of daily living skills and the formation of adaptive behavior. We have not received sufficient evidence to assess special behavioral interventions to determine which ones are most effective for individual children with ASDs. Parameters of cognition and social behavior of in-group of children with ASDs, receiving medication on a background of active rehabilitation were on the higher level, than in groups of comparison.

Conclusions: There may be several potential benefits of EIS: reduced disability, a better prognosis, most likely restore normal development and recovery of psychosocial skills.

ARE THE NEEDS OF YOUNG PEOPLE WITH EARLY MENTAL HEALTH PROBLEMS IN RURAL AUSTRALIA BEING MET OR IGNORED?

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Educational Objectives: At the conclusion of this presentation participants will be able to identify some ecological systems that influence the mental health well-being of some young rural Australians.

Purpose: To understand how young rural people with emergent mental health problems could be helped early following the onset of a mental health problem.

Methods: A mixed methods case study was conducted in rural Northern NSW, Australia, to understand how young rural people with emergent mental health problems could be helped early following the onset of a mental health problem. An ecological framework was used to see how systems and relationships have influenced the early help seeking behaviours of young rural people, their families and their communities.

Rural people were interviewed to gain real life accounts, and a survey was conducted to describe mental health helping experiences. Descriptive and thematic analysis took place and the findings indicated that young rural people, and their families, require a broad range of locally available community-based support systems to assist their uptake of early mental health professional care.

Results: Findings will be presented which describe the difficulties experienced by young people, and their families, associated with understanding the language and processes related to initial access to mental health services. A range of issues identified by respondents' which hindered access to early mental health care will be discussed. These included access to adequate food, shelter, safety and transport in combination with geographical isolation as well as the perception of quality and usefulness of first appointment experiences.

Conclusions: The findings of this study indicate that the capacity for translational mental health promotion and early intervention in rural communities is scant, and that future efforts should focus on locally-based holistic community approaches to improve the mental health of young rural people.

COMPARING PARENT RATINGS OF ADHD SYMPTOMS BETWEEN CHINA AND US: PSYCHOMETRIC ASSESSMENT WITH THE CHINESE ADHD RATING SCALE - IV

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Educational Objectives: This is the first study investigating the psychometric properties of ADHD Rating Scale-IV: Home Version (DuPaul, Anastopoulos, et al., 1998) in an ethnic group outside western countries. The participants will understand better the cross-cultural universality and specificity of the manifestation of the ADHD symptoms between schoolchildren in China vs. US.

Purpose: To assess the psychometric properties of the Chinese ADHD Rating Scale – IV: Home Version and to explore parent ratings of ADHD symptoms in a large sample of Chinese urban schoolchildren.

Methods: Parents of a representative sample of 1,616 schoolchildren (aged 6-17) in 12 Chinese cities completed the ADHD RS-IV: Home Version. Reliability, validity and factor structure were calculated.

Results: The Chinese ADHD RS-IV: Home Version demonstrated good internal consistency ($\alpha \geq 0.85$), moderate test-retest reliability ($r_s = 0.45 - 0.72$ over 4 weeks) and low parent-teacher correlation ($r = 0.32$). The scale showed good discriminant validity between children with and without ADHD ($p_s \leq 0.0001$, Cohen's $d_s \geq 1.84$), with ROC analysis showing optimal sensitivity (91%) and specificity (93%). The scale was significantly correlated with the Attention Problems ($r_s \geq 0.62$) and Externalizing Behaviors ($r_s \geq 0.58$) subscales of the Child Behaviour Checklist, and with the Abbreviated Conners Rating Scale ($r_s \geq 0.68$). Factor analysis revealed the *DSM-IV* two-factor model with 'inattention' and 'hyperactivity-impulsivity' dimensions, accounting for equal variances. Parent ratings revealed lower/similar scores for Chinese schoolchildren compared with the U.S. study.

Conclusions: The Chinese ADHD RS-IV: Home Version is a reliable and valid ADHD screening tool for ADHD assessment among Chinese urban schoolchildren. The factor structure is similar but not identical to the U.S. study. Normative data reveal cultural differences in some aspects of the parent ratings. Considering its clinical implications, the Chinese ADHD RS-IV is not only a useful instrument for identifying ADHD in Chinese youth, but can also be adopted to supplement the clinic diagnosis, supervise the treatment effect, and assist the epidemiological investigation of ADHD in China.

Literature Reference: DuPaul, G. J., Anastopoulos, A. D., Power, T. J., Reid, R., McGoey, K. E., & Ikeda, M. J. (1998). Parent ratings of ADHD symptoms: Factor structure, normative data, and psychometric properties. *Journal of Psychopathology and Behavioral Assessment*, 20, 83-102.

DEPRESSION, DISABILITY AND CHRONIC DISEASE AMONG ELDERLY

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². Netherlands Institute of Health Services Research NIVEL

Educational Objectives: Relationship between depression and chronic disease is mainly explained by disability, all or not related to chronic disease. Especially GPs should be aware of cognitive and physical impairment among elderly and its risk for depression

Purpose: To analyse the relationship between depression and physical impairment among elderly

Methods: Cross-sectional survey in a sample of 378 depressed and 138 “healthy” (no CIDI disorder) elderly from a general practice population of 60 years and older. Psychiatric disorder was assessed with CIDI. Impairments and disability with WHO-DAS. During the interview, social demographic characteristics and chronic diseases were assessed. Data were analysed using bivariate and multivariate statistical techniques (logistic regression).

Results: Depression is significantly related to physical functioning, cognitive functioning and presence of somatic disease. In multivariate analysis it appeared that the latter is not a modifier for the relationship between physical functioning and depression. The reverse however is true: the relationship between somatic disease and depression disappears after controlling for physical and cognitive function.

These results are especially found among “younger elderly”. For persons above 70 years cognitive function is the only disability factor that remains related to depression.

Conclusions: The relationship of depression and chronic disease, often found in the literature for many chronic diseases, disappears in general after controlling for impairment and disability. Although for a number of chronic diseases (e.g. Parkinson disease, some kinds of cancer, CVA) a specific link with depression will exist, we were not able to demonstrate this due to too small numbers of patients with such diseases.

PREDICTING RECURRENT DEPRESSION AMONG PRIMARY CARE PATIENTS: THE IMPORTANCE OF SOCIAL CONNECTEDNESS PERCEPTIONS

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². University of Liverpool, Liverpool, United Kingdom

Educational Objectives: At the conclusion of this presentation, participants should have an increased understanding of how social factors may be used to identify which patients are at greatest risk of experiencing recurrent or persistent depressive symptoms.

Purpose: To investigate the role of social connectedness in predicting recurrent or persistent depression among primary care patients at 12 and 24 months when multiple confounding variables were considered.

Methods: This was a two year prospective cohort study of 789 people recruited from 30 primary care clinics. Participants completed a baseline questionnaire on current depressive symptoms, three dimensions of social connectedness (perceptions, integration and available attachments), neuroticism, health care use, self-rated health, self-reported chronic illness, alcohol intake, partner violence, childhood physical or sexual abuse, socio-economic status and demographic characteristics. The analysis tested for a potential moderating effect of gender and age, and a potential mediating effect of health care use, on the relationship between social connectedness and depression outcome. Multiple logistic regression analysis was used to identify significant predictors of depressive status at 12 and at 24 month follow-up. Generalised estimating equations were used to control for clustering and multiple imputation was used to handle missing outcome data.

Results: At 12 months, 655 (83%) participants were followed up, 40 percent of whom were depressed. At 24 months, 495 (63%) participants were followed up, 30 percent of whom were depressed. Perceptions of social connectedness, baseline depression severity, and neuroticism were significant ($p < 0.01$) predictors of depressive status at both 12 months and 24 months. Self-rated health significantly predicted depressive status at 12 months only and health care use predicted depressive status at 24 months only. Social integration and available attachments did not predict depression outcome. Neither gender nor age moderated the association between social connectedness perceptions and depression outcome and health care use did not mediate the association.

Conclusions: People who perceive that their social connectedness is inadequate are significantly more likely to continue to experience recurrent or persistent depression. The ability of social connectedness perceptions to predict depression outcome is independent of other factors such as initial depression severity, neuroticism, chronic illness, problem drinking, partner violence, child abuse, SES and demographic characteristics. This study shows that the pathway between social connectedness and depression outcome is through an individual's subjective appraisal of the adequacy of their social connectedness and not through objective levels of social integration or available attachments. These results suggest that social connectedness based interventions for depression should concentrate on changing perceptions rather than on increasing objective levels of connectedness.

ACCEPTABILITY TO USERS OF MOODGYM VERSUS INFORMATIONAL WEBSITES IN DEALING WITH DEPRESSION

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Educational Objectives: To present the potential advantages and disadvantages of on-line self-help using a Cognitive Behavioural Therapy (CBT)-based intervention, and open up discussion of how such websites, which are proliferating, may be delivered to greater effect.

Purpose: To investigate views of two on-line approaches to self-help for depression among adults in employment: computerised cognitive behaviour therapy (cCBT) and informational websites. CCBT offers an inexpensive and accessible alternative to face to face therapy, depending on its acceptability to employees.

Methods: Qualitative data were collected within an on-line RCT whose participants had diagnosable depression. The experimental intervention was a five week cCBT programme called MoodGYM, the control condition was five informational websites about mental health. There was no evidence of the superiority of either in terms of treatment outcomes. Here we look at the relative acceptability of each approach over time, including perceptions of cCBT compared to seeing a healthcare professional. We also present analysis of qualitative comments on the process of on-line self-help.

Results: Most people valued the advantages of cCBT at the outset and retained favourable attitudes towards it when they had used it. The control participants found the informational websites somewhat less acceptable over time. Barriers to use fell into four categories: intrinsic, intra-personal problems; extrinsic technical problems; generic issues mostly pertaining to perceptions of cCBT; and specific issues about the intervention or control condition.

Conclusions: As first-aid for mild to moderate mental health problems, evidence-based computerised approaches have broad acceptability. This could be increased by attending to the barriers noted here and by managing users' expectations at individual and organisational levels. The findings have implications for occupational health providers and others addressing the needs of working-age adults with depression.

SOCIAL RELATIONSHIPS AND DEPRESSION: TEN-YEAR FOLLOW-UP FROM A NATIONALLY REPRESENTATIVE STUDY

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Educational Objectives: At the conclusion of this presentation participants should be able to: 1) identify quality of social relationships as a risk factor for major depressive episodes; 2) appreciate the degree of effect poor quality of social relationships on depression risk; and 3) recognize how to assess individuals' quality of social relationships.

Purpose: Social relationships have long been associated with mental health, but the long-term ability to predict depression based on features of social relationships has been less explored. We determined whether quality of social relationships and social isolation predicts the development of major depression ten years later.

Methods: This is a longitudinal cohort study of 4,642 community-residing adults who participated in the Midlife in the United States study. Participants age 25-75 completed surveys at baseline in 1995-1996 and at ten-year follow-up. Weighting adjustments were applied to make the sample nationally representative. Quality of relationships was assessed with multi-item scales of social support and social strain. Social isolation was measured by presence of a cohabiting spouse/partner and reported frequency of social contact with family, friends, and neighbors. The primary outcome was past year major depressive episode ascertained at follow-up. Multiple logistic regression was conducted, adjusting for the presence at baseline of major depression, psychiatric comorbidity, sociodemographics, and other potential confounders.

Results: Risk of depression at 10-year follow-up was significantly greater in those with social strain (OR, 2.03; 95% CI, 1.49 - 2.76), lack of social support (OR, 1.79; 95% CI, 1.36 - 2.36), and poor overall relationship quality (OR 2.65; 95% CI, 1.86 - 3.76) with spouse/partner, family, and friends. Poor quality of relationship with spouse/partner (OR, 1.47; 95% CI, 1.16 - 1.87) and family (OR, 1.45; 95% CI, 1.10 - 1.90) each independently increased risk of depression. Those with the lowest overall quality of social relationships had more than double the risk of depression (14.1%; 95% CI, 12.0-16.1; $p < .001$) than those with the highest quality (6.6%; 95% CI, 5.2-8.0; $p < .001$). Social isolation did not predict future depression, nor did it moderate the effect of relationship quality.

Conclusions: Poor quality of social relationships is an important risk factor for major depression. Interventions aimed at preventing depression should consider addressing social relationships and targeting individuals with low quality of social relationships.

DEPRESSION IN BRAZILIAN ADULTS: A CROSS-SECTIONAL POPULATION-BASED STUDY

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Educational Objectives: Update on the prevalence of Major Depressive Episode (MDE) in Brazil. At the conclusion of this presentation, the participants should be able to know the prevalence and factors associated with MDE in Brazilian adults.

Purpose: The present study aimed to assess the prevalence of MDE and to describe demographic, socioeconomic and behavioral factors associated in adult.

Methods: A population-based cross-sectional study was conducted in Pelotas, southern Brazil, in 2012 using a sampling design of two-stage conglomerates with probability proportional to size. All adults aged 20 or more living in the selected households were invited to participate in the study. MDE was assessed using the Patient Health Questionnaire-9 (PHQ-9) with a cutoff ≥ 9 . Demographic, socioeconomic and behavioral variables were evaluated.

Results: The study sample comprised 2,925 respondents. The prevalence of MDE in the sample studied was 20.4% (95% CI 18.9;21.8). After adjustment for confounding factors according to a conceptual analysis model the following variables were associated with a higher prevalence of depression: female gender; younger age; white skin color; lower socioeconomic condition; lower education; smoking; being single or separated; being unemployed; and reporting a heart condition. Alcohol use, arterial hypertension, and diabetes mellitus were not found to be associated with depression

Conclusions: Our findings support the relevance of depression as a prevalent condition among adults. It also provided evidence of the factors associated with depression, and that some are potentially modifiable risk factors may have implications for policy and health service planning.

DEPRESSION SELF-MANAGEMENT SUPPORT GROUP: OUTCOMES OF A PILOT STUDY

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Educational Objectives: At the end of this presentation, participants should be able to recognize depression self-management support as a promising approach in primary care.

Purpose: The objective of this 1-year pilot study was to evaluate the effectiveness, acceptability and feasibility of a depression self-management support group among primary care patients with depressive symptoms.

Methods: Using a pre- and post-intervention prospective design, 40 patients with depressive symptoms received a weekly self-management group intervention lasting 10 weeks. Inclusion criteria were: a) ≥ 18 years old; b) major depressive episode in the previous two years, based on the SCID; c) score ≥ 6 to Quick Inventory of Depressive Symptomatology-Clinician (QIDS-C) and ≥ 8 to Hamilton Rating Scale for Depression (HDRS). Exclusion criteria were: a) bipolar disorder; b) psychotic disorder; c) pregnancy or $\leq$ six months postpartum. Clinicians blind to the intervention completed pre-intervention and post-intervention telephone interviews assessing participants' depressive symptomatology (QIDS and HDRS) and antidepressant adherence (MMAS). Knowledge about depression, self-efficacy and self-management behaviors were measured by self-administered questionnaires. Participant satisfaction and perceived usefulness of the intervention were also evaluated at post-intervention.

Results: Participants had significantly lower levels of depressive symptoms after the group intervention. Self-management behaviors also improved. Based on these findings, patients' feedback and rates of retention, the self-management support group intervention was acceptable. Feasibility is high because our recruitment was quicker than expected.

Conclusions: Providing self-management support to depressive patients seems to be a promising intervention in primary care. This study demonstrates the acceptability and feasibility of a group intervention. A randomized controlled trial is needed before we can recommend implementing the program.

DOSE-RESPONSE RELATIONSHIP BETWEEN EXERCISE AND CLINICAL DEPRESSION. A SYSTEMATIC REVIEW

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Educational Objectives: To inform mental health professionals about dose-response issues related with the prescription of exercise to clinically depressed adults.

Purpose: To determine the optimum dose-response relationship between exercise and clinical depression.

Methods: A systematic literature review of randomized controlled trials (RCTs) on exercise intervention was conducted (1980 to 2011-June). Inclusion criteria included adult patients (18-65) diagnosed with major depressive disorder. The dose-response relationship in each RCT was assessed with the Cribbie and Arpin-Cribbie (2009) method that clarifies if treatment changes (reduction in depression) are equivalent to the normal population at the 0.5, 1.0, and 1.5 standard deviation (SD) intervals. Based on the 10-item Physiotherapy Evidence-Based Database Scale (PEDro), two independent raters evaluated the internal validity qualities of each RCT to control for the confounding impact of systematic errors of bias as these are related with larger treatment effects. Due to inability to blind patients/therapists in exercise RCTs, the two related PEDro items were excluded. Thus, the maximum quality score was 8. Interrater agreement was calculated as Cohen's kappa.

Results: Fourteen RCTs met the inclusion criteria. Aerobic exercise compared favourably to other exercise modes (relaxation, low intensity, stretch or strengthening exercise) in three RCTs and equally in two RCTs. Aerobic exercise showed higher effects than traditional treatments in eight RCTs and equally in one RCT. PEDro scoring ranged from 1 (lowest) to 8 (highest) with substantial interrater reliability (Cohen's kappa=62). RCTs were hierarchically classified on the basis of top PEDro scoring to identify the optimum dose-response relationship toward the most proximal equivalence interval (0.5SD) to the normal population. One RCT (PEDro score=4), and two RCTs (PEDro score=5) with low-moderate intensity exercise delivered three times/week (for 3, 8, or 9 weeks) reflecting on the patients' preferred mode/intensity exercise brought about an improvement in depression scores equivalent to the normal population (0.5SD, and 1.5SD intervals, respectively). The 4 and 5 PEDro scoring is moderate pointing unfulfilled key design criteria including random/concealed allocation, blinding assessor.

Conclusions: Both short- and longer-term (3, 8, or 9 weeks) aerobic exercise protocols at low-moderate intensity delivered three times/week reflecting on the patients' preferred intensity/mode exercise improved depression to a state of normalcy. However, the optimum dose-response relationship between exercise and depression cannot be determined due to moderate methodological qualities of the RCTs. Robust methodological RCTs focusing on the patients' preferred mode/intensity exercise are needed to establish the optimum dose-response relationship between exercise and clinical depression.

CHANGING PSYCHIATRIC PERCEPTION OF AFRICAN- AMERICANS WITH MOOD DISORDERS, 1788-2012

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Educational Objectives: At the conclusion of this presentation, the participants will 1) understand the link between historical stereotypes and low reported rates of mood disorders in African Americans and 2) recognize the importance of historical perspective when assigning psychiatric diagnoses to members of minority populations.

Purpose: This presentation will explore the origins and implications of the underdiagnosis of mood disorders in African-Americans.

Methods: To facilitate this historical inquiry, the author 1) searched MEDLINE, American psychiatric journals, and old collections using relevant key words; and 2) reviewed references from the bibliographies of articles that were collected by this procedure.

Results: The historical record indicated that the psychiatric perception of African-Americans with mood disorders changed significantly during the last 200 years. In the antebellum period, the mental disorders of slaves mostly went unnoticed. By the early 20th century, African-Americans were reported to have high rates of manic-depressive disorder compared with whites. By the mid-century, reported rates of manic-depressive disorder in African-Americans plummeted, and rates of depression remained virtually nonexistent. In recent decades, reported suicide and rates of diagnosed depression and bipolar disorder, whether in clinical or research settings, were inexplicably low in African-Americans compared with whites. Regardless of year, whether early last century or as recently as 2012, studies 1) linked mood disorders in African-Americans to severe mental disorders, such as schizophrenia or organic psychoses; 2) judged psychotic symptoms in African Americans to be more severe in their own right; and 3) deemed affective disorders without psychotic features in African Americans to be more severe and debilitating.

Conclusions: Given these results, American psychiatry has come to perceive that blacks are prone to severe psychotic disorders, such as schizophrenia, rather than mood disorders. Low reported rates of depression and suicide in African Americans may be influenced by past stereotypes that portray blacks as being insusceptible to or unaffected by depression. Psychiatry, as a whole, needs to appraise the deep-seated effects of historical stereotypes on the diagnosis of minority populations and exercise appropriate caution in clinical and research settings.

THE INTERRELATIONSHIP BETWEEN RESILIENCY AND PSYCHOSOCIAL MEASURES FOR PRETERM BIRTH

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Educational Objective: To understand how maternal psychosocial measures are related to the risk of early or late preterm birth.

Purpose: To investigate the relationship among composite pregnancy anxiety and the risk of early preterm (EP; <34 weeks) and late preterm (LP; 34-36 weeks) compared to term delivery (>37 weeks) and to further examine this relationship among women with high perceived social support and optimism.

Methods: We used data from the All Our Babies study, a prospective community-based pregnancy cohort in Alberta, Canada (n=3388). Composite pregnancy anxiety included excessive symptoms of state anxiety in early pregnancy, history of abuse and feelings about timing of pregnancy. We performed bivariate and multinomial logistic regression to examine the effect of composite pregnancy anxiety on preterm delivery after controlling for demographics, lifestyle and pregnancy-related factors.

Results: Pregnancy anxiety was an independent risk factor for LP birth (Odds ratio (OR) 1.72; 95% CI: 1.06, 2.79), but not for EP birth (OR 2.45; 95% CI: 0.96, 6.38) after adjusting for known risk factors. However, pregnancy anxiety was not a significant risk factor for preterm birth among women with high perceived social support or high optimism.

Conclusions: The results suggest that that both external and internal resiliency factors mitigate psychosocial risk for shortened gestation. In specific, high social support and high optimism buffer the effect of pregnancy anxiety on the risk for delivering a late-preterm infant. Being connected to others and the perceived availability of social support is a coping mechanism related to resiliency, while optimism is related to a sense of control or mastery over life. Our findings add to the accumulating evidence that self reported measures of stress-related emotions are related to adverse pregnancy outcomes, and suggest the importance of effective prenatal screening to identify anxiety. In addition, the important role of spouses, families and communities in providing support is highlighted.

CHILDREN'S MENTAL HEALTH AND PARENTING AMONGST MULTICULTURAL CANADIAN FAMILIES: ASSOCIATIONS WITH UNIQUE PROFILES OF ENVIRONMENTAL RISK

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Educational Objectives: To illustrate the fact that distal environmental risk factors for mental health problems in children (e.g. neighbourhood quality, immigration status, poverty, marital conflict, maternal history of abuse, etc.) combine in unique and distinct profiles amongst urban and multicultural Canadian families. These risk profiles are differentially associated with both child psychopathology and parent-child relationships. To date, only one study has explicitly addressed this issue in the context of academic and behaviour problems (Lanza et al, 2010).

Purpose: To statistically identify prototypical patterns (Latent Classes) of environmental risk and examine the corresponding patterns of child psychopathology and parent-child relationships amongst 501 diverse urban families from Ontario, Canada.

Methods: Participants came from the Kids, Families & Places Study, which is largely representative of the urban Canadian population with the exception of slightly higher education and less divorce. A Latent Class Analysis was conducted across 33 multi-informant risk factors, which concerned maternal history/functioning, household characteristics, socioeconomic indicators, and neighbourhood quality. The optimal number of classes was selected based on statistical fit indices (the Akaike and Bayesian Information Criteria, Entropy, and the Lo-Mendell-Rubin Likelihood-Ratio Test). Subsequently, the identified classes were compared on psychiatric screening measures derived from the Canadian National Longitudinal Survey of Children and Youth (hyperactivity-inattention, physical aggression-conduct disorder, emotional disorder-anxiety), interviewer observation of child behaviour, and psychometric and observational measures of parenting (parental positivity and negativity).

Results: A four class solution for the Latent Class Analysis was selected: (1) intact families with low risk (43%), (2) intact immigrant families with low-SES living in disadvantaged neighbourhoods (28%), (3) intact families with maternal history of adversity (16%) and (4) single-parent families with multilevel risk (13%). Differential associations with child psychiatric problems and parenting practices were observed across risk profiles.

Conclusions: Distal environmental risk factors are distributed in a nominal fashion similar to the risk profiles previously described by Lanza and colleagues (2010). This is with the exception of the low-SES immigrant group living in disadvantaged neighbourhoods, which is reflective of the Canadian urban landscape. Findings suggest that scientists should not only be concerned with the amount of psychosocial risk children experience, but also the pattern of risk and the way these patterns differentially correlate with child mental health problems and family relationships.

THE MENTAL HEALTH IMPACT OF ABORTION

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Educational Objectives: At the conclusion of this presentation, the participants should be able to understand the evidence regarding mental health problems following an elective abortion.

Purpose: To review the best available evidence assessing the link between mental health problems and elective abortions.

Methods: We undertook a comprehensive and systematic review of the associations between abortion and mental health.

Results: Most of abortions carried out in the UK and commonwealth countries are undertaken on the grounds that continuing with the pregnancy would risk physical and/or psychological harm to the woman or child. However, there has been some concern in recent years that abortion itself may lead to an increased psychological risk and negatively affect the woman's mental health. Indeed, two recent meta-analyses have claimed that abortion leads to a deterioration in mental health. Neither of these meta-analyses was done systematically, nor did they comprehensively review the field of abortion and mental health in terms of prevalence and factors associated with a poor outcome. Previous reviews concluded that the mental health outcomes following an unwanted pregnancy are very similar whether the woman gives birth or has an abortion. One of these was comprehensive but not systematic; the other was systematic but not comprehensive. The review highlighted multiple flaws in the evidence base currently available to assess the question. findings suggested that there may be a link between mental health problems and an unwanted but this risk is unchanged by going to abortion or giving birth.

Conclusions: Mental health problems are associated with an unwanted pregnancy regardless of pregnancy resolution e.g. abortion or live birth. Meta-analysis is particularly susceptible to bias in this area. The physical health outcomes for women with an unwanted pregnancy have improved greatly by making abortion legal. To further improve the mental health outcomes associated with an unwanted pregnancy we should focus practice and research on the individual needs of women with an unwanted pregnancy, rather than how the pregnancy is resolved.

THE ADDITIVE EFFECTS OF EXPOSURE TO VIOLENCE, SOCIOECONOMIC STATUS, AND POVERTY ON AFRICAN AMERICAN YOUTH DELINQUENCY AND VIOLENCE: A STRAIN THEORY APPROACH.

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Educational Objectives: The objective of this paper is to highlight a new etiological framework, called chronic cumulative community strain, on youth delinquency. Chronic cumulative strain (CCS) considers the additive and chronic effects and processes of risk factors across an individual's many environmental systems, which insidiously erodes potentially buffering factors. This new paradigm has the potential to inform multi-level and multi-systemic community interventions programs and policy.

Purpose: The project provides a unique etiological model on youth delinquency, one that incorporates risk and protective factors in a general strain theory perspective.

Methods: The current study examined the relationship between chronic cumulative community strain (CCCS), an additive construct of exposure to violence and poverty stressors, and delinquency and violence in a sample of 74 African American adolescent boys. In addition, the study investigated the risk and protective properties of coping, family environment, parenting styles, peer affiliation and male identity on the putative relationship between CCCS and delinquency and violence.

Results: Results demonstrated a significant positive correlation between CCCS and juvenile delinquency, specifically a positive correlation between exposure to violence and juvenile delinquency, and a negative correlation between SES and juvenile delinquency. In addition, the moderational effects of positive coping, family cohesion, authoritarian parenting styles, prosocial involvement and male identity on the relationship between CCCS and delinquency were examined. Findings from moderation analyses showed that negative coping strategies and a conflictive family environment were positively correlated with juvenile delinquency, but the relationships were no longer significant after controlling for exposure to violence. More importantly the study found that some male identities moderated the relationship between CCCS and juvenile delinquency. Specifically, reference group nondependent (RGND) and no reference group (NRG) male identities, adolescent boys who either base their male identity on non-traditional masculine ideology or do not subscribe to any male ideology, weakened the positive relationship between violence victimization and delinquent behavior.

Conclusions: The study's unique socio-ecological perspective on risk and protective factors has the potential to revolutionize youth delinquency interventions. It offers a comprehensive understanding of a vexing social issue: the contribution that long term community strain has on endemic delinquency among male African American youth.

WESTERN-TRAINED HEALTH CARE PRACTITIONERS' BEHAVIORAL INTENTIONS TO WORK WITH TRADITIONAL HEALERS: IMPLICATIONS FOR INTEGRATION OF TRADITIONAL HEALING AND WESTERN HEALING

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Educational Objectives: This study was informed by South Africa's proposal to integrate traditional African healing and Western medicine in state health care institutions.

Purpose: The study aimed to investigate how Western-trained health care practitioners' opinions, attitudes, knowledge and experiences with traditional healing could predict their intentions to work with traditional healers in the future. Participants were 319 Western-trained healthcare practitioners at state hospitals and clinics in Gauteng and Limpopo provinces in South Africa.

Results: Results of standard multiple regression analysis revealed that the predictor variables (opinions, attitudes, knowledge and experiences) explained 51% of the total variance of health care practitioners' intentions to work with traditional healers in the future. Attitudes made the strongest unique contribution to explaining health care practitioners' intentions to work with traditional healers in the future when the variance explained by other variables in the model was controlled for.

Conclusions: In conclusion, it would appear that the current potential to integrate the two health care models is remote and can only be realised with considerable effort from all stakeholders.

THE MANIFESTATION OF ANXIETY AMONG SESOTHO SPEAKERS

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Educational objectives: Many aspects of mental health may be influenced by culture, including how individuals manifest and express their symptoms, their support from the family and communities, coping styles, and willingness to seek treatment. Diagnosis, treatment and service delivery are also influenced by the cultures of the service system and clinician. This is also true for anxiety. Anxiety is a universal phenomenon. However, cross-cultural studies have shown that there are significant differences in the way anxiety is described and experienced.

Purpose: This study investigates the way in which anxiety is clinically manifested among Sesotho speakers in Mangaung, Free State, South Africa

Methods: The participants consisted of 101 Sesotho speakers from Mangaung, South Africa, diagnosed with anxiety disorders. They were drawn from consecutive patients presenting at various health establishments. The participants were between 18 and 65 years of age. Written informed consent was obtained from each participant. The study was approved by the research committee of the University of the Free State. A semi-structured interview, based on the Psychiatric Interview Questionnaire (PIQ) was used to elicit the information. The PIQ consists of two types of data collection: open-ended interview and clinical observation.

Results: About 64.0% of the participants were between 26 and 45 years of age. Almost 50.0% of the participants were single. Although anxiety is found across cultures, its expression, in terms of interpretation and experiences, is influenced significantly by cultural factors. Furthermore, it was found that the core symptoms of anxiety among Sesotho speakers are similar to those that have been reported in other cultures except for the prevalence of perceptual disturbances and physical symptoms. There was also culture-specific expression of anxiety among Sesotho speakers.

Conclusion: The present study strongly confirms other research reports that anxiety is a universal psychological or emotional disorder. However, the way in which anxiety is experienced and interpreted, and how people respond to it, is strongly influenced by cultural forces. Another important finding of this research is the marked variation in manifestation of the symptoms of anxiety among Sesotho speakers in comparison with Westerners. The main differences were observed in perceptual disturbances, specifically the prevalence of hallucinations, which are regarded as indicative of psychosis in the western world. Although this study revealed important findings, the results should be interpreted with caution, especially as far as generalization is concerned.

PSYCHOSOCIAL SUPPORT IN MENTAL ILLNESS: CREATING CHANGE TO IMPROVE SERVICES

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Educational Objectives: Participants will recognise uses of change management models and measurement tools in putting improvements into practice in psychiatry-related services such as psychosocial support.

Purpose: Many best practice recommendations in biopsychosocial psychiatric care are not delivered to patients, often because planned practice changes are not properly implemented. This project identified and assessed a change management tool in implementing improved psychosocial support delivery in community mental health.

Methods: *Background:* Psychosocial support is a key element of biopsychosocially oriented mental health care, but one with a continually evolving evidence and theoretical basis. To maintain alignment with current best practice, providers must continually adapt their services. Such service changes are notoriously difficult to put into practice therefore leaders need appropriate and proven implementation tools.

Setting: The study setting was the introduction of a new program, the Flinders Chronic Condition Management Program (Flinders ProgramTM), to underpin 15 recovery-based psychosocial support programs delivered by a non-government organisation in South Australia, UnitingCare Wesley Port Adelaide (UCWPA). The Flinders Program had been assessed by UCWPA as empirically tested and consistent with the client-partnership and recovery orientations of the organisation. The research team assessed the usefulness of a health service change tool in implementing this planned change.

Literature review: A literature search and review was conducted to select a health service implementation model which had corresponding measurement tools and face applicability for psychosocial support services in community mental health.

Application of the tool: The selected measurement tools were applied early in the implementation (T1) and 9 months later (T2). Changes in scores for the 3 domains of the model were matched against change strategies used between T1 and T2 (such as worker training and awareness, measurement systems, and integration with performance management) and against organisational measures of practice change.

Results: The literature review found few implementation models which had corresponding tools that were easily accessible for service practitioners. Of those found, the Promoting Action on Research Implementation in Health Services (PARIHS) model and corresponding Organizational Readiness to Change Assessment (ORCA) tool were selected for the project.

Lowest scoring subscales of the ORCA tool at T1 pointed to domains of the PARIHS model which could be strengthened through change strategies. Changes in subscale scores at T2 showed good alignment with strategies applied and with greater use of the Flinders Program.

Conclusions:

The PARIHS model and aligned ORCA tool were found useful in showing gaps, guiding strategies, structuring change processes, and reflecting progress in implementing change in psychosocial support services in our setting. We believe that such models and tools warrant further use by psychiatrists and other service leaders wishing to implement improvements in biopsychosocially oriented mental health care services.

IMPLEMENTATION OF MODERN MENTAL HEALTH CARE PRINCIPLES IN LITHUANIA: ANALYSIS OF OBSTACLES FOR MAKING SHIFT OF PARADIGM POSSIBLE

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¹. Vilnius University, Lithuania

Educational Objectives: At the conclusion of this presentation, the participants should be able to identify factors which might facilitate or impede implementation of evidence-based mental health policies and services.

Purpose: Main objective was to identify basic obstacles impeding so far implementation of modern mental health policies.

Methods: Multidisciplinary group of researchers, representing social and biomedical sciences, analyzed steps undertaken in attempt to transform mental health services in Lithuania during two decades (1990-2010). Analysis of dynamics of public mental health indicators, mental health system performance indicators and documents reflecting formulation and implementation of national mental health policy during 1990-2010 was performed, as well as a qualitative study of interviews with representatives of major stakeholders.

Results: Several stages in the area of mental health policy formulation and implementation have been identified. Enthusiastic development of innovative preventive and clinical services during the 1990's has faded away during the second decade of transition, with increasing tendencies to keep investing in traditional system based on biomedical model, with overuse of institutional long-term care and drug treatment. The following basic needs for change in mental health care system have been identified as priorities:

- a) substantially invest in modern psychosocial interventions and to reduce over-reliance of mental health care system on drug treatment and long-term institutional care;
- b) introduce a broad spectrum of sustainable evidence-based modern interventions in the area of prevention and mental health promotion, including suicide prevention;
- c) move from „self-feeding“ tradition of evaluation to independent monitoring of performance of mental health care system;
- d) introduce independent monitoring of human rights in mental health care system;
- e) facilitate public discourse among general population, academic and other groups about how to transform culture of mental health services from the model based on paternalism and stigmatization, to the one based on principles of autonomy and participation.

Conclusions: Contextual and attitudinal factors, including low level of tolerance to vulnerable groups among population, and lobby of interest groups supporting tradition of overuse of institutional care and biomedical treatment, and lack of political will to invest in modern community-based psychosocial interventions, have been blocking so far the shift of paradigm in mental health care system in Lithuania. Analysis performed on challenges for implementation of modern principles in Lithuanian mental health care system, may be used as a template for identification of factors, which might facilitate or impede reforms, in other countries of Eastern Europe and other regions.

THE PATHWAYS TO CARE OF ACUTE PSYCHOSIS IN A DEPARTMENT OF MENTAL HEALTH IN NORTHERN ITALY: A RETROSPECTIVE STUDY.

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Educational Objectives: To study the pathways to care for patients affected by acute psychosis in the Department of Mental Health (DMH) of Modena (Northern Italy).

Purpose: To describe the pathways to care of patients presenting with acute psychosis in the Department of Mental Health (DMH) of Modena during the year 2011 and to examine the demographic, clinical and social factors influencing routine integrated treatment for acute psychosis.

Methods: Through both retrospective charts review and interviews to specialists working in the 8 out-patient clinics of the DMH of Modena, we collected demographic, clinical and social characteristics of all patients who presented with an episode of acute psychosis (affective and non affective) from January 1st to December 31st of 2011 at the DMH of Modena. We compared patients who underwent NON psychopharmacological intervention (psychotherapy, social inclusion, supported employment, psychoeducational and family intervention) versus subjects who did not.

Results: 47 subjects, 68% males, 77% single, with a mean age of $27 \pm 5,4$, were included in our analysis. 40 patients (89%) received a psychopharmacological treatment as a part of usual care; 19 (41%) received a NON psychopharmacological treatment. We observed that subjects with lower education and foreign nationality were less likely to receive a NON pharmacological treatment, with a statistically significant difference ($p=0,036$ and $p=0,013$ respectively). Comparing Italian patients (29, 62%) vs foreigners (18, 38%) no differences were observed in terms of numbers of admission to the psychiatric hospital and in terms of disengagement from the out patient clinic.

Conclusions:

- According to literature, our data confirm that psychopharmacological treatment is the predominant treatment in acute psychosis attending MHD but 41% of the total sample attended non pharmacological treatment as well.
- Our findings are consistent with international and national guidelines for interventions in acute psychosis: pharmacological treatment is the first line intervention, whereas non pharmacological ones are strictly related to the stage of illness, particularly indicated when acute psychosis symptoms are decreased.
- Foreigners and subjects with lower level of education were less likely to attend non pharmacological interventions, this may be due to social, linguistic and cultural barriers.
- Our findings are preliminary data and more analysis are needed to explore pathway of care in the different local and national mental health systems.
- Our study, despite its limitations of a small sample and the retrospective design, could be useful to achieve a higher quality of service through specific patient-centered programs that should take into consideration cultural, social and linguistic features.

Literature Reference:

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29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

**Life-Span perspectives of
mental health**

MULTI-FACTORIAL MEASURE OF PARENTING AND CHILDREN'S PSYCHOLOGICAL DISORDERS: A CROSS CULTURAL RESEARCH

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Background: Studies on parenting typically focus on one or two parental factors such as authoritarian, authoritative, and permissive parenting or acceptance-rejection factor.

Methods: Based on the understanding that parenting is a complex process and on that parenting factors may overlapping (such as authoritarian and rejection), the author (Dwairy) has suggested a multi-factorial method of research and has developed a scale that measures seven different factors: *Punishing in the name of love, addressing the child's conscience, addressing the child's rational thinking, conditional love, inconsistent parenting, unconditional acceptance, and authoritarian parenting*. The questionnaire in addition to another questionnaire that measures psychological disorders among children was administered to 900 teenagers (15-17 years old) in three cultures: Palestinians, British, Lebanon, and Algerian. The results shows that the scales were valid and reliable and revealed four different patterns (profiles) of parenting each consists from seven factors. Each pattern was associated with different level of psychological disorders. Interesting cross-cultural and gender differences in parenting patterns were found.

Results: To our knowledge, this is the first study of parenting that is based on a multi-factorial scale of parenting. Based on further research the Dwairy Multi-Factorial Parenting Scale (DMFPS) may contribute a lot to parenting research and to clinical work with families.

SCREENING FOR RISK OF LATER MENTAL HEALTH PROBLEMS: A LONGITUDINAL STUDY

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Purpose: This is one of the first studies to report that the Achenbach internalising scales were much more effective at identifying those with current comorbid depression and anxiety, rather than individual mood disorder.

Introduction: The Achenbach behaviour checklists (YSR, YASR) are widely used, low cost screening tools used to assess problem behaviour. Several studies report good association between the checklists and psychiatric diagnoses; although with varying degrees of agreement. Most are cross-sectional studies involving adolescents referred to mental health services; few are in large community-based studies. This study examined the usefulness of the Achenbach internalising scales in the primary screening (both predictive and concurrent) for depression and anxiety.

Methods: The sample was 2400 young adults from an Australian population-based prospective birth cohort study. The association between the empirical anxiety and depression scales were individually assessed against DSM-IV depression and anxiety diagnoses. Odds ratios and diagnostic efficiency tests report the findings.

Results: Adolescents with internalising symptoms were twice (OR 2.3, 95%CI 1.7 to 3.1) as likely to be diagnosed with later DSM-IV depression. YASR internalising scale predicted DSM-IV mood disorders (depression OR = 6.9, 95% CI 5.0–9.5; anxiety OR = 5.1, 95% CI 3.8–6.7) in the previous 12 months. The internalising scales were much more effective at identifying those with comorbid depression and anxiety.

Conclusions: Adolescence and early adulthood are key risk periods for the onset of anxiety and depression. This study found that young people with internalising behaviour problems were more likely to have comorbid depression and anxiety DSM-IV disorder.

Literature Reference:

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PATTERNS OF ANXIETY ACROSS THE REPRODUCTIVE LIFE COURSE OF A COHORT OF WOMEN FOLLOWED OVER 27 YEARS

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Educational Objectives: At the conclusion of this presentation participants should demonstrate an understanding of reproductive life course variations in anxiety in women.

Purpose: Anxiety is a major source of morbidity particularly for women, this long term, prospective study aims to describe the natural history of anxiety disorders over women's reproductive life course.

Methods: Two thousand, four hundred and fifty-six women from a prospective mother-child birth cohort study (Mater-University of Queensland Study of Pregnancy (MUSP)) were followed over 27 years from 1981 through to 2012. These women were interviewed seven times over this period: at first hospital antenatal appointment, a few days after the birth of the index child, then at 6 months, 5, 14, 21 and 27 years after the birth. Mental health was measured at each phase using the Delusions-Symptoms-States Inventory (DSSI, a validated and reliable measure of anxiety and depression symptoms).

Results: Of the women surveyed 1021 (41.6%) reported at least one episode of severe anxiety symptoms over the 27 years of follow-up. Nearly half of women (48%, n=490) had severe anxiety during the index pregnancy or in the immediate post-partum period, they had a mean age of 25 years (SD=5.3 years, their ages ranged from 14 to 42 years old). Of the 490 women anxious either at the time of the index pregnancy or in the post-partum period nearly a third (n=140) reported anxiety only in this period, whilst the remaining women reported additional episodes to 27 years. The remaining 531 women reported first measured episode of severe anxiety symptoms after the index pregnancy. These women were on average 39 years of age (SD=8.5 years, their ages ranged from 21 to 65 years old) when assessed. Just under a half of the women with anxiety symptoms (48.7%, n=494) experienced only anxiety, the other half reported comorbid depressive symptoms: 24.6% (n=250) experienced concurrent anxiety and depressive symptoms, 22.4% developed anxiety before depressive symptoms, whilst only 4.3% had depressive symptoms followed by later anxiety. The majority of women reporting no anxiety (n=1369) also had no depressive symptoms, less than five per cent (4.5%, n=64) of women without anxiety reported lifetime depressive symptoms only.

Multivariate analyses adjusting for socio-demographic and life style factors as well as life stressors at initial assessment, found that poverty, incomplete schooling, and severe stress during the index pregnancy remained significant predictors of anxiety regardless of time of onset. Women experiencing severe stress during pregnancy had 19 times the odds (95%CI 12.3,30.1) of severe symptoms of anxiety than women reporting few or no stressors.

Conclusion: This study provides one of the first long term, population based studies of anxiety across a woman's reproductive life course. It shows that there is a high level of continuity of anxiety symptoms with severe stress during the pregnancy remaining a consistent, major, contributing factor.

UNDERSTANDING THE IMPLICATIONS OF THE PHILOSOPHY AND PRACTICE OF RECOVERY FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS

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Educational Objectives: At the end of the presentation, participants should be able to understand the implications of recovery for older people and will hold an awareness of the issues involved in undertaking evaluation of recovery training within older people's mental health services.

Purpose: The purpose of the project is to understand the philosophical and practice implications arising from the concept of recovery for older people with mental health problems and upon service delivery.

Methods: A qualitative study was undertaken with 28 service users and 10 carers, using grounded theory techniques to produce a conceptual framework of recovery for older people with mental health problems (Daley et al, Int J Geriatr Psychiatr, in press). This framework was used to develop the RECOPE model comprising an intervention (a 3-day team-based recovery training package for staff working within older people's mental health services) and intended effects. The RECOPE intervention was delivered to 203 staff working in clinical teams in South London, UK. The primary and secondary hypotheses were that the RECOPE intervention would improve recovery and quality of life for service users.

The primary outcome evaluation used a controlled pre/post design, with service user participants (n=65) across three time points, using the Illness Management and Recovery Scales (Meuser et al, 2004) and two quality of life measures, the DEMQOL (Smith et al, 2007) for people with dementia and the Short Form Health Survey (SF12) (Ware et al, 1996). Process evaluation comprised: qualitative interviews with staff (n=19), pre-post staff ratings (n=176) of recovery knowledge and attitudes using the Recovery Attitudes Questionnaire (Borkin, 2007) and the Recovery Knowledge Inventory (Bedregal et al, 2006), and review of longitudinal care plan data (n=250) over seven time points.

Results: The results from the primary outcome evaluation will be presented. The process evaluation highlighted that:

- a) The fit between trainer and team, and team organisational culture was a significant mediator in the successful delivery of training and transfer of learning into practice
- b) Significant change was found in measures of staff knowledge and attitudes, and team and professional group membership were found to impact upon the results.
- c) Change in the behavioural intent of staff was evident through the review of care plans

Conclusion: The need to develop recovery measures for use with older people is indicated. The need to tailor pre and post intervention implementation strategies to the local team context to maximise effectiveness is required.

THE LISBON STUDY ON FAMILIES OF PEOPLE WITH DEMENTIA (FAMIDEM)

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Educational objectives: At the conclusion of this presentation, the participants should be able to discuss some findings of the FAMIDEM study in Portugal, namely on the importance of caregiver knowledge in dementia and the risks of being a non-primary caregiver.

Purpose: Important issues remain unanswered regarding family caregiving in dementia (e.g. the importance of disease-related knowledge, or the risks of non-primary caregivers). Many international findings should be locally replicated, and measures cross-culturally validated. A comprehensive study of families of people with dementia (FAMIDEM) was conducted in Lisbon (Portugal), with international collaboration. We aimed: 1. to understand how caregivers' knowledge about dementia could relate to particular aspects of the caregiving experience, including burden; 2. to compare the experience of caregiving in primary caregivers and other less directly involved relatives; and 3. to contribute to the validation of some caregiving measures in Portugal.

Methods: FAMIDEM was a non-randomised cross-sectional study, conducted in three waves. Patients were in contact with outpatient neurology or psychiatric services in Lisbon. Dementia diagnoses were confirmed (ICD-10 Diagnostic Criteria for Research), and demographic and clinical data were collected. Caregivers' assessments included: Zarit Burden Interview, Caregiver Activity Survey, Positive Aspects of Caregiving, General Health Questionnaire, Social Network Questionnaire, Sense of Coherence Questionnaire and Dementia Knowledge Questionnaire. The translations of these measures or previous validation studies in Portugal were documented.

Results: In wave II, 116 caregivers were studied. No associations were found between caregivers' knowledge and their burden, positive aspects of caregiving or psychological distress (1). In another wave II study, two related samples of caregivers of the same patient (primary caregivers versus others) were compared (n=41 in each sample). Primary caregivers were older and tended to live with the patient. They reported less emotional support and higher objective burden, according to the Caregiver Activity Survey. Regarding other domains, no significant differences were found between groups (2). Finally, psychometrics of the Portuguese translations of two questionnaires were established, the Burden Interview and the Positive Aspects of Caregiving scale, which allows for further comparative research.

Conclusion: A large proportion of caregivers in wave II FAMIDEM, albeit informed about dementia, were at risk of high burden and distress. As would be expected, risks for primary caregivers were greater, but our findings suggest further exploration is needed, given the importance of secondary caregivers in Portugal. For the moment, it is prudent not to assume that only key-relatives are at risk. Wave III results are now under analysis.

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29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

**Natural Disasters/Man-made
(including Fukushima) and
mental health**

AGONY OR ACTUALISATION? HOW GLOBAL WARMING MAY AFFECT MENTAL HEALTH. A CASE STUDY FROM AUSTRALIA

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Purpose: Continued global warming will mean systemic climatic changes and, consequently, more intense, unpredictable and (possibly) frequent weather-related disasters. There are immediate psychiatric impacts and sometimes severe longer-term sequelae from such disasters. To help predict future impacts and adaptive responses, a program of research at The University of Canberra, Australia, aims to identify possible causal mechanisms and explanatory models and to test these models.

Methods: Data matching with large panel and cross-sectional studies to quantify selected interacting causal parameters in a proposed explanatory model. *Drought* impacts were examined by matching precipitation records from the Australian Bureau of Meteorology to data from Waves 1-8 of the Household, Income and Labour Dynamics in Australia Survey, a nationally representative panel study, N~15,000 participants, collected annually from 2001. To investigate *flood* impacts, we partnered with Queensland Health to include our *Brief Trauma Exposure and Impact Screen* (N~5,500) in that State's routine screening which, in the summer of 2010-11, coincided with extreme flooding. Statistical techniques: prevalence estimates; regression modelling approaches; cluster analysis; path modelling.

Results: Study 1. We identified five types of drought exposure: zero-to-moderate; constant; very dry; very prolonged; constant and very long. Those experiencing very prolonged and constant drought had worse mental health than did other categories. Those in the very prolonged category had the worst outcomes of any group – but only if they lived in rural locations. For city-dwellers, prolonged drought was slightly associated with *better* mental health compared to zero-to-moderate drought. Study 2. Over 14% of adults felt terrified, helpless or hopeless, with a further 3.9% thinking they might be badly injured or die. The prevalence of each of these two symptoms of post traumatic stress varied markedly with the extent of physical impact of the disasters and by two other factors: rurality; and dis/advantage. Poorer circumstances were associated with greater exposure and, separately, with greater impact.

Conclusions: 'Drought' and 'floods' require careful definition. Experiencing such an event does not automatically confer a psychiatric exposure. 'Drought' *as an exposure* is a period of long cumulative dryness *relative to the local norms*, particularly if it culminates in a recent very long period of extreme dryness. Floods may be an exposure if people experience two or more forms of damage (e.g., their home *and* their business is flooded). Further, disasters seem to have specifically traumatic impact with little impact on general mental health. However, if traumatic impact is of sufficient magnitude, general mental health can also be affected. These findings suggest that climate change adaptation planning, including disaster preparedness policy, must engage with systematic differences between sub-populations as well as with climate modelling.

AN UPDATE OF OUR EVIDENCE-BASED CARE MODEL FOR PSYCHOLOGICAL SUPPORT FOR DISASTER VICTIMS. INTEGRATING THE EXPERIENCE (SYMPOSIUM)

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Background: In 2010, our group proposed a model of disaster response, based on systematic reviews and meta-analysis, which was based on five stages. (Reference 1) I. Diffusion, II. Social support, III. GP Management, IV. General psychiatric management and V. Psychiatric management experts. Each of these levels is implemented in different physical locations and with different objectives, beneficiaries, duties, executors and referral criteria to the next level, which will determine the flow of patients from centers of low to high level of expertise.

The whole community should be informed about the disaster and receive psychoeducation and offer counseling through the media. We try to keep psychotherapy and pharmacotherapy only for patients with psychiatric disorders, because it is the only group that has shown benefit from these treatments. For the rest of those affected, including those with subclinical distress, we recommend limiting attention to so-called psychological first aid

Results: This model was been tested and evaluated in the multiple disasters that occurred in our country after its publication. The main ones were the earthquake and tsunami of February 2010 and the rescue of 33 miners in September 2010. These disasters allow us to gain experience on their effectiveness in real life as well as their strengths and weak points of our model.

Conclusions: Our goal is to show and comment our model and our experience of implementing it in a South American country with a history of major natural disasters. The importance for listeners will hear the experience of applying a model of evidence-based trauma but also is designed to be applied in health systems with limited resources.

NATURAL DISASTER AND MENTAL HEALTH: EFFECTS OF FLOODING ON A POPULATION IN SE SPAIN

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Introduction: Post-disaster mental health problems may affect population in different ways.

Population exposure to a natural disaster has been associated with psychological distress, in particular, in the development of Posttraumatic Stress Disorder (PTSD).

Most people experience distress after their exposure to an extreme event.

For people with good psychosocial resilience and access to social support, mental health problems can be relatively less important since supporting relationships and inner capabilities may begin the adaptation processes. Mental disorders occur often, but less commonly than distress, and in some cases they may require intensive and long term continuing interventions and treatment(1).

Objectives: The aims of this study were to investigate the effects of flooding on mental health population, particularly on the general health and the symptom's emergence of PTSD.

Method: A random sampling method was conducted in a population affected by a flood occurred in September 2012, an area of 20.000 inhabitants in the North of Almería (Spain).

A sample of 52 individuals were screened with a socio-demographic questionnaire, 12-item General Health Questionnaire(GHQ-12) and the Questionnaire to rate Traumatic Experiences(TQ). We also counted the distribution of stress exposure among people with various kinds of exposures (physical risk or/and economical losses).

Results: The mean age of the individuals was 53, 02 years, sd 16, 35. Distribution by sex was 34,62% men – 65,38% women. There were no statistical differences between genders in TQ scores and GHQ scores.

An association between age and TQ scores was demonstrated, increasing TQ scores by age. Also, there were no statistical differences between individuals that suffered physical risk in the flood versus people that didn't suffered in TQ scores. On the other hand, a multiple regression model was adjusted by age and sex. Significant differences were found in the TQ scores mean values for individuals that suffered economical losses (9,51 TQ score) versus individuals that didn't suffered it (2,94).

Conclusions

1. Older people were more likely to develop PTSD
2. It's necessary to consider secondary stressors, such as economical losses, in the develop of PTSD.

References:

1. Lock S, Rubin GJ, Murray V, Rogers MB, Amlôt R, Williams R
Secondary stressors and extreme events and disasters: a systematic review of primary research from 2010-2011.
PLoS Curr. 2012 Oct 29;4

THE ASSOCIATION BETWEEN SLEEPING HOURS, SMOKING, HEALTH AND NUTRITIONAL STATUS WITH DEPRESSION

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Objectives: Depression is associated with increased rates of disability and mortality. There are very few studies looked at the association between nutritional status and depressive symptoms.

Purpose: The main purpose of this study was to look for if there is any association between nutritional statuses, sleeping hours, smoking, and having headache or hair loss with depression.

Method: Cross-sectional study was conducted from 787 subjects in different age groups, who had participated in a major campaign in Riyadh, Saudi Arabia during March 2012. The questionnaires that had been distributed among subjects contained specific questions regarding the nutritional status, sleeping hours per day and smoking habit. Blood pressure (BP), random blood glucose (RBG), Serum hemoglobin (Hb), self-rated health status questionnaire and depressive symptoms using Beck Depression Inventory Scale (BDI) had been measured. Covariates included age, sex, and being ex-smoker or not.

Results: We classify the sleeping hours into different categories; most of subjects were present in 3-6 hours of sleeping per night (42.7%). Its association with depression appears clearly that extreme groups have high prevalence of depression, the group with less than three hours of sleep showed (40.5%), and more than nine hours of sleep (46%) compared to groups who sleep 3-6 hours (28.6%), and 6-9 hours (26%). The prevalence of smoking among male was (21%), and among female (2%). The presence of severe and extreme depression among smoker was (4%) compared to non-smoker (3.5%). Among non-smoker the depression among ex-smoker was (3%). Hair loss was present among (60.4%) with prevalence of depression (34.3%) compared to subjects with no hair loss (24.3%). Headache was less common (38.5%) with the presence of depression (38.6%) much higher than subjects with no headache (25.2%). Regarding the nutritional behavior, most of subjects had 2-4 meals per day (82.2%) and only (26.8%) of them with fixed time in the day. Subjects who used to drink a coffee or tea had less depressive symptoms (27.7%) than who didn't (34.4%). Drinking soft drinks or energy drinks was clearly associates with presence of depressive symptoms (38.8%) compared to subjects who didn't drink them (29%).

Conclusions: Nutritional status profile of the population has a significant association with the depression and depressive symptoms. Certain type of food has differences with its association with BDI score of the subject. The lower the sleeping hours, the most likely to develop depressive symptoms. Being smoker or an ex-smoker has a strong association with depression. Hair loss and Headache have another strong association with depression especially among female. Certain Socio-Demographic differences and their association with the depression have been clarified in this study. Further studies will be conducted to find the strength of depression associated with those Socio-Demographic differences.

THE ASSOCIATION BETWEEN EXPOSURE TO TRAUMATIC EVENTS WITH ANXIETY DISORDER: RESULTS FROM A CROSS-SECTIONAL COMMUNITY STUDY IN THE POST-CONFLICT SOUTH SUDAN

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Background: The negative effect of exposure to traumatic events on mental health is well known. Most studies of the effects of trauma on mental health in war-affected populations have focused on posttraumatic stress disorder (PTSD) and depression. Although some studies confirm the existence of anxiety symptoms in war-affected populations, to what extent exposure to traumatic events are independently associated with anxiety diagnosis (other than PTSD) is less investigated.

Purpose: The study aimed to determine whether having an anxiety diagnosis was associated with experiencing traumatic events in a post conflict setting, after controlling for demographic and socioeconomic variables.

Methods: In this cross-sectional community study (n=1200) we applied the Harvard Trauma Questionnaire (HTQ) to investigate the extent of trauma exposure. MINI International Neuropsychiatric Interview (MINI) was used to investigate the prevalence of anxiety disorders (Generalized anxiety disorder, panic disorder, agoraphobia, and obsessive-compulsive disorder). Multinomial logistic regression analyses were conducted to examine the association between these disorders, previous trauma exposure, and socioeconomic factors.

Results: 41.4% of the participants had an anxiety diagnosis. 25% reported more than eight traumatic events during the war and 9.8% reported to have experienced more than 4 recent traumatic events. Exposure to traumatic events and socioeconomic disadvantage were significantly associated with having one or more anxiety diagnoses. After controlling for age, sex, rural-urban setting and socioeconomic position, exposure to trauma was independently associated with anxiety diagnosis.

Conclusion: in individuals with history of war-related trauma exposure, in addition to PTSD and depression symptoms, attention should be given to symptoms of anxiety disorder (Generalized anxiety disorder, panic disorder, agoraphobia, and obsessive-compulsive disorder).

EXPOSURE OF PALESTINIAN ADOLESCENTS TO PROLONGED AND CUMULATIVE MILITARY VIOLENCE: A STUDY OF ITS PSYCHOLOGICAL EFFECTS AND RESILIENCY FACTORS

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BACKGROUND: The mental health consequences of living in war zones and exposure to military violence have been investigated extensively over the past six decades. However, there is a dearth of research on the consequences of Palestinian children's exposure to chronic, cumulative, and prolonged military violence. Furthermore, there is a lack of research on intergenerational transmission of those consequences on the one hand, and on protective and resiliency factors that buffer the consequences of exposure to military violence among children and their parents on the other.

METHODS: In an attempt to fill this gap, self-administered questionnaires were utilized among a random systematic cluster sample of 2,934 Palestinian adolescents and their parents from the West Bank and East Jerusalem, who live under conditions of prolonged and chronic exposure to military violence. For adolescents, the study included measures about their exposure to military violence during the previous year as well as between the last year and September 2000, i.e., since the outbreak of Al-Aqsa Intifada. For parents, the study related to the following periods: (1) during the last Intifada (i.e., from late September 2000 to the day of filling-out the questionnaire); (2) from end of the first Intifada (around the signing of the Oslo accords in September 1993) until the outbreak of the last Intifada (i.e., September 2000); and (3) from the June 1967 war until the period of the first Intifada (i.e., between June 1967 and September 1993). This time frame of exposure to military violence provides a basis for examining the consequences of multiple and cumulative risk factors. Thus, the main objective of this study was to investigate the psychological consequences (e.g., anxiety, depression, aggressive behavior, attention and thought problems, PTSD, etc.) of adolescents' and parents' exposure to prolonged military violence as well as intergenerational transmission of those consequences from the perspectives of parents and their offspring. Concomitantly, the study aimed to investigate the contribution of protective and resilience factors among parents (e.g., self-efficacy, family environment, parenting styles, and social capital) and their adolescent offspring (e.g., ego resilience, self-esteem, and support from family and friends) to mitigating the effects of exposure to prolonged and cumulative military violence.

RESULTS: The results of this study revealed that the more the Palestinian adolescents had been exposed to military violence the higher the levels of all psychological symptoms, i.e., withdrawal, somatization, anxiety and depression, attention problems, thought problems, social problems, delinquent behavior, aggressive behavior, and post-traumatic stress disorder. The results also revealed that significant amounts of the variance in all of these symptoms could be attributed to adolescents' exposure to military violence, over and above the variance in these psychological states that could be explained by participants' gender, self-esteem, parents' loving and intimate parenting styles or rejecting and hostile parenting styles, parents' self-efficacy, positive family environment, parents' perceptions of their social capital. The results also revealed that the parents' exposure to military violence during the three above-mentioned periods was significantly related to their symptoms of post-traumatic disorder (PTSD) and psychological distress. More specifically, the results revealed that the higher (or more frequent) the parents' exposure to military violence, the higher the levels of these symptoms were. Significant positive relationships were also found between these symptoms among parents and the above mentioned psychological states among the adolescents. Interaction analyses revealed that *none* of the protective and resilience variables examined in this study (either among adolescents or among their parents) was found to contribute significantly to moderating the relationship between the exposure of adolescents to military violence and the above-mentioned psychological states.

CONCLUSIONS: This particular finding yields at least to two possible conclusions. First, the exposure of Palestinian adolescents to military violence has very serious long-term mental health consequences, which are so severe that they cannot be moderated by any protective and resilience factors. Second, the exposure of Palestinian adolescents and their parents to military violence had detrimental effects on resilience and protective factors among both groups, to the extent that those factors could not mitigate the severe consequences of exposure to military violence.

The strengths and limitations of the study are discussed in detail. Furthermore, the implications of the results for future research, practice, and service delivery are delineated.

29 June - 3 July 2013
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Oral Presentations

**Co-morbid mental and
physical illnesses**

CO-MORBIDITY OF DEPRESSION AMONG CANCER SUBJECTS AND ITS IMPLICATION TO OVERALL TREATMENT OUTCOME: A PERSPECTIVE FROM A DEVELOPING COUNTRY

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Educational Objectives: Co-morbidity of depressive symptomatology is a common indication for use of mental health services in oncology. At the end of this presentation the participants should have an understanding of the burden of depression among cancer patients in this context and see its implication on cancer treatment.

Purpose: This study is set to evaluate the burden of depression in cancer and describe its cancer treatment implications.

Methods: A designed questionnaire, Centre for Epidemiological Studies Depression Scale Revised (CES-DR) and the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) were administered by the researchers on 200 participants made up of attendees of a Nigerian hospital with histological diagnoses of cancer. The data were analysed with statistical package of social sciences version 15.

Results: Majority of participants, 85.5% were females. The mean age for the participants was 51.48(±11.45) years. The largest proportion of them (35.5%) belonged to age group of 51 to 60 years and one hundred and thirty (65.0%) were married. The commonest type of malignancy was breast cancer (51.0%), cervical cancer 59(29.5%), colon/rectum and prostatic cancers were 21(10.5%) and 18(9.0%) respectively. Slightly less than half (49.0%) of subjects had advanced cancer. Most participants (36.5%) had symptoms for between 1 to 2 years. Two-thirds (66.0%) had pain and 104(52%) had weight loss while 20.0% had external ulcer resulting from complications of the cancer

Ninety-eight (49.0%) participants had significant depressive symptomatology (CES-DR scores of ≥16) as against the diagnosis of depression in 55(27.5%) of them following SCAN interview. A substantial proportion of subjects 36(65.5%) had moderate depression, 15(27.3%) were mildly depressed and 7.2% had severe depression. In this study, the diagnosis of depression among cancer patients was significantly associated cancer stage ($p=0.006$), duration of cancer ($p=0.048$), pain ($p<0.001$), physical complication ($p<0.001$) and past family history of mental illness ($p=0.002$). However, only pain and duration of cancer were predictive of depression.

Conclusions: A significant burden of depression was observed in cancer patients. Prompt identification and treatment of cancer, mental disorders like depression, management of psychosocial problems and care for pain should be integrated into cancer care in this part of the world. The development as well as popularization of screening instrument(s) with good diagnostic and administration property to ensure prompt identification of mental disorders to improve overall treatment outcome in cancer care are implied. Furthermore, replication of similar research is warranted.

THE ASSOCIATIONS OF RELATIONSHIP QUALITY WITH PHYSICAL FUNCTIONING AND DEPRESSIVE SYMPTOMS ARE MEDIATED BY SOCIAL SUPPORT PROCESS AMONG CANCER CAREGIVERS

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Educational Objectives: This study provides one of the first preliminary data on the social relationship and supportive experience of cancer caregivers and suggests interpersonal intervention for improving caregivers' physical and mental health.

Purpose: This study aims to study the mediating effect of perception of provided support and patients' supportive needs in the association between relationship quality and physical and psychological functioning of cancer caregivers.

Methods: A total of 44 caregivers of people newly diagnosed with colorectal cancer (time since diagnosis < six months) were recruited and administered a questionnaire set. Relationship quality (i.e., intimacy in and commitment to the relationship) with their ill family members was assessed using the Social Relational Quality Scale (Hou et al., 2009). An adapted Chinese version of the Berlin Social Support Scale (BSSS; Schwarzer & Schulz, 2000) assessed provided support and perceived supportive needs in the past two weeks. Sample items: "Did you show him/her how much you cherish and accept him/her?"; "Do you think your care-recipient wants you to show him/her this?" Physical functioning was measured using the 10-item version of the Chinese MOS 36-item Short-form Health Survey, which has been validated among Hong Kong Chinese (Lam et al., 1998). Depressive symptoms were measured using the Chinese version of the 21-item Beck Depression Inventory II (Byrne et al., 2004).

Results: Regression analyses showed that controlling for the effect of demographic variables, levels of provided support significantly mediated the inverse association between relationship quality and depressive symptoms, whereas levels of perceived supportive needs significantly mediated the positive association between relationship quality and physical functioning.

Conclusions: Your conclusions should address the following questions:

- Higher relationship quality could increase caregivers' (1) perception of support provided for their ill family members, resulting in lower levels of depressive symptoms, and (2) perception of patient supportive needs and, in turn, contribute to higher self-reported physical health.
- Patients' perceived social support and physical and psychological functioning should also be assessed and compared with their caregivers' report in order to gain a holistic picture of the support process.
- Interpersonal intervention could be implemented for improving physical and mental health of both caregivers and patients.

Literature Reference:

Reynolds JS, Perrin NA. 2004. Mismatches in social support and psychosocial adjustment to breast cancer. *Health Psychol* 23:425-30

ACUTE MEDICAL COMPLICATIONS OF PATIENTS IN PSYCHIATRIC UNITS. A LITERATURE REVIEW

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People with severe mental illness (SMI) have increased rates of physical illness compared to the general population. Physical medical problems have been associated with an increased burden on psychiatric patients resulting in poorer outcomes. People with SMI have a life expectancy that is up to 25 years shorter compared to the general population.

Yet the physical needs of inpatient psychiatric patients are neglected, underdiagnosed and undertreated. Nurses play a key role in prevention and early intervention in the physical wellbeing of people with SMI. We suppose that not only the chronic diseases need to be focused on but also on acute medical complications in inpatient psychiatric settings.

Purpose: to identify the most common acute medical complications in inpatient psychiatric settings. To discuss interventions that increase acute physical care in people with SMI.

Method: literature was reviewed between June and August 2012 by utilizing 'MEDLINE' and 'CINAHL' databases. The key words used were „mental health“ or “psychiatry”, “acute medical comorbidity“ or “physical comorbidity”, “referral” or “admission”. The broad search strategy focused on publications in German, French and English.

Results: Five studies correspond to the research questions. They evaluate the reasons for required transfers from a psychiatric ward to a medical-surgical unit. The most common acute medical complications in inpatient psychiatric settings are cardiovascular or endocrine causes, respiratory failure, electrolyte imbalances and infections. Acute medical complications in people with SMI are mostly overlooked. Incidence and prevalence are unknown. Interventions require more skilled nursing and qualified physicians.

Conclusion: Although more and better prevalence data are needed the existing data call for more attention to be paid to the general medical needs of inpatients with SMI. Regarding inpatients there is an additional reason for addressing active medical comorbidity. However there are many studies describing chronic medical illness in people with SMI.

Professionals must be better trained in managing acute medical problems and must be made aware of the possibility that their patients may also have physical (acute or chronic) diseases in addition to psychiatric diagnosis.

In addition this review has demonstrated that structural cooperation between acute medical wards and psychiatric wards is necessary.

INVESTIGATING THE CO-MORBIDITY OF ANXIETY AND DEPRESSION IN A COMMUNITY SAMPLE WITH TYPE 2 DIABETES

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Educational Objectives: Diabetes is associated with an increased likelihood of being diagnosed with depression or anxiety, however little research explicitly examines both anxiety and depression. This presentation will demonstrate why it is important to screen for both anxiety and depression in diabetes research and clinical practice.

Purpose: Establish the association of anxiety alone, depression alone and co-morbid anxiety and depression with self-care indicators and clinical outcomes.

Methods: Data for this study is taken from 2,028 community-based individuals who took part in the Quebec EDIT study. Participants in this study were required to have a doctor diagnosis of type 2 diabetes for less than 10 years, be insulin-naïve and aged 40-75. All participants took part in a telephone survey and answered questions pertaining to psychological well-being, self-care, sociodemographic characteristics, physical complications and functioning. Groups with elevated anxiety symptoms, elevated depression symptoms, and elevated co-morbid anxiety and depression symptoms were compared to a reference population with below threshold anxiety and depression using logistic regression analysis.

Results: Those participants with elevated anxiety alone were more likely to report more physical complications, report poor eating habits and report poorer functioning. Those participants with elevated depression alone were more likely to report more physical complications, were more likely to be overweight/obese, were more likely to be a current smoker, were less likely to be physically active and report more problems with functioning. The group with co-morbid depression and anxiety reported similar problems to the depressed group but also were more likely to report non-adherence to medication. They also reported the highest frequency of problems with functioning.

Conclusions: Those people who meet criteria for elevated anxiety and/or depression symptoms are more likely to report physical complications, non-adherence to self-care recommendations and more problems with functioning. These associations are particularly marked in those people with co-morbid depression and anxiety symptoms. To our knowledge this is the first study that has explicitly examined anxiety and depression co-morbidity in people with diabetes and the association of this co-morbidity with important clinical outcomes. Furthermore, this study has important clinical implications indicating that along with screening for depression in people with diabetes, that screening for a co-morbid anxiety may be important.

PSYCHOLOGICAL MORBIDITY AND PAIN IN SUBJECTS WITH SPINAL CORD INJURY

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Educational Objectives: Spinal Cord Injury (SCI) is one of the most clinical and physical severe condition, often associated with high levels of anxiety and depression. With this presentation, the participants should be aware for the incidence of psychological morbidity in this condition and specially its association with SCI's secondary complications.

Purpose: Spinal cord injured individuals are at risk of developing additional health problems - physical or psychological - which can result in secondary complications to his disability and, consequently, additional functional limitations. The aim of this study is to assess the psychological morbidity associated with this clinical picture of spinal cord injury and its probable association with the most frequent SCI's secondary complications.

Methods: This study was conducted Nationwide during the year 2012 in collaboration with: Centro Hospitalar do Porto (HSA); Sul and Roisco Pais' Rehabilitation Center; Gaia's Professional Rehabilitation Center, Salvador Association and Portuguese Association of Disabled People. 168 subjects with Traumatic Spinal Cord Injury participated in this study. The Hospital Anxiety and Depression Scale was used to evaluate the Anxiety and Depression symptoms and a clinical, socio-demographic questionnaire to identify the SCI's secondary complications.

Results: SCI subjects present anxiety symptoms (73.8%) in which 26.8% have moderate/severe Anxiety. On other hand 71.4% of the SCI subjects present depressive symptoms and 20.8% of those have moderate/severe depression.

When questioned about secondary complications, subjects with SCI report: 66.7% urinary tract infections, 48.8% Bladder and sphincter complications, 42.3% pain, 42.3% sexual dysfunction, 19.6% pressure ulcers and 16.7% respiratory complications.

To verify dependence between the anxiety and depression symptoms and SCI secondary complications we used the Chi-squared test. The results show that the depression symptoms don't vary with SCI secondary complications, however anxiety symptoms vary with pain. In this sense the incidence of anxiety symptoms are greater for those who have pain as a secondary complication ($p = 0.00$).

Conclusions: This study calls attention to the high levels of anxiety and depression symptoms in subjects with SCI as well as the presence of pain in a considerable part of the sample. Pain in Spinal Cord Injury (SCI) it's a high prevalent clinical secondary condition and difficult to treat. This complication is seen as debilitating as the injury itself. The results suggest the need to consider multidisciplinary teams capable of managing multiple and integrated treatment. The ultimate goal is to restore the biopsychosocial balance of the subject with SCI and the reintegration into the society.

PHYSICAL, EMOTIONAL AND SOCIAL OVERLOAD OF INFORMAL CAREGIVERS OF SUBJECTS WITH SPINAL CORD INJURY

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Educational Objectives: Traumatic spinal cord injury (SCI) is perhaps one of the the most devastating orthopaedic injuries. In this dynamic process of the rehabilitation the informal caregivers (IC) live tremendous challenges: - to promote the maximization of physical functioning, the prevention of secondary complications, the reintegration into the community of the people with SCI, - to the challenge to deal with their one personal needs.

With this presentation, the participants should be able to recognize the importance of evaluating the experience of IC and whose overload can cause psychological, emotional, social and financial damage, that can seriously affect the patient and IC's well being.

Purpose: The aim of this study it's to evaluate the physical, emotional and social overload expressivity in Portuguese IC of people with SCI.

Methods: Nationwide and during the year 2012, 160 IC of subjects with Traumatic SCI participated in this study. The physical, emotional and social overload was evaluated by the QASCI (Caregiver Burden Questionnaire).

Results: 83,1% of the informal caregivers are female and 16.9% are male, with a mean age of 51.2 years (SD = 14.3). The results suggest that the informal caregivers of people with spinal cord injury present moderate overload levels (mean values ranging from 26 to 50) especially relative to: Financial Overload (M=48.70; DP=35,10), Implications in the personal life of caregiver (M = 39.68, SD = 25.54), Family Support (inverted sub-scale with M = 33, 06, SD = 31.53) and Emotional Overload (M = 29.15, SD = 25.38). The three sub-scales that present low overload levels (mean values ranging from 0 to 25) are: Satisfaction with the paper and the relative (inverted sub-scale with M = 16.85, SD = 15.62), Reactions to demands (M = 21.71, SD = 20.70) and Mechanisms of effectiveness and control (inverted sub-scale with M = 24.89, SD = 20.46).

Conclusions: Caregiving can be an overload experience especially with personal implications in daily life, emotional and financially. Mental health professionals should consider the IC as a vulnerable group and embrace strategies to promote their well being. Doing so they are not only contributing to enhance IC's quality of life but also the quality of care, quality of life and preventing the institutionalization of their relatives.

29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

**Mass movements of
populations: migrants,
refugees, others**

IMMIGRATION, DISCRIMINATION AND MENTAL DISORDERS (SYMPOSIUM)

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Background: Unfavorable health conditions as well as adverse morbidity and mortality data have been consistently reported across minority ethnic groups both in the US and the United Kingdom (UK) (Sorlie, 1995; Marmot, 1984). In recent decades, the experiences of racism and daily encounters with different forms of discrimination and prejudice started to be recognized as a major burden in the lives of ethnic minority individuals. As a result, there is a growing concern about the negative impact of racism and discrimination on the health standards of unprivileged individuals.

It is now understood that the experiences of social disadvantage, racial discrimination and marginalization tend to progressively accumulate over the life course (Williams, 2002). Racism plays a role as a social force that agglutinates additional detrimental factors such as socio-economic deprivation; restricted access to jobs, education and leadership roles in society; aesthetic marginalization from mainframe cultural life; residential exclusion to peripheral and dilapidated neighborhoods; and a consequent increment of exposure to violence and criminal influences. Research evidence demonstrates that members of minority groups not only earn less than members of dominant groups in society, but also work in less desirable occupations and present longer periods of unemployment (Krieger, 1993). Racism is fundamentally involved in the structuring of social-economic opportunities and the quality of health and social services that minority individuals receive.

The limited research conducted in the US and in UK to investigate the impact of racism on health status and well-being suggests that racism is an unrelenting societal hazard that remains unaddressed and neglected. Results from a study in which the interplay between blood pressure and racism was investigated among African-Americans revealed that 80% of individuals within this group experienced racial discrimination at some point in their lives (Krieger, 1996). Similarly, a national survey conducted in the UK revealed that more than 12% of respondents experienced at least one incident of harassment during the preceding year (Virdee, 1997). Immigrants frequently suffer additional lifetime distress as a result of the forcing factors towards migration that occur in source countries such as social upheaval, economic hardship, environmental catastrophe, war and famine. Such adversities are also known to produce long lasting psychological effects (Toar, 2009).

Several studies have demonstrated a relationship between self-reported experiences of racism and a series of adverse health outcomes, such as psychological distress, hypertension, diabetes and inferior levels of self-rated health (Krieger, 1993; Krieger, 1996, Karlsen, 2002, Gravlee, 2009). Racism and discrimination tend to be directed at migrant groups, resulting in high levels of anxiety (Thompson, 1996), which may evolve to the status of post-traumatic stress disorder (Ritsner, 1997). It has been observed in longitudinal studies that 'everyday encounters with discrimination are casually associated with poor mental and physical health outcomes' (Schulz, 2006).

A timely research agenda: The evidence presented above substantiates the need for additional research on the association between discrimination and mental disorders. This symposium proposes an international approach to the interplay between immigration and discrimination, and consequently mental disorders. There is now an outstanding opportunity for consolidating this theme as a priority research agenda. This initiative should also create the opportunity for additional research consortiums to be created around the core areas of mental health, social justice and international migration.

3 YEARS OUTCOME IN FIRST-EPISODE PSYCHOSIS AMONG MIGRANTS IN PARIS

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Background: Migration is known to increase the risk for psychosis in western countries but studies show that there is low use of mental health services by this population.

This is the second part of a retrospective study based on case files of all first admissions for psychosis in the 20th district of Paris between 2005 and 2009. One hundred and thirty six native patients and one hundred twenty two migrant patients met the criteria. In the first part of the study we found higher risk for psychosis in the migrant group (IRR 2.9, 95% CI 0.9-9.8) compared to patients born in France. Among migrants, incidence was higher in patients from sub-Saharan Africa compared to natives (IRR=7.1; CI95%= 2.2-21.8) whereas the incidence was similar for those from Europe (IRR=1.2; CI95%= 0.3-5.1) and from North Africa (Algeria, Morocco, and Tunisia) (IRR=1.4; CI95%= 0.4-5.6).

In this second part of the study we will compare the outcome of native and migrant patients with first admission for psychosis.

Methods: We will study all re-admissions between the two groups. At one and three years we will analyse rates, gender, age, country of birth, type of admission (compulsory or voluntary), clinical diagnosis, use of outpatient services, and treatment at discharge.

MENTAL HEALTH STATUS AMONGST RURAL-TO-URBAN MIGRANT WORKERS IN GUANGZHOU, CHINA: COMPARISON TO PERMANENT URBAN WORKERS AND AGE MODIFICATION EFFECT

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Objectives: The last three decades have seen a dramatic increase in rural-to-urban migrant workers in China; in 2011 the number reached 160 million. In Guangzhou, the largest city in southern China, the 7.3 million migrant population accounted for half of the city's population. Past studies of mental health status amongst Chinese migrant workers showed conflicting results; some found poorer mental health in migrant workers than in permanent urban workers whilst others showed the contrary. There is also a recent concern about the poor mental health in young migrant workers. The aim of this study is to investigate the mental health status of young and older migrant workers in comparison to their urban counterparts in Guangzhou.

Methods: A cross-sectional survey was conducted amongst 914 migrant workers and 814 urban workers recruited from four districts in Guangzhou city between May and July 2012. The World Health Organization Five-item Well-Being Index Scale (WHO-5) and the 36 Item Short Form Health Survey (SF-36) mental health scale were used to assess mental well-being. Linear and logistic regression models were used to investigate differences between migrant and urban workers and factors related to poor mental health.

Results: The mean age was 30 and 36 years for migrant and urban workers respectively. Migrant workers showed modestly higher scores than their urban counterpart for both WHO-5 (12.94 vs 12.40; difference = 0.54, 95% Confidence Interval [CI] 0.04-1.04) and SF-36 mental health scale (73.12 vs 71.06; difference = 2.06, 95% CI 0.56-3.56), whilst there was some evidence for age modification effect (p for interaction = 0.16 and 0.10). Higher scores in migrant workers than urban workers were mainly seen in people aged 30 years or above but not in the younger group aged <30, and the difference attenuated to some extent after controlling for income satisfaction. Amongst migrant workers factors that were independently associated with poor mental health included younger age, being male, longer working hours, lower income, and unsatisfactory income, whilst very good / good self-reported general health and more use of social support resources were associated with reduced risk of poor mental health.

Conclusion: Older Chinese migrant workers showed better mental health than their urban counterpart, and this was partly attributable to greater income satisfaction, whilst younger migrant workers did not show similar advantage over young urban workers. Measures to improve mental health amongst migrant workers may be usefully targeted on the younger group.

DIFFERENTIAL MODERATING FACTORS OF DISTRESS, PSYCHOPATHOLOGY AND SOMATIZATION AMONG NATIVE-BORN AND IMMIGRANT FEMALES: A CROSS-SECTIONAL STUDY IN AN OBSTETRIC UNIT

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Objectives: The present study aims to compare the relation of psychosocial distress, quality of life, psychopathology (anxiety and depression symptoms) and somatization with socio-demographic data, coping strategies and spirituality among female native-born and Latin American immigrant patients.

Methods: We present a cross-sectional, comparative study, based on the description of 222 female patients (73 natives, 149 immigrants) admitted in an obstetrics unit.

Clinical, socio-demographic characteristics and quality of life were registered using an ad-hoc questionnaire. Structured interviews were carried out using the PHQ to evaluate somatization, HADS for anxiety and depression symptoms, CAE for coping strategies, PSS10 for psychosocial distress and SSRS for spirituality.

Following a stratified design, Pearson correlation coefficients and linear regression were used to measure the strength of linear dependence between independent, moderator and dependent variables in both samples.

Results: After carrying correlational analyses, statistically significant variables were used to perform regression analyses, using as dependent variables psychosocial distress, quality of life, somatization, anxiety and depression symptoms. For immigrants, a negative self-focused coping strategy directly predicted all dependent variables except for quality of life, which was indirectly predicted by this strategy. Overt (hostile) emotional expression predicted anxiety and depression symptoms. Furthermore, positive reevaluation indirectly predicted depression and psychosocial distress. For native women, positive reevaluation indirectly predicts only depression symptoms. Depression, anxiety and psycho-social distress were also predicted by negative self-focused coping. No variable was found to predict somatization.

Conclusions: Firstly, in both groups, resignation, feeling undefended and guilty (negative self-focused coping) is related to higher scores of depression, anxiety, psychosocial distress and poorer quality of life. Furthermore in both samples a positive reevaluation of the conflict tends to decrease depression, but only in native-born this strategy is related to higher quality of life. Secondly, among immigrant females is seen that a hostile style of coping (overt emotional expression) raises both levels of anxiety and depression symptoms. Interestingly, only in this group, to actively practice a religion is related to a better quality of life.

Finally, negative self-focused coping conditions higher rates of somatization in the Latin American sample. This relation has not been confirmed in the native sample, in which a moderator could not be identified.

We have not found evidence of spirituality being associated with the dependent variables in any of the groups.

It can be concluded that there is a different structure of relations between coping strategies and our dependent variables among native-born and Latin American females.

AN INVESTIGATION OF MENTAL HEALTH STATUS OF ECOLOGICAL MIGRANTS IN WESTERN CHINA

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Educational Objectives: At the conclusion of this presentation, the participants should be able to develop a brief knowledge of the mental health status of those ecological migrants who were expected to benefit from the massive “ecological migration project” initiated by the Chinese government.

Purpose: To compare the mental health status of those ecological migrants with local residents; and, to explore the predictors for better mental health status among ecological migrants.

Methods: The survey was conducted in Ningxia Hui Autonomous Region, Western China. Multi-stage cluster sampling method was used to identify individuals from households in randomly selected villages. Symptom Checklist-90 (SCL-90) Chinese version was used for evaluating mental health status. Information on demographic characteristics was also collected. Comparison was made between ecological migrants and local residents by using X^2 test; logistic regression was used to identify the predictors for mental disorders.

Results: There were 684 people being recruited into the study among which 626 of them completed the survey (response rate 91.2%), including 365 ecological migrants and 319 local residents. The proportion of Hui ethnicity people was significantly larger among the migrants than the local residents (65.7% vs. 53.5%, $P=0.002$). The proportions of people having low education level and low family income were significantly larger among migrants comparing with the local residents (73.0% vs. 63.1%, $P=0.008$; 64.8% vs. 50.4%, $P=0.001$, respectively). Among male participants, migrants has significantly higher depression score and psychoticism score than local residents ($P<0.05$ and $P<0.01$, respectively). Among female participants, migrants had significantly higher somatization score and anxiety score than local residents ($P=0.01$ and $P<0.05$, respectively). Among the Hui ethnic participants, almost all SCL-90 subscores, except phobic anxiety, were significantly higher among the migrants than local residents. The proportion of SCL-90 positive psychiatric cases among Hui ethnic migrants was significantly larger than that among Hui ethnic local residents (79.3% vs. 47.4%, $P<0.001$). For these migrants, female, being older and Hui ethnicity had higher probability to have SCL-90 positive psychiatric status.

Conclusion: Overall, the ecological migrants were more vulnerable to mental disorders, especially for the elderly, women and Hui ethnic people. Comparing with local residents, migrants had lower education level and family income. In order to achieve the goals of “ecological migration project” and ensure those migrants to have better lives in the new places, the Chinese government and health sectors should take specific consideration of ethnicity and gender in their work.

29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

Suicide and its prevention

SUICIDE: NEW DIMENSIONS OF SOCIAL DISORGANIZATION WITHIN THE MILITARY AND AMONG CIVILIAN SURVIVORS OF WAR

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Objectives: Suicides among coalition forces, notably American service personnel, serving during the “wars on terrorism” played out in Iraq, Kuwait, Pakistan, and Afghanistan, and among the survivors of the Balkan Wars (1991-2002) is a compelling challenge for the veterans administrations and mental health service agencies within the former Yugoslavia and the NGOs serving these new nations. What is baffling among the U.S. population is the fact that a greater incidence of suicide occurs among military personnel who did not serve in a combat area. Male and female differences and socio-economic status also are factors for consideration in the prevention of military-related suicides and suicide-attempts. In the former Yugoslavia sample, untreated Post-traumatic Stress Disorder (PTSD) among displaced and interned victims and secondary PTSD among their off-spring appear to represent the bulk of untreated individuals with a potential for suicide or suicide-attempts.

Methods: Any viable analysis of this phenomenon requires comparisons and contrasts with the Vietnam-era veterans, the cohort upon which the Post-traumatic Stress Disorder (PTSD) was based in the 1980 Diagnostic and Statistical Manual-Third Edition (DSM-III). A review of Slavic-language medical and clinical articles, as well as personal observations, account for the Balkan War sample.

Results: Military suicides are at a record level among U.S. service personnel actually outnumbering battlefield casualties for those deployed in the Gulf War and Afghanistan. This phenomenon is similar to that which occurred during the Vietnam conflict where, in the long run, it is estimated that more veterans died from suicide than that died in combat (58,000+). A similar picture has surfaced from the victims of the 1991-2002 Balkan Wars involving the former Yugoslavia. Where economic hardships have relegated mental health services to the bottom of the social and political agenda in all of these break away nations. Our clinical assessment looks at both of these populations with the indication that suicide is often the result of untreated or otherwise unresolved personal conflicts that are not adequately addressed within the person’s family, religion, or subculture.

Conclusions: War trauma suicide often reflects a significant detachment from the person’s social existence while suicide, and suicide attempts among children and youth are often the result of impulse-control dysregulation. Another dimension of suicide today is that of the suicide bomber – a reflection of intense group solidarity contrary to suicides due to social disorganization. On-going research seeks out a better understanding of the neuro-chemical processes involved in mental illnesses that are prone to suicide ideations -- and medications and other treatment protocols that may be helpful in suicide prevention among those directly, or indirectly, affected by war trauma.

CHILD SUICIDE IN RUSSIA: CHARACTERISTICS, CAUSES, PREVENTION METHODS

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Educational Objectives: The purpose of this presentation is to reveal the findings of a recent study conducted by our Centre for the Ministry of Education and Science of Russia on the social and psychological causes of child suicide.

Characteristics of suicide in Russia: There are 19-20 suicide cases for every 100,000 teenagers in Russia. This is 3 times more compared to the global rate. In recent years, mass suicide has become a serious issue and the most common way to commit suicide has been jumping off tall buildings. 60% of all suicide cases take place in the spring (when mental illnesses are more common) and summer periods (at the time of school exams). In only 10% of adolescent suicide cases there is a true desire to commit suicide, the other 90% - are considered "cries for help." Often suicidal behaviours of adolescents take on a demonstrative nature, in the form of "suicide blackmail" (when a child threatens to commit suicide to gain attention). Further, the rate of failed suicide attempts often triggered by punishments, which the teenager considers unfair, is 10 times higher than the actual number of suicides committed.

Some causes found to trigger suicidal ideation and attempt:

- **specific personality traits:** vulnerability, immaturity, a tendency to self-analyse, shyness, sensitivity, lack of self-control, impulsivity, under-developed value system, the inability to adequately process conflicts, etc.
- **specific mental states** - depression, anxiety, fear, apathy, hopelessness, guilt, shame and disgrace, trouble sleeping, loss of appetite, alcohol and drug abuse, etc.
- **damaged pride**, the loss of valuable attention, rejected love, etc.
- **necessity to get out of a serious situation** - debts, obligations that are impossible to meet, communication problems, etc.

Suicide prevention interventions are based on an understanding of the child's developmental situation, the social and psychological problems of his environment, the implementation of appropriate methods of prevention, the potential use of the mass media, etc. The main conclusion we drew from our findings is that love and compassion help young people value their lives, and that the opportunity to speak "heart-to-heart" with someone who will listen, sympathize and understand can prevent young people from taking that desperate step.

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SUICIDE IN PRISON: THE ONSET OF DEPRESSION AS THE FOLLOW- UP OF THE VICIOUS CIRCLE “OFFENDER TO VICTIM”

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Background: Suicides in prison reflect how incarcerated men/women enter the vicious circle of “offender-victim-offender”. Current prison policies are traumatizing formerly normal prisoners and making them angry, violent, and vulnerable to severe emotional problems. The above, along with psychological factors of personal identity induce the transition of an offender to a victim and vice versa, forming a vicious circle followed either by recidivism or self-destructive acts. It is of fair interest to detect, rationalize and in cases predict the vicious circle.

SPACE statistics on suicides in prison reveal a rate above 10 per 10,000 in 10 European countries. Thus, can be seen that correctional services do not offer chances for reform other than the feeling of exclusion through punishment and they offer no clinical evaluation of suicidal symptoms.

Method: This study explores the patterns by which incarcerated men/women enter the vicious circle of offender-victim-offender. A prototype self-completion Test and personal interviews of 270 incarcerated men/women in penal institutions in Greece and Iran were used. The survey constructs a conceptual framework for understanding the progression and transition from offender to victim and back to offender, assessing how this dual-role change can motivate the onset of mental disorders during incarceration, such as depression disorders which are more often linked to suicide. We explore the relationships between prison quality, prisoner well-being and distress causing emotional breakdown.

All data are extracted from a survey on offending behavior, victimization, punishment and other sensitive objects, through self-completion questionnaires and interviewing. During this stage, the participating incarcerated men/women were attending inside-prison educational programs. Their ages were from 19 to 58 years old the eldest. Penalties varied from 5 years to life sentences with the exception of death penalties in Iranian prisons. The substantive field work took place between March of 2011 and September of 2011. Surveys were completed by inmates in seven (7) public sector prisons in Greece (with a multinational convicted population) and two (2) in Iran.

Conclusion: As we begin to define the relation between offending and victimization among people involved in crime, we cast light on inmate's “emotion-perception- behaviour”; identifying signs and symptoms of role changing between offender and victim; recognizing, dealing with, and understanding the motivations behind suicidal behaviour aiming to prevention. Last, offering recommendations to change prisons into institutions that respect human life and the constitutional rights of all citizens.

Literature Reference

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29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

**Stigma of mental disorders
and psychiatric institutions**

THE LIVED EXPERIENCE OF INVOLUNTARY PSYCHIATRIC TREATMENT IN THE COMMUNITY

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Objectives: There is limited research examining the lived experiences of consumers and carers subject to involuntary psychiatric treatment in the community via the use of community treatment orders (CTOs). Several studies provide some insight into the lived experience of involuntary community mental health treatment, but no such research has been conducted in Australia. This researcher sought to describe the lived experience of CTO's from the perspectives of patients and their carers.

Purpose: To described the lived experience of involuntary psychiatric treatment in community mental health care settings.

Methods: Eleven participants – five patients and six carers – participated in the research project by taking part in in-depth interviews about their experiences. This interview data set was analysed using qualitative methodologies – specifically a Grounded Theory analysis of the data.

Results: The lived experience of consumers and carers of CTOs in NSW had five themes: 'access', 'isolation', 'loss and trauma', 'resistance and resignation' and 'vulnerability and distress'. These spoke to the experiential components of the losses and trauma associated with a severe mental illness, the compromises associated with the assumption of the sick role, and the challenges of managing the relationships and engagements necessitated by these processes.

Conclusions: The distress, isolation, grief and loss experienced by those affected by CTOs appeared to be a part of the experience of a severe mental illness. Putting aside instances where CTOs were implemented poorly, the kind of illness and level of disability experienced by those who needed such treatment interventions was an intrinsic source of distress. The need for a CTO emerged from that illness and, by extension, that distress. In essence, the experience of distress around a CTO seemed to be indistinguishable from the distress of the severe illness that necessitated it. From these data the study proposed a model of experience of being subject to a CTO in NSW is one of a core distress, emerging from the distress of the illness, communication gaps, difficulty accessing services, and the perceived benefits of CTOs.

SELF-STIGMA AND ORGANIZATIONAL EMPOWERMENT IN COMBINED-COMMUNITY MENTAL HEALTH AND CONSUMER-RUN SERVICES: TWO RANDOMIZED CONTROLLED TRIALS

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Objectives: Participants should recognize the importance of meaningful participation in treatment planning as a factor in both positive and negative patient outcomes.

Purpose: Self-help agencies (SHAs) are consumer-operated service organizations, managed as participatory democracies involving members in all aspects of organizational management. SHAs assume that organizational empowerment promotes recovery. Hierarchically organized board-and-staff-run consumer-operated service programs (BSR-COSPs) while led by consumer management and boards, accord less decision-making powers to their membership. This study considers the relative effectiveness of SHAs and BSR-COSPs working jointly with community mental health agencies (CMHAs) and the role of organizational empowerment in reducing self-stigma, a key to recovery.

Method: Weighted-samples of 505 and 139 new clients seeking CMHA services were randomly assigned in separate randomized control trials to, respectively, regular county-CMHA vs. combined SHA/CMHA service, or regular county-CMHA vs. combined BSR-COSP/CMHA-service. Self-stigma and organizational empowerment were assessed at baseline and eight months in each RCT using the Attitudes towards the Mentally Ill Scale and the Organizationally-Mediated-Empowerment Scale. Outcomes were evaluated with fully-recursive path analysis models.

Results: Combined-SHA/CMHA-service-participants experienced greater positive change in self-stigma than CMHA-only participants, a result attributable to both participation in the combined condition ($b = 1.20$; $p = .016$) and increased organizational empowerment ($b = .27$; $p = .003$). BSR-COSP/CMHA-service participants experienced greater negative self-stigma change than CMHA-only-participants, a result attributable to participation in the combined service ($b = -4.73$; $p = .031$).

Conclusions: *Opinion of authors.* Differential organizational empowerment efforts in the SHA and BSR-COSP appeared to account for the differing outcomes. Persons with mental illness experience reduced self-stigma when they are engaged in responsible roles with other consumers. When placed in positions implying they are less responsible, participants place more stigmas on themselves and others with similar disabilities.

Project objectives. The study successfully demonstrated the role of meaningful participation in treatment planning as a factor in both positive and unexpectedly negative patient outcomes.

New knowledge and implications. The study provides a better understanding of the contributions that can be made by consumer-run services to improved outcomes and shows the need for more discriminating endorsement of such care based on the service's commitment, organization, and ability to empower participants in a true self-help experience.

MOVING TOWARDS PSYCHO-SOCIAL INTEGRATION IN MENTAL HEALTH THROUGH THE ARTS: A PERSPECTIVE ON COMMUNITY ART INTERVENTIONS AT A SOCIO-OCCUPATIONAL FORUM IN PORTUGAL

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Educational Objectives: at the conclusion of this presentation the participants should be able to recognize the effects of community art projects in individuals with severe mental illness as well as to understand their implications in the engagement against social stigma regarding mental illness.

Purpose: Being exclusion and stigmatisation of individuals with severe mental illness, not a geographical but a social/political/economical/cultural and even a collective psychological problem- it is the main objective of this presentation to illustrate the work and the art projects that have been developed by an art therapist/fine artist and a group of individuals with severe mental health problems in diverse community (cultural and mental health) settings.

Methods: The methods being used include multiple case studies presented within a heuristic perspective of the therapist, artist and researcher in relationship with the phenomena. As the majority of the artworks being presented were born of collective collaborations in between persons with mental illness and an art therapist (in a time frame of nine months) - the systemic and dynamic field within interaction, as well as the effects that this kind of interaction produces in both sides, will be the main focus of this presentation.

Results: Within this context the arts played a significant role supporting the attainment of some of the major objectives of psychosis rehabilitation and personal development, as they also produced significant subjective experiences in the art therapist which supported her personal development as well as an enhancement in the relationship established with other fellow human beings.

Conclusions: Some of the most significant results include the development of capabilities and self-esteem through the training and application of technical competencies as well as expressive and creative ones. There was a reinforcement of cognitive rehabilitation, through 'abstract exercises' and metaphors inherent to 'quality' art productions. The arts provided a container for a safe exteriorization, contemplation - a safe mirror for potential acceptance of the internal parts being created and transformed into an art object. They enhanced the readiness for change, re-connection with the city and community structures, socialisation and social re-integration through regular visits, workshops and community art studios created in relevant art museums in the community. Another relevant aspect of this work is that it was particularly focused and directed to the community, raising questions regarding the phenomena of psychosis and mental health in general, as well as a deconstruction of the myth of normality in a world which, regarded and contemplated by an attentive observer, becomes rather chaotic, dehumanized and tremendously diseased.

Literature Reference:

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NOT IN MY WORKPLACE! ATTITUDES AND PRIORITIES OF HUMAN-RESOURCE PERSONNEL IN NIGERIA TOWARDS WORKPLACE MENTAL HEALTH

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Educational Objectives: At the conclusion of presentation, participants should have some insights into the degree to which mental health is prioritized in workplace health-promotion initiatives among human-resource personnel in Nigeria, as well as their attitudes towards employee and potential employees with mental illness.

Purpose: To determine the attitude of human-resource personnel in Nigeria towards current and prospective employees with mental illness, and assess the degree to which mental health is prioritized in workplace health promotion initiatives.

Methods: In the course of work-place health and safety seminar for human resource personnel in Nigeria, questionnaires assessing their attitudes towards employees and potential employees with mental illness, as well as the health promotion priorities of their workplaces were assessed. Attitude questionnaires were on a 5-point Likert scale with a score of 4 or 5 on the negative scale taken as poor attitude.

Results: A total of 90 human-resource personnel returned completed questionnaires. They were mostly (62%) managerial-level. About 16% reported having handled the case of an employee with a suspected mental health problem in the preceding year. Attitudes toward employees and prospective employees with mental illness were largely poor. For instance, more than 65% of respondents would feel uncomfortable to share same office or socialize with someone with a history of mental illness, while about 55% of respondents considered it unreasonable to place someone who is returning to work after treatment for mental illness at their previous post. More than 70% were likely to consider for employment someone with a pre-existing physical disability than for someone with a history of mental illness. The key concern for not wanting to employ someone with a history of mental illness was workplace safety. In terms of workplace health promotion priorities, 88% of respondents' workplace have organised physical health and safety seminars for their employees in the preceding year, while only 6% have organised a seminar addressing common signs and symptoms of mental ill-health.

Conclusions: Study suggests that discriminatory attitudes and social distance from employees and prospective employees in Nigeria may be very high. Mental health-promotion initiatives in the workplace also appeared lower in the priorities of employers compared with physical health initiatives. Being the first study to examine the potentials for stigma in the workplace in Nigeria, this study has the potential of setting an agenda for combating discrimination on mental health grounds in the Nigerian workplace.

FIGHTING STIGMATIZATION OF MENTAL DISORDERS IN PORTUGAL - THE ROLE OF PATIENTS' ASSOCIATIONS: TWO CASE STUDIES

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The stigma of mental disorders is widely recognized as a major problem in the mental health field and it represents a very negative issue for patients and their families.

This paper analyses the role of mental patients' associations in the fight against stigma and discrimination by examining the way these organizations approach the problem in Portugal.

Case methodology was applied using mainly qualitative data gathered through qualitative interviews and document analysis.

We studied two organizations. The first one, with 3,800 members nationwide, aims to support people suffering from depression or bipolar disorders. The second one is a 120 member organization that operated between 2001 and 2010 in Lisbon for the development of educational programs and support of people living with schizophrenia.

Our study shows that both organizations targeted their members and families to avoid self-stigmatization. This study also shows that both tried to reach larger audiences through the internet, leaflets, brochures, by organizing open debates and through media advocacy.

Although these organizations did not assess their own activity, both seem to be effective and their methods very appropriate for fighting the stigma of mental disorders.

THE STIGMA OF MEMORY LOSS AND DEMENTIA: HOW IS THE MEDIA HELPING?

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Objectives: The media, including printed papers, television and radio stories, have a powerful way to communicate and perpetuate community attitudes and beliefs about health conditions. Ageist attitudes are reflected in sensational reporting of events involving older people, especially those involved dementia and other mental conditions. Our objective was to understand how dementia is reported in the media and whether stigma associated with the condition is being perpetuated through reporting.

Methods: We analysed changes in the quantity and quality of media reporting about dementia in Australian media between two time periods. A media retrieval service collected all news items related to dementia in a sample of reports. Quality ratings based on previously developed criteria were made for a stratified random sample of items - 1,129 items for 2000/01 and 1,606 for 2006/07. Nine items of quality were assessed. A summary score for quality was constructed. The content of the sampled media items was also coded.

Results: We found that the quality of media reporting improved over the study period. Overall, the mean total quality score for dementia related items significantly improved over the study period. There were very large improvements in quality of reporting of 'sensationalism' 'language' and 'provision of information about help services' and some small deterioration in quality for 'medical terminology' and 'illness versus person'.

Conclusions: Generally the quality of reporting dementia improved over the period studied. However further work needs to be carried out on guidance for media outlets in reporting stories about dementia and other mental illnesses.

UNDERSTANDING STIGMA AMONG HOMELESS PERSONS: PATHWAYS INTO HOMELESSNESS

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⁵Mental Health Commission of Canada, ⁶Centre for Addiction and Mental Health University

This study examined how homeless individuals with mental illness make meaning of pathways into homelessness. Study participants are currently enrolled in the *At Home/Chez Soi* project, a Pan-Canadian, mixed methods Randomized Controlled Trial comparing the *Housing First* approach with Treatment as Usual interventions for homeless adults with mental illness in five Canadian cities.

Educational Objectives: At the conclusion of this presentation, the participants should be able to better understand how stigma and discrimination are pervasive in the lives of people who are homeless and have a mental health problem.

Purpose: The purpose of this research was to understand the lived experiences of participants through life story interviews. Our aim was to explore at baseline: (a) pathways into homelessness, (b) life on the street or in a shelter, and (c) experiences of mental health issues and mental health services.

Methods: In all 225 qualitative baseline interviews were conducted with homeless persons between December 2009 and June 2011. Sampling was purposeful in order to ensure diverse representation of participants (e.g., gender, ethnicity, age, sexuality, etc.). The interview guide focused on pathways of participants into homelessness, life on the streets, experiences with mental health services, and key life events. Interviews were between 45-90 minutes in duration and were audio recorded and transcribed verbatim. Data analysis involved thematic analysis and content coding. Researchers sought and identified “common threads” throughout the data, drawing out significant concepts that emerged from individual interviews along with cross-cutting themes and concepts that occurred across interviews.

Results: The experience of stigma and discrimination was among the most salient theme across the five sites. Participants described being stigmatized by their families, in shelters, and on the streets. For many participants, the experience of stigma caused them to avoid accessing services. Discrimination limited opportunities to obtain work, education, and stable and safe housing, contributing to continued marginalization. Issues of stigma and discrimination were so pervasive one site recommended that programs and services raise awareness by implementing training and strategies for lessening stigma and discrimination.

Many participants internalized the stigma they routinely experienced. Stigma adversely impacted their identities, leading to further social isolation, poor self-esteem and worsened mental health. Participants describe the accumulation of stress from stigma and marginalization, as they perceived widespread discrimination due to homelessness, mental illness, and lost identities.

Conclusions: The widespread experience of stigma and discrimination underscores the need for interventions and services to support participants in developing social relationships and in becoming integrated into their communities as valued members. From a policy standpoint, this finding suggests the need for campaigns to address and minimize stigma and discrimination. Further, it is essential to understand the neighborhood, community, social, and cultural contexts in which the participants are embedded. Chronic homelessness is not just a problem faced by individuals, but is heavily influenced by structural injustices and economic inequalities.

YOUTH DESIRE FOR SOCIAL DISTANCE FROM PEOPLE WITH SCHIZOPHRENIA

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Objectives: Social distance is one of stigma facets. It represents the degree in which an individual is comfortable being close or around a mental ill person. The desire for social distance can be influenced by various factors, including the perceived dangerousness and unpredictability of a person suffering from a mental disorder and the incurability of the disease. We intend to evaluate the desire for social distance in Portuguese youth, in order to design an intervention to increase their mental health literacy about schizophrenia and reduce their desire for social distance from people who suffer from this disorder.

Methods: This study is based on a questionnaire, administered to a representative sample of 4938 adolescents and young Portuguese (43,3% males and 56,7% female), living in the central region of Portugal in the districts of Aveiro, Castelo Branco, Coimbra, Guarda, Leiria and Viseu. Their ages range from 14 to 24 years (mean age of 16,75 years; standard deviation of 1,62 years). They attend schools circumscribed in the Regional Direction of Education – Center.

To evaluate the desire for social distance, a vignette describing a boy named Miguel suffering from schizophrenia according to the diagnostic criteria for this disorder of DSM-IV was presented. The following question was asked: “In what extent would you...” followed by these options: To go out with Miguel on the weekend?; To work on a project or group work with Miguel?; To invite Miguel to go to your house?; To go to Miguel’s house?; Be happy to develop a close friendship with Miguel?. The respondents had to mark a number from 1 – No way to 7 – Without any problem, using a Likert type scale.

Results: All of the items had a low mean, revealing a higher desire for social distance. The item with the higher mean (3,18) was ‘Go out with Miguel on the weekend’, the situation in which the desire for social distance was lower. The item with the lower average (2,59) and with the higher desire for distance was ‘Be happy to develop a close friendship with Miguel’.

Conclusion: There are no other studies in Portugal that measure social distance concerning schizophrenia in youth. However, there is evidence that social distance can be reduced through planned interventions.

If intervention programs modify youth attitudes and beliefs about mental illness and schizophrenia, they can stop them from becoming adults who stigmatize and desire social distance from mental ill.

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Lisbon, Portugal

Oral Presentations

Investing in mental health

AMERICA'S CLINICAL/LEGAL DIVIDE REGARDING THE ADJUDICATION VERSUS CLINICAL TREATMENT OF JUVENILES: A MODEL OUT OF STEP WITH THE EU

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Objectives: Societal reactions toward the treatment of troubled juveniles, many who suffer from some degree of psychological distress, vary throughout the world. The United States of America has long subscribed to a more punitive versus treatment orientation setting it aside from other Western societies. Here, we address the discord between the USA and the UN and EU perspectives as well as the slow progress being made in providing better care for youth in the United States.

Methods: An analysis of current laws and programs within the USA in comparison with UN standards and EU practices.

Results: Remarkable progress has been made within the past decades in the treatment of juveniles worldwide with the adoption of UN-recommended clinical and legal standards by the European Community and other industrialized societies, including those standards promulgated by the UN Convention on the Rights of the Child; UN Standard Minimum Rules for the Administration of Juvenile Justice – the Beijing Rules; and the Standard Minimum Rules for Non-Custodial Measures – the Tokyo Rule. These legal standards plus the advances in brain mapping topography and clinical interventions has led to a movement toward clinical versus punitive efforts regarding the behaviors of children and youth. Yet, the United States stands out as a Western/industrialized society that still resorts to extreme punishment for certain youth, at the expense of clinical treatments and interventions. A problem with a “republic” system like the U.S.A. is that uniform standards are difficult to ascertain, relying instead on the often slow process of the U.S. Supreme Court, which, in itself, is not usually in concert with UN and EU standards.

Conclusions: As it stands now, many states treat juveniles as harshly as adults despite the 1967 “*In re Gault*” Supreme Court decision advocating a “due process” format. More recently, in 2005, the Supreme Court, in “*Roper v. Simmons*,” outlawed the death penalty for youth under age 18. Even then, mandatory life sentences without the possibility of parole were quickly adopted in place of execution for juvenile offenders. This changed in 2012 when the U.S. Supreme Court ended the *mandatory* life without parole administered in certain states, not the possibility of continuing this practice per se, -- in its “*Miller v. Alabama*” decision. This clinical/legal dilemma continues to plague the treatment of youth, especially minorities, in the U.S.A. with emphasis often on punishment over clinical treatment protocols despite their obvious efficacy.

SECONDARY TORTURE VICTIMS: THE IMPACT OF DETENTION ON FAMILY MEMBERS OF PALESTINIAN POLITICAL PRISONERS IN ISRAELI PRISONS

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Objectives: The main objective of the study is to identify the impact of the head of household (HOH) being imprisoned in Israeli detentions on their well-being and socioeconomically status, and their mental health.

Methods: The study was performed on the West Bank in Nov.2011 amongst 358 families, who were selected from the database of the Ministry of Detainees and Ex-detainees who's HOH were detained as political prisoners for one year or more. Of all families the replacing HOH as well as up to four other family members filled in a special designed questionnaire to identify the conditions of the arrest, and the impact on the family. Moreover the PTSD, BDI, BSI, FAD were used to measure the socio-economic and mental health impact.

Results: In total 35% men and 62% women were interviewed. The impact of the (conditions of) arrest on the family mentioned: almost 60% reported severe damage to the house; 40% mentioned their houses had been repeatedly raided after detention and they felt scared and intimidated and, 42% reported that their family members had been verbally insulted and abused during the arrest. 89.3% of the study sample out of 358 reported that the HOH detainees were tortured or ill-treated during their detention. When visiting their relatives almost 90% were harassed and intimidated and subjected to excessive physical searches. Over three quarter reported being detained on the checkpoints. A third reported they were strip searched.

The socio-economic impact of detention of the head of the family meant that > 85% of the families suffered from financial hardship, the most severe suffering was amongst newly married women whose husband were detained. More than half of the families reported that they lost the source of protection. The mental health assessments revealed that > 60% of children suffered from recurrent nightmares; both men and women showed signs and symptoms such as sadness, anxiety, stress, sleeping disorders, loss of appetite and headaches. Moreover, diagnoses of PTSD (57%), depression (22%), anxiety disorder (44%) and physical pains of psychological origins (33%) were assessed.

Conclusion: The impact and effect on family members of the arrest and detention circumstances of political Palestinian prisoners is enormous, both in socio-economic as well as mental health terms. Families of detainees are repeatedly exposed to ill-treatment, collective punishment and sometimes torture.

29 June - 3 July 2013
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Oral Presentations

**Mental health care in
developing countries**

THE SETUP AND VALUE OF AN EXPERIMENTAL MODEL OF COMMUNITY PSYCHOLOGICAL COPING INTERVENTION

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Objective: To set up the experimental model, seek the methods and value of community psychological coping intervention, and provide the basis of psychological theory and practice for the work of community mental health.

Methods: The scale of crisis fragility and BCQ were employed to evaluate and compare the mental state before and after intervention.

Results: 1) Crisis fragility of residents was negatively correlated with positive coping, positively correlated with negative coping. 2) After intervention, scores of scale for crisis vulnerability and negative coping dropped. 3) Through the regression model analysis, the linear relationship between positive coping factor and the crisis vulnerable is closest.

Conclusion: The intervention of psychological coping in community is an effective method, and the setup of experimental model has provided the theory and the practice basis for development psychology counseling in community.

Key Words: Community; Crisis fragility; Coping style; Intervention model

SUBCORTICAL EXISTENCE: SOMATIZATION AS THE MAIN MODE OF COMMUNICATION IN SOME CULTURES

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Objective: In some cultures, direct explanation of inner world is inhibited. Talking about emotions is prohibited and evaluated as a sign of weakness. In these cultures, somatization is the main outlet for emotional discharge. In this paper, with reference to Maclean's theory of "Triune brain" and sensorimotor approach of Ogden to the treatment of trauma and dissociation, we suggest a hypothesis about the function of the brain in such cultures and convey the impression that the behavior of some people are mediated by subcortical areas of the brain rather than cortex. They employ a bottom-up approach for information processing. The therapist has to consider this mode of thinking in the treatment of psychiatric problems of such patient.

MENTAL HEALTH POLICY AS PROCESS IN A GLOBAL CONTEXT: EVIDENCE-BASED RESEARCH IN PARTICIPATORY DEVELOPMENT

R. Hayward¹, P. Cutler

¹ InterAction

Objective: The future of mental health systems and services relies on the ability of all stakeholders to work together to address the challenges posed by globalization and rapidly changing social environments. For developing countries this is a priority as there is a vacuum in mental health policy. A gap exists between those at the grassroots and those charged with the responsibility to develop effective and equitable services. The situation is exacerbated for people who have mental health problems and their families as they are further excluded from policy processes by stigma, power differentials and lack of information.

Methods: This paper reports on five years of work and research by staff from an international mental health agency, InterAction, in many countries including Estonia, Kyrgyzstan, Armenia, Cuba, Bosnia, India and Romania using the Pathways to Policy model. This model is theoretically based on policy-as-process and public action concepts and has successfully enabled grassroots stakeholders, including service users, carers, psychiatrists and members of local communities, to work together to develop services and address local issues such as rural livelihoods, gender and transparency / corruption.

Results: The model has developed local and national policy forums that are run by service users and other stakeholders. By providing the training, support and resources for these grassroots lead forums, the model provides evidence that bottom-up approaches can build partnership and collaborative activities based on mutual respect and trust. The research draws on data including participatory analysis, semi-structured interviews, focus groups and reflective records.

Conclusions: By addressing the twin questions of how people at the grassroots can shape mental health services and how they can have a voice in the policy debate, the paper demonstrates that real outcomes are possible in countries where poverty, conflict and low funding of services are common. The implications of this work are significant for the wider development of mental health policy as it challenges accepted orthodoxies and indicates the need for more inclusive responses to the problems of long term mental health needs.

Key words: Policy / Participation / User Involvement / Globalization

EVALUATION OF SOCIAL PSYCHIATRY PROGRAMMES IN KERALA USING THE RE-AIM FRAMEWORK: A PRELIMINARY STUDY

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Background: The state of Kerala, in South India is unique with high morbidity and comparable mortality rates. It has a history of very progressive social movements and non governmental organisations making inroads into health care. This is especially so in the mental health care sector. These organisations in the voluntary sector serve to supplement and fill in gaps in the provision of mental health care. Most of these organisations receive little funds and are subserved by a group of caring volunteers.

Objective: To evaluate the impact of social psychiatry programmes in Kerala.

Methods: This was a preliminary study to look at the feasibility of using the RE-AIM framework to study the performance and impact of two voluntary organisations working in the field of mental health in Kerala. The study collected data using a structured interview. The directors of two programmes were asked to complete a 15 item questionnaire assessing domains on the RE AIM domains and a checklist of good practices. This was followed by an in depth interview with the director of the programme which was recorded, transcribed and analysed. RE AIM profiles were compiled for the two programmes.

Results: The two programmes, one providing support and empowering parents of children with a learning difficulty (dyslexia, Dysgraphia and dyscalculia) and the other providing support for adults affected by learning disability (mental handicap) had been functioning for more than 10 years in Kerala. Several good practices such as the spirit of volunteerism, involvement and empowering of carers, low cost techniques were identified. Some areas for improvement were identified similarly.

Conclusion: We have demonstrated, on a small scale the feasibility of using RE-AIM framework to look at voluntary organisations in a developing country. The approach is replicable and ensures that the scope of involvement is widened. The RE AIM domains provide a good framework to study public health interventions and to identify good practices as well as areas for improvement.

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Oral Presentations

**Creating alliances to respond
to mental health challenges**

MENTAL HEALTH POLICY AS PROCESS IN A GLOBAL CONTEXT: EVIDENCE- BASED RESEARCH IN PARTICIPATORY DEVELOPMENT

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Objective: The future of mental health systems and services relies on the ability of all stakeholders to work together to address the challenges posed by globalization and rapidly changing social environments. For developing countries this is a priority as there is a vacuum in mental health policy. A gap exists between those at the grassroots and those charged with the responsibility to develop effective and equitable services. The situation is exacerbated for people who have mental health problems and their families as they are further excluded from policy processes by stigma, power differentials and lack of information.

Methods: This paper reports on five years of work and research by staff from an international mental health agency, InterAction, in many countries including Estonia, Kyrgyzstan, Armenia, Bosnia-Herzegovina, India and Romania using the Pathways to Policy model. This model is theoretically based on policy-as-process and public action concepts and has successfully enabled grassroots stakeholders, including service users, carers, psychiatrists and members of local communities, to work together to develop services and address local issues such as rural livelihoods, gender and transparency / corruption.

Results: The model has developed local and national policy forums that are run by service users and other stakeholders. By providing the training, support and resources for these grassroots lead forums, the model provides evidence that bottom-up approaches can build partnership and collaborative activities based on mutual respect and trust. The research draws on data including participatory analysis, semi-structured interviews, focus groups and reflective records.

Conclusions: By addressing the twin questions of how people at the grassroots can shape mental health services and how they can have a voice in the policy debate, the paper demonstrates that real outcomes are possible in countries where poverty, conflict and low funding of services are common. The implications of this work are significant for the wider development of mental health policy as it challenges accepted orthodoxies and indicates the need for more inclusive responses to the problems of long term mental health needs.

Literature Reference: Hayward R. & Cutler P. *"Evidence-based Policy in Mental Health"* in Knapp M., McDaid D., Mossialos E. & Thornicroft G. (2005) *Mental Health Policy and Practice Across Europe*. Milton Keynes: Open University Press.

Key words: Policy / Participation / User Involvement / Globalization

29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

Others

IMPACT OF THE PHYSICAL ACTIVITY ON THE MODERATION OF THE SYMPTOMS AND THE REMEDIATION AMONG SCHIZOPHRENIC PATIENTS: CASE OF TUNISIAN PATIENTS

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Objectives: This research is part of studies that highlighted the effectiveness of the Pilate method in the relief of certain organic attacks such as the fibromyalgia or the breast cancer (Altan et al., 2009). The aim of our research was to check the impact of the Pilate's method, that's a method of physical activity which refers to soft exercises, on the moderation of the negative and positive symptoms among schizophrenic patients and its effectiveness of a better psychological balance of the patient (Eyigor et al., 2010).

Methods: The sample of our study consisted of N=20 patients of the medico-legal service of the care and readjustment unit of psychiatric hospital "ERRAZI" in Tunis. All patients were males have the same type of schizophrenia (paranoia) and they were between 21 to 63 years old (average age 42 years). Most of them were of elementary level of schooling. The sample is divided into two groups: an experimental and a control group. Because of the reduced size of manpower we chose the case study with directing maintenance by calling upon two scales of appreciation of the negative and positive syndromes "the SAPS and the SANS" (Andreasen, 1982, 1986).

Results: The quantitative and qualitative analysis of the results has shown that the physical activities based on the Pilate method have a positive impact on the moderation of the negative symptoms such as emotional poverty and the attention. Moreover, our analysis reveals a certain improvement of the moderation of the positive syndromes and a significant influence on the management of the disease of the psychotics and the schizophrenics in particular while acting on the reduction of the negative symptoms of schizophrenia. However, it is obvious that the physical activity based on the Pilate's method cannot replace the traditional treatments of serious psychiatric diseases, but it can be considered as an important additional therapeutic. The Pilates method can be also a useful method to keep the positive symptoms under control.

Conclusion: The positive effect of the Pilate's method on the moderation of the negative and positive symptoms among Tunisian schizophrenic patients has been checked. Furthermore, this method tends to develop active strategies of coping which allows a compensation of the side effects of drugs and treatments (i.e. obesity, passivity). Finally our study makes it possible to open the way with future research on the improvement of the construction functions of the psychotic oneself.

Key words: physical activities, schizophrenia, Pilate's method, positive and negative symptoms

AN INTERPERSONAL COGNITIVE PROBLEM-SOLVING STRATEGY ON CHILDREN WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER: A ONE-YEAR FOLLOW-UP

C.T. Ozcan¹

¹. Gulhane Military Medicine Academy, Ankara, Turkiye

Objective:

To evaluate the efficacy, predictability, and stability of an Interpersonal Cognitive Problem-Solving Strategy / “I Can Problem Solve” (ICPS) program on behavioral and emotional problems in all children with Attention Deficit Hyperactivity Disorder (ADHD), it was completed a 1-year follow-up study on 32 children of the totally 33 children with ADHD into the study. The results of this follow-up are presented.

Methods: The researcher taught ICPS to 33 children with ADHD ranging between 6 to 11 years old over a 14 week period. The ICPS was associated with significant reductions in behavioral and emotional problems (attention problems, hyperactivity problems, anxious/depressed, withdrawn/depressed, oppositional defiant problems, rule breaking behavior, and aggressive behavior).

The “Child Behavior Checklist for Ages 6-18 (Teacher Report Form/TRF)” and “*DSM-IV based screening and assessment scale for Attention Disorder and Disruptive Behavior Disorder* (parents’ and teacher’s forms)” were used to evaluate the efficacy of the program. The scales were applied to mothers, fathers and teachers of the children before and after ICPS and 1 year after training ended.

Results: The results of this follow-up have shown that the improvement in behavioral, social and emotional adjustment lasted 1 years after training ended. Findings indicated that the measured pre-training scores for behavioral and emotional problems (attention problems, hyperactivity problems, anxious/depressed, withdrawn/depressed, oppositional defiant problems, rule breaking behavior, and aggressive behavior) were significantly decreased for all children post-training. In addition, children’s total competence scores increased (working, behaving, learning and happy) after the ICPS. On both the DSM-IV based screening and assessment scales and TRF, the comparison between initial ratings and at 1-year follow-up was significant ($p < 0.05$).

Conclusion: According to the results of this study, it is likely that the ICPS program would be a useful tool to decrease certain emotional and behavioral problems associated with ADHD. Specifically, to increase the competence level of the children with ADHD in the following areas: working, behaving, learning and happy. An additional benefit of the program might be to empower children to deal with problems associated with ADHD such as attention problems, hyperactivity-impulsivity, and Oppositional defiant problems.

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Shure, MB (1992), I Can Problem Solve (ICPS): An Interpersonal Cognitive Problem Solving Program for Kindergarten and the Primary Grades. Champaign, IL: Research Press.

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INCREASE IN CHILD BEHAVIOR PROBLEMS AMONG BRAZILIAN PRESCHOOLERS: A COMPARISON OF THE 1993 AND 2004 PELOTAS BIRTH COHORTS

A. Matijasevich¹, A. Stein², L. Anselmi¹, A. M. Menezes¹, I. S. Santos¹, A. J. Barros¹, D. P. Gigante¹, F. C. Barros^{1,3}, C. G. Victora¹

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Educational Objectives: At the conclusion of this presentation, the participants should be able to understand time trends in preschool behavioural/emotional problems among children from a middle-income country.

Purpose: To investigate trends in preschool behavioral/emotional problems in two birth cohorts from a middle-income country born eleven years apart.

Methods: We analyzed data from the 1993 and 2004 Pelotas birth cohort studies from Brazil. A sub-sample of four year olds from the 1993 cohort (634) and all four year olds from the 2004 cohort (3750) were assessed for behavioral and emotional problems through mother report using the same measure, Child Behavior Checklist (CBCL). Similar methods were used in these two population-based cohorts, and response rates were above 90%.

Results: We found a significant increase in CBCL total problems and externalizing mean scores over the eleven-year period: mean values (SE) CBCL for total problems scores were 27.9 (0.8) and 34.7 (0.3) and for externalizing scores, 12.4 (0.4) and 15.5 (0.1) in 1993 and 2004 Pelotas cohorts, respectively. Aggressive behavior syndrome score showed the largest increase: means (SE) of 9.7 (0.3) and 13.0 (0.1) in 1993 and 2004 studies. Changes in familial, maternal and child's characteristics did not help to explain the observed increase in child behavior problems during the study period.

Conclusions: this study provides evidence of a substantial increase in psychological problems, particularly behavioral ones, among preschool children over a recent 11 year period. Given the potential long-term effects of childhood psychological problems on an individual's social and psychological life course, early identification of such problems must be a key priority for mental health services.

NEEDS ASSESSMENT OF PATIENTS TREATED IN COMMUNITY PSYCHOSOCIAL CENTERS IN SÃO PAULO, BRAZIL

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². Hospital Alemao Oswaldo Cruz, Sao Paulo, Brazil

Educational Objectives: at the conclusion of this presentation, the participants should be able to estimate the needs of care of patients treated in community psychosocial services in a large city in Brazil and to compare them with results of previous studies conducted in Europe

Purpose: To describe the needs of patients treated at community psychosocial centers in Sao Paulo, Brazil.

Methods: We performed a cross-sectional study with 373 patients who were attending psychosocial care activities at least three times per week in community psychosocial centers in São Paulo, Brazil, during 2007-2008. Needs were assessed using the “Camberwell Assessment of Need” (CAN). Psychotic symptoms were assessed using the “Positive and Negative Symptom Schedule” (PANSS).

Results: Mean age of patients was 40.0 years (standard deviation, SD = 12.6 years); 57.6% were male, 57.9% had fundamental education, 40.5% have schizophrenia, 15.9% have worked during last 12 months, 14.7% were living alone and 21.9% have no previous psychiatric hospitalizations. Median time attending in community psychosocial centers was two years (range of 15 days to 30 years) and mean number of weekly therapeutic activities was 3.6 (SD = 2.3). The mean score for the total number of needs was 7.1 (SD = 2.8), with a range of 0 to 15 (maximum = 22). Mean scores of PANSS positive, negative and general scales were 13.4 (SD = 4.8), 14.9 (SD = 5.7) and 29.0 (SD = 8.7), respectively. Basic needs (accommodation and food) were reported by 38 (10.2%) patients; at least one social need was reported by 90.9% and 18.8% have needs related to company, intimate relations and sexual expression. At least one functioning need (self-care, child care, basic education, looking after home, daytime activities, money) was reported by 94.4% patients; 85.5% have at least one health need (physical health, psychological distress, psychotic symptoms, safety to others, alcohol abuse, drug abuse) and 86.3% have at least one service need (information, telephone, transport, benefits). Women showed higher number of needs than men ($p = 0.02$) and educational until fundamental level was also associated with more needs ($p = 0.02$). We did not observe associations between weekly activities, unemployment, age, diagnosis and number of needs. Patients with higher PANSS scores showed more needs ($p < 0.001$).

Conclusions: We managed to estimate needs of care of these patients. We observed higher number of needs than in studies conducted in Europe, in all conceptual domains assessed by CAN. Many patients showed needs related to health and services, despite the time that they were attending in community psychosocial centers. Patients’ needs should take in account in order to improve the quality of care offered in mental health services.

EMPATHY IN NURSING STUDENTS: RELATED SOCIO-DEMOGRAPHIC CHARACTERISTICS AND FAMILY FUNCTIONING

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². University of Yeditepe, Istanbul, Turkiye

Objectives: This study was designed as descriptive to evaluate the socio-demographics and family functioning related to the empathic skills and tendency of nursing students.

Methods: The study was conducted in a School of Nursing and all the registered students (all students were female and the average age was 19-21) were asked to participate into the study. Of the totally 731 students, 689 students participated (94.3%) into the study. A socio-demographic questionnaire (including family types, number of siblings, birth order, parental educational status, parents' profession, the number of persons living in the same house, income level and parents deceased or alive), Empathic Communication Skills Scale (ECSS), Empathic Tendency Scale (ETS), and Turkish version of McMaster Family Assessment Device (FAD) were used to collect data. ECSS measures affective and cognitive components of empathy and verbal response dimension of communication. ETS was developed in order to measure the potential of persons' ability to establish empathic relationships in daily life. The FAD measures "Problem Solving", "Communication", "Roles", "Affective Responsiveness", "Affective Involvement", "Behavior Control" and "General Functioning".

Results: There were statistically differences among the groups on measured ECSS, and ETS scores in terms of some characteristics of students such as number of siblings, birth order, professions of fathers, and the number of persons living in the same house. There was a significant negative correlation both between FAD scores and ETS ($r=-0.343$, $p<.001$) and between FAD scores and ECSS ($r=-0.090$, $p=.020$) of students. The higher scores on the FAD showing unhealthy/pathology functions of the families were increased in parallel with the decrease in ETS and ECSS scores of students. Multivariate analysis have shown that students who were raised in families showing high levels of unhealthy "Communication", "Roles" had lower ETS and ECSS scores ($p<0.05$).

Conclusion: The negativities in family functioning affect students' empathic tendency and skills. Also some characteristics of family system such as the increase in the number of siblings and the number of persons living in the same house seem related to lower both empathic tendency and skills the status of being the first child in a family seem related to higher empathic tendency and people-oriented professions of fathers seem related to higher empathic skills.

Literature Reference:

Miller IW, Kabacoff RI, Epstein NB, Bishop DS, Keitner GI. (1985) The McMaster Family Assessment Device: Reliability and Validity, *Journal of Marital and Family Therapy*, 11 (4), 345–356.

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INFORMATION SYSTEMS: DO THEY IMPROVE THE QUALITY OF MENTAL HEALTH CARE?

R. Tempier¹, E. M. Bouattane¹
University Of Ottawa ¹

Objectives: Participants will understand the importance of collecting clinical data in order to improve the quality of care. Participants will be more familiar with the Resident Assessment Instrument for Mental Health, a data collection instrument made in Canada.

Information systems allow clinicians to understand better clinical activities helping informed decisions taking. The Minimum Data Set for Mental Health (MDS-MH) has been in use in Ontario since 1999, initially as a research instrument, now part of normal clinical practice. Since 2005, the MDS-MH, the basis of the Ontario Mental Health Reporting System (OMHRS), is used for patients hospitalized in mental health beds. The OMHRS is designed for outcome measurement and quality improvement. It collects 21 domains of care including mental state indicators, substance use or excessive behaviour, service utilization and treatments, etc. We are using MDS-MH-based results in a Teaching Hospital, the Montfort Hospital, in Ottawa, Canada.

Some clinical indicators that MDS-MH and OMHRS bring to those clinicians interested by improving the quality of care. Pros and cons of using such tools to improve services will be discussed.

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*The bio-psycho-social model:
The future of Psychiatry*

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29 June - 3 July 2013
Lisbon, Portugal

**Lectures, Symposia,
Workshops, Oral Presentations**

29 June - 3 July 2013
Lisbon, Portugal

Lectures
Symposia
Round Table
Workshops
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29 June - 3 July 2013
Lisbon, Portugal

Lectures

THE BIO-PSYCHO-SOCIAL MODEL : THE FUTURE OF PSYCHIATRY

Driss Moussaoui

President, World Association for Social Psychiatry

Psychiatry has been historically based on psychopathology during the 19th Century, on clinical, biological and therapeutic approaches during the 20th Century, and has largely forgotten its social aspect.

How can we apprehend the complexity of a human being, in good or bad health, without including in the equation the social environment: culture, beliefs, structure of the family, religious practice, traditional practices to fight illness, perception of gender, urban environment, all kinds of existing pollutions, and the impact of globalization?

The bio-psycho-social model must remain at the heart of psychiatry, not in adding the biological, the psychological and the social determinants of mental health, but in making them interact in the most sophisticated way. A number of examples will be given to illustrate such complexity.

DIAGNOSTIC ISSUES FOR TRAUMATIZED REFUGEES

Marianne C. Kastrup¹

¹.Competence Centre for Transcultural Psychiatry, Psychiatric Centre Ballerup, Denmark

Background: In the first half of the 20th century the prevailing thought was that traumatic life events per se did not leave lasting consequences for mental health but were a result of a premorbid vulnerability. Following the Second World War studies of concentration survivors and war sailors revealed that exposure to different forms of extreme stress may induce fairly comparable mental problems among previously well individuals.

Results: PTSD has been a nosological entity since DSM-III (1980) attempting to unite different stress responses. Subsequently, revisions of DSM have modified diagnostic criteria and ICD-10 has introduced two diagnostic categories (F 43.1 and F 62.0) covering consequences of traumatic stress.

The tendency to inclusiveness of a biomedical paradigm has been criticized from several sources claiming that this is a Western trend that does not sufficiently take into consideration the socio-political context.

The paper will discuss the advantages and shortcomings of current diagnostic categories including the latest DSM revision vis-à-vis reflections of the universe of traumatized refugees.

SOCIAL PSYCHIATRY IN THE ERA OF NEUROSCIENCE

Jin Van Os¹

¹. Maastricht University, Netherlands

Background: The human brain has evolved as a highly context-sensitive system, enabling behavioural flexibility in the face of constantly changing environmental challenges. Bottom-up sensory stimuli interact with top-down cortical expectations, giving rise to affectively meaningful representations of the social world that motivate adaptive, goal-directed interactions. Multidimensional psychotic and affective syndromes can be understood as an imbalance in the cycle of adaptation to the social context. At the symptom level, paranoid delusions express alterations in experience of the social environment, and cognitive impairments associated with psychotic disorder reflect difficulties in the ability to read the emotions and intentions of other people, contributing to the reduced social competence that accompanies symptoms. We have developed technology to directly assess *situated* phenotypes indexing dynamic, within-person environmental and mental reactivity as substrate for molecular genetic studies and diagnostic systems; and to increase the translational potential to study developmental social-reactive mechanisms associated with psychotic disorder.

However, as DSM5 and ICD11 are being completed, new pressing questions arise. Particularly, how can the concept of clinical staging be applied in psychosis, depression and mania? And, even more importantly, how can a mental disorder diagnosis be individualized? To date, the most commonly used attempt at individualization is based on assigning individuals to diagnostic categories, in combination with rating individual psychopathology across different dimensions. In theory, this system of ‘dimensionalised categories’ ought to yield acceptable precision, given that two individuals within the same diagnostic category will nearly always have different psychopathological profiles. While attractive, recent research nevertheless indicates that it is based on the false premise that symptoms always vary together as a function of a latent dimension or a latent category – which research suggests is not the case. Instead, it has been argued that mental “disorders” in fact may represent sets of symptoms that are connected through a system of causal relations that may explain the co-occurrence of different symptoms. For example, the depressive and manic symptoms of bipolar disorder, and the negative and positive symptoms of schizophrenia have partly independent courses and aetiological factors appear to operate at the symptom level rather than the diagnostic disorder level. Therefore, there is increasing interest in how multiple symptoms in individuals arise not as a function of a latent construct, but as a function of symptoms impacting on each other

Results: The notion that traditional diagnostic categories and dimensions need to be transformed to represent the dynamics of symptoms impacting on each other over time in a final ‘mental causal pathway’ is tantalizing, and relevant for bipolar disorder. It implies that special methodology is required to collect repeated measures of symptoms over time in the flow of daily life, both at the momentary level and over more extended periods that subsequently need to be analyzed in such a way that the pattern of symptoms impacting on each other can be described systematically

POVERTY AS A FACTOR IN SOCIAL CRISIS AND HUMAN DISASTERS

Ruiz P¹
¹.WPA

Abstract: Studies conducted over the last one hundred years have clearly demonstrated the relationship that exists between social class and mental illness. The work of E. Durkheim vis-à-vis suicide behavior, of R.E.L. Faris and H.W. Durham related to schizophrenia, of M.H. Brenner with respect to levels of unemployment and mental hospital admissions and of A.B. Hollingshead and F.C. Redlich insofar as the relationship between social class and mental illness have all clearly demonstrated the impact of poverty as a factor in social crisis and human disasters.

Other similar studies have more recently demonstrated the relationship that exists between the economic status and levels of stress vis-à-vis health and mental health related outcomes; thus, poverty, stress and mental illness clearly interrelate among themselves, and can lead to a large variety of mental disorders. It is also important to realize and study the mediators that exist between stress, poverty and mental illness; for instance, age, marital status, education levels, social class, cultural factors and health status.

In this presentation, we will present, address and discuss the close relationship that exists between stress, poverty and mental illness.

Educational Objectives: At the end of this lecture, the attendees should be able to identify and address:

1. The relationship between poverty and mental illness
2. The role of disparities in the current health care system of the U.S.A.
3. Identify the set of values that need to be implemented in the current health and mental health care system in the U.S.A.

References:

1. Disparities in Psychiatric Care: Clinical and Cross- Cultural Perspectives. Philadelphia, Pennsylvania, Lippincott Williams & Wilkins, 2009.
2. 133rd Presidential Address: Addressing Patient Needs: Access, Parity and Humane Care. American Journal of Psychiatry
3. Addressing Culture, Race and Ethnicity in Psychiatric Practice. Psychiatric Annals.

COMORBIDITY OF MENTAL AND PHYSICAL DISORDERS: A MAIN CHALLENGE FOR MEDICINE IN THE EARLY 21ST CENTURY.

N. Sartorius¹

MD, PhD, FRCPsych

Background: The comorbidity of mental and physical disorders has acquired epidemic proportions in most parts of the world. What is worse is that it is likely that this type of comorbidity is likely to grow in the years to come and that this development is simultaneous to the continuous fragmentation of medicine into subspecialties.

Results: The presentation will summarize the current findings about comorbidity and discuss reasons for the prediction that the simultaneous presence of a mental and one or more physical illnesses will increase in absolute and relative numbers.

INNOVATIONS IN PSYCHIATRIC CARE: THE ROLE FOR SOCIAL PSYCHIATRY

Tom K J Craig

Kings College London, Institute of Psychiatry, London, UK..

Background: The golden age of social psychiatry is often said to have been the middle decades of the last century where there was a blossoming of our understanding of the ways in which personal relationships play an important role in the cause, course and outcome of mental illness. The logical extension of these insights has been the more recent emphasis on psychological processes and brain-based mechanisms that might translate the social experience into individual pathology. Exciting though these developments have been, they have not led to any step change in treatment and the time is ripe to consider how a re-focus on the earlier lessons from social psychiatry may inform the development of improved treatments and services for our patients and their families.

When patients are asked what they want from contact with mental health services, they are often more interested in what we can do to help them address problems of unemployment, social exclusion and discrimination than they are in symptomatic relief. Not to say that the latter is unimportant, but rather that the goal of symptom reduction may be neither necessary nor sufficient to achieve good functional outcomes. In this lecture I will review the opportunities and challenges of tackling mental ill health through interventions primarily focused on the social arena and illustrate what may be possible by reference to recent research and to studies underway. These studies include interventions to enhance social support in chronic depression, the prevention of milder forms of post natal depression and interventions that tackle social exclusion head on. Few of these interventions are directly delivered by the psychiatrist and beg the question of the future role of a highly trained medical professional. In the last part of the lecture I will outline why I believe we will continue to be needed and the key part we have to play in developing socially informed mental health care.

29 June - 3 July 2013
Lisbon, Portugal

Round Table

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	WCSP LISBON: ASIA- PACIFIC ROUND TABLE: 'THE PRESENT STATUS AND PROSPECTS FOR SOCIAL PSYCHIATRY'			
Chairperson	Roy Kallivayalil, General Secretary WASP, India			
Co-chairperson				
Abstract				
References				
Speakers	1."Social Psychiatry in Asia: Current scenario, relevance and future perspectives- Prof Roy Abraham Kallivayalil, Secretary General, WASP (Moderator) 2.Importance of service users and carers in service development in Asia/ Pacific- Dr Afzal Javed (Secretary for Sections- WPA) 3.New developments in therapy in Asia/ Pacific- Prof BS Chavan (Chandigarh, India) 4. Impacts of aspects of society/economy on mental health in Asia/Pacific- Prof Mohan Isaac (Australia) 5.Present status and prospects for Social Psychiatry in Japan- Prof Mizuno Masufumi (Japan)			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Social Psychiatry in Asia: Current scenario, relevance and future perspectives			
Speaker	Prof Roy Abraham Kallivayalil, Secretary General,			
Abstract	Asia represents more than half of humanity. Most of the countries represent traditional societies, with deep cultural values and influences. Families had been strong with very important role in everyday life. Mental illness was considered more a problem of the western societies, and hence most countries accorded low priority to mental illness. The mental health infrastructure in most countries is woefully inadequate. Besides, there is severe dearth of mental health professionals. Widespread stigma, poor funding, lack of support from planners, politicians and administrators complicate the situation further. Some countries also have substantial number of illiterate people. Globalisation has added its own problems. It is now recognized, psycho social factors play a key role in the causation of mental ill health in Asia. To cite an example, it was long believed, suicide rates were very low in countries like India and that majority were due to mental illness. But recent data suggests, not only suicide rates are higher but also psycho social factors like economic burden, loneliness or break in relationships play a more important role than mental illness in the causation of suicides here. It is also seen, social factors play a key role in treatment compliance and well being. Social Psychiatry needs to get a new focus and renewed			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Psycho education programme for the Caregivers: Experience from Pakistan			
Speaker	Afzal Javed, Pakistan Psychiatric Research Centre and Fountain House Lahore, Pakistan			
Abstract	The increased focus towards community care of psychiatric patients is leading to an increase in care giving responsibility on family and friends. It is a demanding and challenging task and places great demands on the caregivers. This change highlights the relevance of emotions and affections within a family, as well as the great amount of burden experienced by the family while taking care of a psychotic patient.			

	In Pakistan, family plays a vital role in patients' life keeping in view of the closed family system /norms & Families are considered the backbone of the healthcare system. Mostly the primary caregivers are patients' parents, spouses, siblings and children, who are providing physical and emotional support to patient for long period of time varying from months to years. The responsibility of caring can affect physical and mental health of caregivers adversely. Having a psychiatric patient as family member can lead to greater amount of burden on whole family like economic burden, feelings of hopelessness, depression, disturbed and unhealthy home environment, lack of social support, fear of stigmatised attitude, dysfunctional family roles. Keeping in view the needs for involving families and care givers, a psycho education programme was started at Fountain House, Lahore. The aim of this service was to explore psychological and emotional stressors or burden in caregivers who are caring for patients with psychiatric illnesses and to provide them support to deal with these stresses. This talk will give a brief outline about this programme and would argue about the effectiveness of mental health promotion services in a low income country.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Present status and prospects for Social Psychiatry in Japan			
Speaker	Masafumi Mizuno, Vice-President, The Japanese Society for Social Psychiatry, Chair, Department of Neuropsychiatry, Toho University			
Abstract	Japanese Society for Social Psychiatry (JSPS) is a national membership organization founded in 1981 to advance research for social psychiatry and contribute toward promotion of mental health. Masaaki Kato was the first president of the society followed by Ichizo Sato, Kenshiro Ohara, Yoshibumi Nakane, Tetsuya Hirose, and Shimpei Inoue. Its membership includes mental health professionals of all disciplines with the majority of psychiatrists. The main projects include annual academic meeting, publication of the quarterly journal (Japanese Bulletin for Social Psychiatry), and provision of up-to-date information on social psychiatry through its web. The 32nd annual academic meeting was held on March 7-8, 2013 in Kumamoto organized by Professor Manabu Ikeda of the University of Kumamoto with more than 400 delegates. As usual, its program included keynote speeches, symposia, oral/poster sessions and some educational sessions. The main theme was entitled as "Mental health in the confused society: from new born to aged generation". The symposia were as follows; Depression and suicide-comparison north and south, Supporting patients with cancer, Social psychiatric issues on sleep and related disorders, Community lives of people with schizophrenia, Psychiatric approaches to the children damaged by the Great East Japan Earthquake.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Impacts of aspects of society/economy on mental health in Asia Pacific			
Speaker	Mohan Isaac MD (Psy), DPM, FRCPsych, FRANZCP, Professor of Psychiatry			
Abstract	Most countries in the Asia pacific region are currently going through a period of unprecedented and rapid social, political and economic change. Although a broad range of literature across different disciplines dwells on possible impact of such change on health and mental health, there is little direct research on the effects of such changes on population mental health. While it is widely recognized that political and economic factors outside the world of academic and clinical psychiatry influence mental health, mechanisms of how societal change affects mental health is under researched due to a variety of methodological problems and is poorly understood. The brief presentation will highlight the widening income inequality, rising mental health inequity and growing prevalence of common mental disorders, sub-threshold and adjustment disorders, alcohol use related problems and suicidal behaviour. Socio economic issues related to globalization and the problem of suicides by large number of farmers in India during the past decade (as a case study example) will be raised for discussion.			
References				

29 June - 3 July 2013
Lisbon, Portugal

Symposia

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	HARM REDUCTION IN PSYCHIATRY			
Chairperson	Michael Krausz, University of British Columbia (UBC), Vancouver, Canada			
Co-chairperson	Michaela Amering, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria			
Abstract	Harm reduction is an interventional approach, a political concept and a medical principle. While it has polarized the discussion in the addiction field for years, harm reduction has also gained interest in the wider field of mental health care. A recovery approach with a focus on consumer choice and individual support requires a balanced approach to risk and harm reduction. Globally, the existing scarcity, inequity and inefficiency of mental health resources as well as the enormous treatment gap underscore the significance of harm reduction policies. This symposium will inform about history and current developments of the harm reduction concept and will present examples of its relevance. Michael Krausz from the University of Vancouver/Canada will set the scene by presenting the case for following the basic paradigm of harm reduction with examples from addiction medicine and the challenge of an integrated approach to health and mental health care. Jonathan Burns from the University of KwaZulu-Natal in Durban/South Africa will discuss policy chances and challenges for the South African situation with its various areas of necessary harm reduction. Ingrid Sibitz from the Department of Psychiatry and Psychotherapy at the Medical University of Vienna/Austria will present on stigma resistance and will argue for novel approaches to combat stigma and discrimination on the societal as well as on the individual level in order to reduce the harmful impact on peoples' living and treatment situations. Finally, Richard Warner from the University of Boulder in Colorado/USA will introduce a community treatment program of collaboration between the mental health and substance abuse treatment services, the sheriff's and the probation departments, and the courts, to prevent relapse and recidivism among clients with coexisting mental disorder and substance use problems. He will present data on the impressive harm and cost saving capacity of this approach.			
References				
Speakers	1. Michael Krausz, University of British Columbia (UBC), Vancouver, Canada mkrausz@mail.ubc.ca Harm reduction a basic paradigm for mental health care – lessons learned from addiction medicine 2. Jonathan Burns, Department of Psychiatry, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban, South Africa, burns@ukzn.ac.za Harm reduction in psychiatry - the South African situation 3. Ingrid Sibitz, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria, ingrid.sibitz@meduniwien.ac.at Stigma Resistance – combating stigma and discrimination on a societal as well as on an individual level 4. Richard Warner, Colorado Recovery, Inc. and University of Colorado, Boulder, USA, rwarner@coloradorecovery.com Keeping People with Mental Illness out of Jail and Prison			
Contact:	Michaela Amering Department of Psychiatry and Psychotherapy Medical University of Vienna Waehringer Guertel 18-20 1090 Vienna Austria Tel +43 699 11991030 Fax + 43 1 40400 3605 michaela.amering@meduniwien.ac.at			

Session:	Symposium	SPEAKER 1	Code	
Title:	Harm reduction a basic paradigm for mental health care – lessons learned from addiction medicine			
Speaker	Michael Krausz, University of British Columbia (UBC), Vancouver, Canada mkrausz@mail.ubc.ca			
Abstract	Mental health care is guided by explicit and implicit values and paradigms. Although we are only able to serve about 1 third of people in need according to the US National Comorbidity Survey and only a small minority is seeing a specialist for care, the mental health system is focussing on the concept of treatment and cure. Mental health care is normally not organized on a population level. Addiction medicine adopted the political and therapeutic concept of harm reduction as key of clinical pathways. It resulted in better access to care, prevention of infectious disease like HIV and HCV and methadone being the most effective measure against the spread of HIV. What does that teaches us for the future of mental health care?			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Harm reduction in psychiatry - the south african situation			
Speaker	J.K. Burns Nelson R Mandela School of Medicine, University of KwaZulu-Natal Durban, KwaZulu-Natal South Africa			
Abstract	Nearly 10 years ago, new mental health legislation was enacted in South Africa. The Mental Health Care Act (2004) was based on a number of important human rights principles including: integration of mental health into primary health care, decentralisation of services, minimum level of coercion possible, user empowerment and access to representation, promotion of community based mental health care and equality of mental health within the health care system. While the principles of this legislation aimed to improve care and reduce harm, the lack of funding for mental health and the absence of a strategy to implement change has resulted in a system that perpetuates multiple forms of harm experienced by users. These include: grossly inadequate community mental health facilities; minimal psychosocial rehabilitation and the continued long-term institutionalisation of many users; poor funding and maintenance of mental health facilities; inadequate training and support at district level with resulting poor quality of decentralised care; and continued stigmatisation of users and their families both within the health service and in the general community. A lack of political commitment to ensuring effective functioning of regional review boards has meant that users continue to have little recourse to legal representation. Thus this attempt to institutionalise a legislated vehicle for harm reduction, has largely failed in implementation; and users remain largely unprotected and voiceless. This presentation will review the above issues and challenges and will suggest practical steps that could be taken to reduce harm in current mental health practice in South Africa. These steps are relatively simple and inexpensive and are based on the principle of strengthening community empowerment, participation and collaboration in mental health planning and provision. The major barriers are political commitment and competence to implement commitments to change; as well as public prejudice, ignorance and apathy regarding mental health. The presenter will conclude by proposing a strategy aimed at breaking down these harmful political and social barriers within this middle-income context.			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Focusing on stigma resistance as a new approach to combat stigma and discrimination in people with schizophrenia			
Speaker	Ingrid Sibitz, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria			
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should be able to define			

	stigma resistance and give recommendations about how to build up stigma resistance both on an individual level as well as in society. Purpose: The aim of the study was to shed more light on the new concept of stigma resistance, i.e. the capacity to counteract the stigma of mental illness. Methods: Transcripts of recorded interviews with 32 people with schizophrenia were coded and analysed thematically using a modified grounded theory approach. The analyses were conducted with the help of NVivo 7 (QSR International). Results: Stigma resistance is referred to being immune to stigma, being able to counteract it and being open about the mental illness. Developing stigma resistance is a life-long process and the use of various strategies is essential. The processes of development of stigma resistance described by our interview partners do refer to both common generic topics regarding the development of a mature personality (e.g. self-esteem, self-efficacy, confidence, social competence, resilience) and specific topics such as dealing with the illness and the stigma associated to it. Positive and encouraging relationships, the possibility to work, enough money, high quality integrated person directed care and specific anti-stigma therapies are suggested to further stigma resistance on the individual level. On the societal level stigma resistance can be fostered through building resilience in kindergarten and school and educating people about mental illness. Information provided by people with experience in mental illness is regarded as especially important to counteract prejudices and negative attitudes among family, friends and special groups such as the police or scholars. Conclusions: Interventions to increase stigma resistance should consider the multifocal general and specific aspects. Societal support of self-help groups and movement may be a crucial step to promote stigma resistance.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	Keeping people with mental illness out of jail and prison.			
Speaker	R. Warner 1,2 1 Colorado Recovery, Boulder, Colorado USA 2 University of Colorado, Denver, USA			
Abstract	Educational Objectives: Participants will be able to describe two different programs which are effective in diverting offenders with mental illness and/or substance abuse problems from jail and prison incarceration into community-based treatment. Purpose: The programs, developed in the same county in Colorado, are run collaboratively by criminal justice system and the county mental health and substance abuse treatment services in an attempt to reduce the number of inmates of the county jail who suffer from mental illness or a substance abuse disorder. Methods: Involved in the selection of program candidates and the delivery of services are the sheriff's department (which operates the jail), the probation department, the district attorney, the public defender and the courts. One program uses the techniques of assertive community treatment to prevent relapse and recidivism among clients with coexisting mental disorder and substance use problems. The other program, the integrated treatment court, works with felons who are failing to comply with the requirements of probation because of substance abuse. In the latter program the judge employs the strategies of positive reinforcement and motivational interviewing. This program, like 3,000 similar courts across the US, is oriented towards rewarding and applauding progress rather than simply punishing failure. Results: These two programs use very different approaches to successfully divert two different populations of offenders with mental health or substance abuse problems from repeated or long-term incarceration and, as a result, they reduce the overall costs to government by considerable amounts. Conclusions: Both diversion models are effective with different offender populations, are complimentary and, overall, save considerable funding resources			
References				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	IMPLEMENTING FAMILY WORK IN SEVERE MENTAL ILLNESS: PEARLS, MYSTERIES AND PITFALLS		
Chairperson	Manuel Gonçalves-Pereira (Faculdade de Ciências Médicas, Universidade Nova de Lisboa)		
Co-chairperson	Julian Leff (Emeritus Professor of the Institute of Psychiatry, King's College London)		
Abstract	Family work, including so-called psychoeducational interventions, is highly effective in severe mental illness. Despite the evidence on benefits for patients and families, a large implementation gap remains. We aim to discuss the difficulties in implementing family approaches, particularly in schizophrenia. We will present suggestions on how to overcome barriers at the management and staff training level, and regarding practical family engagement. First, a review of the evidence on the effectiveness of family work will be presented. High-quality trials have been conducted within different theoretical frameworks but sharing common principles (improving knowledge on the disease and competence to deal with it, and building partnerships with families) Lack of implementation will be discussed and practical suggestions made (e.g. systemic changes at service level, active involvement of managers). Second, an example of a tentative implementation at national level will be described. In Portugal, following the guidelines of the National Mental Health Plan, a family psychoeducation staff training program was launched. The trainees' acquisition of competences was satisfactory. However, several difficulties emerged, including work overload and little time allowed for family approaches. Thirdly, a technical issue will be explored. Regardless of the focus of family work (e.g. lowering expressed emotion, problem-solving), there is a dearth of knowledge on the active ingredients of the process. The intervention by Kuipers, Leff & Lam (1992) will be broadly described, along with preliminary results of a qualitative study on its key-components. Finally, recent Portuguese data on family intervention studies (groups for relatives, behavioural family therapy) will be discussed in the light of international literature. Determinants of acceptance and adherence to family work will be specifically addressed. These topics may be of high importance for the congress participants. Family work remains a core component of global investment in mental health, although implementation issues are still somehow neglected.		
References	□ Gonçalves-Pereira M, Xavier M, van Wijngaarden B, Papoila AL, Schene AH, Caldas de Almeida JM (2012). Impact of psychosis on Portuguese caregivers: A cross-cultural exploration of burden, distress, positive aspects and clinical-functional correlates. <i>Social Psychiatry and Psychiatric Epidemiology</i> [epub ahead of print]. doi: 10.1007/s00127-012-0516-7 □ Leff, J. (2000). Family work for schizophrenia: Practical application. <i>Acta Psychiatrica Scandinavica</i>. Supplementum, (407, 78-82. □ Magliano, L., Fiorillo, A., Fadden, G., Gair, F., Economou, M., Kallert, T., et al. (2005). Effectiveness of a psychoeducational intervention for families of patients with schizophrenia: Preliminary results of a study funded by the European commission. <i>World Psychiatry: Official Journal of the WPA</i>, 4(1), 45-49.		
Speakers	1. Julian Leff (Institute of Psychiatry, King's College London; London, United Kingdom) 2. Miguel Xavier (Faculdade de Ciências Médicas, Universidade Nova de Lisboa; Lisboa, Portugal) 3. Jaime Grácio (Clínica Psiquiátrica de S. José, Irmãs Hospitaleiras; Lisboa, Portugal) 4. Manuel Gonçalves-Pereira (Faculdade de Ciências Médicas, Universidade Nova de Lisboa; Lisboa, Portugal)		

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Session:	Symposium	SPEAKER 1	Code	
Title:	Family work in schizophrenia: revisiting the issues on practical application			
Speaker	Julian Leff. Emeritus Professor of the Institute of Psychiatry, King's College London, United Kingdom			
Abstract	Family work for schizophrenia developed in the 1980s simultaneously in the UK and US. The early studies indicated that this was an effective intervention in reducing the relapse rate of schizophrenia. A number of international replications followed, creating a convincing body of evidence which will be reviewed. Despite this there were considerable barriers to implementing family work in routine clinical practice. The reasons for this and ways of overcoming the barriers will be discussed. The extension of family work to other psychiatric conditions will be presented and the possibility of adapting this approach to physical diseases will be explored.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Barriers to the implementation: lessons from a staff training program in Portugal			
Speaker	Miguel Xavier (Faculdade de Ciências Médicas, Universidade Nova de Lisboa; Lisboa, Portugal)			
Abstract	Introduction: Notwithstanding of mounting confirmation of their effectiveness, psychoeducational family interventions for schizophrenia and other non-organic psychotic disorders are still not consistently applied in clinical routine. In Portugal, the scarcity of original studies in family interventions is bewildering. After the launching of the Portuguese National Mental Health Plan, a psychoeducational training program has been prepared by the Ministry of Health. Objectives: a) to implement a psychoeducational training program on a national basis and b) to identify barriers to implementation in routine work. Methods: Professionals from public mental health services across the Country attended a 3 days full-time program in which they were trained in the psychoeducational intervention through presentation of guidelines, demonstrative audios and role-playing. Results: The trainees' acquisition of competences was found rather satisfactory. The most frequent obstacles in the enactment of the intervention included work overburden, the difficulty to integrate family work with other duties, and the poor allowance of time from the service to run the intervention. Conclusions: Arrangements need to be conceived in order to deal with obstacles limiting the accomplishment of family interventions in clinical practice. These should include changes in the services governance, like liveness of timetable and career incentives for professionals involved in the implementation process			
References	WHO Mental Health Improvements for Nations Development - -- Report from Portugal. Mateus P & Xavier M. WHO, 2009. Available at: http://www.acs.min-saude.pt/cnsm/2010/03/17/countrysummary/			

Session:	Symposium	SPEAKER 3	Code	
Title:	Searching for the active ingredients of effective family work in schizophrenia			
Speaker	Jaime Grácio (Clínica Psiquiátrica de S. José, Irmãs Hospitaleiras; Lisboa, Portugal)			
Abstract	Despite their proven efficacy, little is known about the process of family interventions in schizophrenia (FIS). So far we have detailed descriptions of the elements, structure and some process issues of the most important models. However, this information is still not enough for one to grasp the active ingredients that actually make FIS work. In this presentation, we will describe a systematic literature review regarding the process of FIS. Major findings of this work will be discussed, namely the need to conduct comprehensive qualitative research in the field, and the further development of a new generation of studies controlling process related variables. In this regard, a qualitative analysis of the five-year (1977-82) clinical trial of Julian Leff and his collaborators will be outlined.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Family work: focusing on engagement and adherence			
Speaker	Manuel Gonçalves-Pereira (Faculdade de Ciências Médicas, Universidade Nova de Lisboa; Lisboa, Portugal)			
Abstract	Family work is highly effective in severe mental illness. Despite the evidence on benefits for patients and families, an implementation gap remains. We revisit Portuguese data on family intervention trials, aiming to discuss the difficulties around initial engagement and adherence to family work. The FAPS study (a quasi-experimental study of families of people with psychosis) included a family intervention in the format of groups for relatives. At baseline, carers who accepted to participate tended to report more consequences of caregiving, albeit only in specific domains. In the 'Psychoeducational' study (a European trial which involved the training of staff in the implementation of behavioural family therapy) family engagement was indirectly analysed in therapists' reports, through qualitative analyses. There are multiple determinants of acceptability and engagement, the same applying to what retains the family in the intervention. Carers' variables are involved, but acknowledging their needs by means of empathetic approaches is also an issue. This is a matter of ongoing debate for researchers and therapists involved			
References	☐ Gonçalves-Pereira M et al. Impact of psychosis on Portuguese caregivers: A cross-cultural exploration of burden, distress, positive aspects and clinical-functional correlates. Soc Psychiatry Psychiatr Epidemiol, 2013; 48: 325-335. ☐ Gonçalves-Pereira M, Papoila A, Xavier M. The FAPS study on severe mental illness: views on the implementation of psychoeducational family work in Portuguese settings. Eur Psychiatry, 2009; 24(1): S232. ☐ Magliano L et al. Effectiveness of a psychoeducational intervention for families of patients with schizophrenia: Preliminary results of a study funded by the European commission. World Psychiatry, 2005; 4(1): 45-49.			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	FAST PROGRAMME: DEVELOPING ACCESS TO MENTAL HEALTH CARE IN LOW AND MIDDLE INCOME COUNTRIES			
Chairperson	Prof. Driss Moussaoui, Ibn Rochd University Hospital, Casablanca, Morocco Prof. Thomas Craig, King's College, London, United Kingdom			
Co-chairperson				
Abstract	In most countries, mental health services are inadequate. It is estimated that in Low and Middle Income Countries (LAMIC) 80% of people with mental disorders do not receive treatment¹. This has severe consequences for the patients and their families, including suffering, exclusion, precariousness... The World Association for Social Psychiatry (WASP) and the Access to Medicines department of Sanofi have joined forces to develop better access to mental health care in LAMIC, and in 2009 they launched the Fight Against Stigma (FAST) programme. The FAST programme is implemented through local partnerships, which involve local key stakeholders, including the Ministry of Health, NGOs, and other associations depending on the local situation. The programmes are articulated around a comprehensive set of initiatives including: ☐ Awareness / education programmes for communities, to address the stigma faced by people with mental disorders ☐ Supporting patients and families' associations ☐ Psycho-education of patients and their families ☐ Training of primary Healthcare professionals (GPs, nurses...) ☐ Supply of adapted and affordable The programme has demonstrated its efficacy in two pilot regions where it has been implemented, in Morocco and in Mauritania. In Nouadhibou (Mauritania), at baseline (May 2009), only 7% of people with schizophrenia were treated. As a result of the programme implemented, it is now estimated that over 50% of people with schizophrenia have access to care. Similar programmes are now rolled-out in several countries in Africa and in Latin America (Guatemala in particular). During this symposium, the WASP and the Access to Medicines Department of Sanofi will present their shared vision of the FAST programme, while a representative from the MoH of Mauritania will discuss the impact of the Nouadhibou pilot, and a Psychiatrist from Guatemala will present his perspective as he is involved in the local implementation in his country.			
References				
Speakers	1. Prof. Driss Moussaoui, Ibn Rochd University Hospital, Casablanca, Morocco - Why WASP is committed to FAST 2. Dr Robert Sebbag, Access to Medicines, Sanofi, Paris, France - Sanofi: its role in the FAST Programme 3. Mr Sidi Aly Ould Sidi Boubacar & Mr Youssef Ould Limane, Ministry of Health, Nouakchott, Mauritania - What has FAST brought to Mental Health in Mauritania? Views from the MoH. 4. Dr Alejandro Paiz, Ministry of Public Health and Social Welfare, Sololá, Guatemala - Improving access to mental health care in Guatemala: main challenges.			
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Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	PEER SUPPORT IN MENTAL HEALTH CARE			
Chairperson	Richard Warner, Colorado Recovery, Inc. and University of Colorado, Boulder, USA			
Co-chairperson	Michaela Amering, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria			
Abstract	Recovery orientation is guiding mental health policy in the English speaking world with growing interest internationally. Peer support is an essential ingredient of recovery oriented mental health care. Experiential and scientific evidence for its feasibility and specific effects is growing. This symposium will present examples of projects that support and evaluate peer work in mental health and provide insight into current developments and discussions of the concept and its practice. Jörg Utschakowski from Bremen/Germany will introduce the multi-national European Leonardo da Vinci project of Experience Involvement (www.ex-in.info) and its training programmes for people with experience of using mental health services to work as trainers and peer supports and will report on the resulting developments in different European countries. Candelaria Mahlke from the University of Hamburg will present on a randomized controlled trial of peer to peer – support in severe mental disorders in Germany. Richard Warner from Boulder/Colorado/USA will highlight the importance of service-user communities with successful examples from different parts of the world and the US that build on the value of the mutual support available in a community of people with psychiatric disabilities. From Portugal, the Advisory Committee for User and Carer Participation (Maria Neves) will present the working group composed of users, informal and formal carer representatives created in 2010 within the National Mental Health Program with the aim to provide support and advice in the field of user, carer and community participation, self-help networks and advocacy in the current Portuguese mental health reform (Marta Ferraz).			
References	1. Jörg Utschakowski, FOKUS - Initiative zur sozialen Rehabilitation, Bremen, Germany, 2. Candelaria I. Mahlke, Department of Psychiatry and Psychotherapy, University of Hamburg, disorder – a randomized controlled Trial 3. Richard Warner, Colorado Recovery, Boulder, Colorado, and University of Colorado, USA, 4. Marta Ferraz, Programa Nacional para a Saúde Mental, Direção-Geral da Saúde, Lisboa,			
Speakers				
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Session:	Symposium	SPEAKER 1	Code	
Title:	Peer to peer - Support in severe mental disorders: experience involvement (EX-IN)			
Speaker	Jörg Utschakowski, social worker, Initiative for social rehabilitation, Bremen/Germany Coordinator EX-IN Europe			
Abstract	Educational Objectives: The participants will learn about the concept and the value of We- Knowledge arising from the individual and collective experiences of mental distress. Purpose: The purpose of the so called EX-IN training is, to qualify people who have experienced severe mental disorders on base of their experiences as peer-experts who work in all fields of mental health Methods: The main method of the project is the use of we-knowledge of people who have experienced			

	severe mental disorders as a new source in mental health in the fields of support, treatment, rehabilitation, research and training. As support workers the peer-experts have a strong impact in their function as role model, bilingual interpreter, recovery guide, peer, trusted person... Results: The concept of training experts by experienced has been developed in the frame of an European project and is still spreading further in Europe. The strength of concept lies in the production and application of we-knowledge Conclusions: ☐ The training and employment of experts by experience in the field of mental health supports more effective, more recovery orientated and more satisfying mental health services. It also gives people who are usually excluded from the labour market due to their experience with severe mental disorders the chance to earn money with a job which values their experiences. This supports also the recovery process of the peer workers. ☐ The EX-IN project has been a success story. It improves the support of clients of mental health services, it develops new concepts of understanding mental distress and it supports the recovery process of the peer workers themselves. The EX-IN training is implemented in a growing number of countries in Europe on different educational levels (as vocational training or as university course) ☐ The knowledge of people experienced in severe mental disorders has been ignored or underestimated in the history of psychiatry. The project has shown how strong the the values of experiences are if the are structured on an individual and collective level. The we-knowledge is an important source to improve mental health practice, research and theory. ☐ The results of the project and the collateral research leads to the need of more and wider research about the impact of peer work, but it leads also to the need of defining the role of experts by experience properly and to the question of an appropriate salary.
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Peer to peer - Support in severe mental illness: affective disorders, schizophrenic spectrum disorders and personality disorder – A randomized controlled trial			
Speaker	Candelaria I. Mahlke, Department of Psychiatry and Psychotherapy, University of Hamburg, disorder – a randomized controlled Trial			
Abstract	Introduction Severe mental illness like affective disorders, schizophrenic spectrum disorders and personality disorders generate the highest cost in mental health system. The phenomenon of cyclic hospital re-admission is well known and along with heavy losses in quality of life and high suicidal rates in these diagnoses a refinement of intervention is still required. In mental health Services (MHS) there is an international trend toward recovery-orientated interventions, like Peer-support^{1,2}. For Germany this is the first try to implement peer-support area wide in a metropolis expecting to increase self-efficacy, global functioning and health status. Former studies revealed that mental health customers had higher adherence in medical use and service engagement by receiving additional Peer-Support¹. This project forms a part of “psychnet – Hamburger Netz psychische Gesundheit“, supported by the Federal Ministry of Education and Research during 2011 - 2014. Educational Objectives: Like former mentioned there is a trend toward recovery-orientated interventions, like Peer-support^{1,2}. In this project people with own experiences of mental disorders support after a one-year-qualification at “Experienced Involvement” others with affective disorders, psychoses and personality disorders additional to their “treatment as usual”, supplying individual self-help on eye-level leaning on reciprocity. At the conclusion of this presentation we want to give an understanding of the broad potential of peer counselling for patients with severe mental illness and share experiences of implementing peers in psychiatry. The particular approach of peer-support will be revealed during the symposia. Purpose: The purpose of the Peer to Peer-Project is to prove the effectiveness of Peer-counselling for patients with severe mental illness, with the further aim to implement it as a regular part of mental health system in Germany. Methods: Presented are results of a randomized controlled trial: • Multi-centre: involving 8 psychiatry's • Sample: N=200, in- and out-patients with affective disorders, schizophrenic spectrum disorders and personality disorders • Intervention: up to 6 months of peer-counselling; Control: Treatment as usual			

	• Intention to treat analysis • 3 observation points: pre-, post-intervention, six-month follow up • Questionnaires and rating scales for: Quality of life, self efficacy, illness management, social functioning, severity of illness and days of hospitalization Results: Until now the study isn't concluded, but first extrapolations support most of the expected findings - the results will be presented. Also a high level of acceptance and service satisfaction is observed. Conclusion: Preliminary findings support that the project achieved its objectives. Controversial results will be discussed
References	1 Doughty C, Tse S. Can Consumer-Led Mental Health Services be Equally Effective? An Integrative Review of CLMH Services in High-Income Countries. <i>Community Ment Health J.</i> 2011; 47:252–266.; 2 Davidson L, Chinman M, Sells D, Rowe M. Peer support among adults with serious mental illness: a report from the field. <i>Schizophr Bull.</i> 2006; 32:443-450.

Session:	Symposium	SPEAKER 3	Code	
Title:	The importance of service user communities. Is mainstreaming always the answer?			
Speaker	Richard Warner, Colorado Recovery, Boulder, Colorado, and University of Colorado, USA			
Abstract	Educational Objectives: Participants will be able to name and describe programs which illustrate the benefits of service-user mutual support. Purpose: Drawing an analogy with immigrant and ethnic minority communities, the presenter will argue that there is a value in the mutual support found in identity communities of people who have experienced mental illness and that mainstreaming is not always the best solution for these clients. Methods: Ethnic minorities have multiple successful pathways towards community. They can choose to live, work and socialize in the dominant community, they can remain in their sub-communities, or they can move back and forth, choosing some activities in each. The presenter will suggest that people with psychiatric disabilities should be allowed these same choices and that we should not assume that integration into the broader community must always be the ultimate goal. Results: The presentation will cite successful models such as social firms and the psychosocial clubhouse model that build on the value of the mutual support available in a community of people with psychiatric disabilities. These include business incubators that help community members develop micro-businesses and a user-friendly bank to assist in capitalizing such ventures. The presenter will describe an economic development approach which points the way to enterprises that can advance the economic circumstances of the service-user community and offer members of the group work opportunities and leadership roles. Conclusions: Service-users should be given the opportunity to appreciate the mutual support which comes from those with whom they share experiences, concerns, needs and goals, and not feel they should abandon this resource in order to integrate themselves into the broader community.			
References	Mandiberg, J.M. Warner, R. (in press) Is Mainstreaming Always the Answer? The Social and Economic Development of Service User Communities, <i>The Psychiatrist</i> .			

Session:	Symposium	SPEAKER 4	Code	
Title:	Effective collaboration between mental health stakeholders in Portugal			
Speaker	Marta Ferraz, Programa Nacional para a Saúde Mental, Direção-Geral da Saúde, Lisboa,			
Abstract	Educational Objectives: At the end of this presentation participants should be able to identify what the Advisory Commission for User and Carer Participation (CCPUC) is and its role in the current mental health reform in Portugal. Participants ought to be able to recognize guiding principles and work methodologies that allow for an effective collaboration between mental health stakeholders. Purpose: This presentation aims to share with participants the experience of the CCPUC as an example of			

	the much desired and effectively possible collaboration between users, family members and mental health professionals at a governmental level. Since 1998, the Portuguese government, through the Ministry of Health, seeks to promote the participation of professionals, family members and users of mental health services in advisory bodies. This right is enshrined in the Mental Health Act and subsequent Decree-Law n. ° 35/1999 which regulates it. The need to ensure the citizens' participation in the effective operation and management of these services, more specifically, that of family and user associations is again asserted in the amendment and republication of 2009. Community participation is part of the values and principles advocated by the National Mental Health Plan 2007-2016 (approved by the Ministers Council in March 2008) which states that "people with mental illness should be involved and participate in the planning and development of the services they benefit from. Family members of people with mental illness should be considered key partners, encouraged to participate in the provision of mental health care and receive the necessary training and education to do so." In this context, in October 2010, the Advisory Committee for User and Carer Participation was created within the National Coordination for Mental Health (currently the National Program for Mental Health/Directorate-General of Health). The ultimate goal of this committee is to identify and disseminate a model for the involvement of users and caregivers in mental health services nationally, and to inform and evaluate its implementation. Composed by users, formal and informal caregivers and/or their representatives, the CCPUC operates according to a model that aims for the involvement, empowerment, recovery and empowerment of stakeholders, increased awareness by civil society and promotion of advocacy. Conclusions: As far as we are concerned CCPUC has successfully achieved its objectives through the promotion of and participation in various capacity building initiatives (workshops, conferences, publications, etc.) that have allowed, not only for stakeholders to come together and share their opinions and concerns in a positive and collaborative manner, but also to gain more significant power and influence over the current mental health reform in Portugal.
References	

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	CHALLENGES TO PRACTISING SOCIAL PSYCHIATRY IN SOUTH AFRICA		
Chairperson	Prof Jonathan Burns Department of Psychiatry, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban, South Africa		
Co-chairperson			
Abstract	One of the Grand Challenges in Mental Health is to promote the development and implementation of progressive mental health legislation and policy in low- and middle-income countries. Ten years ago, a new Mental Health Care Act (MHCA) (2002) was passed in South Africa, prioritising decentralisation of mental health care, integration of mental health into primary care, improved access to care, and human rights for users. In this symposium four clinician/researchers with extensive experience in mental health policy and health services development, and representing various regions and contexts in South Africa, will present their work guided by this legislative framework. Dr Grobler will provide an overview of the process of implementation of the MHCA (2002), highlighting challenges encountered over the last decade in attempting to translate policy into practice. Prof Janse Van Rensburg will review 7 years of experience and data from his direct involvement in establishing and running an acute district level mental health service in an urban context. Dr Sukeri will present data on the development of a mental health programme within the low-resourced, mainly rural Eastern Cape Province. Dr Nassen will present a programme based in urban townships around Cape Town that integrates public health, NGO and community-based groups focused on improving access to care for children and adolescents affected by HIV, sexual violence, substance abuse and mental health disorders. This symposium aims to provide a broad case study of efforts to implement good mental health legislation within a middle-income country where multiple political, social and economic factors create barriers to successful implementation. The central focus will be a discussion of innovative methods of overcoming these seemingly insoluble barriers that may be useful models for similar global contexts		
References			
Speakers	1. Dr Gerhard Grobler, President of the South African Society of Psychiatrists, Johannesburg, South Africa; email: gpgrobler@sasop.co.za; "The implementation of the South African Mental Health Care Act (2002)" 2. Prof Bernard Janse Van Rensburg, Department of Psychiatry, University of Witwatersrand, Johannesburg, South Africa; email: bernardj@gpg.gov.za; "Social psychiatric practice in an urban South African acute public care setting." 3. Dr Kiran Sukeri, Department of Psychiatry, Walter Sisulu University, East London, South Africa; email: ksukeri@telkomsa.net; "Developing a mental health programme for a low middle-income region of South Africa." 4. Dr Rene Nassen, Department of Psychiatry, Stellenbosch University, Tygerberg, South Africa; email: rnassen@sun.ac.za; "An integrated programme for child and adolescent mental health in peri-urban Cape Town townships."		
Contact:	Professor Jonathan K Burns Department of Psychiatry Nelson R Mandela School of Medicine University of KwaZulu-Natal Durban 4000 South Africa Tel: +27 31 2604321 Fax: +27 31 2604322 Email: burns@ukzn.ac.za		

Session:	Symposium	SPEAKER 1	Code	
Title:	An overview of the process of the implementation of the south african mental health care act (Act No 17 of 2002)			
Speaker	Dr Gerhard Grobler, President of the South African Society of Psychiatrists, Johannesburg, South Africa; email: gpgrobler@sasop.co.za; “The implementation of the South African Mental Health Care Act (2002)”			
Abstract	Educational Objectives: This presentation will examine the implementation of the South African Mental Health Care Act in the context of a post-liberation, democratic South Africa. It will engage in a critical discussion of the progress made by the Act as well as barriers to and limitation of implementation. Purpose: The Mental Health Care Act replaced the Mental Health Act (Act No 18 of 1973) and improved it in several significant ways. The Mental Health Care Act aims to protect the person and dignity of mental health care users. Methods: The paper will examine and contrast the Mental Health Act and Mental Health Care Act with particular reference to the democratic Constitution of the Republic of South Africa. Empirical research on the implementation of the Mental Health Care Act will reviewed. Conclusions will be drawn from both the conceptual – philosophical analysis as well as empirical findings. Results: The Mental Health Care Act espoused the values of the Constitution but also infringes on basic human rights of mental health care users. It differs significantly in approach and design from the previous Mental Health Act. The implementation of the Mental Health Care Act is hampered by infrastructural and resource related problems. Conclusions: ☐ The Mental Health Care Act aligns closely with the Constitution of the Republic of South Africa and take the founding principles as well as the Bill of Rights into consideration ☐ The Mental Health Care Act varies markedly from the previous Mental Health Act. It moves from a community-centred custodial philosophy to an individually focused, community-based approach ☐ Despite its regards for basic human rights of mental health care users, the Mental Health Care Act does infringe on certain human rights. This infringement is balanced by oversight and appeal mechanisms ☐ There are several factors limiting the implementation of the Mental Health Care Act			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Social psychiatric practice in an urban south african acute public care setting			
Speaker	Prof Bernard Janse Van Rensburg, Department of Psychiatry, University of Witwatersrand, Johannesburg, South Africa; email: bernardj@gpg.gov.za; “Social psychiatric practice in an urban South African acute public care setting.”			
Abstract	Educational Objectives: During the past 10 years several clinical reviews of public sector psychiatric services at Helen Joseph Hospital (HJH) in Johannesburg, South Africa have been undertaken, including: (1) HIV-positive users; (2) inpatient services for schizophrenia; (3) morbidity, treatment outcome, cost and appropriate unit design for acute in-patient care; and (4) a 5-year comparative outcomes review of inpatient and outpatient services. Purpose: To present the most important trends of these reviews in terms of clinical profile, treatment outcome, cost and inpatient unit design at this regional general hospital, in the context of its role in the local urban referral system. Methods: These reviews were mainly retrospective, quantitative clinical reviews. The clinical records of users admitted to HJH for acute inpatient psychiatric care and who attended the outpatient clinic for follow-up were reviewed. Descriptive and comparative quantitative analyses were made.			

	Results: At the time, only 17.4% of the total number of service users' were tested for HIV status, either prior to, or during admission. In terms of inpatient care for schizophrenic users, four factors (age, gender, substance abuse and follow-up referral) had a significant association with longer and more costly admissions to this unit. At the time, the total cost of acute inpatient psychiatric care at this facility amounted to only 2.4% of the total hospital expenditure. Considering safety, as well as upholding patients' human rights, design solutions for this acute inpatients unit were developed and the projected capital cost was calculated. The subsequent review of services from 2008 to 2012 included a comparative review of all in and out-patient services, in the context of adherence to treatment, of the prevention of re-admissions and of psychosocial-rehabilitation in the region. Conclusions: ▪ These studies highlighted the importance of delineating catchment areas for regional referral specialist hospitals, and identified the significance for community programs to address adequate accommodation and co-morbid substance abuse of users with schizophrenia ▪ Managers were assisted to make evidence-based decisions regarding resource allocation, using an approach whereby clinicians were involved in a bottom-up approach to cost the activities of their department ▪ Appropriate structural adjustments to acute mental health care units should be implemented in order for facilities not to be in violation of the regulations of the mental health legislation on patients' basic human rights and safety ▪ The necessary resources, capacity and infrastructure must be provided to ensure the effective follow-up of patients through the referral system, by local mental health review boards.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Developing a mental health plan for the Eastern Cape Province, a low middle income region of South Africa			
Speaker	Dr Kiran Sukeri, Department of Psychiatry, Walter Sisulu University, East London, South Africa; email: ksukeri@telkomsa.net; "Developing a mental health programme for a low middle-income region of South Africa			
Abstract	The Eastern Cape Province is located on the south east coast of the Republic of South Africa. It has a population of 6.5 million. 72% of the population live below the poverty line. The unemployment rate is 28%. More than half of the population is dependent on social grants. The Eastern Cape is a resource limited province with a fragmented mental health service. The objectives of the study were to determine the status of public sector mental health service delivery and to develop an informed model of public mental health. METHODOLOGY The study design is a descriptive cross sectional study. The research tool was an audit questionnaire based on the Norms Manual for Severe Psychiatric Conditions and the World Health Organisations' Assessment Instrument for Mental Health Systems (WHO)AIMS). Data analysis followed WHO requirements and the Norms Manual for Severe Psychiatric Conditions. RESULTS The Eastern Cape Province does not have a provincial policy or plan for mental health. The Department of Health was unable to provide information on its budgeting for mental health, data on service utilisation, training of nurses at primary health care level and inter-sectoral collaboration. There is an inequitable distribution of resources between the eastern and western regions of the province. The poorer eastern region has limited access to mental health facilities, human resources and non-governmental organisations. CONCLUSIONS The Eastern Cape Department of Health faces a challenge in the development of a comprehensive mental health plan in the context of its limited human resources, public sector mental health facilities and absence of a mental health information system. A model of mental health service delivery has to be developed to address the distinct differences between the eastern and western regions.			

	A comprehensive mental health policy and plan is possible with the development of novel techniques that are evidence based.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	An integrated approach to the provision of services to hiv positive children and adolescents			
Speaker	Dr Rene Nassen, Department of Psychiatry, Stellenbosch University, Tygerberg, South Africa; email: rnassen@sun.ac.za;			
Abstract	Educational Objectives: This presentation will describe the establishment of group based interventions at a primary clinic servicing 95 HIV positive children and adolescents resident in Khayelitsha Township, a large peri-urban community on the outskirts of Cape Town. A collaboration was established between the local specialist child and adolescent mental health (CAMH) service, a primary care clinician at the HIV clinic, lay counsellors and allied professionals. This collaboration was extended to include clinicians from Medecins Sans Frontieres. Purpose: This initiative aimed to establish groups in order to improve adherence to antiretroviral treatment, particularly among adolescents, and to provide a confidential space for adolescents to engage about sensitive issues. Methods: The CAMH team and HIV clinicians met initially, after which a site visit was conducted to observe groups. Written inputs and recommendations were provided to documents describing group content, by the CAMH team. Training on group facilitation was provided by the CAMH occupational therapist and inputs provided about screening for psychiatric and neurocognitive problems. Results: Groups have been established but occur infrequently, due to limited human resources and large numbers of patients serviced at the clinic. The CAMH team is in the process of facilitating a formal link between the HIV clinic and mental health clinicians at primary level. The aim is to increase the frequency of the groups and strengthen a referral pathway to CAMH services. Following establishment of more regular caregiver and adolescent groups, mental health and cognitive screening will be established. Conclusions: ☐ Integrated models of care to HIV positive youth and their families demonstrate improved outcomes, both in terms of HIV disease but improved adherence and mental health outcomes. ☐ The proposed model is a more integrated method of assessment and intervention for a vulnerable group of patients, who are failing to access care at specialist level, but who present with a complex range of medical and psychosocial problems. ☐ Clinicians from disciplines such as medicine, child psychiatry, psychology and possibly social work, from primary, general and specialist level services will collaborate to provide both psychosocial as well as medical intervention. ☐ This model will cut across the current model of a division between specialist, district and primary healthcare services, in South Africa. It will require an interaction between facility managers as well as consent from senior management, in order to formalize an agreement between the various levels of service and the non- governmental sector (Medecins Sans Frontieres) ☐ This initiative will provide opportunities to research treatment outcomes of improved psychosocial interventions, screening and integrated models of care for children and adolescents living with HIV.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	TRIALOGUE – COMMUNICATION BETWEEN USERS, CARERS AND MENTAL HEALTH WORKERS BEYOND ROLE STEREOTYPES		
Chairperson	Michaela Amering, Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria		
Co-chairperson	Thomas Bock, Department of Psychiatry and Psychotherapy, Medical University of Hamburg, Germany		
Abstract	The active involvement of users and relatives and friends is essential for the development of recovery-oriented mental health practice and research. However, accepting each other as equally entitled experts is still a challenge. In Trialogue-groups users, carers and friends and mental health workers meet regularly in an open forum, that is located on ‘neutral terrain’ - outside any therapeutic, familial or institutional context - with the aim of discussing the experiences and consequences of mental health problems and ways forward. Trialogues offer new possibilities for gaining knowledge and insights and developing new ways of communicating beyond role stereotypes. They also function as basis and starting point for trialogic activities on different levels - e.g. serving on quality control boards or teaching in trialogic teams - and different topics - e.g. a task force on stigma busting or a work group on trauma and psychosis. In German speaking countries well over hundred Trialogue groups are regularly attended by altogether ~ 5000 people. International interest and experiences are growing fast. The concept of Trialogue was first introduced internationally at the World Congress of Social Psychiatry 1994 in Hamburg/Germany. This symposium will present an update on Trialogue starting with co-founder Thomas Bock from Hamburg/Germany giving an overview of the concept and its roots and developments. Liam McGabhann and Patrick McGowan from Dublin City University in Ireland will introduce the Mental Health Trialogue Network Ireland and present experiences and data on a large implementation project in several Irish locations. Michaela Amering from the Medical University in Vienna/Austria will highlight the work of the first trialogic WPA Task Force on Best Practice in Working with Service Users and Carers and will use data from a qualitative research project in Berlin/Germany to argue that Trialogues facilitate a discrete and independent form of acquisition and production of knowledge. Finally, Friederike Ruppelt from the University of Hamburg/Germany will present a first empirical evaluation of German-speaking Trialogue groups with a focus on search of meaning, empowerment and recovery.		
References			
Speakers	1. Thomas Bock, Department of Psychiatry and Psychotherapy, Medical University of Hamburg, Germany, 2. Liam MacGabhann, Paddy McGowan, School of Nursing and Human Sciences Dublin City University, Ireland, I 3. Michaela Amering, Department of Psychiatry and Psychotherapy, Medical University of Vienna, 4. Friederike Ruppelt, Department of Psychiatry and Psychotherapy, Medical University of Hamburg, Germany,		
Contact:	Michaela Amering Department of Psychiatry and Psychotherapy Medical University of Vienna Waehringer Guertel 18-20 1090 Vienna Austria Tel +43 699 11991030 Fax + 43 1 40400 3605 michaela.amering@meduniwien.ac.at		

Session:	Symposium	SPEAKER 1	Code	
Title:	Trialogue and psychosis seminars – concept, roots and developments			
Speaker	Thomas Bock, Department of Psychiatry and Psychotherapy, Medical University of Hamburg, Germany,			
Abstract	Educational Objectives: What is the meaning of trialogue on various levels – in psychiatric practice, education, research and public relations? What is already accomplished and what should be achieved? Is there a ‘philosophy of trialogue’? At the conclusion of this presentation participants shall be sensitized, how to promote recovery and participation in and throughout trialogue work. Purpose: Meeting as experts, mutual learning in trialogue is essential for the development of recovery-oriented mental health practice and research. The philosophy of trialogue, as an anthropological point of view, is necessary for reducing stigma and facilitating coherence. Methods: The “germ cell” of trialogue is the psychosis-seminar, an open forum on neutral terrain outside of institutional or familiar dependence, a place of mutual learning and meeting as experts. It creates a special “language area”, an “anarchistic” meeting of people, looking for new insights and new ways of communication beyond role stereotypes. – In the last years new steps of the trialogue movement can be observed including trialogue in education, research, public relations with books, newspapers, associations and campaigns. Clinical practice is evolving, e.g. open dialogue with first episode-patients. Important will be, how to counteract medical reductionism, which has proven unable to reduce fear in the community or to promote recovery. We have to look for alternative ways and peer-support of users and relatives are essential for change. Results: Trialogue is a precondition of recovery and should be a cachet of quality in psychiatry. Conclusions: ☐ No public relations work should be done without trialogue. ☐ The idea of open dialogue has to be transferred from first episode patients to overall psychiatry. ☐ Trialogue participation has to be a requirement for research – like ethical commissions. ☐ Trialogue can help to limit the normative powers of psychiatry: The anthropological point of view serves as a counterbalance to the pathological one. ☐ Peer-support of users and relatives will help to establish trialogue in daily psychiatry			
References	• Bock, Th., Priebe, St. (2005); Psychosis-seminars, an unconventional approach for how users, carers and professionals can learn from each other, psychiatric Services, Vol. 56, No. 11, 1441-1443. • Bock T, (2012); Partizipation in Klinischer und Sozial-Psychiatrie – Impulse aus dem Trialog, in: Rosenbrock R, Hartung S, Handbuch Partizipation im Gesundheitswesen, Vincentz-Verlag Berlin.			

Session:	Symposium	SPEAKER 2	Code	
Title:	Mental Health Trialogue Network Ireland (MHTNI) – Transforming Dialogue in Mental Health Communities			
Speaker	Liam MacGabhann, Paddy McGowan, School of Nursing and Human Sciences Dublin City University, Ireland, I			
Abstract	Educational Objectives Folowing this presentation participants will: know how the MHTNI evolved and Trialogue Meetings were established as a living tradition in Irish communities; recognise the benefits of Trialogue Meetings as a place of learning, emancipation and generation of collective expertise for mental health professionals, service users, families/friends and community members in relation to mental health and mental illness. Purpose of MHTNI The purpose of establishing this project was: to facilitate the establishment of community leaders in the area of mental health; to develop a community forum using the ‘Trialogue’ processes; to strengthen the voice of people with mental health problems & families/ carers regarding needs & supports in their communities; and to provide a focus for developing awareness and action around mental health within Irish communities Methods The MHTNI developed as a Participatory Action Research community development project. It evolved			

	from another project that also brought service users, family members and mental health professionals together as a leadership team with the task of initiating and completing a service improvement in their local mental health service (Mac Gabhann et al. 2010). Over several years participants had recognised the benefits of open dialogue communications through a Trialogue process in enabling significant changes within mental health services. Concurrently the authors had an ongoing research and practice interest in open dialogue processes and particularly Trialogue. Collectively there was an impetus to establish Trialogue Meetings outside of services in participating communities and the authors successfully bid for funding to establish the MHTNI. The initial timeframe for the project was eighteen months with the aim of establishing the network as a stand alone sustainable process within this period. Monthly Trialogue Meetings were established in seven participating sites with the plan to snowball from these sites over time. Local leaders were identified who were trained in open dialogue processes, had Trialogue experience and they formed the core co-ordinating team for each emerging Trialogue group. A core project team co-ordinated; training, advertisement, marketing, facilitation of initial meetings, development of guidelines and conducted the ongoing evaluation for all participating communities. This process was enabled through a national project co-ordinator and an interactive website www.trialogue.co. Quantitative and qualitative tools were utilised to evaluate the experience, knowledge generation, sustainability and extent of collective experience generated in Trialogue. Results The MHTNI has been established as a stand alone community network of Trialogue Meetings in Ireland, with almost half of initial participants continuing to participate on a monthly basis. The website continues to provide learning, information and a communication hub for people interested in Trialogue around the globe. Specific learning and engagement in the evolving process has been quantified and the qualitative results provide an inductive framework on how people change how they think about mental health/illness, engage with them, and develop new understandings and ways of relating to their community. Conclusions Objectives were achieved and the Trialogue Meetings as MHTNI established in Ireland. A wealth of knowledge and transformations occurred and the implications suggest that this process provides a forum for communities to embrace emancipatory change that goes towards enabling a genuine recovery for individuals and communities (Mac Gabhann et al. 2012).
References	Mac Gabhann, L., McGowan, P., Walsh, J. & O'Reilly, O. (2010) Leading change in public mental health services through collaboration, participative action, co-operative learning and open dialogue. The International Journal of Leadership in Public Services. Volume 6, (Supplement), September. Mac Gabhann, L., McGowan, P., Ni Cheirín, L., Spencer, A., Amering, M. (2012) Mental Health Trialogue Network Ireland: Transforming Dialogue in Mental Health Communities. Dublin City University

Session:	Symposium	SPEAKER 3	Code
Title:	this openness must continue' – changes through trialogue		
Speaker	Michaela Amering, Department of Psychiatry and Psychotherapy, Medical University of Vienna,		
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should have gained insight into how changes through Trialogue come about. Purpose: Trialogs are widely popular, but scarcely researched. Methods: Focusgroups as well as written narratives were qualitatively analysed. Results: Communication in trialogue groups is clearly different from clinical and other encounters. All three groups cherish and aspire to interest for each other, good will, openness and truthfulness. Clinical routine with role prescriptions, power balance and constant pressure to act is experienced as an impediment. Conclusions: Trialog facilitates a discrete and independent form of communication and acquisition and production of knowledge.		
References			

Session:	Symposium	SPEAKER 4	Code
Title:	Dialogue and Search of Meaning, Recovery and Empowerment. A first empirically evaluation of German-speaking psychosis seminars.		
Speaker	Friederike Ruppelt, Department of Psychiatry and Psychotherapy, Medical University of Hamburg, Germany,		
Abstract	Educational Objectives: The Hamburger SuSi-Project will be presented and especially one of the latest study in this project. At conclusion of this presentation, the participants shall be sensitized for subjective sense and meaning of psychoses and should be able to recognize that dialogue has effects on recovery, empowerment and search for meaning. Purpose: Psychosis seminars provide an innovative opportunity for consumers, family members, and mental health professionals to meet in a neutral forum and share their perspectives. They are hitherto a rare subject of scientific evaluations. This study explores positive effects of psychosis-seminars on their participants regarding changes in the understanding of the emergence, experience of symptoms and consequences of psychoses. Changes in recovery attitudes and empowerment are focussed as well. Methods: The survey uses a pre-post-design with a non-randomized control group in 16 German-speaking psychosis-seminars. Participants i.e. patients, relatives and mental health professionals, complete questionnaires at the start and the end of a psychosis-seminar cycle which include at least six seminars during a five-months-period. Besides sociodemographic data and qualitative questions the following instruments are used: (I) German Subjective Sense in Psychosis Questionnaire (SUSE), (II) Recovery Attitudes Questionnaire (RAQ 7) and (III) Making Decisions (Empowerment Scale). Outcomes are compared using t-tests. Analyses of qualitative questions follow Mayring's qualitative content analysis by building inductive categories. Data collection started in August 2011 and is continued until today. Results: Concerning the search for meaning, psychosis patients and relatives showed significantly more positive experiences of symptoms after participating at psychosis-seminars. In qualitative data categories like "experiences of sense and coherence" were derived. Regarding attitudes towards recovery, patients developed a significant more positive attitude towards recovery from severe mental illnesses. In qualitative data categories like "paths to recovery" or "recovery is possible" were found. Concerning perceived empowerment, patients were significantly more empowered after participating at dialogue. In qualitative data categories like "group affiliation" or "equality" were derived. Furthermore, qualitative data underline the improvement of psychoses comprehension. Conclusions: This study indicates a change in meaning and sense of psychoses in patients and relatives. Patients benefit concerning their attitudes towards recovery und empowerment. All three groups develop an anthropological understanding of psychoses and knowledge about how to deal with acute crises. These results support a further establishment of psychosis-seminars in the psychosocial healthcare system		
References			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	INTERNATIONAL PERSPECTIVES ON ASSERTIVE COMMUNITY TREATMENT			
Chairperson	Dr Helen Killaspy, University College London and Chair, Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists			
Co-chairperson	Professor Alan Rosen, Senior Consultant Psychiatrist, University of Newcastle, Professorial Fellow, University of Wollongong, Clinical Associate Professor, University of Sydney, Australia alanrosen@med.usyd.edu.au			
Abstract	Background - Assertive Community Treatment (ACT) is a form of intensive case management for people with serious mental health problems who are high users of inpatient care and have difficulties engaging with standard community case management. There international evidence base for ACT is strong, but in some European countries, notably the UK, studies have failed to replicate the international findings. Goals- This session will include presentations from experts in ACT from the UK, Australia and Spain who will describe the implementation of ACT in their country and give an interpretation of the international evidence for ACT from their perspective Importance – ACT is an international model of care that has been widely implemented but has inconsistent findings for its efficacy in different countries Interest to the congress participants – this session is likely to be of interest to most conference participants			
References				
Speakers	1.Dr Helen Killaspy, Reader and Honorary Consultant in Rehabilitation Psychiatry, University College London, Chair, Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists h.killaspy@ucl.ac.uk – 2.Associate Professor Carol Harvey, University of Melbourne, c.harvey@unimelb.edu.au - 3.Dr Juan Jose Martinez-Jambrina, Consultant Psychiatrist, Aviles, Spain jjmjambrina@gmail.com			
Contact:	Dr Helen Killaspy, Reader and Honorary Consultant in Rehabilitation Psychiatry, Mental Health Sciences Unit, University College London, 67-73 Riding House Street, London, W1W 7EJ, UK. Tel 0044 207 679 9710, email: h.killaspy@ucl.ac.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	Assertive Community Treatment - the UK perspective			
Speaker	Dr Helen Killaspy, Reader in Rehabilitation Psychiatry, University College London			
Abstract	Objective - Assertive Community Treatment (ACT) is an internationally recognised, well defined form of intensive case management for people with serious mental health problems who are high users of inpatient care and have difficulties engaging with standard community case management. The international evidence base for ACT is strong, but in some European countries, notably the UK, studies have failed to replicate the international findings. This presentation will provide an overview of the history of implementation of ACT in the UK and the evidence for its effectiveness. Methods – review of trials evaluating intensive case management and ACT in the UK. Results –trials of intensive case management and ACT carried out in the UK have not found it to be as clinically or cost-effective as those carried out in the US and Australia in terms of reducing the need for inpatient admission and improving other clinical outcomes. However, many ACT teams in the UK failed to deliver components of the model that were later found to be “critical ingredients”. In addition, unlike comparison services in some of the early US studies, the comparison services in the UK trials were provided by community mental health teams that already delivered some of these “critical ingredients”. Furthermore, the admission threshold in the cities where the UK trials were carried out was probably			

	considerably higher than in some of the US trials. For these reasons, interpretation and comparison of results from ACT studies internationally is complex. Conclusions – given the economic climate in the UK, the evidence has been interpreted to justify devolution of ACT teams. Some have closed, others have had their staff absorbed into community mental health teams, and others are attempting to deliver a more diluted version of the ACT model. The result is that many service users have no access to the components of ACT associated with better clinical outcomes. Researchers need to communicate to policy makers and service planners a more refined understanding of the evidence relating to ACT, taking into account the service context within which it is delivered. Further research on hybrid models of ACT that respond to different socioeconomic contexts is required.
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Assertive Community Treatment - the Australian perspective			
Speaker	Dr Carol Harvey, Associate Professor in Psychiatry, Psychosocial Research Centre, Department of Psychiatry, University of Melbourne, Melbourne			
Abstract	Objectives: Assertive Community Treatment (ACT) is an internationally recognised, well defined form of intensive case management for people with severe mental health problems who are high users of inpatient care and have difficulties engaging with standard community case management. The international evidence for the efficacy of ACT is strong. Early US trials of ACT were successfully replicated in Australia with good clinical outcomes. This presentation will provide an overview of the history of implementation of ACT in Australia, the evidence for its effectiveness and the current status of this model of service delivery in Australia. Methods: Review of trials evaluating ACT and intensive case management in Australia. Results: Fewer studies of ACT and intensive case management have been carried out in Australia than in the USA and Europe. However, the early Australian trial and subsequent evaluations of ACT reported a number of positive outcomes including reduced hospital admissions and length of stay as well as improved functioning. Less positive findings from recent ACT studies conducted in the UK have highlighted the complexities in interpreting the evolving international evidence. A comparison of ACT implementation between Melbourne, Australia and London, UK underscored this, suggesting that the London ACT teams failed to deliver “critical ingredients” of the ACT model. Recent trials of ACT within the Asia Pacific region have been conducted outside Australia. Conclusions: There was early implementation of ACT in many Australian states and territories from the mid-1980s which was supported by evidence-informed policy. Although Australia has been relatively unaffected by the global financial crisis, funding for mental health services has not kept pace with demand. ACT teams continue to be established and maintained in some states and territories. However elsewhere, in an attempt to respond to growing service demands and a perceived failure of standard community case management, well-established teams have been “integrated” with community mental health teams. Within these integrated teams, critical ACT ingredients have been replicated to varying extents resulting in “diluted” versions of the ACT model which have not been rigorously evaluated. Drawing on Australian experience, ACT is being introduced in the Asia Pacific region in standard and hybrid forms, the latter for complex economic and socio-cultural reasons. Further research on hybrid models of ACT that respond to different socioeconomic and cultural contexts is urgently required			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Assertive Community Treatment - the Spanish model			
Speaker	Dr Juan José Martínez Jambrina. Psychiatrist. Director of Mental Health Service. San Agustín Hospital, Avilés, Asturias. Spain			
Abstract	Objectives: Assertive Community Treatment (ACT) is an internationally recognised, well defined form of intensive outreach for people with the most severe mental health problems who are high users of inpatient care and have difficulties engaging with standard community care. The international evidence for the efficacy of ACT is strong. Early US trials of ACT were successfully replicated in Spain with good results. This presentation will provide an overview of the history of implementation of ACT in Spain, the evidence for its effectiveness and the current status of this model of service delivery in our country. Methods: Review of trials evaluating ACT in Spain. Results: Fewer studies of ACT and intensive case management have been carried out in Spain than in the USA and Europe. However, the early Spanish trial developed in Avilés and subsequent evaluations of ACT teams reported an important number of positive outcomes including reduced hospital admissions and length of stay as well as improved functioning. Less positive findings from recent ACT studies conducted in the UK have highlighted the complexities in interpreting the evolving international evidence. A comparison of ACT implementation between Spanish, British and Dutch models is made, suggesting that the London ACT teams failed to deliver “critical ingredients” of the ACT model and that Spanish and Dutch models have interesting points of view. Conclusions: The Avilés ACT team was the first one developed in Spain (1999). Spain has been severely affected by the global financial crisis and funding for mental health services has not kept pace with demand. Surprisingly, ACT teams continue to be established and maintained in some communities. There are 30 ACT teams working in Spain currently. Most of them have integrated critical ACT ingredients resulting in “diluted” versions of the ACT model which have not been rigorously evaluated. Further research on hybrid models of ACT that respond to different socioeconomic and cultural contexts is urgently required. The Dutch model may be a good proposal to discuss			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	MENTAL HEALTH CARE IN DEVELOPING COUNTRIES - PERSPECTIVE FROM INDIA			
Chairperson	R.K.Chadda, Professor of Psychiatry All India Institute of Medical Sciences New Delhi 110029, India			
Co-chairperson				
Abstract	Mental disorders impose a massive burden in the society. Most of the developing countries face huge burden of the mental health problems with limited resources. India has taken a number of initiatives in this direction, which will be discussed in the symposium. Prevalence estimates for mental disorders in India range between 5.82 to 7.3%, translating to a population of about 70 million. There is a gross deficiency of the manpower. Number of psychiatrists, psychologists, psychiatric social workers and psychiatric nurses is estimated at 2, 0.03, 0.03 and 0.05 per 100,000 of the population respectively. The Indian Government has taken a number of initiatives in the last 30 years. The National Mental Health Programme (NMHP) was initiated in India in 1982, aimed at ensuring availability and accessibility of minimum mental health care for all, integration of mental health into general health care and community participation. Its extension, the District Mental Health Programme (DMHP), initiated in 1996 currently covers about one fifth of the country. The Government has also recently initiated dedicated manpower development schemes, aiming at increasing the training capacity in psychiatry, clinical psychology, psychiatric social work and psychiatric nursing. Centers of excellence in mental health have also been set up in the field of mental health by upgrading and strengthening identified existing mental health hospitals/institutes. There are also initiatives taken by the Non-Government Organisations, but still much needs to be achieved. Further initiatives need to be initiated which is not only community based, but also run by community participation			
References	• Chadda RK (2012) Six decades of community psychiatry in India. International Psychiatry, 9, 45-47 • Murthy RS (2011) Mental health initiatives in India (1947–2010). National Medical Journal of India, 24: 98-107.			
Speakers	Prof SK Khandelwal Prof Rakesh Chadda Prof Pratap Sharan Prof BS Chavan Prof JK Trivedi			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Current mental health needs			
Speaker	SK Khandelwal, Professor of Psychiatry, All India Institute of Medical Sciences, New Delhi 110029, India			
Abstract	Some important research studies, Global Burden of Diseases, World Mental Health Atlas, World Health Report 2001 and others, in last two decades have brought a few important messages regarding mental health development, including services, policies, and investments, for all developed and developing countries. The burden of diseases experienced globally on account of mental and neurological disorders has been huge, and is second only to the cardiovascular disorders. This burden is likely to increase in each successive decade, and by 2025 is likely to be around 15 percent. The consequences of this burden is going to be felt more acutely in developing countries as these are least prepared to handle it. The mental health professionals and facilities to provide mental health care is woefully inadequate in most of the developing world. Unfortunately, there are no adequate mental health programmes or policies in developing countries to prepare themselves with the impending increase burden. Severe mental illnesses cause irreparable damage to the intrinsic abilities of human mind causing severe impairment of all functions. The health budget and mental health budget in particular of most of the countries are grossly inadequate. For example, India spends only 1 percent of its GDP on health, and the share of mental			

	health is 0.06. Most of the expenses on health care is born by people, to the tune of 80 percent, out of their pockets, pushing people in to further poverty. If the governments in developing countries wish to look after the health and mental health of their citizens, they should make adequate provisions for development of mental health services, infrastructure, policies and programmes. It makes a huge sense in investing in mental health.
References	

Session:	Symposium	SPEAKER 2	Code
Title:	Existing Mental Health Resources in India		
Speaker	R.K.Chadda, Professor of Psychiatry All India Institute of Medical Sciences New Delhi 110029, India		
Abstract	Mental health resources in India are grossly inadequate in comparison to the needs. India has a vast population about 1.21 billion. As per the World Mental Health Atlas, 2011, India has about 0.301 psychiatrists, 0.047 clinical psychologists, 0.166 psychiatric nurses and 0.033 social workers per 100,000 of the population. There are about 10, 000 psychiatric beds available in general hospitals and 17, 835 beds in for mental health services, about 20,000 in psychiatric hospitals. Facilities of office based psychiatric practice are also available, largely in private sector, with roughly 2000-2500 psychiatrists providing the services. A number of non-governmental organisations (NGOs) are also providing mental health care services in form of community clinics, crisis intervention services, suicide prevention services, and rehabilitation services. However, one of the limitation is concentration of the mental health resources in and around the big cities. Some of the Indian states especially the hill states of Uttarakhand, Jammu & Kashmir, Himachal Pradesh, North Eastern India. The National Mental Health programme has been conducting short term sensitisation programmes for the primary care physicians for more than 2 decades, who also form an important resource for providing mental health care services in the primary care settings. Practitioners from the alternative systems of medicine like Ayurveda, Homeopathy, Unani system of medicine and Siddha, and indigenous and religious healers are also accessed by the patients with mental health problems. Studies have shown 60-75% of the patients with mental health problems access these sources of help at different times during the course of their illness. The facilities are, however, grossly inadequate considering the enormous population with mental health problems.		
References	• Chadda RK (2012) Six decades of community psychiatry in India. International Psychiatry, 9, 45-47 • Mishra N, Nagpal SS, Chadda RK, Sood M (2011). Help-seeking behavior of patients with mental health problems visiting a tertiary care center in North India. Indian Journal of Psychiatry; 53: 234-8 • Mental Health Atlas 2011 - Department of Mental Health and Substance Abuse, World Health Organization		

Session:	Symposium	SPEAKER 3	Code
Title:	National Mental Health Programme		
Speaker	Pratap Sharan, Professor, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi		
Abstract	The National Mental Health Programme was launched in 1982 with the objectives of: ensuring the availability and accessibility of minimum mental healthcare for all, particularly to the most vulnerable and underprivileged sections of the population, in the foreseeable future; (ii) encouraging the application of mental health knowledge in general healthcare and in social development; and (iii) promoting community participation in the development of mental health services and to stimulate efforts towards self-help in the community. The approaches advocated were: diffusion of mental health skills to general health care system; appropriate apportionment of tasks in mental healthcare; and integration of basic mental healthcare into general health services and linkage to community development and mental healthcare. Progress occurred in terms of integration of mental health care with primary healthcare through the district mental health programme (DMHP) that now covers about one fifth of districts in India. Other developments included strengthening of general psychiatry units and human resources and reorientation of mental hospitals.		

	A re-strategized NMHP was launched in 2003. The programme comprised 5 strategic components that included redesigning the DMHP around nodal institutions; strengthening medical colleges with a view to develop psychiatric manpower and general hospital psychiatry; transforming mental hospitals into becoming leaders for community mental health; strengthening central and state mental health governance; and research and training to support public mental health. During the plan period 2007-2013, there was a substantial increase in the funding support for the NMHP especially for the manpower development. Also, efforts at integrating the NMHP with the National Rural Health Mission (NRHM) were initiated. The NMHP has made some progress but has been criticized for lacking effectiveness, for having a top-down approach; for apparently being disconnected with cultural realities of India; and for inadequate involvement of the community. There is clearly a need for much progress in widening the scope and cultural specificity of mental health interventions, and increasing the involvement of all available community stakeholders
References	

Session:	Symposium	SPEAKER 4	Code
Title:	Mental Health Care from Developing Countries: Perspective from India		
Speaker	BS Chavan. Professor and Head of Psychiatry. Govt Medical College Chandigarh, India		
Abstract	Prior to formulation of National Mental Health Programme (1982), major focus of Govt of India (GOI) was setting up mental hospitals in 1950's and 1960's and little later promoting general hospital psychiatry units in 1960's and 1970's. The next big and laudable initiative was to integrate mental health into General health by enacting NMHP (1982) with the objectives of ensuring availability and accessibility of minimum mental health care for all , particularly to the most vulnerable and underprivileged sections of population and for promoting community participation in the mental health services development and to stimulate efforts towards self-help in the community. During last two decades, GOI re- strategised its initiatives and focused on reaching out larger number of patients in far flung rural areas through launch of District Mental Health Programme (DMHP). The DMHP components include early detection and treatment of patients within the community, reduction of stigma attached towards mental illness through change of attitude and public education, to treat and rehabilitate mental patients discharged from the mental hospital within the community , shifting focus and take off burden from Mental Hospitals, and training in basic mental health care of all the personnel at primary health care. Another major initiative by the GOI has been to accord high priority to manpower development in mental health through strengthening the department of psychiatry in medical colleges, setting up centres of excellence (COE) for developing manpower in psychiatry, clinical psychology, psychiatry social work and psychiatry nursing, and upgradation of mental hospitals. GOI is providing funding for building infrastructure , purchase of equipment and hiring faculty. For the first time GOI has come up with Mental Health Policy for the country which is expected to give direction to future development and implementation of comprehensive facilities in mental health. The Mental Health Act (1987) is being replaced with Mental Health Care Bill (2012) with a focus on protection of human rights of persons with mental illness, rehabilitation and commitment to provide mental health facilities to everybody through public health facilities. The GOI has also initiated efforts to design community based mental health model and MOU has been signed with Melbourne University for field testing four different mental health models. These bold initiatives by GOI are expected to bring out a perceptible change in the care of persons with mental disorders.		
References			

Session:	Symposium	SPEAKER 5	Code	
Title:	Challenges ahead and proposed strategies			
Speaker	J.K Trivedi. Professor, 2. Assistant Professor, Department of Psychiatry, King George's Medical University, Lucknow, UP, India			
Abstract	It is widely identified that the high burden of mental disorders, shortage of trained mental health professionals and need to integrate mental health care through the primary health care system are key impact areas acknowledged in mental health care delivery by all national/international programs. Several cost-effective and evidence based strategies have been shown to improve outcome and reduce the disability associated with mental disorders and substance abuse. However, delivery of mental health services in resource poor settings lags unacceptably and unjustly behind services for many other non-communicable diseases. The fraction of those affected who receive appropriate treatment remains alarmingly low. Community psychiatry, empowerment of primary health care centers, involvement of nonmedical community health workers in delivery of mental health care and enhanced training and teaching of the medical graduates are commonly voiced strategies to deal with such wide treatment gap. However, lot of the limitations have been identified and experienced during implementation at ground level. Leadership from politicians, administrators, health and mental health professionals is crucial. Educating the population about mental illness using the mass media will reduce the stigma and increase the demand for services. Users, families, interest groups, health professionals and scientists should come together with the single aim of improved service provision for future transformation. Improving primary health care system in general, restructuring medical and nursing education and simplifying psychiatric training for non-specialist are urgently needed.			
References	WHO World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. JAMA 2004; 291: 2581–90 2. Jacob K S. Repackaging mental health programs in low- and middle-income countries. Indian J Psychiatry, 2011;53:195-8 3. Patel V, Goel DS and Desai R. Scaling up services for mental and neurological disorders in low-resource settings. Int Health. 2009; 1(1): 37–44.			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	WPA CROSS-SECTIONAL SYMPOSIUM MENTAL HEALTH AND WORK ENVIRONMENT			
Chairperson	M. Sadre-Chirazi-Stark, Asklepios Westklinikum			
Co-chairperson	M. Amering, Chairwomen of the WPA section			
Abstract	In industrial countries the burn-out wave is sweeping through the media. Also the health insurance companies report a dramatic rise of call of illness because of depression and anxiety which might be the psychiatric diagnostic equivalent of the burn-out syndrome. This symposium will raise awareness on this problem. It will discuss various objectives such as diagnostic definitions of burnout, socioeconomic pressures, and the role of workplace hierarchical structures			
References				
Speakers	Prof. Rataemane; Prof. Amaddeo, Dr. Rossouw, Dr. Ebert, Prof. Kallivayallil, Prof. Amering			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Managing workplace stress in the south african context: application of conflict management strategies			
Speaker	S. Rataemane, University of Limpopo (MEDUNSA) Pretoria, South Africa			
Abstract				
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	The prevalence of burnout and depression among medical doctors working in the cape town metropole community health care clinics and district hospitals of the provincial government of the western cape: a cross-sectional study			
Speaker	L. Rossouw ¹ , & S. Seedat ² , ¹ Division Family Medicine & Primary Care, University of Stellenbosch ² Department Psychiatry, University of Stellenbosch, South Africa			
Abstract				
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services			
Speaker	G. Cetrano, & F. Amaddeo, Department of Public Health and Community Medicine, Section of Psychiatry, University of Verona, Verona, Italy			
Abstract				
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	INTERNET-BASED PREVENTION OF MENTAL HEALTH DISORDERS IN EMPLOYEES - RESULTS FROM A RANDOMIZED CONTROLLED TRIAL			
Speaker	D.D: Ebert, Leuphana University Lueneburg, Germany			
Abstract				
References				

Session:	Symposium	SPEAKER 5	Code	
Title:	Mental Health and Work Environment: Preventive Aspects			
Speaker	R. Kallivayalil, Chairman of the WPA section			
Abstract	It is very important that the work environment fosters mental health. It leads to increased productivity, job satisfaction, contentment and peace and collegiality at the work place. Psychological support, civility and respect, recognition and reward, psychological and physical protection are essential. An efficient and caring leadership will be most helpful. It is also worthwhile to find the 'psychological fitness' of employees before employment. Some other issues which affect mental health at workplace are stigma and discrimination, job burnout, harassment, bullying or violence, or substance use. These issues should be addressed to prevent mental ill health.			
References				

Session:	Symposium	SPEAKER 5	Code	
Title:	COMMENTS OF THE WPA SECTION OF PREVENTIVE PSYCHIATRY			
Speaker	M. Amering, Chairwomen of the WPA section			
Abstract				
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	MENTAL HEALTH CARE THE WEB AND SOCIAL MEDIA - FACING A PUBLIC HEALTH THREAT			
Chairperson	R.M.Krausz, University of British Columbia (UBC), Vancouver, Canada			
Co-chairperson	M. Schaub, University Zurich, Institute of Addiction and Public Health Research			
Abstract	Background: Only every 10th mental health client is seeing a specialist for treatment, only a third of all mental health clients were getting basic care according to the national comorbidity survey in the US. The gap between necessary capacities in mental health care and available services is one of the biggest international public health threats. It will be impossible to address this with the current structures and resources. Over the last years more websites and programs came up with solutions for mentally ill especially offering information and access to communication. Objectives: We want to present upcoming solutions in the web and the necessary paradigm shift for the structure of Mental Health services integrating online opportunities. We want to start the dialogue in Socialpsychiatry about future solutions to build necessary capacities. Goals: The web and social media provide the opportunity of a paradigm shift and new opportunities to serve mentally challenged individuals. We want to raise awareness about this opportunity to shape the future of Psychiatry. Special opportunity: To learn about an upcoming area of health care delivery and communication and its role in future Psychiatry.			
References				
Speakers	1. Reinhard Michael Krausz (Vancouver, Canada, M.Krausz@mac.com) 2. Christian Schuetz (Vancouver, Canada, schutzc@mail.ubc.ca) 3. Michael Schaub (Zurich, Switzerland, michael.schaub@isgf.uzh.ch) 4. Majid Aldesouki (Riyadh, maldesouki@ksu.edu.sa)			
Contact:	Michael Krausz MD, PhD, FRCPC UBC-Providence Leadership Chair for Addiction Research Director Addiction Psychiatry Institute of Mental Health at UBC David Strangway Building 5950 University Boulevard Vancouver, BC V6T 1Z3 mkrausz@mail.ubc.ca			

Session:	Symposium	SPEAKER 1	Code	
Title:	Health care of the future – ready for a paradigm shift in Mental Health?			
Speaker	Reinhard Michael Krausz (Vancouver, Canada, M.Krausz@mac.com)			
Abstract	Background: The web and social media are changing our communication. Especially young people are networking through changing social platform, contact peers or acquire information and resources. From a mental health perspective young people are a very important target group, which are complicated to reach. For any effective approach in the future the development of effective programs using the possibilities of the web is key. Only 10% of challenged kids ever see a specialist. In rural areas and even a lot of cities it's extremely complicated to access any support. Web based health care: Already today Internet based solutions contribute to mental health care. Everybody is using the web as information hub. We will present examples, which are showing possible directions in the coming years. Paradigm shift in mental health: Mental health care is the area in medicine, which could benefit the most from web based services, social media and new communication. Initiating a dynamic of dialogue about possible, feasible and available solutions, more inclusive and user driven than ever before and building on the dialogue between people with lived experiences, families as well as peers and professionals. That could trigger a reorganization based on empowerment and create more capacity and access to care.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Online interventions for tobacco cessation			
Speaker	Christian Schuetz (Vancouver, Canada, schutzc@mail.ubc.ca)			
Abstract	Smoking continues to be the psychiatric disorder with the highest prevalence and the highest public health impact. Tobacco is responsible for almost 20% of all deaths and it is preventable. Tobacco users have the highest risk to develop dependence among users and it has the youngest age of onset among all substances of abuse. It thus constitutes possible more of a gateway drug than other substances. The Internet is becoming increasingly the main vehicle for spread of information and it increasingly discussed as a vehicle for interventions and web-based treatments can deliver broad reaching, relatively inexpensive, and clinically tested methods for smoking cessation The presentation will focus on various online tools and emerging possibilities. While Internet based interventions may assist online users with methods and strategies to quit smoking, there are some limitations in the efficacy of the currently available interventions			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Internet based therapies for drug addiction			
Speaker	Michael P. Schaub, Swiss Research Institute for Public Health and Addiction, Zurich, Switzerland, michael.schaub@isgf.uzh.ch			
Abstract	Objective: To provide an update on Internet based therapies for drug addiction conducted, identify its strengths, limitations, and to define the next steps for further improvement for such interventions. Methods: The detailed results and limitations of the currently available online intervention studies aiming at the reduction and/or cessation of problematic cannabis or cocaine use will be presented and compared to Internet based therapy studies for tobacco smoking cessation and controlled drinking. Results: The current available data among randomized controlled online intervention studies provides mixed results on the effectiveness of the reduction of substance use in problematic drug users. So far, the more interactive interventions based on motivational interviewing, cognitive-behavioral therapy approaches, and principles of self control seem most promising for the reduction of substance use in problematic drug users. Those drug users with higher depression symptoms and less pronounced severity of addiction symptoms can profit most of such interventions. Chat counseling sessions based on motivational interviewing have not yet been integrated to online self-help interventions for problematic drug users, a method that has been demonstrated to be promising in studies for controlled drinking in problematic alcohol users. There are currently no studies on the integration of Internet based therapy approaches to conventional face-to-face addiction therapies. Conclusion: Future studies should try to integrate anonymous chat sessions based on motivational interviewing and include at least some therapy modules for the reduction of depression symptoms to improve retention and potentially also study effectiveness. There is a strong need for studies investigating the integration of Internet based therapy interventions into face-to-face addiction therapies.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Implementing E-Health initiatives, “why things may go wrong”			
Speaker	Majid Aldesouki (Riyadh, maldesouki@ksu.edu.sa)			
Abstract	The use of information technology has become essential for the practice of medicine. Implementation of such technologies is not always so simple, as is the case for E-Health strategies. A major concern is developing a service, which facilitates sustained adoption by consumers, and this is where many initiatives fail. This talk will brush upon the challenges and obstacles that face E-Health initiatives, and try to shed some light on why many times they cannot even demonstrate their proposed benefits			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	I FIGHT DEPRESSION – USING THE INTERNET TO ENHANCE AWARENESS AND SELF-MANAGEMENT CAPACITY FOR DEPRESSION			
Chairperson	Ricardo Gusmão Universidade Nova de Lisboa, Portugal			
Co-chairperson				
Abstract	By the year 2020, depression is set to take 2nd place in the ranking of Disability Adjusted Life Years (DALYs) for all ages and both sexes. Already unipolar depression ranks first when considering the index “years lived with disability” (YLD) in high income countries (Collins et al., 2011). At the same time for various reasons only a minority of patients receive treatment according to established guidelines. Internet-based interventions could be a cost-effective approach to reduce therapeutic deficits. The internet and modern information and communication technologies offer new ways in targeting mental health. Millions of people access the internet each year for health-related information and more users search for information on depression than any other condition. However, despite growing evidence endorsing the effectiveness of online interventions such as self-help programs based on cognitive-behavioural therapy techniques, a major challenge is participants’ adherence to these interventions. Also, the adoption of internet-based interventions targeting depression is still limited in many countries. The symposium aims to give an overview about internet-based self-management of depression and to introduce the iFightDepression online intervention and awareness website developed in the current EC funded project Preventing Depression and Improving Awareness through Networking in the EU (PREDI-NU). After outlining the state of the art regarding world-wide efforts on internet-based self-management of depression and one successful example from Germany, the comprehensive literature review that delivered the evidence base for the iFightDepression – tool, the programme itself and the multilingual and multifaceted website in which it is embedded will be presented. Both components form part of the European collaborative effort to examine the acceptability and			
References				
Speakers	1. S. Kutcher Dalhousie University and the IWK Health Center, Halifax, Canada 2. C. Rummel-Kluge. University of Leipzig,, Leipzig, Germany 3. M. Maxwell University of Stirling, Stirling, UK 4. N. Koburger. University of Leipzig , Department of Psychiatry and Psychotherapy , Leipzig , Germany 5. R.Gusmão CEDOC Universidade Nova de Lisboa, Lisbon, Portugal			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	On-line based self-management of depression in young people: state of the art			
Speaker	Educational Objectives: Based on the Wagner Chronic Disease Care Model, participants will learn about various approaches and various tools available to address self-management of Depression in youth. Purpose: To provide attendees with an over-view of current concepts pertaining to on-line self-management of Depression in youth. To provide attendees with an over-view of on-line tools pertaining to Depression in youth. Methods: We searched literature and electronic databases to identify various approaches and tools pertaining to on line self-management of Depression in youth. Results: These clustered into the following categories: General self-help and wellness enhancement; Psychological interventions for treatment; Self-monitoring of symptoms and outcomes; Self-monitoring			

	of medications. In each category we identified key tools and have created synthesis of information about each tool identified. We will present these syntheses. Conclusions: A number of potentially useful on-line self-management tools for Depression in youth exist. They all have various strengths and weaknesses. Overall, some are ready for wider clinical application but much more research and development is yet needed
Abstract	
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Results from a German online forum for depression			
Speaker	Educational Objectives: At the conclusion of this presentation, the participants should be able to see that using the moderated online discussion forum for depression can contribute to coping with the illness. Purpose: To evaluate if a moderated online discussion forum for depression is used by people with depression and if this forum can contribute to dealing with depression. Methods: The discussion forum depression for patients and relatives was developed in 2002 within the 'Kompetenznetz Depression, Suizidalität' and is now being operated by its successor, the 'Stiftung Deutsche Depressionshilfe'. Since the opening of the forum more than 300.000 postings from more than 14 000 registered users were written. Diagnosis and treatment status were analyzed within a subgroup of users. Results: The vast majority of participants received the diagnosis depression, and more then 1/3 of the respondents suffered currently from a depressive episode. Frequent comorbid disorders were phobic disorders and somatoform disorders. Within the analyzed subgroup, over 90% had been treated as outpatients, and over 60% as inpatients. The respondents stated that their trust in medical treatment was raised and that they were encouraged to seek professional help. Furthermore, about one third of the interviewed participants rated their attitudes towards the treatment with medication more positive than before being a member in the discussion forum. Conclusions: The online depression forum is reaching the intended group, namely people with depression and their relatives, and is being used in addition to professional psychiatric care. Taking part in the forum is positively influencing the acceptance of and the coping with the illness. Future analyses will include specific subgroups such as high/low-users, different age groups and gender differences as well as linguistic analyses			
Abstract				
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	A realist synthesis for evidence based implementation of internet based self help interventions			
Speaker	M. Maxwell. University of Stirling, Stirling, UK			
Abstract	Educational Objectives: Evidence from meta and systematic reviews has demonstrated that computerised cognitive behavioural therapy (cCBT) interventions are effective treatments for anxiety and depression. However, besides			

	evidence of effectiveness, there is little knowledge to guide the development and delivery (implementation) of such interventions. This presentation will inform on best practice for implementation. Purpose: The aim of the study was to identify best practice recommendations for the implementation of self-management e-health technologies, and key processes involved in implementing these interventions in terms of what works, for whom and in what circumstances. Methods: Informed by the Realist approach (Pawson, 2002), the realist review is a technique for synthesising data on complex interventions that situates questions of ‘effectiveness’ within broader literature in order to answer the question: ‘What works, for whom and in what context’. Steps included: specifying PICO, inclusion/exclusion criteria; developing search strategies, systematic searching; screening, selection and critical appraisal of literature; and data extraction & synthesis of literature produced between January 1990-December 2011. Results: There were 58 included papers ranging from systematic reviews to guidelines and qualitative studies. What works?: purely self-guided cCBT only works if individuals are self-motivated; interventions with some level of support are more effective; there is no clear evidence on guidance (optimal length, content, type of guidance, or type of professional required). For whom does cCBT work better?: women; mild to moderate depression; self-selecting/media-recruited people; existing depressive symptoms; well-educated, and computer literate. Under what circumstances does cCBT work better?: more engagement with the material & tasks; prior belief/expectancy that it will reduce depression. Further recommendations for improving implementation and adherence will also be presented. Conclusions: A realist synthesis of the literature has revealed some evidence for what works in cCBT implementation but greater attention should be paid to reporting implementation issues when reporting clinical trials.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	The predi-nu online intervention: a self-management program based on best practice and expert consensus for adolescents and adults with mild to moderate depression			
Speaker	N. Koburger. University of Leipzig , Department of Psychiatry and Psychotherapy , Leipzig , Germany			
Abstract	Educational Objectives: At the conclusion of this presentation the participants should have a basic understanding of the aims and structure of 1) the Predi-Nu project and 2) the iFightDepression internet-based self-management tool and its implementation as a guided online self-help intervention. Purpose: The purpose of the iFightDepression self management tool is to offer a free, guided self-help intervention in multiple languages for patients with milder forms of depression. Methods: The iFightDepression self-management tool was developed based on a literature review and best practice examples as well as expert advice. In a first step, 58 papers were examined in relation to existing evidence concerning best practice for the development and implementation of computerised cognitive behavioural therapy interventions. At the same time, existing interventions and websites were explored systematically to assess core components and implementation guidance. Then, a first outline for the iFightDepression – Tool was prepared in two versions: for adolescents and younger adults (15-24 years) and adults (25 years and older). The tool contents are consecutively improved and consented by the Predi-Nu project consortium and a broader group of external experts, including representatives from patient and family organisations. The iFightDepression – Tool is available in five European languages and tested for acceptability and feasibility in a pilot study. Results: The iFightDepression self-management tool comprises six core modules as well as target group specific additional modules, printable worksheets, help addresses and a mood rating. The patients using the tool			

	are to determine their personal pace and the order of the modules. For maximising their benefit from the tool, they are provided with recommendations for using it and guided by trained general practitioners, psychotherapists and other mental health professionals. Conclusions: Within the Predi-Nu project, an evidence-based, internationally consented self-management tool (iFightDepression) for patients with milder forms of depression was developed. A pilot study is exploring the acceptability and feasibility of the tool, which will be optimised and further implemented in a second study phase of the Predi-Nu project
References	

Session:	Symposium	SPEAKER 5	Code	
Title:	Ifightdepression.com – an international awareness website for depression			
Speaker	R.Gusmão CEDOC Universidade Nova de Lisboa, Lisbon, Portugal			
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should be able to acknowledge the importance of e-health in improving awareness of depression and suicidal behaviours, reducing stigma, empowering people and improving access to effective care. Purpose: The iFightDepression.com website was setup to become a developable, flexible and sustainable ICT platform in order to meet the needs of average internet users for depression information, the needs of other target audiences, and the needs for light and moderate depression self-management, in eight different languages. Methods: A collaborative work was organized to address the major components within the 3 years of the project: conceptualization and website design, building the self-help tool, developing contents, and programming. To review depression focused websites and CBT interventions through the internet were key steps in the process. Results: A brand – the iFightDepression.com domain and logo – with which the general public could identify in a very genuine and spontaneous manner, a visible, accessible, highly-usable and attractive website, with evidence-based and best practise contents supported by written, graphic and video materials were important deliverables. An information architecture and awareness website structure were developed targeting to capture the attention of the general public but with a communication potential for the several profiles that the consortium deemed necessary to reach through five main tabs/profiles: “For All” includes general information about depression, “For Young People” takes in account teen behaviour and youth specificities, “For Families & Friends” informs family and informal carers on the best identification and management strategies, “For Community Professionals” includes information for gatekeepers such as teachers, pharmacists, police forces, religious agents, media, social workers, etc., and “For Health Professionals” displaying case studies and support materials and a restricted area with clinical tools and training materials. Cross-contents are always present, such as FAQ or the “Self-management programme” including psychoeducational materials and the self-management tool. Conclusions: The website seems to address the needs for E-Awareness and E-Self-management and to reach the audiences set by the consortium. In the future, an E-Learning and E-Referral modules can be developed as well as interactive tools both for patients and family, through monitored chat and blog, and health and community professionals through a forum where to leave questions and obtain specialized answers. This will reinforce sustainability, which along with making available financing to maintain and actualize contents, will be the future challenges for this project after its end, in August 2014			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	ADDICTION AMONG VULNERABLE URBAN POPULATIONS			
Chairperson	R.M.Krausz, University of British Columbia (UBC), Vancouver			
Co-chairperson	Andrej Kastelic, National Center for the Treatment of Drug Addiction, Ljubljana			
Abstract	Background: The prevalence of addiction, physical challenges, trauma and mental illness are not equally distributed. Especially in our growing cities worldwide vulnerable individuals are marginalized and shift to specific neighbourhoods, with high morbidity and mortality rates and little access to care. The use of psychotropic substances is of special importance to these vulnerable urban populations like homeless, women in survival sex trade and prisoners. Together with partners in other services Psychiatry needs to play a proactive role to address those downward spirals. Goals: We want to present and discuss this critical challenge for our mental health system and propose to develop a strategy to reposition Psychiatry especially in the areas of Addiction and Social Psychiatry Objectives: What are specific needs of vulnerable urban populations and who is looking after them today? How to improve care for marginalized mentally ill in the community? Special opportunity: This symposium will offer an opportunity to overcome the existing fragmentation between service and research areas addressing the most vulnerable and most neglected populations in the system.			
References				
Speakers	1. Andrej Kastelic, Nusa Segrec (Ljubljana, Slovenia, andrej.kastelic@psih-klinika.si) 2. Franceso Bartoli, Ester di Giacomo, Paola Sciarini, Giuseppe Carra M. Clerici (Milan, Italia, maxcin@libero.it) 3. Christian Schuetz (Vancouver, Canada, schutzc@mail.ubc.ca) 4. Reinhard Michael Krausz (Vancouver, Canada, M.Krausz@mac.com)			
Contact:	Michael Krausz MD, PhD, FRCPC UBC-Providence Leadership Chair for Addiction Research Director Addiction Psychiatry Institute of Mental Health at UBC David Strangway Building 5950 University Boulevard Vancouver, BC V6T 1Z3 mkrausz@mail.ubc.ca			

Session:	Symposium	SPEAKER 1	Code	
Title:	Addiction, comorbidities and imprisonment			
Speaker	Andrej Kastelic, Nusa Segrec (Ljubljana, Slovenia, andrej.kastelic@psih-klinika.si)			
Abstract				
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Deprivation in comorbid patients: results of a cross-sectional study in Italian Mental Health Care Trusts			
Speaker	Francesco Bartoli, Ester di Giacomo, Paola Sciarini, Giuseppe Carra M. Clerici (Milan, Italia, maxcin@libero.it)			
Abstract				
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Childhood traumatization, addiction and concurrent disorders among homeless in Canada and a possible therapeutic response			
Speaker	C.G. Schütz MD PhD MPH University of British Columbia, Vancouver, BC, Canada			
Abstract	Aims: Studies have found that the homeless population suffer from high rates of mental disorders and substance use disorders. However, few studies have included psychiatric assessments to elucidate the prevalence and the association of mental disorders with substance use disorders, potential risk factors and its impact on health care utilization in this marginalized population. With individuals suffering from concurrent disorder individuals regularly reporting the highest level of unmet needs the Province of British Columbia responded by opening a 100 bed unit to specifically target this population. Methods: A total of 500 individuals living on the street, or in shelters were recruited from the cities of Vancouver, Victoria and Prince George BC. Standardized assessment instruments, such as the Mini International Neuropsychiatric Interview (M.I.N.I), the Maudsley Addiction Profile (MAP) and childhood trauma questionnaire (CTQ) were employed. Results: Overall mean age was 37.9 (SD: 11.0); 39.2% were female; and 39.8% of aboriginal descent. The lifetime prevalence of mental disorders in this population was extremely high. Only 7.2% reported no current disorders, while a total of 53.8% fulfilled criteria for current concurrent disorders. Concurrent disorders were associated with specific risk factors e.g. childhood traumata. The program targeted to the specific needs of this population will be presented. Conclusions: High levels of childhood traumatisation are associated with high levels of substance use disorders and concurrent psychiatric disorders. A specific approach based on the specific need to treat this population within the context of a 100 bed recovery centre will be delineated.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Psychiatry and the most vulnerable – innovative ways of service integration in the community addressing client needs			
Speaker	Reinhard Michael Krausz (Vancouver, Canada, M.Krausz@mac.com)			
Abstract	Background: The prevalence of addiction is high, its beside mood disorders and anxiety the most common mental illness. The majority of chronic clients and high need patients suffer from addiction and concurrent disorders. But it is not on the agenda of Social Psychiatry. Substance use is stigmatized or ignored in the mental health field, which contributes to ineffective services, lack of training and research. Goals: We want to present and discuss this critical challenge for our mental health system and propose to develop a strategy to reposition Psychiatry especially in the areas of Addiction and Social Psychiatry Objectives: To raise awareness on the importance of an integration of efforts. What are specific needs of vulnerable urban populations and who is looking after them today? How to improve care for marginalized mentally ill in the community? How to shift paradigms in Social Psychiatry? Special opportunity: This symposium will offer an opportunity to overcome the existing fragmentation between service and research areas addressing the most vulnerable and most neglected populations in the system.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	COERCION IN PSYCHIATRY- INTERNATIONAL PERSPECTIVES			
Chairperson	Andrew Molodynski, Oxford Health NHS Trust and Oxford University Department of Psychiatry, Oxford, UK.			
Co-chairperson				
Abstract	Coercion in psychiatry has always been a hotly debated yet poorly understood area. With the progressive deinstitutionalisation of psychiatric care in High Income Group countries and the increasing provision of care in Low and Middle Income Group countries the issues are changing and also becoming of wider relevance. In recent years there has been increasing focus on the issue of coercion from various perspectives. This symposium draws together empirical evidence, ethical principles and realities, and the emerging work of the WASP international task force on coercion in an attempt to bring some clarity in this complex area to the audience.			
References				
Speakers	1. George Szmukler, professor of psychiatry and society, Institute of Psychiatry, London, UK. 2. Daniel Maughan, Oxford Health NHS Trust and Oxford University Department of Psychiatry, UK. 3. Andrew Molodynski, Oxford Health NHS Trust and Oxford University Department of Psychiatry.			
Contact:	Andrew Molodynski, Consultant Psychiatrist and Honorary Senior Lecturer, Oxford Health NHS Trust and Oxford University Department of Psychiatry. Social Psychiatry Group, Warneford Hospital, Headington, Oxford, United Kingdom, OX3 7JX. +441235 799800 Andrew.molodynski@oxfordhealth.nhs.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	‘Article 2 ‘Right to Life’ under the ECHR and its implications for the patient at risk of suicide.			
Speaker	George Szmukler, professor of psychiatry and society, Institute of Psychiatry			
Abstract	Article 2 of the European Convention on Human Rights (ECHR) states that “Everyone’s right to life shall be protected by law”. It imposes an obligation on the state to take reasonable measures when there is a “real and immediate risk to life” to an identified person, aimed at avoiding that risk materialising. In a landmark decision the Supreme Court of the UK ruled that Art. 2 applied to voluntary as well as detained psychiatric inpatients (Rabone v Pennine Care NHS Foundation Trust. The case concerned a young woman admitted to a psychiatric hospital following a number of suicide attempts. After being granted leave for two days to stay with her parents, she committed suicide. Key to the Supreme Court’s decision were the answers to the following questions: is the position of the informal psychiatric patient the same as or different to a medical or surgical patient; or is it closer to the position of an involuntary psychiatric patient? Was there a “real and immediate” risk that should have been known, and reasonable measures that could have been taken to avoid it? I will argue that this judgment is another example of legal discrimination against persons with a mental illness.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Daniel Maughan, Oxford Health NHS Trust and Oxford University Department of Psychiatry, UK.			
Speaker	Coercion and compulsion in community psychiatry- where are we now?			
Abstract	Objectives; Review the historical contexts of coercion and compulsion. Summarise the current evidence on different forms of coercion and compulsion. Results; The literature on coercion has been divided along clinical, legal and ethical lines. The former has examined the effects upon clinical outcomes whereas the others have focused on civil liberties, the role of the state and arguments for and against coercive intervention. There is consensus that many experience their community treatment as coercive and that this varies between communities and mental health systems. There has been difficulty in establishing an evidence base for CTOs. Conclusion; There remains a dearth of research on many aspects of coercion. Sources of coercion vary between high and low income countries and more evidence is needed in low and middle-income countries. There is currently not sufficient evidence to determine the specific clinical, ethical, or service use outcomes of CTOs			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Andrew Molodynski, Oxford Health NHS Trust and Oxford University Department of Psychiatry			
Speaker	Coercion in psychiatry- the work of the WASP international working group			
Abstract	Issues of coercion and compulsion remain central in the care of the severely mentally ill, both in hospital and in the community. The source of coercion appears to vary depending on a number of service and social factors but good quality evidence regarding the experience of the mentally ill and those around them is very scarce outside a small group of wealthy nations (and absent in most). This presentation will focus on what we know regarding these complex issues, what we don't know, and how we may be able to move forwards our understanding, both empirically and in a wider sense over the coming few years.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	FROM RECOVERY TO WELL-BEING AND BACK			
Chairperson	Dr. Mary Leamy, Institute of Psychiatry, King's College London			
Co-chairperson	Dr. Beate Schrank, Institute of Psychiatry, King's College London			
Abstract				
References				
Speakers	1. Dr Mary Leamy, Institute of Psychiatry, King's College London, United Kingdom, mary.leafy@kcl.ac.uk. 'The REFOCUS intervention: the reality of implementing and evaluating recovery-oriented practice'. 2. Ms. Victoria Bird, Institute of Psychiatry, King's College London, United Kingdom, victoria.bird@kcl.ac.uk. 'What recovery means to me? Perspectives on the meaning of recovery for individuals from BAME communities'. 3. Dr. Simon Riches, Institute of Psychiatry, King's College London, United Kingdom, simon.j.riches@kcl.ac.uk. 'The WELLFOCUS study: development and evaluation of an intervention to increase well-being in people with psychosis'. 4. Dr. Beate Shrank, Institute of Psychiatry, King's College London, United Kingdom, beate.schrank@kcl.ac.uk. 'Recovery and well-being: comparing concepts and interventions'.			
Contact:	Dr. Mary Leamy, Institute of Psychiatry, King's College London Programme Co-ordinator and Trial Manager, REFOCUS Programme, Section for Recovery Health Service and Population Research Department, Institute of Psychiatry, King's College London De Crespigny Park, Denmark Hill, London SE5 8AF. Tel: 020 7848 5095 Fax: 027 848 5056 mary.leafy@kcl.ac.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	The REFOCUS intervention: the reality of implementing and evaluating recovery-oriented practice'			
Speaker	1. Dr Mary Leamy, Institute of Psychiatry, King's College London, United Kingdom			
Abstract	- to describe the REFOCUS intervention to promote recovery - to outline preliminary findings from the process evaluation embedded within the cluster randomised controlled trial to validate of the REFOCUS model, underlying the intervention and its implementation			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	What recovery means to me? Perspectives on the meaning of recovery for individuals from BAME communities'			
Speaker	2. Ms. Victoria Bird, Institute of Psychiatry, King's College London, United Kingdom			
Abstract	- to summarise findings from a systematic review and narrative synthesis of the recovery literature to develop a conceptual framework of personal recovery - to present qualitative research findings undertaken to validate the conceptual framework with current service users, including the perspectives of individuals from Black Asian Minority Ethnic communities			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	The WELLFOCUS study: development and evaluation of an intervention to increase well-being in people with psychosis'			
Speaker	Dr. Simon Riches, Institute of Psychiatry, King's College London, United Kingdom			
Abstract	- to describe how Positive Psychotherapy has been adapted specifically for people with psychosis - to present initial findings from the process evaluation on the feasibility and potential usefulness of the adapted intervention, currently being evaluated in a pilot randomised controlled trial			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Recovery and well-being: comparing concepts and interventions'			
Speaker	Dr. Beate Shrank, Institute of Psychiatry, King's College London, United Kingdom			
Abstract	- to outline the concept of well-being and compare it to that of recovery - to address the question of what an intervention to increase well-being can add to a recovery oriented service			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	INTERNATIONAL EXAMPLES OF COMMUNITY REHABILITATION PSYCHIATRY SERVICES			
Chairperson	Dr Sridevi Kalidindi, Consultant Rehabilitation Psychiatrist, Complex Care, Psychosis CAG, South London & Maudsley NHS Foundation Trust; Honorary Clinical Lecturer, Institute of Psychiatry, UK.			
Co-chairperson				
Abstract	Across the world, deinstitutionalisation of large mental health asylums/hospitals has been underway for several decades. The process is at different stages in different countries, but some have now moved on to fully integrated community rehabilitation services and are involved in fine-tuning such services to improve their effectiveness and their outcomes for both service users and commissioners. Three systems, each from a different country, from world-renowned psychiatrists, will be presented to the delegates to increase their knowledge of the possibilities and to consider which aspects may be most relevant to their own practise and services. Three speakers as outlined below will present a picture of the services and skills necessary to achieve good results in community rehabilitation psychiatry for complex service users followed by time for questions and discussions from the attendees. The speakers are experienced in this specialist field. Objectives To consider effective approaches to community rehabilitation psychiatry in three different European countries, whose success has led to duplication in other countries. To identify which components are similar between these approaches and can be potentially generalised to set up services / support similar services, globally. Goals It would be expected that the delegates attending would increase their knowledge of the important similarities and differences in such services across different European countries. This knowledge can potentially be applied to the delegates' own practice and services to work towards different ways of working, which in turn may lead to improvements in outcomes for service users and commissioners of services			
References				
Speakers	1. Dr Sridevi Kalidindi, Consultant Rehabilitation Psychiatrist, Complex Care, Psychosis CAG, South London & Maudsley NHS Foundation Trust; Honorary Clinical Lecturer, Institute of Psychiatry, UK. E-mail: 2. Dr. J. R. van Veldhuizen, psychiatrist, The Netherlands Chairman of the Certification Centre for Act and Fact (CCAF) First Author of the Dutch FACT manual Former Inspector of Mental Health Care 3. Professor Roberto Mezzina, Director of Mental Health Services in Trieste, Italy			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	The case for community rehabilitation teams from a UK perspective			
Speaker	Dr Sridevi Kalidindi, Consultant Rehabilitation Psychiatrist, Complex Care, Psychosis CAG, South London & Maudsley NHS Foundation Trust; Honorary Clinical Lecturer, Institute of Psychiatry			
Abstract	Dr Kalidindi, the Vice Chair of the Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists, UK, will focus on recent National commissioning guidelines for rehabilitation psychiatry services(1) and a paper published by the Rehab Faculty on the skills necessary to run such services effectively(2) both of which she co-authored			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	FACT, FLEXIBLE ACT, A Dutch Version of ACT			
Speaker	Dr. J. R. van Veldhuizen, psychiatrist, The Netherlands Chairman of the Certification Centre for Act and Fact (CCAF) First Author of the Dutch FACT manual Former Inspector of Mental Health Care			
Abstract	FACT (Flexible ACT) teams are clinical case management teams with partly an individual approach with home visits and partly (if needed) a shared caseload approach withy assertive outreach , similar to ACT. The model aims to combine treatment, support and rehabilitation to serve all SMI in a certain region with good continuity of care. Compared with ACT, the innovation in FACT teams is the choice to work with two procedures in one team: “low scale” (for the more stable patients) and “high scale” (for the most unstable, hard to engage patients at risk for admission: with full ACT). The FACT team can move flexibly between the two procedures, working with the Digital FACT board in the daily team meetings. FACT teams are serving in a defined region or area of + 50.000 inhabitants all SMI. Certification started by the Centre for Certification ACT and FACT (see www.ccaf.nl) In the Netherlands at this moment 150 teams are implemented. FACT has some interesting opportunities for rehabilitation and recovery support: it’s working in a small region, with optimal continuity of care and with inclusion of IPS and peer specialist. Remmers van Veldhuizen is psychiatrist and developed together with Michiel Bähler the FACT model at the Mental Health Care Services ‘GGZ Noord Holland Noord’. He is the chairman of the Dutch Certification Centre for ACT and FACT (CCAF).			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	The Trieste Approach To Community Rehabilitation Psychiatry			
Speaker	Professor Roberto Mezzina, Director of Mental Health Services in Trieste, Italy			
Abstract	Professor Roberto Mezzina will draw on his experience as a psychiatrist and the Director of a comprehensive, 24-hour Community Mental Health Centre, Department of Mental Health in Trieste, Italy. He has taken a key role in the mental health reforms in Trieste, begun by Franco Basaglia. Roberto is currently Head of the WHO Collaborating Centre for Research and Training, Department of Mental Health, Trieste, focussing on deinstitutionalisation and community-based service development.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	AUTISM SPECTRUM DISORDERS: CHALLENGES IN ADULTHOOD		
Chairperson	Doutor Bernardo Barahona Corrêa. Faculty of Medical Sciences, New University of Lisbon, Portugal CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal		
Co-chairperson	Dra. Sandra Pinho. CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal		
Abstract	Autism is a pervasive neuropsychiatric developmental disorder with a multifactorial, polygenic aetiology. Autism affects about 10-60 individuals per 10 000 people with a marked male predominance of 4,5:1. Although the prevalence of Autism appears to have increased over the last 30 years, it remains unsettled whether this is due to more inclusive diagnostic criteria or to truly biological factors. Autism is probably best conceived of as a spectrum disorder, since it may manifest in various degrees of severity, from the classical non-verbal Kanner syndrome to the so-called higher functioning Autism Spectrum Disorders (ASD). Regardless of their degree of severity, all ASD individuals present pervasive deficits in three core areas of functioning: 1. social interaction; 2. verbal and non-verbal communication; 3. cognitive and behavioural flexibility. Deficits in all three of these areas are often - but not always - accompanied by behavioural and sensory peculiarities such as sensory hypersensitivity, motor clumsiness, psychomotor slowness or, more rarely, some particular, unusually developed psychomotor skill. The deficits of individuals with ASD have a deep impact on their ability to interact with others and with the world around them, as well as on their ability to cope with the simplest challenges of daily life. Moreover, individuals with ASD are at greater risk of developing significant psychiatric co-morbidity, specially mood and anxiety disorders. The best treatment strategies for ASD combine tailored psychosocial interventions with biological interventions for selected psychiatric co-morbidities, in a genuinely bio-psychosocial, multidisciplinary approach involving doctors, psychologists, various therapists and coaches, and family members. ASD are chronic, life-long irreversible conditions that, nevertheless, evolve with age. On the most subtle end of the spectrum, Asperger syndrome patients usually present with an average to above-average intellectual ability and well developed language, but with significant deficits in social interaction, non-verbal communication and behavioural and cognitive flexibility. Although many Asperger syndrome patients manage to finish school successfully, difficulties invariably arise in early adulthood with the need to adapt to university or to the demands and challenges of the work market. Even the most able and qualified individuals with high-functioning ASDs usually face formidable difficulties at this stage of their lives, when, often unexpectedly to themselves and to their families, new needs for treatment become painfully evident. The combination of above-average intellectual ability, high qualification and ASD poses particularly difficult challenges to therapists and all those specialized in treating this population. This is especially the case where it comes to social integration in unpredictable, non-structured settings or to obtaining and keeping a job. In this symposium we propose to review the clinical features and treatment difficulties of high-functioning adults with ASDs. We will present and discuss two different psychosocial interventions specifically aimed at this particular subgroup of patients, one of them developed at the University of Salamanca, and the other one at the Centro de Apoio ao Desenvolvimento Infantil in Lisbon. Finally, we will also present the results of a recent research project on semantic memory deficits on Asperger syndrome patients, and their consequences to therapeutic interventions in this population.		
References			
Speakers	1. Doutor Bernardo Corrêa. Faculty of Medical Sciences, New University of Lisbon, Portugal CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal 2. Prof. Doutor Carlos Filipe & Doutora Joana Carmo 1 Faculty of Psychology, University of Lisbon, Lisbon, Portugal. 2 CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal. 3 Faculty of Medical Sciences, New University of Lisbon, Portugal 3. Dra. Zoila Guisuraga. University of Salamanca, Spain 4. Dra. Sandra Pinho CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal		
Contact:	Bernardo Barahona Corrêa CADIN – Centro de Apoio ao Desenvolvimento Infantil Estrada da Malveira, Edifício CADIn 2750-782 Cascais Portugal +351 214 858 240		

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Session:	Symposium	SPEAKER 1	Code	
Title:	Wanderers in No-man's Land: Asperger Syndrome in Young Adults			
Speaker	Bernardo Barahona Corrêa, MD, PhD. Centro de Apoio ao Desenvolvimento Infantil; Champalimaud Foundation; CEDOC - NOVA University of Lisbon			
Abstract	Asperger Syndrome (AS) is an autism spectrum disorder with unique clinical features. Similarly to other autism spectrum disorders, AS presents with prominent dysfunction of social interaction and non-verbal communication, a typically narrow pattern of interests, and a rigid adhesion to routines. Unlike classical autism, however, AS patients usually have a normal or even precocious development of speech, as well as normal, or often superior, intelligence. AS is a life-long condition. It is usually diagnosed in infancy or adolescence, although occasional cases may go on undiagnosed until adulthood. AS patients suffer prominent psychosocial dysfunction from an early age, and although in many cases both symptoms and the resulting incapacity tend to attenuate with age – mainly as a consequence of imitation learning of conventional social behavior – in most instances transition into adult life poses as formidable challenge for patients, relatives and health care professionals. For patients, entering university or a first-time job will often overwhelm an already limited ability to flexibly adapt to new challenges and rules. Occasionally, it will bring to light AS symptoms that had gone undiagnosed during infancy and adolescence. For more disabled AS patients in particular, leaving the relative safety and predictability of school life often constitutes a catastrophic event, resulting in absolute social isolation and total inactivity. Unsurprisingly, significant psychiatric comorbidity is the rule in young adults with AS, especially affective and anxiety disorders, substance use disorders, and deliberate self-harm. Addressing the special needs of young adults with AS may prove particularly challenging: most adult psychiatry professionals are not familiar with AS and its features; most general psychiatry services do not offer specialized programs for this special population; and most conventional psycho-social rehabilitation programs directed at severe mental disorders – mainly schizophrenia and other chronic psychoses – are certainly not adequate or acceptable for most young adults with AS. Helping young adults with AS to come to terms with their unique disorder implies a tailored, integrated multidisciplinary approach that flexibly addresses such varied needs as psychiatric morbidity, social skills learning, autonomous living skills learning or vocational and professional orientation and advice.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Categorization processing of natural categories in Autism Spectrum Disorder: The effect of typicality.			
Speaker	Prof. Doutor Carlos Filipe & Doutora Joana Carmo 1 Faculty of Psychology, University of Lisbon, Lisbon, Portugal. 2 CADIN – Centro de Apoio ao Desenvolvimento Infantil, Lisbon, Portugal. 3 Faculty of Medical Sciences, New University of Lisbon, Portugal			
Abstract	Recently, several studies (e.g. Bowler, Graigg & Gardiner, 2008; Bowler, Limoges & Mottron, 2009; Sumiyoshi et al., 2011) show that semantic memory processes differ in key aspects from those of neurotypical individuals and cast some doubt on whether semantic memory and categorization processes are truly intact in individuals with Autism Spectrum Disorder (ASD). In this study we aim at understanding if deficits in semantic processing regarding memory tasks are due to an impairment of semantic processing per se, or due to the use of atypical conceptual categories. For that purpose we have tested a sample of high-functioning adults with ASD (n=22) and a sample of control participants (n=22) matched for age, IQ and education level on several tasks. First, in order to evaluate the content and composition of conceptual categories we adapted a task from Lambon-Ralph (2010) where errors on typical, atypical and pseudo-typical items can be observed. Additionally, in an implicit categorization task (Release from Proactive Interference paradigm) we have assessed whether recollection from memory can be aided by the activation of typical or atypical semantic categories. We have also introduced a task that tackles the executive functioning, as the ability to strategically search in memory, and have cluster-analyzed this data regarding the typicality of produced items. Differences found between processing of typical and atypical items from a conceptual category			

	are discussed, taking into account the implicit and explicit nature of the different tasks used.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Psychosocial intervention in college students with ASD			
Speaker	Dra. Zoila Guisuraga. University of Salamanca, Spain			
Abstract				
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Pilot projects on psychosocial intervention in young adults with autism spectrum disorders.			
Speaker	S. Pinho. CADIn – Centre for Child Development, Cascais, Portugal			
Abstract	At the conclusion of this presentation, the participants should be able to recognize behavioural and cognitive strategies for developing adaptive behaviour and employability in young adults and adults with Autism Spectrum Disorders (ASD) Purpose: To develop adaptive behaviour, employability and quality of life of young adults and adults with ASD Methods: In project “Enabling to work”, we used group training of beneficiaries, group training of co-workers in job places and supported work placement to promote 9 months work experiences to 7 adults with ASD. In project “Active Net”, we used group activities of: 1) social skills training; 2) tai chi practice; 3) arts; 4) cooking course; 5) outdoor activities; and 6) volunteering activities of beneficiaries, to promote adaptive behaviour in 10 young adults with ASD. In both projects, the intervention model was adapted from “Access Course” and “Work Preparation Programme”, from Prospects, National Autistic Society (UK). Results: Quality of life, as measured by Self Evaluation of Well Being Questionnaire (European Platform for Rehabilitation) showed an increase in 6 out of 7 beneficiaries. Group training of co-workers in Autism Awareness involved around 100 participants. Monthly job evaluations of the beneficiaries are showing results around 4 in 5 point scale and some companies are showing interest in employing the beneficiaries after project end. A measure of adaptive behaviour was applied in the beginning of “Active Net” project. Though the final evaluation is only programmed for the end of July, beneficiaries show high participation rates and evaluated very positively the social skills training (with 4 in a 5 point scale). Conclusions: Through these projects, we expect the following results ☐ Enhancement in perceived Well Being of the beneficiaries ☐ Increase in Autism awareness of the co-workers in job places ☐ Increase in employability of beneficiaries in the open labour market (three beneficiaries to be employed by the companies were they have been working during project period) ☐ Development in adaptive behaviour of beneficiaries, especially in the areas of daily leaving activities and social skills			
References				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	BURDENS OF MENTAL DISORDERS: RESULTS FROM THE WHO WORLD MENTAL HEALTH SURVEYS INITIATIVE		
Chairperson	Jordi Alonso, Institut Hospital del Mar d'Investigacions Mèdiques, Barcelona, Spain		
Co-chairperson			
Abstract	The goal of this symposium is to discuss the individual and societal costs of mental disorders, based on the last results from WHO World Mental Health (WMH) Surveys Initiative. The speakers will specifically address individual and social disadvantages associated with mental disorders, disability impacts of mental disorders, and implications of these data for mental health policy development. The main objective of the WHO World Mental Health Surveys Initiative was to carry out rigorously implemented general population—surveys in order to: (1) estimate the prevalence of mental disorders, (2) evaluate risk and protective factors for purposes of targeting interventions, (3) study patterns of and barriers to service use, and (4) validate estimates of disease burden world-wide. The WHO World Mental Health surveys, carried out in 24 countries studying more than 120,000 respondents, used the most up-to-date measures, field procedures and analysis methodology. Presentations will focus on the consequences associated with mental disorders across the life course of the individuals with particular attention to productivity losses, disability and worsened perceived health. The results reported and discussed in the symposium represent an important advance in understanding of the societal costs of mental disorders and make a compelling case for the value of expanding treatment resources for people with mental disorders throughout the world. They also provide new knowledge with important implications for the development of mental health policy across the world.		
References	Kessler, R. C, Haro, J. M., Heeringa, S. G., Pennell, Beth-Ellen & Üstün, B. T. (2006). The World Health Organization World Mental Health Survey Initiative. <i>Epidemiologia e Psichiatria Sociale</i>, 15, 161-166. J. Alonso, S. Chatterji, & Y He (2012) (Eds.) <i>The Burdens of Mental Disorders in the WHO World Mental Health Surveys</i>. WHO WMH Surveys Series Volume IV. New York: Cambridge University Press (In Press).		
Speakers	1. Jordi Alonso (Institut Hospital del Mar d'Investigacions Mèdiques, Barcelona, Spain, jalonso@imim.es): 2. Ronny Bruffaerts (Katholieke Universiteit Leuven, Belgium, ronny.bruffaerts@uzleuven.be): “ 3. Maria do Carmen Viana (Universidade Federal do Espírito Santo, Vitória, Brasil, mcviana@intervip.com.br 4. JM Caldas de Almeida (Faculdade de Ciências Médicas, Universidade Nova de Lisboa, Portugal, jcaldasalmeida@gmail.com		
Contact:	Prof. Jordi Alonso, Institut Hospital del Mar d'Investigacions Mèdiques, Barcelona, Spain, jalonso@imim.es		

Session:	Symposium	SPEAKER 1	Code
Title:	Burdens of the Mental Disorders: Contributions of the WMH Surveys		
Speaker	Jordi Alonso, Institut Hospital del Mar d'Investigacions Mèdiques, Barcelona, Spain		
Abstract	The Global Burden of Disease (GBD) study put mental disorder in the map of the burden of diseases. In its 2010 replication, Mental Disorders in developed countries are the second cause of disability and the third cause of combined disability adjusted premature mortality. In developing countries mental disorders are very rapidly catching up as major cause of DALYs. The WHO World Mental Health (WMH) surveys, with over 121,000 respondents surveyed across 24 different countries, is the largest on-going cross-national series of community epidemiological surveys of mental disorders ever carried out. The surveys are multipurpose studies of descriptive epidemiology of mental disorders worldwide: the frequency of mental disorders, their age of onset, and their associated disability and use of services have been assessed. Particular strengths of the WMH surveys include the large size and geographical representativeness of their samples, the exhaustive and well-standardized evaluation of mental disorders (with the WHO Composite International Diagnostic Interview, (CIDI) and		

	health outcomes, and the use of sophisticated analytical approaches capable of accurately estimating the population distribution of the consequences of disease. In addition, while the GBD study focuses on decrements in current health and mortality associated with the health conditions, the WMH data allow for the consideration of a much wider range of adverse outcomes. Very recently, a specific WMH book has been published focusing on a particular way to assess the several burdens associated with the mental disorders across the life course of the individuals: personal disadvantages, productivity losses, disability, and worsened perceived health (Figure). The figure includes both the outcomes and some of the possible intermediate variables that the vast body of literature suggests may play a role in the association between the two. Data in that WMH book show how parental psychopathology is related to mental disorders in offspring are indeed associated with an increased risk for every class of offspring mental disorder, even after controlling for the presence of comorbid parental disorders, as well as for number of parent disorders. Also early-onset mental disorders are associated with a decreased likelihood of satisfactory educational attainment at each of the educational periods (primary, secondary, and college entry and termination). These results suggest that some of the later life effects attributed to lower educational attainment should be considered, at least in part, consequences of early-onset mental disorders. Early-onset mental disorders reduce the amount of time people spend in marital relationships both by reducing the likelihood that they will marry and, more importantly, by increasing the likelihood that they will divorce or separate after marrying. Mental disorders developed prior to marriage are associated with a significantly elevated risk of marital violence in most of the countries studied. Frequently under-evaluated, productivity loss is a major disease burden, which, from a purely economic point of view, might justify intense investments in health restoration. WMH data show that individuals with serious mental illness earn, on average, almost one-third less than others in the population (29% in high income countries to 31% in low and lower-middle income countries). Also, our data show a strong association of common early-onset mental disorders (in this particular case defined as disorders present before completion of educational attainment) with current household income after adjusting for education. This association is considerably stronger in high income than upper-middle income countries and not significant at all in low and lower-middle income countries. After discussing some limitations of the study, conclusions are made about the need to further explore the spectrum of the burdens of mental disorders worldwide and the urgency of designing policies which facilitate addressing these burdens.
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Disability and Treatment of Mental and Physical Disorders: Results from the World Mental Health (WMH) Surveys			
Speaker	Ronny Bruffaerts Universitair Psychiatrisch Centrum – KU Leuven. Herestraat 49. B-3000 Leuven, Belgium			
Abstract	Objective: To present and discuss findings from the World Mental Health Surveys in terms of disability and treatment of mental disorders and common physical conditions around the globe. Methods: We report findings from the World Mental Health Surveys carried out in general population surveys worldwide. Findings will be presented on (a) full and partial disability associated with mental disorders and physical conditions and (b) treatment patterns for these disorders. The CIDI-3.0 version of the WHO-DAS-2 was used to assess partial (i.e. days in which some people are partially unable to perform as usual) and full disability (i.e. days in which people are completely unable to perform as usual). Results: Common mental and physical disorders are consistently associated with both partial and full disability, both at the individual and societal level. At the individual level, these disorders are associated with 31 and 25 of full disability days per year, respectively, and 41 and 28 days with partial disability. At the societal level, population attributable risk proportions were systematically higher for physical conditions (47.6-49.2% on average) than for mental disorders (14.7-16.5% on average). Especially depression and back pain are disabling conditions because of their high prevalence, their association with both partial and full disability, and their mutual comorbidity. Physical conditions were more likely to be treated than mental disorders (47.6-65.3% vs. 5.7-23.7%). In addition, people with mental disorders reported dramatic long delays in seeking professional help.			

	Discussion: Disability of mental disorders and physical conditions may be higher than reported so far because these conditions are not only associated with full disability but also with partial disability, over and above full disability. Especially depression and back pain may be disorders that could be priorities from a public health perspective.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Family burden related to common mental and physical disorders in the world: results from the WHO World Mental Health (WMH) Surveys			
Speaker	Maria Carmen Viana. Department of Social Medicine Federal University of Espírito Santo, Vitoria, Brazil			
Abstract	Objectives: Family caregivers shoulder the vast majority of long-term care responsibilities worldwide. Widespread health trends, such as greater life expectancy and prolonged survival with severely disabling conditions, are steadily increasing the demand for informal care. This study aimed to assess the prevalence and correlates of family caregiver burdens associated with common mental and physical conditions worldwide. Methods: Cross-sectional community surveys interviewed 43,732 adults residing in 19 countries of the WHO World Mental Health (WMH) Surveys, inquiring about chronic physical and mental health conditions of first-degree relatives. Among those reporting affected family members who were directly involved in their care, the associated objective (time, financial) and subjective (distress, embarrassment) burdens were assessed. Magnitudes and associations of burden are examined by kinship status and family health problem; and population-level estimates are calculated. Results: Among the 18.9-40.3% of respondents in high, upper-middle, and low/lower-middle income countries with first-degree relatives having serious health problems, 39.0-39.6% reported burden. Among those, 22.9-31.1% devoted time, 10.6-18.8% had financial burden, 23.3-27.1% reported psychological distress, and 6.0-17.2% embarrassment. Mean caregiving hours/week was 12.9-16.5 (83.7-147.9 hours/week/100 people aged 18+). Mean financial burden was 15.1% of median family income in high, 32.2% in upper-middle, and 44.1% in low/lower-middle income countries. Higher burden was reported by women than men, and for care of parents, spouses, and children than siblings. Conclusions: The uncompensated labour of family caregivers is associated with substantial objective and subjective burden worldwide. Given the growing public health importance of the family caregiving system, it is vital to develop effective interventions that support family caregivers.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Results from the WHO World Mental Health Surveys Initiative: Implications for mental health policy development			
Speaker	JM Caldas de Almeida, Universidade Nova de Lisboa, Portugal			
Abstract	Objectives: 1.- To analyse key findings from the World Mental Health (WMH) Surveys that are relevant for public policy needed to promote better health and well being of persons with mental illness; 2 - To discuss policy implications relevant to both developed and developing countries as they grapple with the challenges of the burden of mental disorders in their populations. Methods: Using population-based, cross-national epidemiological data from both developed as well as developing countries included in the World Mental Health (WMH) Surveys Initiative, we will analyse the data on the burden of mental illness that are relevant for policy development. Results: The results of the WMH surveys reinforce the need to invest on the development and improvement of mental health systems worldwide. Secondly, they show why it is so important to integrate mental health policy into general health policy, as well as into social policies. Finally, they provide a new understanding of associated factors, course, comorbidity, impact and treatment of mental disorders that is relevant for action in several areas of mental health policy (e.g., organization, financing and delivery of services, prevention, psychosocial rehabilitation, child mental health services and interventions, inter-sectoral collaboration, workforce development and training, etc.). Conclusions: The results of the surveys strongly encourage governments to revise, update and develop			

	mental health policies and plans, based on the existing knowledge on the burden of mental disorders, and taking into consideration the available evidence on the cost-effectiveness of services and interventions. They also call the attention of policy makers for the need to improve the provision of integrated mental health care, through strategies contributing to the development and delivery of community-based services, integration of mental health treatment and care into primary care and general hospitals, strengthening of psychosocial rehabilitation programmes, promotion of collaborative care models with task-shifting components, and the use of e-mental health programmes. The surveys findings also reinforce the need to further coordinate efforts at the global level to reduce the global burden of mental disorders and promote mental health of the populations.
References	

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	SOCIAL DETERMINANTS AND MENTAL HEALTH			
Chairperson	Sabine Bährer-Kohler, Dr. Bährer-Kohler& Partners, Switzerland			
Co-chairperson				
Abstract	Social determinants affect mental health directly and indirectly in various life span perspectives. These determinants are diverse and complex, and include social inequalities, social networks, and environmental factors as well as, for example, gender- and stress-related factors. At the beginning of the symposium there will be a presentation on the subject of Mental Health, Socioeconomic Inequalities and Children in Brazil. The data presented relate to various determinants of internalizing behavior problems in children as well as to the potential contribution of socioeconomic inequalities (gender and mothers' education) and community violence in order to show the necessity of social and economic investments in the members of families with children as well in communities. It relates to the intimate realm of the family vis-à-vis the broader socioeconomic context shaped by governments, international agencies and civil society. The data presented also reveals potential key targets for early intervention, especially for children from highly vulnerable families. The second presentation will discuss the interrelationship between social networks and mental health. Individuals have been recognized as social beings living in ecological environments. The level of social integration in communities and the available resources influence the mental health of those individuals. It will be documented that social networks have the potential to provide individuals with protection and support. The construction of social networks can prevent negative mental health conditions and change unhealthy life styles, directly or indirectly. Prevention mechanisms aim at universal (general), selective (at-risk) or indicated (mental disorders) target groups to provide a supportive environment for coping with social stress. The third presentation will discuss the impact of the occupational stress syndrome of burnout on mental health worldwide. Burnout may be result of a complex interaction between workplace-related, social and individual factors. Several epidemiological studies have found a high prevalence of burnout in developed and developing countries. Burnout may affect almost anybody, employees in various occupations as well as caregiving relations. The presenter will underline that preventive approaches are needed, including modifying the work environment and improving the individual's ability to cope with stress.			
References				
Speakers	1. Simone Gonçalves de Assis, Socioeconomic Inequalities, Violence and Internalizing Problems in Brazilian school-children 2. Hui-ching Wu, National Taiwan University, Taiwan 3. Francisco Javier Carod-Artal, Institut Universitaire En Santé Mentale Douglas, Canada			
Contact:	Sabine Bährer-Kohler, Dr. Bährer-Kohler& Partners, Switzerland			

Session:	Symposium	SPEAKER 1	Code	
Title:	Socioeconomic Inequalities, Violence and Internalizing Problems in Brazilian school-children			
Speaker	Simone Gonçalves de Assis, Socioeconomic Inequalities, Violence and Internalizing Problems in Brazilian school-children			
Abstract	Objectives The study aims to investigate the association of internalizing problems in Brazilian school children with the following variables: socioeconomic inequalities, family and community violence. Methods The research is based on a cross-sectional analysis of schoolchildren aged between 6 and 10 years-old, selected by random sampling from a city in the state of Rio de Janeiro, Brazil. Socio-economic variables, violence and internalizing problems were investigated by caregivers' information and organized in blocks for analysis. A binary logistic regression model was applied, according to hierarchical blocks. Results The resulting model indicates that girls developed more internalizing problems than boys (OR=2,56). Children of mothers with low education have more emotional problems than those with more years of schooling. Also, children who suffered community violence have more the studied behavior problem than those who do not suffer it. No family violence variables are associated with internalizing problems. Conclusion The study points to multiple determinants of internalizing behavior problem in children, as well as the potential contribution of socioeconomic inequalities (gender and mother's scholarship) and community violence. It reveals the necessity of social and economic investments in the members of family with children as well in context of the community. It involves the intimate realm of the family towards the broader socioeconomic context shaped by the governments, international agencies and civil society. The study also reveals potential key targets for early intervention, especially for children from highly vulnerable families			
References	The research had the support of the National Council of Scientific and Technological Development (CNPq) and the Carlos Chagas Filho Research Support Foundation of the State of Rio de Janeiro (Faperj), Brazil. 2 All the authors are from "Jorge Careli Latin American Centre for Studies on Violence and Health" (CLAVES), Oswaldo Cruz Foundation/ Brazil.			

Session:	Symposium	SPEAKER 2	Code	
Title:	Social Networks and Mental Health			
Speaker	Hui-ching Wu, National Taiwan University, Taiwan			
Abstract	Objectives: The purpose of the study was to discuss the inter-relationship between social networks and mental health. Multiple social, psychological, and biological factors were found to determine the level of mental health of a person at any point of time. Individuals have been recognized as social beings living in the ecological environments. The level of social integration in the communities and the resources influence the mental health of those individuals. Methods: The study employed literature review to examine the function of social networks on the wellness of mental health and in further to explore how it was affected by a collective culture. Results: The findings suggested that the networks of social integration and interaction provide opportunities through which social support is made available. Networks were viewed as one dynamic element in the process of support and that comprise the properties of social composition, structure and relations. Social networks tend to have a protective effect on mental health by buffering individuals from the ill effects of stressful events or support treatment for the psychological discomfort. When this buffering is absent or withdrawn due to a fragmented or dysfunctional social network, an individual's vulnerability to mental disorder may increase. The social networks and social support are reciprocity. Social networks involve the quantity and structure of a person's relationships, the social support provided by those relationships, and their impact on that person's well-being. Social support was one of the functions provided by a social network, and can be viewed as the comfort and support received from other people through various types of relationship. Culture was an important determinant of mental health for its size, density, ties, and			

	multiplicity of social networks. Conclusion: Social networks have the potential to provide individuals with protection and support. The construct of social networks would prevent the negative mental health condition and change unhealthy life style, directly or indirectly. The preventive mechanism aimed at universal (general), selective (at risky) or indicated (mental disorder) population to provide a supportive environment while they encounter the social stress.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Burnout syndrome and mental health in an international setting			
Speaker	Francisco Javier Carod-Artal, Institut Universitaire En Santé Mentale Douglas			
Abstract	Objective: The impact of the professional stress syndrome of burnout on mental health worldwide will be reviewed. Methods: A systematic review of the literature in search of epidemiological articles was done. Results: Several epidemiological studies have found a high prevalence of burnout in developed and developing countries. Burnout may affect almost anybody, employees in various occupations and caregiving relations. Nevertheless, this specific work-related syndrome may occur more frequently among people who work with human recipients of services. Burnout rates among the society range from 2.4% to 72%, whereas depressive symptoms may affect between 3% and one third of workers. Burnout may be result of complex interaction of workplace and social and individuals factors. The Karasek's job demand-control-social support model predicts that workers with high-strain jobs and low social support in the workplace are at high risk of disease. Common factors that may have an adverse effect on mental health and influence the risk of suffering depression in the workplace include: 1) specific stressful events (interpersonal conflicts, bullying by supervisors; sexual harassment); 2) organizational workload (long hours of work); 3) high job strain, organizational injustice and effort-reward imbalance; 4) low social support at work and outside; 5) personality traits and workaholism. Gender inequalities, poor paths of participation, a lack of occupational health services coverage, poor nutrition and hygiene, illiteracy and general poverty are some additional factors that can aggravate burnout and work-related stress in developing countries, outside the work environment. In Africa, the debilitation of health systems has provoked a heavy workload in health carers and teachers and an increased workforce burnout. Excessive work stress and burnout have negative consequences for the health, safety and well-being of workers, and the productivity and cost-effectiveness of the industries and services. People at risk for burnout and work-related depression can contribute to worsening job performance, and increase absenteeism, job turnover, and decrease productivity. Conclusions: Preventive approaches are needed and include both modification in the work environment and also improvement in the individual's ability to cope with stress. Nevertheless, in developing countries workers may not be familiar with burnout and job-stress prevention strategies.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	RECENT DEVELOPMENTS IN BRITISH THERAPEUTIC COMMUNITIES			
Chairperson	Dr Rex Haigh, Inaugural Committee, The Consortium of Therapeutic Communities. Consultant Psychiatrist, Berkshire Healthcare NHS Foundation Trust			
Co-chairperson				
Abstract	British Therapeutic Communities, originally based on the Social Psychiatry Movement in the 1950s - 1960s and based on the work of Maxwell Jones and others, have undergone a renaissance in recent years. Although many older communities have closed, others have developed and thrived in different sectors – particularly for troubled children, mentally disordered offenders and mental health patients diagnosed with personality disorders. This symposium will bring together four contributions to illustrate this work.			
References				
Speakers	1. Dr Rex Haigh, Slough Therapeutic Community, Berkshire, UK rexhaigh@nhs.net The New Non-Residential Therapeutic Communities for Personality Disorder. 2. Professor Michael Brookes, Grendon Prison, Buckinghamshire, UK. 3. Caryn Onions and Jennifer Browner, Mulberry Bush School, Oxfordshire, UK. 4. Sarah Paget, Programme Manager, Royal College of Psychiatrists, London, UK.			
Contact:	Dr Rex Haigh, Inaugural Committee, The Consortium of Therapeutic Communities. Consultant Psychiatrist, Berkshire Healthcare NHS Foundation Trust. Address: 1 St Marys Rd, Mortimer, Berkshire RG7 3UE UK Phone: +44 (0) 7768 546963 Email: rexhaigh@nhs.net			

Session:	Symposium	SPEAKER 1	Code	
Title:	The New Non-Residential Therapeutic Communities for Personality Disorder			
Speaker	Rex Haigh, Slough Therapeutic Community, Berkshire, UK			
Abstract	OBJECTIVE To demonstrate the change, development and growth of new British Therapeutic Community Practice since 2000. METHOD Analysis of policy, through case description - of quality, training and research projects. RESULTS The English Government's 'National Personality Disorder Programme' was launched in 2002 and saw the end of much 'traditional' therapeutic community practice. However, new forms and approaches to therapeutic community working have emerged, with government sponsorship, in the National Health Service (NHS) and Criminal Justice System (MoJ and NOMS). The main characteristics of the innovations are a focus on (1) quality of therapeutic relationships (2) minimisation of exclusion and (3) coherent working across sectors, organisations and professions. Suitable training programmes have been developed, and new research strategies to evaluate them. CONCLUSIONS Although residential Therapeutic Communities are in decline as part of social psychiatry practice, the radical ideas at their core are surviving and thriving in new formats. The same is true in prisons and elsewhere.			

References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Recent Developments in Therapeutic Community work in Grendon Prison			
Speaker	Michael Brookes, Director of Therapy, HMP Grendon, UK			
Abstract	OBJECTIVES For the past fifty years Grendon prison has pioneered a unique, therapeutic community, approach to the management and treatment of severely personality disordered offenders. The offences committed by prisoners at Grendon include murder, manslaughter, grievous bodily harm, rape and sexual abuse of children and young people. Recently, externally imposed directives combined with internal management changes have altered the structures which surround how the therapeutic communities operate. This paper will explain how Grendon has adjusted to these developments whilst still maintaining the integrity of therapy delivered. METHODS Described will be Grendon's treatment regime and the various government, national and local initiatives that prison managers have had to navigate and respond to over the past five years. These include an offender personality disorder strategy, market testing policy, healthcare and substance misuse funding arrangements, the accreditation of each therapeutic community, prison service audits and, revised management and grading arrangements. RESULTS Outcome data will be presented to demonstrate Grendon's efficacy as a treatment intervention along with the views of Her Majesty's Inspector of Prison and findings from Community of Communities/HM Prison Service therapeutic community accreditation reports. CONCLUSION Grendon prison has been able to successfully operate as a series of therapeutic communities adjusting and adapting to an ever changing external world while maintaining the core and core and essential elements of its internationally recognised treatment programme.			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Bringing the Family into Focus: New Work at a Therapeutic Community for Primary School Aged Children			
Speaker	Caryn Onions and Jennifer Browner Mulberry Bush School & Organisation, Oxfordshire, UK			
Abstract	OBJECTIVES When children are sent away from home or taken into care, the burden of responsibility for change can sometimes lie too heavily and somewhat unfairly on their shoulders. This paper will use two case studies to describe the work of the new Therapies and Networks Team at the Mulberry Bush School in Oxfordshire and how this work is integrated into the therapeutic milieu of the school. METHOD Qualitative: case studies RESULTS The work of the team aims to bring the focus for change more firmly onto the family as a whole in order to share with the child the responsibility for change and emotional development. The case studies will look at how we assess children and their families, whether birth, adoptive, or fostered, and how these assessments inform the range of interventions we offer alongside the milieu therapy in which the children are immersed.			

	CONCLUSIONS Through these case studies, the paper will briefly describe these interventions which include a range of individual therapies, family work or therapy, foster care support, and Family Weekends, in which the whole family is given an experience of the therapeutic milieu.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	Enabling Environments': Healthy Organisations and Relationship-Based Practice.			
Speaker	Sarah Paget ,Programme Manager, Royal College of Psychiatrists, London, UK.			
Abstract	OBJECTIVES The Enabling Environments Project has developed to reflect the importance and impact of the social environment on well being and personal development. The aims and objectives of any organisation will be impacted by the qualities of the social environment. This is more than just focusing on individual well being or promoting healthy lifestyles. The social environment, or culture, is the product of all the relationships and activities and central to enabling all participants to grow, develop and flourish. The result will be happier and healthier staff and improved outcomes for service users. This paper will describe the development of an Enabling Environment Quality Mark and explore the impact on member services. METHOD Qualitative: case studies RESULTS The Enabling Environment project promotes ten simple standards that help us think about the environment in which we live, work or play. The standards relate equally to those who provide a service (staff) as to those who receive it (patients, prisoners, customers etc). The standards apply to a range of settings and break the environment down into specific elements that have been identified as factors critical to a healthy social environment. We will follow the experiences of those applying for the award, identifying specific differences across a range of different environments. CONCLUSIONS Through these case studies, the paper will briefly describe the experiences of a range of services in developing and demonstrating their practice in relation to the qualities of their environment and report on the effect on overall outcomes.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	THE EFFECTIVENESS OF MENTAL HEALTH REHABILITATION SERVICES FOR PEOPLE WITH LONGER TERM AND COMPLEX NEEDS			
Chairperson	Dr Helen Killaspy, University College London and Chair, Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists			
Co-chairperson	Professor Jose Miguel Caldas de Almeida, New University of Lisbon, Portugal			
Abstract	Background – Mental health rehabilitation services focus on people with longer term and complex needs. The majority of this group have a diagnosis of schizophrenia with severe negative symptoms and other problems that have complicated their recovery, such as treatment refractory symptoms, cognitive impairment and comorbidities such as substance misuse. These problems often impact on day to day function and necessitate lengthy admissions to hospital. Highly supported community facilities are often required on discharge to support individuals, through a graduated care pathway of supported accommodation, to achieve their maximum level of independence in the community. For these reasons, this relatively small group absorb a large proportion of mental health and social care resources but, until recently there was little research into the aspects of care that were most beneficial for them and little evidence to guide practitioners and service planners. Goals - This symposium will describe major programmes of research from the UK and Portugal that focus on mental health rehabilitation services and aim to provide evidence for their effectiveness. Importance – The research programmes described in this symposium aim to identify the components of care that are incorporated into the complex intervention of mental health rehabilitation that most help people with complex mental health problems to achieve and sustain successful community living. Details of the development of an enhanced rehabilitation intervention that aims to improve people's engagement in meaningful activities will be described. Variations on this intervention are being evaluated through randomised controlled trials as part of the research programmes in the UK and Portugal and, if found to be effective, have potential for international roll-out. Interest to the congress participants – this session is likely to be of interest to most conference participants but especially those who work with people with longer term and complex mental health problems			
References				
Speakers	1. Dr Helen Killaspy, Reader and Honorary Consultant in Rehabilitation Psychiatry, University College London, Chair, Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists 2. Dr Sarah Cook, Reader in Mental Health occupational Therapy, Sheffield Hallam University, 3. Associate Professor Graca Cardoso, New University of Lisbon, Portugal			
Contact:	Dr Helen Killaspy, Reader and Honorary Consultant in Rehabilitation Psychiatry, Mental Health Sciences Unit, University College London, 67-73 Riding House Street, London, W1W 7EJ, UK. Tel 0044 207 679 9710, email: h.killaspy@ucl.ac.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	The effectiveness of mental health rehabilitation services for people with longer term and complex needs			
Speaker	Dr Helen Killaspy, Reader in Rehabilitation Psychiatry, University College London			
Abstract	Objective – The REAL study is a five year programme of research into mental health rehabilitation services across England, funded by the National Institute for Health Research. These services provide care for people with severe and complex mental health problems such as schizophrenia or schizoaffective disorder, where recovery is complicated by severe negative symptoms, non-response to medication, substance misuse and challenging behaviours. Rehabilitation provide multidisciplinary interventions to help the person gain/regain skills that they have lost through their illness, cope better with their			

	symptoms and gain the confidence and ability to leave hospital. Because of the severity of their problems, this group often require lengthy admissions and therefore absorb a large proportion of resources. Despite this, very little research has been carried out to help understand which aspects of rehabilitation work best and which patients benefit most from these services. Methods Phase 1: National survey of all NHS mental health rehabilitation services in England. Phase 2: Development of a training programme for nursing and other ward staff to improve service user engagement in activities on the ward and in the community. Phase 3: Cluster randomised controlled trial involving 40 inpatient mental health rehabilitation services to investigate the clinical and cost-effectiveness of the staff training intervention developed in Phase 2. Phase 4: Naturalistic cohort study investigating 12 month outcomes for patients of 50 inpatient mental health rehabilitation services. Results Phases 1 and 2 have been completed. Phase 1 has provided a detailed description of inpatient mental health rehabilitation services and those who use them. Results of multilevel models will be presented showing the associations between different components of care and service user outcomes. Progress with Phases 3 and 4 will be reported. Phase 2 will be presented by another speaker (Dr Sarah Cook). Conclusions The results of the REAL research programme will allow us to identify the service and service user characteristics that result in improved clinical outcomes associated with successful discharge from hospital and reduced service costs. This will inform future development and investment in services for people with complex mental health needs.
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	The Rehabilitation Effectiveness for Activities for Life (REAL) study: Phase 2. Development of GetREAL, a training programme for nursing and other ward staff to improve service user engagement in activities on the ward and in the community			
Speaker	Sarah Cook, Reader in Occupational Therapy, Sheffield Hallam University			
Abstract	Objectives 1) To develop GetREAL, a staff training programme aimed at equipping mostly unqualified nursing and other ward staff with the understanding, skills and behaviours to improve service user engagement in activities both on rehabilitation wards and in their local community. 2) To prepare an intervention manual and induction programme for the staff teams employed to deliver this training intervention to 20 psychiatric rehabilitation wards across England within the study. 3) To prepare a fidelity measure to assess the delivery of the training intervention during the study. Methods The development process involved building on existing evidence and theory, consulting with clinical experts and service users, and piloting the intervention in practice. Consultation events were held with service users, practicing occupational therapists, members of the REAL study Steering Group, and staff teams in 5 rehabilitation units. The draft intervention manual was further refined and training materials created by the new intervention teams during their induction week and by piloting the GetREAL intervention in two NHS units. Fidelity criteria were developed by the authors and the REAL study steering group and GetREAL was formally endorsed by The College of Occupational Therapists. Results The GetREAL training was underpinned by theories from organisational change and from occupational therapy including a three-stage model of change. Senior psychiatrists visited senior staff in each health care service provider during the 'Predisposing stage' to engage their commitment to change. A senior occupational therapist and activity worker, with input from a service user consultant, worked alongside ward staff for five weeks during the 'Enabling phase'. This included two training events with all ward staff, goal setting and action planning and intensive, hands on support for staff to gain confidence in the implementation of the specific techniques learned to engage seemingly unmotivated service users in			

	activities of their choice. An appreciative enquiry approach was taken which focuses on good practice. The 'Reinforcing stage' involved long term action plans and continued offers of support in order to maintain sustainable change. Conclusion The GetREAL manual, training materials, induction programme and fidelity criteria were developed through successive phases that consulted many different people with a variety of expertise. The novel features of GetREAL are that it targeted management and senior staff as well as the staff working on the ground and that the trainers worked closely together with ward staff teams for a full five weeks to bring about change in practice.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	The PromQual study: a national study of mental health rehabilitation services in Portugal			
Speaker	Associate Professor Graca Cardoso, New University of Lisbon, Portugal			
Abstract	1. Objectives a. Assessing the quality of care, living conditions, and rehabilitation of people in long-term psychiatric and social institutions; b. Developing a new training intervention for professionals working in these institutions, designed to improve the quality of care and rehabilitation of its users; c. Evaluating the effectiveness of the intervention. 2. Methods A randomized controlled trial is being carried out. All the existing units in Portugal were assessed at baseline with the Quality Instrument for Rehabilitative Care (QuIRC) filled online by the manager, and face-to-face interviews with the Service User Interview Schedule with a random sample of service users. The intervention consisted of workshops attended by the managers and the staff of the residential units in the intervention arm; and of a 4-week local intervention delivered by one occupational therapist and one activity worker to help local professionals integrate the knowledge and skills gained from the workshops into their everyday work with residents. Units will be reassessed at 4 and 8-months after training is completed using the baseline instruments. All managers and users gave their informed consent. 3. Results The majority of the residential units assessed (n=42) were in Lisbon and surrounding districts (59.5%), 50% were in hospital surroundings and 50% in the community, and had a mean number of 11.5±6.9 beds [5-31]. The QuIRC mean score was 52.5% [26.6-78.8%]. The units interviewed users (n=278) were mainly men (66.2%), had a mean age of 49.4±10.6 years [23-83], and had on average studied for 9.1±4.9 years [0-30]. 4. Conclusions The baseline assessment showed significant problems in several areas of the quality of care provided by the residential units. The training intervention was already carried out in half of the units without major problems, proving its feasibility			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	CO-MORBIDITY OF DEPRESSION AND DIABETES: PROBLEMS FOR SCIENCE AND CONSEQUENCES FOR PATIENTS AND PRACTICE			
Chairperson	Norman Sartorius, MD, PhD: Dialogue on Diabetes and Depression			
Co-chairperson	Driss Moussaoui, MD: World Association of Social Psychiatry			
Abstract	Description of the symposium: The psychiatrist should play a central role among the health care providers involved in collaborative care of patients with serious chronic diseases complicated by a co-morbid depression. Depressive disorders are frequently co-morbid with diabetes. Depression can lead to poor self-care, affect glycaemic control and compromise quality of life in patients with diabetes. The prognosis of both diabetes and depression – in terms of severity of disease, complications, treatment resistance and mortality – as well as the costs to both the individual and society is worse for either disease when they are co-morbid than it is when they occur separately. The introduction to the symposium will review epidemiological findings about co-morbidity of depression and diabetes and the public issues related to it. This will be followed by a presentation of the views of professions that are most directly concerned with the management of comorbidity: including the family physicians, nurses, the psychiatrists and the diabetologists. The views of patients with comorbidity will also be presented. The symposium will also describe a major international programme launched to address the problem.			
References				
Speakers	1. Henk Parmentier, M.D., World Association of Family Doctors (WONCA), London, U.K. henk.parmentier@gmail.com “The management of co-morbid depression and diabetes: “views of the family physicians” 2. Seyda Ozcan, RN, MSN, PhD; Associate Professor, Istanbul University; Florence Nightingale Nursing Faculty; Federation of European Nurses in Diabetes (FEND), Istanbul, Turkey. seyda_ozcan@hotmail.com “The management of co-morbid depression and diabetes: “views of the nurses” 3. Driss Moussaoui, MD: World Association of Social Psychiatry (WASP); Casablanca, Morocco. drissm49@gmail.com “The management of co-morbid depression and diabetes: “views of the psychiatrists” 4. Joao Manuel Valente Nabais, President, International Diabetes Federation (IDF), European Region; Lisbon, Portugal; joao@idf-europe.org “The management of co-morbid depression and diabetes”: views of diabetologists and consumers”.			
Contact:	Larry C. Cimino Global Programme Director, Dialogue on Diabetes and Depression 3693 Power Place Carmel, IN 46033 USA Phone: +1 (317) 846-5760 Fax: +1 (317) 846-5760 Email: CiminoLC@Gmail.com			

Session:	Symposium	SPEAKER 1	Code	
Title:	Management of Co-morbid Depression and Diabetes: Views of the Psychiatrists			
Speaker	Driss Moussaoui President, World Association for Social Psychiatry Ibn Rushd University Psychiatric Centre, Casablanca, Morocco			
Abstract	There is ample evidence that there are strong links between diabetes (especially type 2) and depression. As a matter of fact, patients with type 2 diabetes present an increased risk of depression, and depressed patients are at increased risk of developing type 2 diabetes in a 3 year-period. One of the links between the two is the high plasma level of cortisol, which loses its diurnal rhythm. It constitutes a toxic factor for the central nervous system, and explains why there is atrophy in the hippocampus often seen in depressed patients. Cortisol secretion is the indicator of a chronic stress which leads to a decrease in the volume of neurones, in the number of their synapses, and in apoptosis of astrocytes in some regions of the brain. A well-known clinical link between depression and diabetes is the triggering effect on the latter of major negative life events, which in turn can aggravate an emerging depressive episode, which will worsen the diabetic illness. Complications, of course, worsen both clinical pictures. This is why it is essential to introduce in the psycho-education of diabetics notions of management of stress, depression and their interaction with diabetes. The problem is that psychiatrists rarely consider the importance of the somatic component introduced by the discovery of diabetes in a depressed patient, because of depression itself, or because of the prescription of novel antipsychotics in bipolar patients, which aggravate the diabetic illness, among other “metabolic syndrome” components.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	MENTAL HEALTH AND THE MIDDLE EAST CONFLICTS			
Chairperson	Prof. Federico Allodi, Chair, WPA Section on Psychological Consequences of Torture and Persecution. Psychiatrist Member, Consent and Capacity Board of Ontario, Ministry of Health, Toronto, Ontario, Canada.			
Co-chairperson				
Abstract	This symposium includes papers on the social and consequent mental health changes observed in persons directly involved or affected by the violent conflicts in the Middle East and Islamic countries in the last few years. They describe the demographic and clinical characteristics of samples of Libyan adults and women refugees living in Tunisian camps, former members of the police forces in Tunisia after the popular uprising finding their roles converted from oppressors into the oppressed, and Middle Eastern and Muslim exiles and immigrants attending social and mental services in California, USA, and in Uppsala, Sweden. Three papers describe specifically the mental health consequences and professional ethical responsibilities in the Israeli Palestinian conflict. One paper reports on the rates of PTSD rates and the resilience as a protective factor in children subject to the Israeli invasion of Gaza in December 2008-January 2009, another paper describes the stresses suffered by Palestinian children in Israeli detention centres and the factors associated with false or innocent confessions under interrogation. The papers have plentiful numerical data, relevant statistical analysis in graphic, tablets and histograms and conclusions which would be helpful to mental health workers, psychiatric clinicians and future researchers.			
References				
Speakers	1. Nahla El Sayed Nagy, Professor of Psychiatry, Ain Shams University, Cairo, Egypt. 2. Sami Ouanes, Anissa Bouasker, Rym Ghachem. Razi Hospital - La Manouba, Tunis, Tunisia.. 3. Mohammed Belaizi *, Yassine Otheman, Mohammed Zakaria Bichra. * Psychiatrist. My Ismail Military Hospital. Meknes. Med-V-Souissi University. Rabat. 4. Derek Summerfield, Honorary Senior Lecturer, Institute of Psychiatry, King's College, University of London. 5. Graciela Karmon, Psychiatrist, Chairperson, Physicians for Human Rights-Israel, Tel Aviv, Israel. 6. Maria Jose Lera, Professor, Department of Psychology University of Seville, Spain, and Ahmed Abu Tawahina, Clinical Director, Gaza Community Mental Health Program, Gaza, Palestine.			
Contact:				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	THE RELATIONSHIP BETWEEN MENTAL HEALTH, PSYCHOSOCIAL FACTORS AND CHRONIC DISEASE IN CHILDREN AND ADOLESCENTS IN LATIN AMERICA.		
Chairperson	Darci Neves Santos, Psychiatrist. PhD in Psychiatric Epidemiology, University of London. Institute of Collective Health, Federal University of Bahia, ISC/UFBA.		
Co-chairperson	Leticia Marques dos Santos, Psychologist. MSc Psychology, PhD in Public Health. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Caroline Feitosa, Psychologist, MSc Epidemiology, London School of Hygiene and Tropical Medicine (LSHTM). Institute of Collective Health, Federal University of Bahia, ISC/UFBA.		
Abstract	Background In recent years, there has been an increase in the awareness of the role of mental health and psychosocial factors in the aetiology and symptomatology of several diseases. There is evidence that the co-morbidity between mental health problems with chronic illness leads to a worse prognosis, higher burden of symptoms, and more costs for the health system. Furthermore, apart from the individual mental health, the mental health status of the family and other psychosocial factors also account for determining the illness process. However, in Latin America, there is a visible gap in the knowledge concerning the relationship between mental and physical illnesses, particularly for respiratory problems and obesity. Objectives This symposium aims to gather knowledge seeking to: (1) present evidence of the relationship between mental health, psychosocial factors and physical illness from different populations in Latin America, at different stages of development (childhood and adolescence); (2) discuss the appropriate conceptual framework, studies limitations and the guidelines for further research in this topic; Importance Approximately 35 million overweight children live in developing countries and asthma is the most common chronic illness in childhood. Both obesity and respiratory problems account for a major burden of disease in this stage of development. Despite the high prevalence and severe consequences throughout the life course, there is no clear policy for prevention and treatment in Brazil. Understanding this complex relationship can contribute for introducing mental health care for prevention and improvement of the chronic illness prognosis. This work comes from an interdisciplinary group involved in epidemiological research on mental health for many years, which confronts the conceptual and analytical challenges on investigating of mental health, psychosocial factors and chronic illness in two cohorts of children/adolescents living in different low-income settings in Brazil.		
References			
Speakers	Dr. Darci Neves Santos, Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA - Brazil. 2. Dr. Leticia Marques dos Santos. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA - Brazil.”. 3. Caroline Feitosa. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA – Brazil. 4. Dr. Ney Boa-Sorte. State University of Bahia, UNEB. Salvador – BA – Brazil.		
Contact:	Darci Neves Santos Psychiatrist. PhD in Psychiatric Epidemiology, University of London. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Rua Basílio da Gama, s/n - Campus Universitário Canela. Cep: 40.110-040- Salvador – BA. Phone: +55 71 32837453 Fax: +55 71 3336 0695		

Session:	Symposium	SPEAKER 1	Code
Title:	Understanding the complex relationship between mental health, psychosocial factors and chronic disease: a conceptual framework		
Speaker	Dr. Darci Neves Santos, Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA - Brazil		
Abstract	Background: In recent years, there has been an increase in the awareness of the role of mental health and psychosocial factors in the aetiology and symptomatology of several diseases. There is evidence that the co-morbidity between mental health problems and chronic illness leads to a worse prognosis, higher burden of symptoms, and more costs for the health system. Furthermore, apart from the individual mental health, the mental health status of the family and other psychosocial factors also account for determining the illness process. However, in Latin America, there is a visible gap in the knowledge concerning the relationship between mental and physical illnesses, particularly for respiratory problems and obesity. Approximately 35 million overweight children live in developing countries and asthma is the most common chronic illness in childhood. Both obesity and respiratory problems account for a major burden of disease in this stage of development. Despite the high prevalence and severe consequences throughout the life course, there is no clear policy for prevention and treatment for both conditions in Brazil. Understanding this complex relationship in early stages of development can contribute for introducing mental health care to improve the prognosis of chronic illness. Objective: This work aim to gather information from studies in Latin America, presenting the conceptual and analytical challenges on investigating mental health, psychosocial factors and chronic illness in low-income settings in Brazil and to discuss an appropriate conceptual framework, studies limitations, and guidelines for further research in this topic.		
References			

Session:	Symposium	SPEAKER 2	Code
Title:	Maternal mental health and social support: effect on childhood asthma symptoms		
Speaker	Dr. Leticia Marques dos Santos. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA - Brazil.”.		
Abstract	Background: Despite of efforts to identify different risk factors for childhood asthma, the literature didn't establish the etiology for this syndrome, and there is an increasing debate about the psychosocial contribution for this phenomenon. We investigated the effects of family social support and maternal mental health on childhood asthma prevalence, considering differences between asthma phenotypes and the inter-relationship between these factors to explain asthma morbidity. Methods: This is a cross-sectional study of 1013 children participating in the Social Change Allergy and Asthma in Latin America project. Psychosocial data were collected through a household survey utilizing Self Reporting Questionnaire and Medical Outcome Study Social Support Scale. Socio-economic and wheezing information was obtained through the questionnaire of the International Study of Allergy and Asthma in Childhood and level of allergen-specific IgE was measured to identify atopy. Polytomous logistic regression was used to estimate the association between maternal mental health, social support and atopic and non-atopic wheezing. Effect modification was evaluated through stratified polytomous regression according to social support level. Results: Maternal mental disorder had the same impact on atopic (AOR: 1.74, 95% CI 1.12-2.71) and non-atopic (AOR: 1.73, 95%CI 1.17-2.55) wheezing, even after adjusting for confounding variables. Material (AOR: 0.63, 95%CI 0.42-0.95) and informational supports (AOR: 0.60, 0.40-0.90) had protective effects on non-atopic asthma and there is some evidence that social supports may act as a buffer for the impact of maternal mental disorder on non-atopic wheezing. Conclusion: Poor maternal mental health is positively associated with wheezing, independent of whether asthma is atopic or non-atopic, but perception of high levels of social support appears to buffer this relationship in non-atopic wheezers only.		
References			

Session:	Symposium	SPEAKER 3	Code	
Title:	Behaviour problems and asthma: The effect of internalizing symptoms on the onset and course of childhood asthma symptoms			
Speaker	Caroline Feitosa. Institute of Collective Health, Federal University of Bahia, ISC/UFBA. Salvador – BA – Brazil.			
Abstract	Background: In recent decades, there has been an increase in asthma prevalence in Latin America. There is evidence that the psychological characteristics of the child are associated with greater asthma incidence and morbidity. In this presentation we will address the results of two studies, with three aims: 1. to investigate the role of behaviour problems in the incidence of asthma symptoms; 2. to investigate whether the presence of behaviour problems decreases the chance of remission of wheezing; and 3. to investigate how these behavioural factors affect the acquisition of severe symptoms. Methods: These were two cohort prospective studies: the first with 907 healthy children and the other with 371 asthmatic children living in a poor urban area in Salvador, Brazil. The psychological characteristics of the child were assessed using the Child Behaviour Checklist (CBCL) and wheezing was defined using the ISAAC questionnaire at the start and end of follow-up. A multiple logistic regression model with random effects was used to examine the association between the psychological components and both outcomes. Results: Children with internalizing problems had an increased chance of developing wheezing (AOR: 2.46, 95% CI 1.40-4.32, p:0.002). The association of internalizing problems with the onset of wheeze was present among atopic and non-atopic children. The remission of symptoms of wheeze was much lower in those children with internalizing problems (AOR: 0.54, 0.33-0.87, p:0.01). Furthermore, internalizing problems increased almost five times the chance of acquiring severe symptoms during follow-up (AOR: 4.03, 95%CI: 1.39-11.70, p:0.01). Conclusion: Children with internalizing problems had a higher chance of developing wheeze and a lower chance of remission, with also an increased risk of acquiring severe symptoms. These results highlight the importance of psychological care for children with asthma, in order to improve the prognosis of this condition.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Emotional and behavioural problems and overweight in adolescents: The role of gender and resilience.			
Speaker	Dr. Ney Boa-Sorte. State University of Bahia, UNEB. Salvador – BA – Brazil.			
Abstract	Background: Overweight and obesity represents a significant and growing public health problem. Recent data in Brazil revealed patterns of rapid growth in the prevalence of obesity amongst adolescents. Experimental and epidemiological studies consider the effect of psycho-emotional factors on an individual's biological system. Despite recent advances, there are still many gaps in this area, with few works addressing protective aspects, such as resilience against disadvantaged environments. This study aims to evaluate the association between emotional and behavioural problems and excess weight in adolescents living in a poor and semi-rural area and to verify the role of gender and resilience in this relationship. Methods: Cross-sectional study including 951 adolescents aged between 11 and 18 years in the district of Monte Gordo, Camaçari, Bahia, Brazil. The Youth Self Report/11-18 was used to assess behaviour problems. Excess weight was diagnosed using the body mass index indicator (BMI) for age +1 standard deviation (SD) from the standard curve recommended by the World Health Organization (WHO). Resilience was measured using the Resilience Scale. Prevalence ratios were estimated using Poisson regression with robust error. Results: We found a positive association between behavioural problems and excess weight (APR: 1.86, CI95% 1.27- 2.73). This association was only observed amongst girls (PR: 1.90, CI95% 1.27-2.83). This finding was also observed for internalizing (PR: 1.63, CI95% 1.12-2.35) and externalizing problems (PR: 1.64, CI95% 1.04-2.58). The magnitude of the association between behavioural problems and excess weight was 1,6 times stronger among adolescents with low resilience. Moreover, we only found evidence of an association between externalizing problems and excess weight amongst adolescents with low resilience. Conclusion: The association observed reinforces theoretical and empirical evidence of a relationship between behavioural problems and overweight/obesity. Special attention should be paid to gender and resilience in respect of treatment and prevention programs for overweight.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	TRANSCULTURAL PSYCHIATRY: WHAT REALLY MATTERS			
Chairperson	John M. de Figueiredo, MD, ScD Department of Psychiatry Yale University School of Medicine. WPA-TPS Treasurer			
Co-chairperson	Joseba Achotegui MD. Psychiatrist. Professor of University of Barcelona.WPA-TPS Secretary			
Abstract	The field of transcultural psychiatry must broaden to social psychiatry. Several aspects will be discussed in this symposium open to epistemological aspects of demoralisation that has to be understood in the context of the patient's individual, social and cultural background, and patients unfamiliar with western-type psychotherapies have to be oriented to guide their expectations before they are treated Chronic and multiple stress in the Ulysses syndrom show the importance to avoid the misdiagnosis and medicalization of stress reaction in the immigrants. The paradigm that underlie transcultural psychiatry in different european countries will be discussed. The objective is to demonstrate that it is necessary to leave the anthropological dogma and take into account the ethical and sociological problems.			
References				
Speakers	1 John M. de Figueiredo, MD, ScD Department of Psychiatry Yale University School of Medicine Tel:+ 203-272-9628 : Fax: 203-272-5124 2. Joseba Achotegui MD. Psychiatrist. Professor of University of Barcelon SAPPRI. Hospital de Sant Pere Claver. Vila I Vila 16. Barcelona 08004, Spain Telephone; 0034- 3. José López Rodas Instituto Nacional de Salud Mental "Honorio Delgado, Perú 4. Rachid BENNEGADI MD Minkowska Center Paris Honorary Member of the World Psychiatric Association. Chair "Medical Anthropology and Psychiatry" Section of the W.A.S.P 00-33-1-53 06 84 84 00-33-1-53 06 84 85 :			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Culture and demoralization in psychotherapy			
Speaker	John M. de Figueiredo, MD, ScD Department of Psychiatry Yale University School of Medicine Tel:+ 203-272-9628 : Fax: 203-272-5124			
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should be able to recognize how to identify demoralization across cultures, the limitations of our current diagnostic systems, and new approaches to arrive at a diagnosis and select the appropriate intervention. Purpose: The purpose of this presentation is to review the theoretical background and the methodological challenges faced in the cross-cultural study of demoralization and psychotherapy and to describe the clinical applications and research prospects of this area of inquiry. Method: A critical review of recent literature on distress and demoralization was conducted with a focus on the application of psychotherapy across cultures. Results: In most societies, members of a culture have attempted to help each other in times of trouble with various types of healing methods. Demoralization - an individual experience related to a group phenomenon - responds to certain elements shared by all psychotherapies. Demoralization follows a shattering of the assumptive world and it is different from homeostatic response to a stressful situation or from depressive disorders. Only a few comparative studies of this construct across cultures have been undertaken. The presentation of distress may vary widely from culture to culture and even within the same culture. To avoid "category fallacy" it is important to understand the idioms of distress peculiar to a cultural group. A cultural psychiatrist or psychotherapist would have to identify patient's values and			

	sentiments, reconstruct his/her personal and collective ambient worlds, and only then study demoralization. The presenting problem has to be understood in the context of the patient's individual, social and cultural background, and patients unfamiliar with western-type psychotherapies have to be prepared to guide their expectations before they are used. Conclusions: Cultural clinicians should consider using a combination of both “clinimetric” and “perspectival” approaches in order to arrive at a diagnosis and identify the appropriate intervention. Future research should identify the gaps in knowledge on the effectiveness of cultural psychotherapy at reversing or preventing demoralization.
References	de Figueiredo JM, Gostoli S: Culture and demoralization in psychotherapy. In press, Advances in Psychosomatic Medicine (invited article). Volume on “Cultural Psychiatry” edited by Renato Alarcon, MD.

Session:	Symposium	SPEAKER 2	Code	
Title:	Immigrant living in extreme situation. New data about “the Ulysses syndrome” among immigrants in Spain			
Speaker	Joseba Achotegui MD. Psychiatrist. Professor of University of Barcelona			
Abstract	I present/ the data of studies conducted in the Public Health Network of Mental Health in Barcelona that shows that the percentage of immigrants who experience the characteristic symptoms of The Ulysses Syndrome is 14,4% . The sample was of 1042 immigrants visited in SAPPRI (Servicio de Atención Psicopatológica y Psicosocial a Inmigrantes y Refugiados). These data are comparable of the data of other studies conducted in the region of Valencia (Spain) that show that the percentage of immigrants who experience the defining symptoms the Ulysses Syndrome is 17.02%. These data show the importance of using this diagnosis to avoid the misdiagnosis and medicalization and psychiatrization of stress reaction in the immigrants. Because the Ulysses Syndrome is not a mental disorder, when in fact what they suffer is a reactive crisis in response to extreme stress directly related to the process of migration (forced solitude, helplessness, persecution...)			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Mental health in Peruvians returnees			
Speaker	José López Rodas. Psychiatrist. Instituto Nacional de Salud Mental Honorio Delgado - Hideyo Noguchi . Universidad Paruana Cayetano Heredia. . Soc. Renato Lopez Guevara. Universidad Paruana Cayetano Heredia			
Abstract	I would like to present a research about the return of immigrants to Peru. In March this year, 12,000 high school students from public schools answered three questions of the MINI MENTAL DEPRESSION, as one of the 0 Suicide Program – 2012. They were also asked if at least one parent had been living abroad. At least 3% of students said that one parent was living abroad. We report only the information of 48 students from four schools. To them was applied the questionnaire allows us to identify indicators of Ulysses Syndrome in their parents.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Challenges for transcultural psychiatry in the new european society			
Speaker	Rachid BENNEGADI MD Minkowska Center Paris			
Abstract	Transcultural psychiatry in European countries today has many faces and is based on different paradigms. It would appear that the European construction requires inevitably a consistent policy of care for migrants and refugees throughout Europe. The Schengen Protocol regulates the immigration process. What about the harmonization of the provision of mental healthcare regarding the language barrier, the cultural representations of mental illness, posing a diagnosis and therapeutic orientation? Also, what is the focus placed on social determinants of mental illness in migratory process and burden of exile. This presentation will focus on the tools needed to enable mental healthcare professionals to develop cultural competence in clinical practice and social practices.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	PARTNERS FOR WELLNESS: THE FOUNTAIN HOUSE MODEL AND INTEGRATED HEALTHCARE		
Chairperson	Alan Doyle EdD, Fountain House, New York		
Co-chairperson	Ralph Aquila MD, Sidney R. Baer Center, New York		
Abstract	In 2011, Fountain House following a long partnership with Dr. Ralph Aquila of Roosevelt Hospital opened the Sidney R. Baer Center, integrating medical and rehabilitative care for people with serious mental illness. With nearly two decades of experience and the recent emergence of a public interest in integrated health care, Fountain House proposes a Symposium on the topic, Partners for Wellness, that focuses on a collaboration of medical and rehabilitative services in psychiatric care. Working communities modeled after Fountain House in association with an integrated medical health facility offer comprehensive, cost-effective community psychiatric recovery centers. As such, Fountain House and those throughout the globe that adhere to its model deliver daily on the goal of deinstitutionalization and demonstrate that people with severe mental illness can live and thrive in our society. Partners for Wellness goes well beyond coordinated medical care, establishing an “alliance” among patients, their clubhouses, psychiatrists, general practitioners, family members, and even friends all in the concerted pursuit of a patient's recovery and wellness. The following issues will direct our discussion: 1. The adequacy of available health and wellness services—including access to both medical care and recovery resources in the community (i.e. employment, housing, friends, etc.). 2. Whether these services are being offered by practitioners who understand that recovery in mental illness means more than symptom relief and community tenure, and who welcome the opportunity to collaborate with community agents in pursuit of quality of life goals. 3. Thinking beyond the clinical management of the disease that instills hope, a sense of self-efficacy, and self-esteem. 4. Reducing stigma and discrimination in our societies with available results from current research including: • Tod Mijanovich PhD (New York University): assessment on hospitalization and service utilization for recipients of Medicaid. • Michael O'Loughlin PhD (Adelphi University): qualitative study of clients' internal life, psychological stress, and trauma		
References			
Speakers	1. Alan Doyle EdD (Moderator), Fountain House, New York, USA, adoyle@fountainhouse.org, Director of Education. 2. Ralph Aquila MD, Sidney R. Baer Center, New York, USA, raquilamd@gmail.com, Director. 3. John Rivera, Fountain House, New York, USA, sunsetlotus@gmail.com, Consumer. 4. Juan Pedro Sapène MD, La Casa del Paraná, Rosario, Argentina, juanpedrosap@gmail.com, Psychiatrist. 5. • Bertil hartoch, Clubhouse de Waterheuvel, Amsterdam, Holland, Director.		
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Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	PROGRESS IN THE STUDY OF DEMORALIZATION			
Chairperson	John M. de Figueiredo, MD, ScD. Department of Psychiatry. Yale University School of Medicine New Haven, CT			
Co-chairperson				
Abstract	Demoralization is the clinical presentation of many, but not all, individuals who seek psychotherapy, many patients with medical illnesses (“giving up-given up complex”), many patients in the emergency departments (“crisis”) and even some patients with chronic mental illness (“social breakdown syndrome”). Demoralization follows the shattering of the assumptive world and it is different from homeostatic response to stressful situation and from depressive disorders. Although originally recognized in psychiatric outpatients and medical settings, it is estimated that the prevalence of demoralization in general populations is quite high and intimately associated with adversity. Research on demoralization has expanded significantly since Jerome D. Frank introduced this clinical construct in the early 1960s. For example, research diagnostic criteria for demoralization have been proposed and several scales have been developed for its assessment. Sub-types of demoralization have been characterized. Demoralization has been documented among immigrants and refugee and has been shown to be a risk factor for certain mental disorders, including major depressive disorder and post-traumatic stress disorder. This symposium will review and discuss recent advances in the study of demoralization and its position in the spectrum of psychopathology. Demoralization may be conceptualized as involving two components, distress and subjective incompetence. As the stressful situation increases in duration or severity, some people with subjective incompetence experience helplessness, and some with helplessness become hopeless, and, at times, suicidal. The relationship of demoralization to the diagnostic categories of DSM-IV will be discussed. The presentation of demoralization in one particular group of subjects, refugee women, will be reported. The challenges presented by the recognition of demoralization in various social and cultural contexts will be examined. Together, these presentations are designed to stimulate our thinking about an important clinical construct that emerges at the boundaries between person and environment, past and future, “normal” and “abnormal”.			
References				
Speakers	1. John M. de Figueiredo, M.D., ScD. Department of Psychiatry, Yale University School of Medicine, New Haven, CT, U.S.A. 2. Chiara Rafanelli, M.D. Department of Psychology, University of Bologna, Bologna, Italy 3. Lynne Briggs, Ph.D. School of Human Services and Social Work Griffith University, Gold Coast Campus, Australia 4. Renato Alarcón, M.D., M.P.H. Department of Psychiatry, Mayo Clinic, Rochester, MN, U.S.A.			
Contact:	John M. de Figueiredo, MD, ScD P.O. Box 573 Cheshire, CT 06410-0573, U.S.A. Tel: 203-272-9628 Fax: 203-2725124 e-mail: johndefig@sbcglobal.net			

Session:	Symposium	SPEAKER 1	Code	
Title:	Demoralization: criteria, assessment and relevance			
Speaker	J. M. de Figueiredo. Yale University School of Medicine, New Haven, CT, U.S.A.			
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should be able to recognize the criteria for demoralization, methods for its assessment and its central role in the spectrum of psychopathology. Purpose: The purpose of this symposium is to present current, state-of-the art information on the recognition of demoralization in medical, social and cultural contexts, and its implications for research and clinical practice. Methods: Theoretical and empirical studies of demoralization were reviewed using both computerized databases and manual searches of the relevant peer-reviewed literature. Results: Demoralization is a spectrum or a gradient that starts with non-pathological distress, increases in complexity with the overlapping of subjective incompetence, moves on to take the form of helplessness, sometimes grows into hopelessness as negative outcome expectations make their appearance, and becomes pathological when it is enduring and causes significant impairment in social, occupational, or other important areas of functioning. In its most severe form, demoralization can be recognized as a syndrome (i.e., an enduring or persistent constellation of symptoms), including helplessness and distress that may be non-specific or specific (i.e., part of a physical illness or another mental disorder). Conclusions: Demoralization meets a clinical need not currently addressed by our existing diagnostic categories and plays a central role in both adaptation to stress and the natural histories of mental disorders.			
References	de Figueiredo J.M.: Deconstructing demoralization: Distress and subjective incompetence in the face of adversity. In: The Psychotherapy of Hope: The Legacy of Persuasion and Healing, eds. Julia Frank MD and Renato Alarcon MD, The Johns Hopkins University Press, 2012 pp. 107-124 de Figueiredo JM: Distress, demoralization, and psychopathology: Diagnostic boundaries. The European Journal of Psychiatry 27(1): 61-73			

Session:	Symposium	SPEAKER 2	Code	
Title:	Characterization of demoralization in the medically ill			
Speaker	C. Rafanelli, University of Bologna, Bologna, Italy			
Abstract	Purpose: There is increasing interest in the issue of demoralization in the setting of medical disease. The aim of this investigation was to use both DSM-IV comorbidity and the Diagnostic Criteria for Psychosomatic Research (DCPR) for characterizing demoralization in the medically ill. Methods. 1700 patients were recruited from 8 medical centers in the Italian Health System and 1560 agreed to participate. They all underwent a cross-sectional assessment with DSM-IV and DCPR structured interviews. 373 patients (23.9%) received a diagnosis of demoralization. Data were submitted to cluster analysis. Results. Four clusters were identified: demoralization and comorbid depression (27.6% of the cases); demoralization and comorbid somatoform/adjustment disorders (18.2%); demoralization and comorbid anxiety (24.7%); demoralization without any comorbid DSM disorder (29.5%). Conclusions. The findings indicate the need of expanding clinical assessment in the medically ill to include the various manifestations of demoralization as encompassed by the DCPR. Subtyping demoralization may yield improved targets for psychiatric research and treatment trials.			

References	Fava GA, Freyberger HJ, Bech P, Christodoulou G, Sensky T, Theorell T, et al. Diagnostic criteria for use in psychosomatic research. <i>Psychother Psychosom.</i> 1995;63(1):1-8.

Session:	Symposium	SPEAKER 3	Code	
Title:	Demoralization—psychological distress among refugee women			
Speaker	Dr Lynne Briggs, Griffith University			
Abstract	Background The international literature on refugees generally focuses on political, economic, and social issues. There is little reference specifically to refugee women's experiences and the resultant mental health implications. These women suffer a variety of human rights violations, but although they are sometimes subjected to similar abuses as men, such as political repression, women are often invisible victims because the dominant image of the political actor in our world is male. Goal The aim of this paper is to highlight the plight of refugee women. In doing so resettlement issues and their impact on mental health are identified. A discussion of the findings of a three-year study that self-report scales to examine the degree of demoralisation and psychological distress among a sample of seventy refugee and migrant women living in Australasia are presented. Results Major findings included a comparison of the mean total scores between the women and men in the study. Scores on the BDI-II that showed that the women were more depressed (mean=22, SD=13.85), than the men (mean=18.83, SD=11.94). Overall, scores from the BHS demonstrated that the women felt slightly more hopeless (mean=7.37, SD=5.31) than the men (mean=5.77, SD=5.02), had more abnormal hedonic tone (mean=2.90, SD=3.66) in comparison to the men (mean=1.53, SD=2.67), and were generally more demoralized (mean=41.99, SD=20.05) than the men (mean=33.73 SD=17.02). Of interest for participants There is a pressing need for services to ensure the mental health and well-being of refugee women and their families are met in a timely and appropriate way that will allow them to adjust more rapidly, to make full use of their skills and knowledge, and begin to rebuild their lives successfully in their new country			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Demoralization: cultural perspectives and their clinical implications			
Speaker	Renato D. Alarcón, MD, MPH. • Emeritus Professor of Psychiatry, Mayo Clinic College of Medicine, Rochester, MN, USA; Honorio Delgado Chair, Universidad Peruana Cayetano Heredia, Lima, Perú.			
Abstract	Demoralization is a term that seems to describe concepts and kinds of phenomena that differ more or less significantly according to the cultural context in which it occurs. These cultural variants are examined in the presentation, with descriptions that undoubtedly reflect contexts and meanings from a diversity of cultural perspectives, also influenced by individual personality traits and idiosyncratic management approaches. After discussing the role of demoralization in the dynamics of the clinical-psychotherapeutic encounter, a clinical assessment of the concept is attempted, emphasizing its characteristics as a cognitive-emotional product, an eventual, ubiquitous symptom, a pre-syndromic state or an improbable clinical entity in a diagnostic/nosological frame of reference. The cultural nature of demoralization makes it possible, in turn, the formulation of a variety of research projects in clinical and psychotherapy areas.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	SUBSTANCE USE COMORBIDITY IN EARLY-PHASE PSYCHOTIC DISORDERS			
Chairperson	Carol L.M. Caton, Ph.D., Department of Psychiatry and Mailman School of Public Health, Columbia University, New York, New York, USA; and Robert E. Drake, M.D., Ph.D., Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA.			
Co-chairperson				
Abstract	Description and justification of the symposium: Substances with psychotomimetic properties, such as alcohol, cannabis, cocaine, and amphetamine, are widely used internationally, particularly by adolescents and young adults. Their use or abuse can provoke psychotic reactions requiring treatment in people otherwise free of serious mental illness. Moreover, concurrent drug and alcohol use by patients with schizophrenia and other primary psychotic disorders is well documented. Substance use and psychosis comorbidity has been associated with a host of negative outcomes, such as re-hospitalization, treatment non-compliance, and homelessness. The diagnostic distinction between a psychotic disorder that is substance-induced and a primary psychotic disorder that co-occurs with alcohol or other drugs is critical for understanding illness course and planning for appropriate treatment. This symposium focuses on clinical and psycho-social similarities and differences between primary psychotic disorders and those that are substance-induced, drawing heavily on the Columbia University Study of Psychosis and Substance Use Comorbidity carried out in New York City. The overall objective is to share with congress participants what is currently known about this important and under-investigated topic, and initiate a dialogue on appropriate treatment interventions and future research initiatives. It is anticipated that interest in this topic will be high, given that substance use and abuse are increasingly common among patients presenting for treatment in psychiatric settings across the globe.			
References				
Speakers	1. Leanne Hides, BBehSc(Hons), Ph.D (Clin), Institute of Health and Biomedical Innovation, Queensland University of Technology, Brisbane, Australia, 2. Deborah R. Becker, M.Ed., CRC, Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA. 3. Carol L.M. Caton, Ph.D., Department of Psychiatry and Mailman School of Public Health, Columbia University, New York, New York, USA, 4. Robert E. Drake, M.D., Ph.D., Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA,			
Contact:	Carol L.M. Caton, Ph.D., Department of Psychiatry, Columbia University, Unit 56, 1051 Riverside Drive, New York, N.Y. 10032, 212-305-3503, clc3@columbia.edu			

Session:	Symposium	SPEAKER 1	Code	
Title:	Differences between first episode psychosis (FEP) patients with cannabis dependence diagnosed with DSM-IV primary and substance-induced psychotic disorders			
Speaker	Leanne Hides, BBehSc(Hons), Ph.D (Clin), Institute of Health and Biomedical Innovation, Queensland University of Technology, Brisbane, Australia,			
Abstract	Objective: To compare the demographic, family, clinical and substance use characteristics of patients with first episode psychosis (FEP) and cannabis dependence diagnosed with DSM-IV primary and substance-induced psychotic disorders. Methods: A subsample of 119 FEP patients with current cannabis dependence were identified from a larger sample of 386 FEP patients (169 (44%) with substance-induced psychosis (SIP; cannabis, alcohol and cocaine induced psychosis were the most common) and 219 (46%) with primary psychosis (PP)) recruited from 5 psychiatric emergency departments in New York city. Sixty of the FEP patients with cannabis dependence had PP and 59 had SIP on the DSM-IV Psychiatric Rating Interview for Substance and Mental Disorders (PRISM). Almost all of the SIPs (N=46, 88%) were cannabis induced. Baseline data on demographic, family, clinical and substance use variables were compared by diagnostic category using t-tests for continuous data and Chi square analysis for			

	dichotomous data. Results: There were no significant differences between the SIP and PP groups with cannabis dependence on demographic variables, the age of onset of drug use or the rates of borderline or antisocial personality disorders, post traumatic stress disorder (PTSD) or substance use disorders. The SIP group with cannabis dependence had significantly higher levels of premorbid adjustment, higher rates of poly-substance dependence, less severe positive, negative and general psychopathology symptoms and higher levels of insight than those in the PP with cannabis dependence group. Conclusions: Current results indicating patients with SIP with cannabis dependence had less severe levels of psychopathology and higher levels of insight than those with PP and cannabis dependence, parallel those found in the original study comparing SIP and PP across all substance types. However, unlike the original study, which found significant between group differences on all types of concurrent substance use disorders except cannabis abuse/dependence, no differences in diagnostic comorbidity on substance use disorders were found, except the SIP with cannabis dependence group had higher rates of poly-substance dependence. Whether the differences between the SIP and PP groups found in the current study are attributable to the presence of concurrent cannabis or poly substance dependence requires further exploration. The clinical implications of these findings will be discussed.
References	

Session:	Symposium	SPEAKER 2	Code
Title:	Early Psychosis and Employment		
Speaker	Deborah R. Becker, M.Ed.,CRC, Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA.		
Abstract	Objective: Employment may be an important factor in helping patients with early psychosis to recover rapidly and to avoid involvement in disability and welfare programs. Methods: This study followed 351 patients with early psychoses, either primary psychoses or substance-induced psychoses, for two years to examine their patterns of competitive employment in relation to service use, psychosocial outcomes, and disability and welfare payments. Results: Workers differed from non-workers at baseline and over two years. At baseline, they had better educational and employment histories, were more likely to have substance-induced psychoses rather than primary psychoses, were less likely to have drug dependence, had fewer negative symptoms, and had better psychosocial adjustment. Over two years, baseline psychosocial differences persisted, and the workers used fewer medications, mental health services, and disability or welfare payments. Conclusions: Employment predicts less service use and fewer disability claims among early psychosis patients. As supported by initial randomized controlled trials, supported employment may be a mechanism to reduce federal insurance costs and disability payments		
References			

Session:	Symposium	SPEAKER 3	Code
Title:	Gender Differences in Patients with Primary and Substance-Induced Psychotic Disorders		
Speaker	Carol L.M. Caton, Ph.D., Department of Psychiatry and Mailman School of Public Health, Columbia University, New York, New York, USA,		
Abstract	Objective: We present comparative data on gender differences in people with primary psychotic disorders (PP) with concurrent substance use and those with substance-induced psychoses(SIP). Gender differences have been observed in studies of schizophrenia with important implications for treatment. Surprisingly, gender differences in psychotic disorders that are substance-induced have not been reported. Gender differences are essential to understanding the onset, course, and treatment of all types of psychotic disorders, including those that are substance-induced. Methods: This report is based on 385 subjects identified during a crisis admission to psychiatric emergency departments in New York City. Study subjects were between the ages of 17 and 45 years, had at least on psychotic symptom identified by the clinical staff, had used alcohol and/or street drugs within the 30 days prior to admission, and had no psychiatric inpatient history prior to the last six months. DSM-IV research diagnoses were made using the Psychiatric Research Interview for Substance and Mental Disorders (PRISM), which was developed to assess psychiatric and substance use comorbidity. In addition to demographic and family characteristics, assessments included the Positive and Negative Syndrome Scale (PANSS), the Premorbid		

	Adjustment Scale (PAS), the Scale to Assess Unawareness of Mental Disorders (SUMD), and the Sexual Abuse Exposure Questionnaire. The study was approved by the Institutional Review Boards of Columbia University and participating hospitals. Results: 217 subjects had PP (affective or non-affective psychoses), while 168 had a SIP (alcohol, cannabis, and cocaine were the most common). Some of the study's findings parallel those from studies of schizophrenia. For example, men in the PP group were younger at illness onset, had more impaired premorbid adjustment, and were less likely to be married or have children compared to PP women. Men in both diagnostic groups had more arrests compared to women. In contrast, women in both diagnostic groups had greater histories of childhood sexual abuse compared to men, and women with SIP had greater recent partner abuse. Post-traumatic stress disorder was higher among women in both diagnostic groups compared to men. Conclusion: Findings confirm the clinical and social impact of substance use disorders in both psychosis groups. Findings underscore the need for treatment interventions that address substance abuse from the beginning stages of a psychotic illness, which for some may involve the criminal justice system. Gender-specific trauma informed services are needed for women in both diagnostic groups that also address the mothering role and care of children.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	Clinical Approaches with Patients who have Early Psychosis and Substance Use			
Speaker	Robert E. Drake, M.D., Ph.D., Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA,			
Abstract	Objective: When patients present with early psychosis and substance use, immediate diagnostic distinctions, medication treatment, and psychosocial interventions are needed, but guidelines are unclear. This paper attempts to provide a structure for thinking about these issues clinically. Method: A review of clinical issues based on the Columbia Study of Early Psychosis and Substance Use and the author's clinical experience working for several years in a clinic for young patients with co-occurring serious mental illness and substance use disorders. Results: The author reviews diagnostic criteria, findings on which patients are likely to convert to primary psychosis from substance-induced psychosis, protocols for medication treatment and suggestions regarding when and how rapidly to taper antipsychotic medications, the need for residential stabilization, family support and education, supported education/employment, cognitive-behavioral treatments, and peer support interventions. Conclusions: Initial treatment should be comprehensive, balancing the need for safety and psychosocial interventions as well as for medications to control psychotic symptoms, but clinicians must explain the potential risks and benefits of on-going treatment			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	THE PARADIGM BETWEEN PSYCHOTHERAPY AND SOCIAL PSYCHIATRY			
Chairperson	Dr. Rachid BENNEGADI: Director of the Research Pole, Sigmund Freud University Paris, France			
Co-chairperson				
Abstract	The Symposium entitled "The paradigm between psychotherapy and social psychiatry" is presented by Sigmund Freud University Paris and the French Association for Social Psychiatry. This symposium focuses on key issues arising in the field of psychotherapy and social psychiatry, such as the impact of psychotherapy on the social organization of a group, a society, or the importance of acknowledging social determinants in mental health care. Exploring such issues would lead to further important research in the field of social psychiatry and mental health care.			
References				
Speakers	1. Dr. Hervé HUBERT: L'Elan Retrouvé, Paris, France. herve_hubert@hotmail.fr "A new concept to be worked on in psychiatry: social transference" 2. Dr. Jalil BENNANI: Psychiatrist / Psychoanalyst - Rabat, Morocco bennani.jalil@gmail.com "How does psychoanalysis participate in social changes in a society?" 3. Dr. Rachid BENNEGADI: Director of the Teaching, Studies and Research Department at the Centre Françoise Minkowska, Psychiatrist, Anthropologist, Paris, France. bennegadi@minkowska.com "The impact of sickness and the elaboration of diagnosis of migrant patients"			
Contact:	Dr Rachid BENNEGADI: Director of the Teaching, Studies and Research Department at the Minkowska Centre, Psychiatrist, Anthropologist, Paris, France, bennegadi@minkowska.com +33153068484.			

Session:	Symposium	SPEAKER 1	Code	
Title:	A new concept to be worked on in psychiatry: social transference			
Speaker	Dr. Hervé HUBERT: L'Elan Retrouvé, Paris, France			
Abstract	The issue of social integration and its success is a fundamental one for persons with mental health problems. There is a new concept that may help us in addition to the tools that we use, a concept which I will define as "social transferences". The word "transference" in psychiatry is historically linked to psychoanalysis and I propose to extend it from the works of Freud, Lacan and others to social relationships and social relations. The beginning of this presentation will focus on the definition of social transference from Freud's study on "Group Psychology and the Analysis of the Ego." This study leads us to two geometric axes to define the problem of transference: a vertical axis that is directed by the One, and a horizontal axis that is oriented towards the equality between people. The aim of the presentation is to extend this approach to the fact that a human being is a social being, a being constituted by social relations. This will allow us to analyze the phenomena of violence and segregation in both the individual and the collective.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	The impact of sickness in the development of diagnosis among migrant patients			
Speaker	Dr. Rachid BENNEGADI: Director of the Teaching, Studies and Research Department at the Centre Françoise Minkowska, Psychiatrist, Anthropologist, Paris, France.			
Abstract	The approach of Clinical Medical Anthropology developed by Françoise Minkowska Centre, a Medical Psycho-Social Centre for migrants and refugees throughout the Paris area, has put the focus on social determinants, which Clinical Medical Anthropology distinguishes as “sickness”. It is frequent in migrant and refugee mental healthcare to include the impact of sickness within the expression of the patient's pathology. The author illustrates his remarks with the case of a patient presenting PTSD given by his own account of his psychological disorders as well as that of his family and environment. However, after taking into account his migratory path and his coping process, it turns out that it is more likely a Ulysses syndrome than a PTSD since fairly quickly, a number of symptoms related to chronic and multiple stress were reversible after a few interviews.			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	How does psychoanalysis participate in social changes in a society?			
Speaker	Dr Jalil BENNANI: Psychiatrist / Psychoanalyst - Rabat, Morocco			
Abstract	Because the symptom belongs to all social classes and that suffering is universal, psychoanalysis concerns all social backgrounds. Even in traditional societies in which there is a predominance of group, psychoanalysis allows individuals to express themselves and to exist. By the changes taking place in them, it can have an influence on their group, their family or friends. Psychoanalysis follows social changes by integrating them into universal values. Issues of identity, culture, language and religion occupy an essential place today. Examine the individual and sociocultural context as part of a universal symbolic field: these are some of the onerous tasks of psychoanalysis.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	SOCIAL, CULTURAL, AND ECONOMIC INFLUENCES ON POST PARTUM DEPRESSION: THE CASE OF ETHIOPIAN WOMEN IN ISRAEL AND ETHIOPIA.			
Chairperson	Rafi Youngmann, Ruppin Academic Center			
Co-chairperson	Ada H. Zohar, Ruppin Academic Center			
Abstract	Objectives: To present cultural and social influences on post partum depression (PPD) by presenting the symptomatology and prevalence of PDD in Ethiopian women in Ethiopia and Israel, and to put it in the context of rural women in developed and developing countries, as well as in the context of world poverty. Methods: A brief overview will precede the four main presentations, followed by comments by the discussant. Results and Conclusions: While PDD is best understood in the context of MDD, the social, cultural, and personal context in which it appears and the way in which it is labeled affect the symptomatology, prevalence, and outcome. The intersection of being poor, living in a rural area, being a member of a minority group, and in stress as a result of childbirth, puts women at considerable risk for PDD. The idiom of distress is affected by cultural, social and economic forces, and needs elaboration if women at risk are to be identified and helped.			
References				
Speakers	1. Dr. Rafi Youngmann, Ruppin Academic Center, Emek Hefer, Israel, 2. Prof. Charlotte Hanlon, Kings College London, London, England 3. Dr. Glasser, The Gertner Institute for Epidemiology and Health Policy Research, Tel-Hashomer, Israel 4. Prof. Coast, London School of Economics, London, England 5. Prof. Ada Zohar, Ruppin Academic Center, Emek Hefer, Israel			
Contact:	Prof. Ada H. Zohar, Ruppin Academic Center, Emek Hefer Israel, 40250. Phone 972-98983013; Fax: 972-98981062			

Session:	Symposium	SPEAKER 1	Code	
Title:	Opening remarks			
Speaker	Rafi Youngmann, Senior Lecturer, Ruppin Academic Center, Israel			
Abstract	In my opening remarks I will briefly address the following issues: • Why study post-partum depression? • What is the validity of this diagnosis and how does it relate to major affective disorder? • What is the prevalence of the disorder and what are generally known to be risk and protective factors? • Why are social, cultural and economic influences of particular interest re post-partum depression?			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	On affective disorders in Ethiopia with special reference to perinatal maternal mental health			
Speaker	Lars Jacobsson, Professor Emeritus, Psychiatric Department, University of Umea, Sweden.			
Abstract	Background: There is a growing body of research on women's health in developing countries, and			

	particularly in African countries. Objectives: In my presentation I will review the research of the last decade in Ethiopia on peri- and post-natal affective disorders in women, with special emphasis on the most recent population study of post-partum depression. Methods: The Perinatal Mental Disorder in Ethiopia study by Dr Charlotte Hanlon and coworkers. The study ascertained a population based sample of 1065 pregnant women and followed then to and after delivery, using culturally appropriate measures and approaches, as well as the EPDS. In addition, qualitative methods were employed for describing the peri- and post-natal local practices. Findings: Self-reported mental disorders in pregnancy had a prevalence of 12%, and postpartum around 5 %. These prevalence estimates are lower than those found in studies in other African settings. Discussion: The lower rates of mental disorders may be a reflection of a high level of adherence to socio-cultural perinatal practices, which were studied in the very interesting qualitative study. Some methodological issues will be discussed, as well as implications for preventive work.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	A Review of Perinatal Depression among Arab women in Israel			
Speaker	Nabil N. Geraisy M.D, M.P.A.H- Deputy of District Psychiatrist- Northern District Health Office- Ministry of Health			
Abstract	Background: The epidemiological data regarding mental health problems in the Arab countries, and regarding Arab women among the Arab minority in Israel are scanty, although the last decade has seen a growth of relevant research. Goals: This report will review the mental health of Arab women in Israel, with a special emphasis on perinatal depression. Results: There is a strong relationship between perinatal depressive symptoms, socio-demographic traits, various risk factors, and interethnic differences among Arab women attending Mother- Child Health Care clinics within the Arab minority in Northern Israel. Recent research shows a high level of emotional distress among the elderly Arab female population, In adolescent Arab girls there is research on eating related attitudes, psychological traits, suicidal behaviors, and treatment lag among first time female patients attending out- patient mental health clinics. Discussion: There is an elevated level of emotional distress among Israeli Arab women, starting with adolescence and culminating in elderly women. In this context the elevation of perinatal emotional difficulties and post-partum depression is easily understood. The implications for clinical care will be discussed. Health policy authorities should be informed regarding the needs of the various sub-populations.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Diagnosis and treatment of postpartum depression in Australian Aboriginal and Torres Island women: Barriers, challenges, and emerging therapeutic interventions			
Speaker	Rachel Bachner-Melman. Social and Community Sciences and Clinical MA Program, Ruppin Academic Center, Emek Hefer, Israel. 2 Psychology, Hebrew University of Jerusalem, Jerusalem, Israel			
Abstract	Objectives: Elevated rates of postpartum depression relative to those of the white Australian population have consistently been reported among Aboriginal women, as well as Torres Strait Island women, whose culture and history are inseparable from the broader indigenous story, yet distinctive from it. There is a significant lack of understanding of the mental health needs of these women during and after pregnancy, and a lack of culturally appropriate clinical tools to help women experiencing postpartum depression and offer them appropriate support. The aim of this presentation is to discuss the unique problems experienced by Aboriginal and Torres Strait women when they give birth, and describe promising, preliminary, culturally sensitive interventions that have been designed and implemented. Methods: A brief overview of some relevant cultural features of Australian Aborigines and Torres Strait Islanders			

	will be given, as well as their unique perspectives towards mental health. The literature on postpartum depression in Australian Aboriginal and Torres Island women will be reviewed, and Australian government initiatives for perinatal care presented. Several initiatives that have been launched throughout Australia to recognize and manage peri- and postnatal distress and depression in indigenous populations will be described. Results: Programs targeting perinatal health in Aboriginal and Torres Strait Islander women via culturally sensitive postnatal services appear to have been successfully implemented. The development of collaborative partnerships between the local community and teams of clinicians and researchers may be cause for cautious optimism. Various cultural considerations in diagnosing and treating peri- and postnatal disorders in Aboriginal and Torres Strait Islander contexts will be highlighted, alongside strengths that exist within the culture that potentially promote postnatal wellness. Results of research evaluating these interventions will be presented, and observations will be offered on the efficacy of existing interventions, problems that have arisen and recommendations for improvements. Conclusion: Evaluations have suggested that a collaborative model of care utilizing cultural consultants or health workers improves the access to and efficacy of the services. Yet postnatal depression still remains a severe problem for a disproportionate number of Aboriginal mothers. Despite encouraging beginnings of collaborative interventions and culturally appropriate services, the need for improved detection and treatment of postnatal depression within Aboriginal and Torres Strait Islander communities remains urgent.
References	

Session:	Symposium	SPEAKER 5	Code	
Title:	Concluding Remarks and Discussion			
Speaker	Ada H. Zohar, Professor, Ruppiner Academic Center, Israel			
Abstract	Objectives: To tie together the diverse findings presented by the three speakers, describing the situation on three continents: Asia, Africa and Australia, by integrating common risk and resilience factors, as well as pointing out differences owing to particular social, cultural or economic factors.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	SERVICE USER AND FAMILY PERSPECTIVES ON COERCION IN PSYCHIATRY			
Chairperson	Andrew Molodynski, consultant psychiatrist, Oxford Health NHS Trust and honorary senior lecturer, Oxford University, Oxford, UK. George Szumukler, professor of psychiatry and society, Institute of Psychiatry, London, UK			
Co-chairperson				
Abstract				
References				
Speakers	1. Dr Jorun Rugkåsa, Senior Researcher, Health Services Research Unit, Akershus University Hospital, Norway 2. Dr Kryisia Canvin, Research Fellow, Oxford University Department of Psychiatry, Oxford UK 3. Dr Yasser Khazaal, Geneva University Hospitals and Swiss Society For Social Psychiatry			
Contact:	Andrew Molodynski Oxford health NHS Trust and Oxford University department of Psychiatry Social Psychiatry Group, Warneford Hospital, Headington, Oxford OX3 7JX, UK. +441235799800 andrew.molodynski@oxfordhealth.nhs.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	Family experiences of community coercion			
Speaker	1. Dr Jorun Rugkåsa, Senior Researcher, Health Services Research Unit, Akershus University Hospital, Norway. jorun.rugkasa@ahus.no			
Abstract	Since 2008, mental health professionals in England and Wales have had the option of using Community Treatment Orders (CTO) to oblige patients (who meet the legal criteria) to adhere to treatment while living in the community. As part of a general deinstitutionalisation of care, it is acknowledged that the introduction of CTOs is likely to have impact on patients' families. Little research has been conducted, however, to elucidate exactly what these impacts may be and how they are experienced. As a result, the implications of CTOs on for family life is are currently poorly understood. Based on a series of qualitative interviews, this presentation will begin to address this knowledge gap by providing an outline of family carers' experiences and opinions of CTOs as currently used in England. Particular attention will be directed towards views about interactions between families and health services.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Pressures in community psychiatric services: Service user perspectives			
Speaker	2. Dr Kryisia Canvin, Research Fellow, Oxford University Department of Psychiatry, Oxford UK. Kryisia.canvin@psych.ox.ac.uk			
Abstract	Deinstitutionalisation and the shift in the delivery of the majority of psychiatric services to the community setting has led to new demands on the practices, policies and legislation for managing individuals with mental illness. There exist numerous informal and formal pressures aimed at managing service users in the community setting. Informal pressures are those that fall outside legal and policy provision or guidance, such as the practice of 'leverage' (also known as 'informal coercion'), while formal pressures include the use of the Mental Health Act and, more recently in England and Wales, the Community Treatment Order (CTO). Little is known about how these pressures are experienced by			

	service users in the England, especially since the introduction of CTOs. This presentation will discuss the findings of an extensive qualitative study of service users' experiences and perceptions of formal and informal pressures in community psychiatric services. A model depicting the type and range of pressures that service users perceive will be introduced with a view to shedding some light on the mechanisms that impact upon their effectiveness.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Advance directives based on cognitive therapy: a way to overcome coercion?			
Speaker	3. Dr Yasser Khazaal, Geneva University Hospitals and Swiss Society For Social Psychiatry yasser.khazaal@hcuge.ch			
Abstract	Mental health advance directives (ADs) are potentially useful for patients with bipolar disorder. Advance directives based on cognitive therapy (ADBCT) is a cognitive intervention aiming to help the patients during the ADs creation process The aim of the present preliminary study is to evaluate the impact of ADBCT on the number and duration of hospitalizations as well as compulsory admissions and seclusion procedures. Number and duration of psychiatric hospitalizations and number of compulsory admissions and seclusion procedures were recorded for a sample of non-adherent and committed patient 2 years before ADBCT and during a 2 year follow-up period. The number and the duration of hospitalizations as well as the number of compulsory admission procedures reduced significantly after ADCBT in comparison to the 2 years who preceded this intervention. The preliminary study at hand suggests that ADBCT is effective for patients with compliance and coercion problems. These results need to be confirmed in further randomized controlled trials.			
References				

Symposium:**MENTAL HEALTH CARE, MIGRATION AND SOCIETY**

Principal Organizer – Medical Anthropology and Psychiatry Section of the World Psychiatric Association

Co-organizers – Association Française et Eugène Minkowski (AFEM) & Centre Française Minkowska (CFM)

The symposium entitled “Mental health care, migration and society” focuses on the challenges met in the field of mental health care, including the articulation between health services and the need for treatment. The impact of such reflections and expertise are enlightening in terms of mental health spending and public health concerns. The consequences are obvious in terms of best practices and training professionals in the field of mental health. It is important to improve migrants and refugees’ access to mental health care as well as services while taking into account simultaneously social, cultural and psychological elements.

Speakers (Names, affiliations, city, country, email and tentative titles)

1. Mr. Christophe PARIS, Managing Director of the Française Minkowska Centre, Paris, France (paris@minkowska.com):

“Public health approach in offering mental health care for migrants and refugees in France”

2. Stéphanie LARCHANCHE, Medical Anthropologist and Coordinator in the Department of Teaching and Research at the Française Minkowska Centre, Paris, France (larchanche@minkowska.com)

“The role of the Anthropologist in a mediation consultation at the Française Minkowska Centre”

3. Marie Jo BOURDIN, Social worker and Director of the Training Department at the Française Minkowska Centre, Paris, France bourdin@minkowska.com : “Sickness and mental distress”

4. Dr Rachid BENNEGADI, Psychiatrist, Anthropologist and Director of the Teaching, Studies and Research Department at the Française Minkowska Centre, Paris, France bennegadi@minkowska.com

“Psycho-anthropological aspects of acculturation”

Full information of the proposal contact person

Dr. Rachid BENNEGADI, Honorary Member of the World Psychiatric Association. Vice -President of the French League for Mental Health ; Director of the Research Department, Sigmund Freud University ,Paris ; Chair "Medical Anthropology and Psychiatry" Section of the W.A.S.P; Director of the Teaching, Studies and Research Department, CFM, Paris, France ; Co-editor in chief of the Journal "TranSfaire et Cultures" ; Editor in chief of the French Version of the World Psychiatry Journal.

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Other considerations that you would like the Scientific Program Committee to know

Thank you very much

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	IMPROVING ACCESS TO PRIMARY CARE MENTAL HEALTH IN OLDER PEOPLE AND ETHNIC MINORITIES: DESIGN AND EVALUATION OF THE AMP MODEL			
Chairperson	Linda Gask: Professor of Primary Care Psychiatry, University of Manchester, United Kingdom			
Co-chairperson	Carolyn Chew-Graham, Professor of General Practice Research, Research Institute, Primary Care and Health Sciences, Keele University, United Kingdom			
Abstract	Evidence-based interventions exist for common mental health problems. However many people are unable to access effective care, because it is not available to them or because interactions with care-givers do not address their needs. We have developed and evaluated a new multifaceted model for increasing equity of access to high quality primary mental health care for under-served groups (www.amproject.org.uk). There are three components: Community engagement involves information gathering, working with community champions and focus groups and a task oriented community working group to work on identified problems. There is strong engagement with non-governmental organizations and an emphasis on improving health literacy. Primary Care: provision of an interactive needs-led training package to family practice including knowledge transfer, systems review and active linking to other domains of the model. The third element is delivery of culturally sensitive psychosocial Wellbeing Interventions to people with mental health problems (we focused on older people and those from ethnic minority South Asian communities, as these were priorities for the primary care organization with whom we worked in partnership), with individual, group and sign-posting options. This symposium will address important challenges for delivering psychosocial interventions at the interface of primary care, public health and mental health. We will share our experiences of implementing and evaluating this new approach in two deprived communities in the North West of England.			
References				
Speakers	1 Prof Linda Gask, Professor of Primary Care, University of Manchester, UK 2 Prof. Carolyn Chew-Graham, General Practice Research, Research Institute, Primary Care and Health Sciences, Keele University. UK. 3 Dr. Susan Beatty, Research Associate, University of Manchester. UK 4 Ms Saadia Aseem. Research Assistant, University of Manchester, UK			
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Improving access to primary care mental health in older people and ethnic minorities: design and evaluation of the amp model			
Speaker	L Gask, University of Manchester, UK			
Abstract	Educational Objectives: At the end of this session, participants will be able to understand: a). Barriers for patients from under-served groups in accessing primary care b). The development of the AMP (Access to Mental Health in Primary Care) model and its three components c). How to specifically implement the community engagement intervention Purpose: Our aim was to increase equity of access to high quality primary mental health care for under-served groups.			

	Methods: Examination of evidence from seven sources brought forward a better understanding of dimensions of access, including how people from under-served groups formulate (mental) health problems and the factors limiting access to existing psycho-social interventions. This informed a multi-faceted model to improve access with three elements: community engagement, primary care quality and tailored psychosocial interventions. Using a quasi-experimental design with a no-intervention comparator for each element, we tested the model in four disadvantaged localities, focusing on older people and minority ethnic populations. Community engagement which we will focus on in this presentation, involved information gathering, community champions and focus groups and a community working group. Results: For Community Engagement, there was strong engagement with third sector organisations, and variable engagement with health practitioners and commissioners. Outputs included innovative ways to improve health literacy. Results from other parts of the intervention will be described in the following presentations. Conclusions: Mental health expertise exists in communities, but needs to be nurtured. Primary care is one point of access to high quality mental health care. Psychosocial interventions can be adapted to meet the needs of under-served groups. A multi-level intervention to increase access to high quality mental health in primary care can be greater than the sum of its parts. Further research is needed to test the generalisability of our model.
References	Dowrick C, Gask L, Edwards S, , et al. Researching the mental health needs of hard-to-reach groups: managing multiple sources of evidence. BMC Health Serv Res. 2009;9:226. Gask L, Bower P, Lamb L, et al. Improving access to psychosocial interventions for common mental health problems in the United Kingdom: narrative review and development of a conceptual model for complex interventions. BMC Health Services Research. 2012; 12(1):249

Session:	Symposium	SPEAKER 2	Code	
Title:	Improving access to primary care mental health in older people and ethnic minorities: design and evaluation of the amp model – primary care quality			
Speaker	C.A. Chew-Graham, University of Keele, UK			
Abstract	Educational Objectives: At the end of this session participants will: Understand a model used to improve Primary Care Quality Appreciate lessons learned from working with practices Purpose: To understand development and evaluation of the Primary Care Quality component of the AMP model to improve access to mental health services in under-served groups. Methods: The process of developing the practice intervention will be described. The aim of the training was to work with whole practices, not just clinicians, and to embed ‘access-friendly’ systems in the practice. The training model included three components: knowledge transfer (sharing information and expertise), systems review (facilitating change within practices) and active linking (with community resources). The model was designed to be relevant to the practice’s everyday work, and flexible enough to respond to the challenges posed by the needs of an individual practice. A process evaluation, using qualitative methods, was conducted. Results: Some practices engaged with the AMP study team more than others, and numbers of workshops held with practices varied from one to 7. Topics covered in workshops included consultation skills training, working with asylum seekers, older people’s mental health, triage. Qualitative data suggests that the training intervention was well received and changes to practice systems were made. Conclusions: ☐ It is possible to develop and offer (and deliver) a flexible package of training to a whole practice			

	☐ Factors influencing engagement are important to consider ☐ A 'Practice champion' is crucial ☐ Practice has to be understood as an organization ☐ Role of research team must be considered ☐ Tensions between research and service ☐ Primary care is necessary but not sufficient
References	Grol R. Knowledge transfer in mental health care: How do we bring evidence into day-to-day practice? Can J Psychiatry 2008;53:275-6.

Session:	Symposium	SPEAKER 3	Code	
Title:	Delivering a tailored psychosocial intervention to older people with depression: patients' and therapists' perspectives			
Speaker	S. Beatty, University of Manchester, Manchester, UK			
Abstract	Educational Objectives: At the conclusion of this presentation, the participants should be able to understand the barriers and enablers to recruiting older people with depression and engaging them in treatment for common mental health problems, and to appreciate older people's and therapists' perspectives on the tailored psychosocial intervention that was delivered. Purpose: To evaluate the accessibility and acceptability of a tailored psychosocial intervention for older people with depression as part of a research programme to improve access to mental health services in primary care for people from under-served groups. Methods: The third element of the AMP model comprised a feasibility study to test the effectiveness and acceptability of a tailored psychosocial intervention for people from under-served groups. As part of the evaluation process, we conducted semi-structured interviews with 14 patients aged 51 to 85 in South Manchester to elicit their views on being referred into the study and receiving the psychosocial intervention. Therapists who delivered the psychosocial intervention were also interviewed. All interviews were audio-recorded, transcribed, and analysed using Framework analysis. Results: Housebound patients appreciated the option of receiving one-to-one sessions at home. Patients who joined a group reported benefit from the mutual support and activities provided. Some patients felt that an age difference between therapist and patient was difficult. Patients reported that they continued to use the behavioural activation techniques to motivate themselves, and some had developed links with organisations where they could then work as volunteers. Therapists commented on the particular challenges in working with older patients: the need to be proactive in encouraging participation, the impact of complex physical health problems on patients' mental health, and how issues from the past impinged on patients' current wellbeing. Conclusions: Accessibility was enhanced by having multiple referral routes. The intervention was generally acceptable in that it met patient need in a timely way, offered choice, and enabled patients to develop strategies to prevent relapse and to make links with organisations to maintain wellbeing.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Delivering a tailored psychosocial intervention to south asians with common mental disorders: balancing choice and necessity			
Speaker	S. Aseem. University of Manchester, UK.			
Abstract	Educational Objectives: At the conclusion of this presentation participants will have an appreciation of the views and experiences of South Asian women in receipt of a culturally sensitive psychosocial intervention for depression in the United Kingdom. They will also understand the importance of balancing choice and necessity in delivering a culturally sensitive intervention.			

	Purpose: To evaluate the delivery, acceptability and cultural appropriateness of a tailored well-being intervention for the South Asians with common mental disorders. Methods: Semi-structured interviews were conducted with 14 South Asian patients in Longsight, Manchester to share their views and experiences about referral, engagement and delivery of the well-being intervention. Additional questions were added to obtain information on the acceptability and cultural appropriateness of the well-being intervention. Three therapists and one supervisor who delivered the psychosocial intervention were also interviewed. All the interviews were transcribed, and data was analysed using computer software MaxQDA and Framework analysis. Results: Being able to experience a sense of empathic connection with the therapist was valued to be as important as cultural matching with and cultural or linguistic competence of the therapist. Some participants preferred to see a therapist who could understand their culture and/or speak their language, but for others the key to satisfaction was feeling that their problems could be understood by the therapist, regardless of their race or ethnicity. Conclusions: When designing interventions to improve access to therapy, it is important that assumptions are not made about requirements based on expectation about desire for cultural matching and language skills. Client choice may vary with time, nature and urgency of presenting problem and specific needs at the time of presentation.
References	

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	NARRATIVE APPROACH TO TREATING OBSESSIONAL DOUBTS AND DELUSIONAL BELIEFS			
Chairperson	Kieron O'Connor. Fernand-Seguin Research Center, Louis-H. Lafontaine Hospital, Montreal (Quebec) Canada			
Co-chairperson				
Abstract	Background information. Obsessional doubt forms a part of obsessional thinking, where the person doubts actions, information, or the self, and ruminates excessively that harm or error 'may' have occurred. Obsessional doubts can become overvalued ideas and form a dimension with delusional beliefs. Such obsessional doubts, overvalued and delusion ideas, are justified by the person through idiosyncratic narratives. These narratives are often overlooked by a symptom based approach but are essential to understanding the personal sense of the beliefs. The person considers the narrative based on authority, prior personal experience, hearsay, facts and logical calculation. But the personal stories contain rhetorical devices and reasoning fallacies which convincingly lead the person into a possible and imaginary world. Hence, restorying the person is a non-confrontational option to modifying beliefs. Goals. This workshop presents a novel narrative approach to evaluating and treating obsessions and delusions. The workshop describes a narrative treatment explicitly targeting obsessional doubt and delusional beliefs. Objectives. The first part of the workshop discusses: the conceptual underpinning of the narrative approach and in particular its grounding within both narrative and reasoning theory; and how the self stories become invested in the obsessional/delusional narrative so making any cognitive challenge extremely menacing to the person. The program is illustrated with clinical case illustrations and audience interaction step by step, soliciting the background narrative, the accompanying reasoning processes, and replacing remote narratives with other more relevant narratives. Distinctions between the current approach and the current cognitive therapy focus are outlined. Interest to the congress participants. The participants will learn how narrative techniques can aid understanding of abnormal beliefs. They will become familiar with narrative case formulation of belief maintenance as the rehearsal of personal stories. They will acquire information on the empirical base of the narrative approach.			
References				
Speakers	1. Kieron O'Connor. Fernand-Seguin Research Center, Louis-H. Lafontaine Hospital, Montreal (Quebec) Canada			
Contact:	Kieron O'Connor, Ph.D. Fernand-Seguin Research Center Louis-H. Lafontaine Hospital 7331 Hochelaga Street Montreal (Quebec) H1N 3V2 Canada Tel: 514-251-4015 x2343 Fax: 513-251-2617 e-mail: kieron.oconnor@umontreal.ca			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	CHALLENGES FOR A FUTURE PSYCHIATRY AND PSYCHOTHERAPY			
Chairperson	Ammon, Maria (Berlin/Munich), Burbiel, Ilse (Munich), German Academy for Psychoanalysis			
Co-chairperson				
Abstract	The objective of this symposium is to present holistic treatment methods for psychotherapy and new approaches of psychosomatic medicine. The authors describe the challenges for a future psychiatry and psychotherapy in a globalized “postmodern” society including the developmental task for the formation of identity as individuals and in groups. Classical contributions of the identity theory in psychoanalysis are reviewed and the consequences of the “intersubjective turn” in psychoanalysis for the definition of self and identity are considered. Guenter Ammon’s interpersonal theory of identity and his concept of social energy are described. Consequences from Guenter Ammon’s theory for the functioning and development of society are drawn. Günter Ammon’s health concept of Dynamic Psychiatry is presented including the conditions necessary to enable groups to facilitate an identity development for their members, virtual their mental-psychological-social health. The authors thus emphasise in particular the promotion of efforts of groups and their members to undertake for autonomy and emancipation as a forceful constructive potential against conformance, resignation and powerlessness in an increasingly unmanageable, bureaucratic, power-focussed and capital-controlled world, estranged from the human being. In addition a survey of the schools of learning in the field of modern psychosomatic medicine is included and the results of special psychosomatic field with the causes of specific psychosomatic illnesses.			
References				
Speakers	1. Maria Ammon, German Academy for Psychoanalysis, Berlin, Germany, DAPBerlin@aol.com The importance of personality as a challenge in our society 2. Ilse Burbiel, German Academy for Psychoanalysis, Munich, Germany info.kalb@psychoanalysebayern.de, Mental health, emancipation and group 3. Bast, Sieglinde, German Academy for Psychoanalysis, Berlin, Germany, bast_sieglinde@gmx.de Psychosomatic Crises or the loss of the human being and modern psychosomatic medicine			
Contact:	Maria Ammon, German Academy for Psychoanalysis, Kantstraße 120, 10625 Berlin, Germany, phone: +4930 3132698, fax: +49303136959, DAPBerlin@aol.com			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	MENTAL HEALTH CONSEQUENCES OF CONFLICT AND DISPLACEMENT: RESEARCH CHALLENGES (PART 1)			
Chairperson	Namrita S. Singh, Johns Hopkins Bloomberg School of Public Health			
Co-chairperson				
Abstract	This symposium, comprising two panels, will examine various aspects of mental health consequences of conflict and displacement. Mental illness contributes significantly to the global burden of disease. Communities affected by conflict and displacement experience unique stressors and barriers to mental health and psychosocial services. Additional research is needed to identify levels of illness across displacement contexts, the relationship between particular stressors and mental health outcomes, and the particular coping mechanisms of groups affected by conflict. Evaluation studies are also needed to assess the efficacy of interventions. The goal of the first panel is to elaborate research methodologies, challenges, and innovations in measuring mental illness among conflict-affected groups. Prevalence levels of disorders and psychosocial problems across conflict-affected groups; measurement of the impact of displacement on mental health; and methods for evaluating the efficacy of mental health and psychosocial interventions will be discussed. What are strategies for accessing 'hidden' displaced populations? What are specific cross-cultural research challenges in defining mental health and illness? What are methods for eliciting local terminology and mental illness constructs? This panel will emphasize psychometric challenges and strategies in the development of mental health instruments in conflict settings, as well as approaches for integrating ethnographic and epidemiological methods. Presentations by panelists will include discussions of: a randomized controlled trial of mental health interventions with torture survivors on the Thailand-Burma border; applying a bio-psycho-social-spiritual theoretical approach to mental health interventions; measuring idioms of distress and well-being among Iraqi refugees in Syria; the development of an integrated mental health diagnostic interview protocol for conflict-affected populations; validation of a symptom measure of psychological distress among Somali refugees in Ethiopia; and validation of a set of mental health measures, as well as the ethnographic assessment of local mental illness constructs, among elderly internally displaced persons in the Republic of Georgia.			
References				
Speakers	1. Courtland Robinson, PhD Johns Hopkins Bloomberg School of Public Health Center for Refugee and Disaster Response, Assistant Professor, Baltimore, USA crobinso@jhsph.edu 2. Constanze Quosh, MA United Nations High Commission for Refugees (UNHCR) Syria, Psychosocial Advisor, Damascus-Kafarsouseh, Syria, and University of New South Wales, PhD Candidate, Sydney, Australia quosh@unhcr.org 3. Brian Hall, PhD Johns Hopkins Bloomberg School of Public Health Department of Mental Health, Baltimore, USA, NIMH Postdoctoral Fellow in Psychiatric Epidemiology bhall@jhsph.edu 4. Alvin Tay, MSc World Health Organization (WHO), Research Assistant, Geneva, Switzerland and University of New South Wales, PhD Candidate, Sydney, Australia alvin.tay@unsw.edu.au 5. Namrita S. Singh, MSc Johns Hopkins Bloomberg School of Public Health Center for Refugee and Disaster Response, NIH Predoctoral Fellow and PhD Candidate, and Behavioral Health Leadership Institute Project Connections community mental health program, Research Associate, Baltimore, USA nasingh@jhpsh.edu			

Contact:	Namrita S. Singh, MSc NIH Predoctoral Fellow and PhD Candidate Department of International Health, Social & Behavioral Interventions Center for Refugee and Disaster Response Johns Hopkins Bloomberg School of Public Health 615 N. Wolfe St., Room E5527 Baltimore, MD, 21205, USA nasingh@Jhsph.edu (m) 1-719-339-3327

Session:	Symposium	OVERALL ABSTRACT	Code
Title:	DEPRESSION AND PSYCHOLOGICAL TRAUMA: AN OVERVIEW FOR INTEGRATING EPIDEMIOLOGICAL, NEUROBIOLOGICAL AND CLINICAL ASPECTS IN THE TREATMENT OF DEPRESSION.		
Chairperson	Veronica Vitriol MD, Psychiatrist, Professor of Psychiatry, Medical School of Universidad de Talca, Chile		
Co-chairperson	Alfredo Cancino MD, Family Physician, Psychoterapist, Chief of the Mental Health Unit Cesfam Curico, Chile Carolina Salgado MD, Psychiatrist, Mental Unit Health Talca Hospital, Chile, Professor Psychology Universidad Católica del Maule, Talca, Chile Soledad Potthoff MD, Psychiatrist, Chief of the Mental Unit Health, Talca Hospital, Chile. Kristina Weil MD, Psychiatrist, Associate Professor of Psychiatry, Chief of the Department of Psychiatry, Medical School of Universidad de los Andes, Santiago de Chile		
Abstract	Background information, goals, objectives, importance, and interest to the congress participants, better within 200-300 words. Depression is a major cause of morbidity worldwide. In most countries the number of people who would suffer from depression during their lives falls within an 8–12% range. According to the World Health Organization, unipolar depressive disorders were ranked as the third leading cause of the global burden of disease in 2004 and will move into the first place by 2030. Among the factors that are associated with its development and its increased clinical severity, is the exposure to traumatic events, such as childhood abuse, either sexual or physical, domestic violence, natural disasters, and others. The discussion of the differentiation of depression as "neurotic" or "biological", or the existence of a single depression postulated by DSM classifications has not been elucidated. However clinical experience and evidence have corroborated many decades the effect of certain biographical facts about the psychic apparatus and the appearance of adult disease. Most of the approaches related to trauma have considered PTSD as the main diagnosis. However, depression is a disorder two times more prevalent than PTSD in the general population. The goal of this symposium is to integrate the epidemiological and clinical findings in patients with depression and trauma history, and then to discuss how relevant these findings are for treatment of depression. The objectives will be to review the epidemiological, neurobiological, clinical, therapeutic, and gender related findings that are present in depression associated with psychological trauma. The importance and interest to the participants will be in the possibility to discuss from a bio-psychosocial model the impact of a traumatic event during the life cycle for the development of depressive disorders, and how important it is to deal with such an impact during the treatment of depression.		
References	--Vitriol V, Ballesteros S, Florenzano R, Weil K, Benadof D. Evaluation of an outpatient intervention for women with severe depression and a history of childhood trauma. Psychiatr. Serv. 2009; 60: 636-942. -Cancino A, Asenjo A, Jofre C, History of childhood trauma in women with depression attending in to the Depression Program in 2006, Cegis,año3 no7 ,2007 Weil K , Florenzano R, Vitriol V et al Child battering and adult psychopathology :an empiric study. Rev Med Chile 2004; 132: 1499-1504 Salgado C, Potthoff M.S., Vitriol V. The prevalence of early trauma in 590 outpatients with different diagnoses of complex problems of mental health, in Ambulatory Psychiatric Service of Hospital Regional Talca, Chile 2012, preliminary data		
Speakers	1.- Alfredo Cancino, MD, Family Physician, Psychotherapist, Chief of the Mental Health Unit Cesfam Curico, aecancino@gmail.com, 2.- Carolina Salgado and Soledad Potthoff, Psychiatrist, Hospital de Talca, Chile, carolslg@hotmail.com, 3.- Kristina Weil, MD, psychiatrist, Associate Professor of Psychiatry, Chief of the Department of Psychiatry, Medical School of Universidad de los Andes, Santiago, Chile, kweil@uandes.cl, 4. - Veronica Vitriol, Psychiatrist, Professor of Psychiatry Medical School Universidad de Talca, Chile		
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Session:	Symposium	SPEAKER 1	Code	
Title:	Depression and psychological trauma: epidemiological aspects			
Speaker	Dr. Alfredo Cancino Arce, Ps. María Andrea Asenjo Ramírez			
Abstract	During the past decade, international studies showed that 50% of general population is exposed to potentially traumatic events. Risk factors associated with the further development of psychopathology are female gender, interpersonal trauma and childhood trauma. A series of epidemiological studies has demonstrated that childhood sexual abuse is associated with a range of psychiatric disorders in adulthood that includes mood, anxiety, and substance use disorders. Post-traumatic stress disorder (PTSD) is the most studied diagnosis as a result of trauma. However, depression is a disorder that happens very often after a trauma and it is two times more prevalent than PTSD in general population. Depression is a major cause of morbidity worldwide. In most countries, the number of people who would suffer from depression during their lives falls within an 8–12% range. According to the World Health Organization, unipolar depressive disorders were ranked as the third leading cause of the global burden of disease in 2004 and will move to the first place by 2030. In Chile, the prevalence of depressive symptoms in the last year is 17.7% in general population, with a 25.5% in women. Since 2006, this disease is incorporated to the Explicit Health Guarantees (GES). Since 2002, we have developed research on the prevalence of childhood traumatic antecedents in adults who consult for depression in primary and secondary care in the Public Health Service of Región del Maule, Chile. All these studies have used the Marshall Scale. This scale asks whether an individual has memories of having one or more of the following traumatic experiences before the age of 15 years: traumatic separation from a parent or caregiver, alcohol or drug abuse of a family member, physical injury associated with punishment, and forced sexual contact with a relative or a non relative. Results have shown that between 55% and 82% of depressed patients recall at least one childhood traumatic event, of which 35 to 42% include sexual abuse, in both men and women. In women, the abuse is most frequently perpetrated by family member and in men by non family member. One of these studies demonstrated that traumatic history in women was associated to severe depression with greater symptomatic intensity, suicidal behavior and 49% in prevalence of PTSD. These findings were independent of severity of depression in primary care. These results evidence the high prevalence of childhood trauma, including sexual abuse, in patients who consult for depression in the Mental Health System in Chile. These records are associated to greater severity and comorbidity. According these findings, it requires to ask actively for childhood trauma history, to determine comorbidity and to design specific treatment strategies in patients with depression.			
References	-Caron Zlotnick, Jennifer Johnson, Robert Kohn, Benjamin Vicente, Pedro Rioseco, Sandra Saldivia. Childhood trauma, trauma in adulthood and psychiatric diagnoses: results from a community sample. Compr Psychiatry. 2008; 49(2) 163-169. -Cancino A., Asenjo M. Antecedentes traumáticos infantiles en personas ingresadas al programa de depresión en el CES Curicó-Centro durante el año 2006. FACE- ESGS, año 3, n° 7. Universidad de Talca, noviembre de 2007			

Session:	Symposium	SPEAKER 2	Code	
Title:	Depression and psychological trauma, gender differences and their neurobiological aspects.			
Speaker	Carolina Salgado and Soledad Potthoff, Psychiatrist, Hospital de Talca, Chile,			
Abstract	The clinical considerations in relation to how women respond to experiencing illness in a distinctly different way than men, has only been evaluated in the last decade. Previous to the year 2000 only male study groups were considered for research and the conclusions from those studies were extrapolated to the female gender. However, sexual dimorphism does exist and it is expressed in cerebral functions also and thus in the way illness is manifested and in mental health. Researchers, such as Mary C. Blehar and Miranda Olff, have focused their work on trying to understand the many differences of gender in the rate of prevalence, etiopathogeny, social-cultural factors, and in the response to treatment in different psychiatric disorders, especially PTSD and depression. Hence, different explanations have emerged that concern the exposure of particular types of traumatic experiences which have greater risk in the development of PTSD. Those explanations also include			

	specific gender differences and genetic vulnerability in both psychological and biological response to trauma. Social cultural factors, such as the early exposure to trauma, the role of gender, social position, legal rights, access to education and healthcare, gender violence, previous history of childhood negligence and early attachments problems during infancy, are seen as determining different manifestations and effects of psychological trauma in both sexes. These factors, together with others, can influence an increased frequency of depression and PTSD in women. These social cultural factors are equally as important as considering the intergenerational perspective of the repetition of certain extremely dysfunctional relationship patterns (ex. Domestic violence, sexual abuse, adolescent pregnancy) and also as important as considering the perspective of individual vulnerability. It has been determined that from the occurrence of a traumatic event progressing to the generation of a psychiatric disorder, a cascade of psychological and neurobiological events exist (exposure to trauma, subjective assessment of the event, emotional and behavioral response, neuroendocrine response, coping mechanism, defense mechanism, existence and search of social support). These play an important role in the development of the disorder like depression, PTSD, other anxiety disorders, addictions, etc. It is proposed that there could be a major gender difference in each of the steps of such a cascade of events. It is known that after a traumatic event a neuroendocrine system response is produced, specifically by the SAM axis and HPA axis, and that the principal hormones adrenalin and cortisol are released by each axis and have complementary roles. To reference Miranda Olff's work: Males could be more likely to have sensitized physiological hyper arousal systems (resembling the classical fight or flight paradigm) with relates symptoms such as poor impulsive control, aggression, and hyper vigilance. Women are said to more often have sensitized dissociative systems (resembling more passive defense mechanism) and to be more likely to exhibit corresponding symptoms like anxiety disorders, mayor depression and dissociative disorders. The subjective interpretation of the trauma is as important as the event for the generation of distress and, it has been seen that women tend to subjectively characterize an event in a very threatening way. This is crucial in starting the cascade of psychobiological responses to trauma and could be associated with increased neuroendocrine reactivity. Women and men tend to apply different mechanisms of stress reduction. Women are socialized to use more passive and emotion-focused coping behaviors (dissociation, avoidance) and men are socialized to use more active, instrumental behaviors (hyper vigilance, fight and flight). The lack of social support after a traumatic event plays an important role in how the event is resolved and in the development of psychiatric disorders. It is evident that women are particularly more affected by the availability of social support networks and/or the lack of them. In summary, all these interrelated factors in and of themselves could greatly explain the differences in the prevalence of depressive and anxiety disorders that are found to be more frequent in women.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Clinical Aspects of Trauma			
Speaker	Kristina Weil Parodi. Associate Professor of Psychiatry – Medical School – Universidad de los Andes – Santiago / Chile			
Abstract	Several studies demonstrate the relationship between traumatic experiences and psychopathology. Psychological trauma increases the risk for somatization disorder, personality disorder, depression, alcohol and drugs abuse, eating disorders and others. The relationship between psychological trauma and Post-traumatic Stress Disorder (PTSD) is well known, and the risk of developing the illness is higher if child abuse is given. Certain authors report that PTSD is superimposed with Borderline Personality Disorder, and define a “complex PTSD”. Politraumatized patients should receive a special category, joining axe I and II of DSM classification and should be seen as different as borderline patients. Women with early sexual abuse reported higher rates of complex PTSD and Borderline Personality Disorder, than those with delayed abuse. Sexual abused or victims of parents’ negligence have 4 more possibilities to be diagnosed as Personality Disorder in the adulthood than control subjects. Sexual abuse is related to several diagnoses, with the higher odds ratio with bulimia, alcohol and drugs abuse. Our studies in 4 general hospitals in Chile, recluding 505 patients, revealed high exposure to child			

	trauma, and high association with PTSD, somatization disorder, affective disorder, depression and personality disorder. The transgenerational transmission of trauma and child mistreat was often, expressed by autodestructive behaviours and actual exposure to psychological trauma.
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	Depression and Psychological Trauma, Therapeutic Approaches			
Speaker	Veronica Vitriol, Psychiatrist, Professor of Psychiatry Medical School Universidad de Talca, Chile			
Abstract	Depression is a significant public health problem. Risk factors involved in its development and clinical course include a history of childhood trauma. Patients with depression and early trauma often present a more severe and complex psychopathology including posttraumatic chronic symptoms of anxiety and depression, emotional dysregulation and interpersonal impulsiveness, and interpersonal difficulties. The complex clinical picture observed among adults who have a history of childhood trauma has been explained as a process of neurobiological and psychological vulnerability. Patients with depression and early trauma needs multimodal treatment including psychotherapy, pharmacotherapy that will be effective in quieting the body's hyper responsiveness to stress and reverse epigenetic modifications induced by trauma and stress and environmental interventions that provide a support network . According the above in 2000 at Curicó Hospital, located 180 km south of Santiago, In view of such evidence, we developed an intervention for this patient group. In addition to standard pharmacological treatment, the model incorporated a three-month structured intervention by a multidisciplinary team. Its objectives were to actively explore early traumatic experiences among women with depression, determine PTSD comorbidity and to focus psychological treatment on interpersonal difficulties in the present understanding them as repetition of the traumatic past. . The goal of the intervention is to discriminate the present from the past, avoid the re-victimization and promote the desvictimization. This interview was evaluated in a randomized clinical trial in 2002. 44 women with severe depression were treated with the proposed intervention and compared with 43 women who followed the usual treatment. The patients were evaluated at the start, at three and six months with the Hamilton scale, Lambert's Outcome Questionnaire (OQ-45.2), and the posttraumatic eight item treatment outcome (PTO8) After three months there were significant differences in favor of the experimental group in the Hamilton 22.1 versus 27.5 ($p < 0.01$) and in Lambert's OQ45 92.7 versus 105.4 t ($p < 0.05$). At six months there were significant differences in favor of the experimental group in the number of patients with recuperating indicators in the OQ45: 39% versus 14% ($p < 0.05$) and remission in Hamilton scale: 22% versus 5% ($p < 0,05$) We demonstrated that the proposed intervention was more effective than the usual treatment. However, the intervention group persists with symptomatic and dysfunctional indicators at the end of the observation. It must continue to validate long term treatment in these patients.			
References	Saveneau RV, Nemeroff CB. Etiology of depression: genetic and environmental factors. <i>Psychiatry Clinics North Am</i> 2012 35 51-71 Vitriol V, Ballesteros S, Florenzano R, Weil K, Benadof D. Evaluation of an outpatient intervention for women with severe depression and a history of childhood trauma. <i>Psychiatr. Serv.</i> 2009; 60: 636-942.			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	PROBLEMS ON CLASSIFICATION AND LINGUISTIC DISSEMINATION			
Chairperson	Toshimasa Maruta, Department of Psychiatry, Tokyo Medical University, Tokyo, Japan			
Co-chairperson	Norman Sartorius, Association for the Improvement of Mental Health Programmes, Geneva, Switzerland			
Abstract	The publications of the ICD-11 and the DSM-5 are rapidly approaching. In particular, the DSM-5 will be published in May, 2013. Both systems will give huge impact not only to mental health professionals and researchers and but also lay peoples. In this circumstance, it is very valuable to reconsider them from many fields. Firstly, Dr Sartorius will introduce and discuss about the processes of the two systems entitled as “Present challenges facing those proposing of mental disorders” Secondary, Dr. Craig will present and discuss useful classification relevance to rehabilitation entitled as “Diagnostic classification: relevance to rehabilitation psychiatry” Thirdly, Dr. Maruta will present and discuss about linguistic translation problems entitled as “Linguistic translation problems in the Japanese version of the ICD-11 and the DSM-5”.			
References				
Speakers	1. Norman Sartorius, Association for the Improvement of Mental Health Programmes, Geneva, Switzerland, sartorius@normansartorius.com, “Present challenges facing those proposing of mental disorders” 2. Tom K J Craig, Kings College, London, UK, thomas.craig@kcl.ac.uk, “Diagnostic classification: relevance to rehabilitation psychiatry” 3. Toshimasa Maruta, Department of Psychiatry, Tokyo medical University, Tokyo, Japan, maruta@tokyo-med.ac.jp, “Linguistic translation problems in the Japanese version of the ICD-11 and the DSM-5”			
Contact:	Toshimasa Maruta M.D., Ph.D, Department of Psychiatry, Tokyo medical University, 6-7-1, Nishi-shinjuku, Shinjuku-ku, Tokyo 160-0023, Japan, Tel: +81-3-3342-6111(ext. 5754), Fax: +81-3-3340-4499, E-mail: maruta@tokyo-med.ac.jp			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	INCENTIVES & OBSTACLES TO DEINSTITUTIONALISATION IN 21ST CENTURY EUROPE			
Chairperson	Justine Schneider, University of Nottingham, UK			
Co-chairperson	Chiara Samele, Informed Thinking Consultancy, London, UK			
Abstract	The closure of large psychiatric hospitals has been a policy objective for half a century yet they remain the main form of provision in a number of European countries, including Malta, Hungary, Croatia, Bulgaria, Lithuania, Latvia, Romania, Greece, Hungary, Portugal, Slovenia and the Czech Republic. Speakers representing 3-4 of these countries will present the obstacles and incentives to deinstitutionalisation in their particular context, to explore the factors that appear to promote it and those that impede it. The symposium will be steered by the convenors to generate discussion about the most promising 'pressure points' for improving inpatient psychiatric services.			
References				
Speakers	1. Justine Schneider – Introduction to the symposium 2. Ray Xerri, Malta: Fostering de-institutionalisation through legislation in Malta 3. Tomas Petr, Martin Holly, Petr Winkler, Czech Republic: Psychiatric reforms in the Czech Republic. 4. Chiara Samele (UK), Overview of psychiatric inpatient provision in Europe and description of EuroPOPP study. Chair: Justine Schneider, Professor of mental health and social care, University of Nottingham, UK			
Contact:	Justine Schneider, Institute of Mental Health, University of Nottingham, Triumph Road, Nottingham, UK NG7 2TU. Tel: 44 (0)115 846 7307/(0)7843607085. Justine.Schneider@nottingham.ac.uk			

Session:	Symposium	SPEAKER 1	Code	
Title:	Introduction to the symposium			
Speaker	Justine Schneider, Professor of mental health and social care, University of Nottingham			
Abstract	"The mental health care field needs both a debate on the values of care and good research on the effects of different forms of institutionalized care" wrote Priebe et al. in 2008, and they also reminded us that "Institutions as such are neither good nor bad, but they always absorb funding" (Psychiatric Services 59, 5 570-3). This symposium will look at hospital care for mental health problems across Europe. Its purpose is to stimulate debate and attention to a topic which has largely disappeared from the research agenda, but which has huge implications for the lives of people affected. The negative impact of deinstitutionalisation on community-based mental health services is debated – what factors mitigate against this? Negative impact on service users may also be relevant - for instance, in England, one of the first countries to embrace deinstitutionalisation, Keown et al. (2011) have demonstrated an association between bed closures and rates of compulsory admissions to the beds remaining in psychiatric hospitals. Contextual factors appear to influence successful deinstitutionalisation – a buoyant labour market and effective social security safety net are likely to promote successful bed closures. European hospitals contain many thousands of psychiatric inpatients. Publicly-available data collated for a recent survey of mental health policy in European Member States and other countries will be used to explore the variations in bed ratios and taking account of different country contexts, to look at the feasibility of deinstitutionalisation, the desirability of implementing alternatives to hospital care, and the factors that promote optimal outcomes for service users.			

References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Fostering de-institutionalisation through legislation in Malta			
Speaker	Ray Xerri, Malta			
Abstract	The new Maltese Mental Health Act was ratified by Parliament in December 2013. De-institutionalisation is one of the main trusts of the new law. Contrary to other countries' policies, the Maltese Ministry of Health has no intention of closing down its main psychiatric hospital though it has been downsized it over the years through a process of integrating previous inmates in the community after a programme of intense rehabilitation. Buildings and healthcare settings do not cause institutionalisation. It is the processes and the professional culture within such institutions that give rise to clients' dependency on the service and facilitates their institutionalisation. The new Act puts the patient at the focus of the service and makes it mandatory that the services provided must cater for the holistic needs of the patient and his social network to foster their effective socio-economic integration. Inter-alia the Act: • Promotes and safeguards the human rights of such a client group • Introduces checks & balances to safeguard patients' welfare and wellbeing through the establishment of the "Office of the Commissioner for the Promotion of Rights for Persons with Mental Disorders". The role of the Commissioner is not solely that of a patient's advocate but also has executive and monitoring roles to ensure that the length of a patient's stay in institutions is appropriate to one's needs. • Ensures that all healthcare professionals are accountable for their interventions in terms of patients' holistic wellbeing. • Specifies that all clients must have a multidisciplinary care plan with clear outcomes within specified timeframes. Health professionals will be constantly audited to ascertain that targets set in the care plans are attained within the shortest possible time. • Any interaction between clients and the service, of what ever nature, must be regulated by standardised patient management protocols which are legally binding to ascertain that the risk of service dependency and institutionalisation is minimised whilst promoting the concept of value for money in service provision			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Psychiatric reforms in the Czech Republic.			
Speaker	Tomas Petr, MSc, Chairman at Psychiatric Section of Czech National Nurses Association Martin Holly, MD, Chairman at Committee of Czech Psychiatric Society of Czech Medical Association of Jan Evangelista Purkyně			
Abstract	The system of mental health care in the Czech Republic is based on the existence of large psychiatric hospitals. A large proportion of these hospitals were built in the early 20th Century. Another important feature of the present system is very sparse network of community services and unequal distribution of outpatient psychiatric care. At the end of 2012, the Ministry of Health decided to transform current system of care for the mentally ill. Main reasons for transformation: - Increase of number of people with mental health problems - compared to 2000 there is the increase in the number of patients, who seek help of psychiatrist by 54% - Mental disorders represent a very significant burden for society - the share of neuropsychiatric disorders in the total amount of years lost to premature mortality and morbidity was 22%, which is the first place before cardiac disease (20.4%) and cancer (13.7%). - the existing system of care based on the existence of large psychiatric hospitals with inadequate levels of hotel services is outdated and rigid and does not effectively provide services and support to the patients			

	- Czech Republic is criticized by European Institutions because not fulfil a human rights of patients. - Psychiatry is underfunded - for mental health care in the Czech Republic goes around 3.5% of the health care budget, while the average in developed European countries is about 8% - stigmatization of people with mental illness is a major problem that can result in delaying the help of professional services and present the negative social consequences following the provided psychiatric care These are the most commonly cited reasons for reform, but there are many others such as the aging population and related problems with dementia, underdeveloped area of child psychiatry, etc. In the symposium we shortly describe the current system of mental health care in Czech Republic, its strengths and weaknesses. We, as members of working group of Ministry of Health, will present the vision of a new structure of psychiatric services and describe the process to achieve a vision step by step. We will share and discuss the main challenges and obstacles, which we experience during the process of transformation
References	

Session:	Symposium	SPEAKER 4	Code	
Title:	Overview of psychiatric inpatient provision in Europe			
Speaker	Chiara Samele (UK), Overview of psychiatric inpatient provision in Europe and description of EuroPOPP study			
Abstract	The latter part of the last century saw the closure of many large mental hospitals across Europe. Some European Union Member States continue to have a predominance of psychiatric hospitals with few mental health services based in the community. While inpatient psychiatric beds form an important part of any mental health service more recent debates have discussed the issue of striking the right balance between psychiatric hospital and community based care. Despite a general decline in the number of inpatient psychiatric care beds over the past decade several European countries have increased their bed numbers in recent years; with growing concerns about the 'new institutions' with the rise in long-stay supported residential accommodation. Inpatient psychiatric care can consume large proportions of expenditure allocated to mental health services, leaving little scope for investing in community based care. Using data from EUROSTAT and the recent literature we show how the rates for inpatient psychiatric care beds in Europe since 2001 have both declined and increased for some countries. These data also reveal the countries with the highest and lowest rates. We also describe the EuroPoPP-MH (European Profile of Prevention and Promotion of Mental Health) project which includes an overview of mental health systems across European Member States and other countries.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	GENDER VIOLENCE: MUTILATED MIND, BEATEN BODY			
Chairperson	Luísa Branco Vicente, Faculty of Medicine, University of Lisbon			
Co-chairperson	Elza Pais, National Parliament Gabriela Moita, Superior Institute of Social Work of Porto Manuel Lisboa, Faculty of Social and Human Sciences, New University of Lisbon			
Abstract	Violence is a social and historical problem which does not obey to any economical, religious or cultural specific levels. Gender Violence remains a multicomplex and controversial problem, even though there were redefinitions to every social levels, namely on its illegitimacy and criminality. The consequences of these violent acts had become a global problem, overcoming cultural and political aspects. Their resolution comes as an emergency when facing repercussions in terms of health, both physical and psychological, given its deconstructing power and its worrying impact above every women life's levels. All over the world, statistics show an increase of Domestic Violence's levels. On the whole, these values are a positive side of the problem, as showing a greater social openness to the approach of this theme and the consequent emancipation of the violated woman. In several of the most developed countries, we are now noting alerts and commitments to pursue policies intending to minimize or eliminate these forms of Violence. Not only prevention, but also victim's assistance comes now as a priority, allowing women to access different support structures, such as mutual support groups and other therapeutic specific projects. Attending to the fact that the fight against Violence has been considered by the World Health Organization as one of the greatest current challenges to Public Health Worldwide, this symposium emerges as a way to actively combat gender violence by sensitizing the participants for this phenomena's complexity, attending to its several cultural, social and psychological meanings and specific dynamics.			
References				
Speakers	1. Luísa Branco Vicente, Faculty of Medicine – University of Lisbon, Lisbon, Portugal, luisabrancovicente@gmail.com, Psychiatrist, Paedopsychiatrist, President of the Portuguese Society of Group Psychoanalytic Psychodrama, Didactic Psychoanalyst. 2. Elza Pais, Parliament, Lisbon, Portugal, elzapais@ps.parlamento.pt, Sociologist, Chairwoman of the Equality Subcommittee of the Committee on Constitutional Affairs, Rights, Freedoms and Guarantees, Researcher of the CESNOVA (Sociology Studies Center -New University of Lisbon). 3. Gabriela Moita, Superior Institute of Social Work of Porto, Porto, Portugal, gabnobmoita@gmail.com, Psychologist, President of the Federation of European Psychodrama Training Organizations. 4. Manuel Lisboa, CESNOVA (Sociology Studies Center - New University of Lisbon), Lisbon, Portugal, m.lisboa@fesh.unl.pt, Sociologist, Director of the National Observatory of Gender and Violence, International expert on gender-based violence for the European Institute for Gender Equality.			
Contact:	Name: Luísa Branco Vicente Institution: Faculty of Medicine – University of Lisbon Address: Alameda dos Oceanos, Lote 4.07.01M, 2º Dto., 1990-235 Lisboa Phone: 91 7592665 E-mail: luisabrancovicente@gmail.com			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	MENTAL HEALTH CONSEQUENCES OF CONFLICT AND DISPLACEMENT: SERVICE NEEDS (PART 2)			
Chairperson	Namrita S. Singh, Johns Hopkins Bloomberg School of Public Health			
Co-chairperson				
Abstract	This symposium, comprising two panels, will examine various aspects of mental health consequences of conflict and displacement. Mental illness contributes significantly to the global burden of disease. Communities affected by conflict and displacement experience unique stressors and barriers to mental health and psychosocial services. Additional research is needed to identify levels of illness across displacement contexts, the relationship between particular stressors and mental health outcomes, and the particular coping mechanisms of groups affected by conflict. Evaluation studies are also needed to assess the efficacy of interventions. The goal of the second panel is to examine the particular mental health service needs of conflict-affected groups and displaced persons. The panel will discuss different types of mental health and psychosocial interventions with conflict-affected and displaced groups, as well as panelists' direct experiences with service provision. What is the evidence for the effectiveness of different intervention models? What new intervention ideas are emerging? Challenges in service delivery in emergency and humanitarian contexts will be considered, as well as innovations, strategies, and guidelines. Differences in intervention models and service structures with displaced persons in low and middle income countries versus high income countries will also be discussed. The panel will also consider some of the more practical aspects of service delivery, including the hiring, training, supervision, and retention of mental health staff, and strategies for increasing service utilization. Panelists' presentations will include discussions of: best practices in training mental health professionals for work with displaced persons; implementation of community mental health programs in urban contexts, using Cairo as a case study; experiences with mental health service delivery and telemental health for refugees in the West Bank and Gaza Strip; training and retention of community mental health workers on the Thailand-Burma border; and a review of intervention and service models across emergency and resettlement contexts.			
References				
Speakers	1. Nancy Baron, EdD Psycho-Social Services and Training Institute in Cairo (PSTIC), Director; Global Psycho-Social Initiatives (GPSI), Director; and International Trauma Studies Program, International Training Director, Cairo, Egypt drnancyl@gmail.com 2. Bassam Saeed Madi, MD United Nations Relief and Works Agency (UNRWA), Community Mental Health Program, Manager and Public Health Advisor, West Bank, Palestine b.madi@unrwa.org 3. Catherine Lee, PhD Mental Health Assessment Project (MHAP), Program Director, Thai-Burma Border, and Johns Hopkins Bloomberg School of Public Health Center for Refugee and Disaster Response, Postdoctoral Fellow, Baltimore, USA cilee@jhsph.edu 4. Sarah Meyer, MPhil United Nations High Commission for Refugees (UNHCR) Consultant and Johns Hopkins Bloomberg School of Public Health Center for Refugee and Disaster Response, PhD Candidate, Baltimore, USA smeyer@jhsph.edu			
Contact:	Namrita S. Singh, MSc NIH Predoctoral Fellow and PhD Candidate Department of International Health, Social & Behavioral Interventions Center for Refugee and Disaster Response Johns Hopkins Bloomberg School of Public Health			

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Session:	Symposium	SPEAKER 1	Code	
Title:				
Speaker				
Abstract				
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Session:	Symposium	SPEAKER 2	Code	
Title:				
Speaker				
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Session:	Symposium	SPEAKER 3	Code	
Title:				
Speaker				
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Session:	Symposium	SPEAKER 4	Code	
Title:				
Speaker				
Abstract				
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	ACHIEVEMENTS, BARRIERS AND FACILITATING FACTORS IN THE IMPLEMENTATION OF NEW COMPREHENSIVE SERVICES FOR PEOPLE WITH SEVERE MENTAL DISORDERS IN PORTUGAL			
Chairperson	José Miguel Caldas de Almeida, Faculdade de Ciências Médicas, Universidade Nova de Lisboa (FCM/UNL).			
Co-chairperson				
Abstract	In the last decade significant strides have been made in many countries in implementing services and programs designed to improve comprehensive mental health care for people with severe mental disorders. The goal of this symposium is to analyze the achievements, barriers and facilitating factors found in this process in Portugal. The members of the panel will discuss the results of studies developed in the country at three different levels – services, programs and interventions. The first study evaluated the implementation of a new psychiatric service in a general hospital responsible for the provision of comprehensive mental health care in a large catchment area of the Region of Lisbon. The second study evaluated the outcomes of an innovative integrated program for people with schizophrenia and schizoaffective disorders in another catchment area of Lisbon. The last study had as its main objective to increase the knowledge on the barriers and facilitating factors found in the implementation of an evidence-based model of case management for people with severe mental disorders at the national level. The symposium will contribute to the discussion of the specific problems found in the implementation, with the resources usually available in the real world, of innovative evidence based practices for the treatment of people with severe mental disorders. A special attention will be dedicated to the identification of the ingredients that proved to have a key role in the successful implementation of those best practices. All these issues are especially important in a time of significant financial constraints, when people with severe mental disorders are particularly vulnerable and the use of existing resources must be based on solid evidence.			
References	Caldas de Almeida JM, Killaspy H (2011). Long-term mental health care for people with mental disorders. European Union, Luxembourg.			
Speakers	1. Graça Cardoso (FCM, Universidade Nova de Lisboa, Portugal, Gracacardoso@gmail.com) & Teresa Maia Correia (Hospital Fernando da Fonseca, Amadora, Portugal): “Implementing a new psychiatric service in a general hospital responsible for the provision of comprehensive mental health care in a large catchment area” 2. Joaquim Gago (Faculdade de Ciências Médicas, Lisboa, Portugal, joaquimgago@me.com): “Outcome study of an integrated program for the treatment of people with schizophrenia and schizoaffective disorders” 3. Pedro Mateus (Programa Nacional para a Saúde Mental, Lisboa, Portugal, pedromateus@mac.com): “Barriers and facilitating factors in the implementation of an evidence-based model of case management for people with severe mental disorders” 4. JM Caldas de Almeida (FCM, Universidade Nova de Lisboa, Portugal, jcaldasalmeida@gmail.com): “Policy implications”.			
Contact:	Prof. José Miguel Caldas de Almeida, Faculdade de Ciências Médicas, Universidade Nova de Lisboa, Campo dos Mártires da Pátria 130, 1169-056 Lisboa, Portugal, jcaldasalmeida@gmail.com.			

Session:	Symposium	SPEAKER 1	Code	
Title:	Implementing a new psychiatric service in a general hospital responsible for the provision of comprehensive mental health care in a large catchment area			
Speaker	Graça Cardoso (FCM, Universidade Nova de Lisboa, Portugal,			
Abstract	1. Objectives			

	To create and run a department of Psychiatry providing comprehensive mental health care in the general hospital and in the community, meeting the WHO and the National Mental Health Direction principles. The main objectives of the new department were to address the mental health care needs including: mental health promotion; prevention and treatment with special focus on severe mental disorders; rehabilitation and social inclusion of people with mental health problems in the catchment area of the district of Amadora and of part of the district of Sintra. 2. Methods Presentation and discussion with the hospital managers of the department plan, main structure, objectives and professional resources, before the department's opening. Regular team discussion of the patients followed, and a weekly meeting of the whole department to insure information updating and continuity of care. Taking in account the opinions of patients and their families, and working with them to meet their needs. Collaboration with the primary care centers, the municipalities and NGOs in the community. Creation of residential facilities and rehabilitation programmes in the community. Annual assessment of the achievements and planning of next year's activities. 3. Results The department comprises the following units working in close articulation: acute inpatient unit, day hospital and consultation-liaison psychiatry in the general hospital, and a community intervention unit. The later comprises four community teams functioning in the primary care and mental health centers, with an assertive outreach intervention. Along with general outpatient mental health care they also provide home visits, psychoeducation, social support, rehabilitation programmes, and an early intervention for psychosis. Two day centers complete the community intervention for severe mental disorders. 4. Conclusion This model of mental health service, including an inpatient unit in the general hospital e multidisciplinary teams in the community, in articulation with primary care and with rehabilitative and residential structures, has proven to be feasible and to respond adequately to the challenges of a large catchment area in Portugal.
References	

Session:	Symposium	SPEAKER 2	Code	
Title:	Barriers and facilitating factors in the implementation of an evidence-based model of case management for people with severe mental disorders			
Speaker	Pedro Mateus (Programa Nacional para a Saúde Mental, Lisboa,			
Abstract	1. Introduction Implementation science considers the steps that influence the translation of evidence-based treatments into routine use. The implementation of a new Portuguese National Mental Health Plan started in 2007. In order to improve the way services are delivered, an implementation process for an evidence-based case-management (CM) model was initiated by the National Programme for Mental Health. 2. Objectives To assess the results of a national implementation programme, considering the following dimensions: a) mental health services main characteristics, b) leadership profile, c) main barriers and facilitators to implementation, d) implementation fidelity. 3. Methods 40 public and private mental health services were included in a cross-sectional evaluation. Implementation activities included a CM training programme. Implementation degree, main barriers and facilitators to implementation were rated by: Barriers and Facilitators Assessment Instrument (Peters, 2001) and Illness Management Fidelity Scale (Mueser, 2009). 4. Results Assessment of services showed: liaison with PHC (50%), guidelines use (57%), single clinical record			

	(50%), in service continuing professional education plan (85%), research practice (21%). Regarding professionals profile, 70% used case management in practice, only 20% with previous formal training. After the implementation programme full CM implementation occurred in 36,3% of services, fair implementation in 45,4%, but still not enough implementation fidelity in 18,3%. Main barriers were lack of time (61%), lack of dedicated facilities (59%), low motivation (38%) and absence of financial incentives (36%). 5. Conclusion Despite the efforts to implement evidence-based practices in Portuguese mental health services and a good degree of implementation fidelity, there are still several obstacles that undermine full implementation. Structured implementation programmes may constitute coadjutants to ameliorate the delivery of effective practices.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Outcome study of an integrated program for the treatment of people with schizophrenia and schizoaffective disorders			
Speaker	Joaquim Gago (Faculdade de Ciências Médicas, Lisboa, Portugal)			
Abstract	1. Introduction There are psychological and psychosocial interventions well supported by scientific evidence, which show benefit in conjunction with psychopharmacological treatments. Although this evidence we know that a significant number of people with severe mental illness do not receive the care mentioned. This reality led to the development of integrated programs. 2. Objectives 1) Assessment the feasibility and implementation of an integrated care program, for people with schizophrenia or schizoaffective disorder; 2) Impact evaluation of the program, for these patients and their mental health care delivery. 3. Methods We drew up an integrated care program based on the clinical case management model. Were selected the appropriated interventions: psycho-educative, family-based interventions, strategies for dealing with the symptoms and the disorder, relapse prevention and interventions to improve social and occupational functioning. We did a prospective study with two assessments (one year follow-up). 4. Results Of the 146 patients who started the study, 116(79,4%) were diagnosed with schizophrenia and 30(20,6%) with schizoaffective disorder. After one year the program dropout rate was 18%. The individual care plan was done for 98% of patients. Regarding their employment status, in the first assessment 8(7,4%) were in full time employment and the number rise to 18 (16,7%). In relation to psychopathology, disability, social and occupational functioning, quality of life and patient satisfaction there was a significant improvement. This was not the case with attitudes towards medication and with insight. It happened a decreased in unmet needs and partially met needs and increased in the situations where relevant needs were no longer found. When we compared the year prior to this program and the year after, there were fewer hospitalizations (reduction of 64,1%). Regarding the length of hospitalization there was a reduction of 999 days (65,6%). There was also a 45,6% reduction of relapses. 5. Conclusions It was possible the feasibility of an innovative integrated care program and the implementation of it. In assessing the impact of the program, the results suggest potential application, to improve clinical state and psychosocial variables for these patients. The results obtained are promising for the development of similar programs at nationally and internationally level, that could benefit a wider group of patients.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Policy Implications of studies on the implementation of new comprehensive services for people with severe mental disorders in Portugal			
Speaker	JM Caldas de Almeida (FCM, Universidade Nova de Lisboa, Portugal)			
Abstract	1. Objectives 1- To analyse the impact of the national mental health policy and plan in Portugal in the last 15 years on the improvement of care provided to people with severe mental disorders; 2 - to discuss the policy implications of the results of the studies on the implementation of community-based services for people with severe mental disorders in Portugal. 2. Methods Methods will include the analysis of the results from the studies included in the symposium and of data related with mental health policy and services development in Portugal in the last 10 years. 3. Results The national mental health policy and plan in Portugal resulted in significant developments in community-based services for people with severe mental disorders. Main achievements include significant advances in the replacement of care provided by old institutions by care provided by general hospitals and new community facilities and programs. Several studies proved to be possible with the available resources to develop integrated programs with case management for people with severe mental disorders. Barriers found in this process include inadequate management and financing models as well as lack of trained human resources. 4. Conclusion Strategies to improve the implementation of the national mental health plan in Portugal should include the development of a new financing model, training of mental health professionals in integrated community-based care and continued support to psychosocial rehabilitation programs.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	DISASTER PSYCHIATRY AND PTSD: LESSONS FROM THE PAST AND HOPE FOR THE FUTURE			
Chairperson	Pr Raymond TEMPIER, University of Ottawa & Montfort Hospital, Ottawa, Canada			
Co-chairperson				
Abstract	Goal : to give participants an update on disaster psychiatry and recognition and management of psychological traumas. Background Information: Natural and human disasters can have extensive immediate and long-lasting psychosocial effects. Psychosocial interventions need to be planned and implemented as soon as possible. Traumas can be extended by fears of recurrence. Unique aspects of psychosocial reactions to earthquakes and disasters alike will be addressed and draw on recent experiences of intervention programmes. Objectives: Inform on psycho-therapeutic and pharmacologic treatment of victims and survivors of psychological trauma. Identify factors of severity and long term effects of disasters. Importance & Interest: Disasters can occur anywhere and disaster psychiatry is becoming a major topic for clinicians as any population could be exposed to natural or man-made disasters and bear chronic memories, suffering and bereavement. Immediate response in a form of a tool kit as well as long term treatments will be addressed in this symposium. This symposium will also provide an update on disaster psychiatry and PTSD in light of future developments regarding PTSD diagnoses and treatments.			
References				
Speakers	1. Pr Issack Biyong, University of Ottawa, Ottawa, Canada 2. Pr William Yule, King's College London, London, UK 3. Pr Ka Sunbaunat, University of Cambodia, Pnomh Penh, Cambodia 4. Pr Louis Jehel, University of Antilles Guyane, Fort de France, Martinique, French West Indies 5. Pr Raymond Tempier, University of Ottawa & Montfort Hospital, Ottawa, Canada			
Contact:	Raymond Tempier, Montfort Hospital, 713 Montreal Rd, Ottawa, On, Canada 16137644621 ext 3982, Fax 16137484938 e mail: raymondtempier@montfort.on.ca			

Session:	Symposium	SPEAKER 1	Code	
Title:	Post Traumatic Stress: Update and future developments			
Speaker	Pr Raymond Tempier MD, MSc, FRCPC, DFCPA CES Psy. (France) Professor of Psychiatry, University of Ottawa & Department Chief, Montfort Hospital, Ottawa			
Abstract	-Remind participants that post-traumatic stress focuses on trauma psychological consequences - Appraise the extent of PTSD in various populations, clinical features, new therapeutic approaches and models - Learn about a possible reclassification of the syndrome in light of the DSM V			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Social Psychiatry and primary health care for migrants in the developed countries			
Speaker	: Issack Biyong ¹ , Raymond Tempier ² , B. Kounou ² 1) Department of psychiatry, University of Ottawa, Canada 2) Pr of psychiatry, University of Ottawa, Canada Head Department, Montfort Hospital, Ottawa, Canada 3) Laboratoire du Stress Traumatique (EA 4560), Toulouse, France			

Abstract	1. Show the inventory of primary health problems among migrants in developed countries 2. Highlight mental health as part of overall health problems of migrants. 3. Show the importance of integrating mental health care into primary health care to demystify psychiatric disorders educate and make prevention among these most vulnerable populations. 4. Demonstrate that this approach can overcome the lack of mental health specialists and psychiatrists to better promote social psychiatry for the right for mental care for everybody.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Psychosocial responses to earthquakes			
Speaker	Pr William Yule, Emeritus Professor of Applied Child Psychology, Institute of Psychiatry King's College London			
Abstract	It is now recognised that natural disasters can have extensive and long-lasting psychosocial effects. It is understandable that until now, most effort of emergency services has been aimed at meeting immediate needs for safety, shelter, and physical injuries. However, psychosocial intervention needs to be planned and implemented from the beginning. Not all disasters have the same consequences. It is sometimes said that earthquakes do not cause deaths but that bad buildings do. In other words, earthquakes are natural disasters with a man-made dimension. The trauma can be extended by the fears of recurrence and the presence of aftershocks. Buildings are seen as unsafe – but when is it safe to return to them? Sudden bereavement impacts on the survivors. Trapped and decomposing bodies are difficult for survivors and rescuers alike. Spinal injuries may be common among survivors and greatly complicate the long term psychosocial needs. This paper explores some of the unique aspects of psychosocial reactions to earthquakes and draws on recent experiences of intervention programs.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	The France's National Psychological Response System to Disasters			
Speaker	Pr Louis Jehel (1)(2)(3), F Ducrocq (4), Aforcump-SFP (1) University Antilles Guyane (French West-Indies), (2) University Center Hospital of Martinique, France (3) Research Unit INSERM U669 (4) University Center Hospital of Lille, France			
Abstract	Objective: The organization and implementation of France's national system to respond to terrorism and other catastrophes is described. Method: Following a series of terrorist bombings, France's President established a task force to develop a centralized national system in 1997 to respond to the psychological needs of victims. This network was reinforced in January 2013. As a result, multidisciplinary regional response teams were implemented throughout France. Systematic training was provided these response teams. Response teams were made part of France's national emergency medical system. Results: Since the system's inception, the teams have been activated systematically, responding to several needs of psychological distress after a traumatic event. Victims and professional rescuers reported high satisfaction with these specific psychological services. Conclusion: Discussion will include establishing cooperation between Emergency Medical Service & and the Medico-Psychological teams appropriate protocols, and the advantages and disadvantages of a centralized national response system			
References				

Session:	Symposium	SPEAKER 5	Code	
Title:	Trauma treatment or prevention			
Speaker	Pr Ka Sunbaumat, Dean & Consultant psychiatrist, Faculty of Medicine, University of Cambodia, Phnomh Penh, Cambodia			
Abstract	So far, since the WWI, a lot of man-made disasters, in addition to natural disasters, have caused a lot of victimizations to billions people of many generation. Since “ Société des Nations” has been created nothing changed. Now UN has replaced this first world organization, since then still manmade disasters still continued to occur; traumas existed and continue from individual to individual, from group of persons to groups of persons, communities even nation and from nation to nation and worldwide. A lot of regulation and rules convention have been developed and signed between many countries especially convention for peace. Physicians treated physically damaged people from trauma, psychiatrist, and allied professional tried to operate and build mental health care systems and policy to help those survivors; but still traumas repeated again and again, from generation s to generations traumas continued to cause tremendous psychiatric disorders especially PTSD. Not only the victims but the killers, including militaries themselves, suffered from many kind of psychiatric illness, such as post Vietnam war. Prevention of trauma is not the task of health professionals, but the responsibility of politicians, warriors, weapon producers, and all peace keepers. Traumatization of new generations of victims appears increasing too much faster and greater then what health professional tried to build network, technology to help trauma survivors. To help people in the world to suffer less and less from trauma and to reduce manmade traumas, human being should have a real attitude and ethic as what has been described what human being is different for other being/animals in the world such as wild animal, that they never expand disasters as men.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	PSYCHOSOCIAL BURDEN AMONG THE MARCH 11, 2011 GREAT EAST JAPAN EARTHQUAKE AND FUKUSHIMA DAIICHI NUCLEAR PLANT ACCIDENT VICTIMS			
Chairperson	Jun Shigemura (Department of Psychiatry, National Defense Medical College)			
Co-chairperson				
Abstract	On March 11, 2011, Great East Japan Earthquake and subsequent tsunami struck the northeast coast of Japan. The damage was devastating, with nearly 19,000 people dead or missing. The Fukushima Daiichi Nuclear Power Plant accident subsequently followed, and had caused complexity to this already tragic disaster. Mandatory evacuation measure has been in effect in the neighboring region; the displaced residents are uncertain of if they will ever be able to go back to their hometown. The invisible nature of radiological contamination provokes immense fear and uncertainty; health concerns are prominent, younger people are moving out, and there have been reports of discrimination and stigma to the affected people. A large number of nuclear plant workers are also local victims, and they not only experience the clean-up responsibility but also strong guilt for the outcome of their workplace. The decommissioning process is expected to take decades, but such struggle makes it challenging for these workers to maintain their mental health. This symposium will have talks from three Japanese professionals that have been providing care to the victims of this complex disaster.			
References	1. Shigemura J et al: Psychological distress in workers at the Fukushima nuclear power plants. JAMA 308:667-9, 2012. 2. Shigemura J et al: Launch of mental health support to the Fukushima Daiichi Nuclear Power Plant workers. Am J Psychiatry 169:784, 2012			
Speakers	1. Yuriko Suzuki, MD, PhD National Institute of Mental Health, National Center of Neurology and Psychiatry yrsuzuki@ncnp.go.jp “Psychological distress of the residents in Fukushima” 2. Jun Shigemura, MD, PhD National Defense Medical College Tokorozawa, Japan shige@ndmc.ac.jp “Mental health consequences of the Fukushima nuclear plant workers following the Fukushima Daiichi Nuclear Power Plant accident” 3. Kazuma Yonekura Director Soma Wide Area Mental Health Care Center Nagomi yonekura-k@soso-cocoro.jp “Activity Report concerning the Great East Japan Earthquake: What happened then? What should be done next?”			
Contact:	Jun Shigemura, MD PhD Department of Psychiatry National Defense Medical College 3-2 Namiki, Tokorozawa, Saitama 359-8513 Japan Tel +81-4-2995-1619 Fax +81-4-2996-5203 Email shige@ndmc.ac.jp			

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	NONCOMMERCIAL ALCOHOL			
Chairperson	Matthew Testa, International Center for Alcohol Policies (ICAP)			
Co-chairperson	Andrey Soloviev (Deputy Director, Institute of Psychology and Psychiatry, Northern State Medical University; Arkhangelsk, Russia; ASoloviev@nsmu.ru)			
Abstract	The World Health Organization estimates that nearly 30% of all alcohol produced, sold, and consumed around the world is not reflected in official statistics. These beverages, which can be called “noncommercial alcohol,” include traditional drinks produced for home consumption or limited local trade, unregistered and counterfeit products, and nonpotable surrogate alcohol. The products are generally not taxed or regulated, and their sale and purchase cannot be easily monitored or quantified. Because they are usually significantly cheaper than commercial products, noncommercial beverages tend to be favoured by poor and marginalized populations, and are often the beverage choice of many individuals who drink excessively. In addition, since they are not subject to formal quality checks, they may pose health risks due to adulteration or unsanitary production and storage. This symposium is focused on understanding the informal alcohol market as well as its public health implications in various low- and middle-income countries, including Russia, China, Brazil, Kenya, and India. Speakers will share the results of recent surveys in these countries addressing noncommercial alcohol consumption patterns, socioeconomic status, and mental and physical health outcomes. Speakers will also discuss possible treatment, intervention, and prevention strategies to reach groups that are most at risk of consuming noncommercial products harmfully, as well as policy considerations for reducing harm			
References				
Speakers	1. Andrey Soloviev (Deputy Director, Institute of Psychology and Psychiatry, Northern State Medical University; Arkhangelsk, Russia; ASoloviev@nsmu.ru) – chair 2. Ian Newman (Director, Nebraska Prevention Center for Alcohol and Drug Abuse, University of Nebraska–Lincoln; Lincoln, Nebraska, USA; ian@buffalobeach.com) 3. Elisaldo A. Carlini (Director, Brazilian Centre for Information on Psychotropic Drugs [CEBRID]; Professor, Universidade Federal de São Paulo, Departamento de Medicina Preventiva; São Paulo, Brazil; eacarlini@gmail.com) 4. David Ndeti (Professor, University of Nairobi and Africa Mental Health Foundation; Nairobi, Kenya; dmndeti@amhf.or.ke) 5. Amit Chakrabarti (Professor of Pharmacology, Sikkim Manipal Institute of Medical Sciences; Sikkim, India; amitchakrabarti@hotmail.com)			
Contact:	Mr. Matthew Testa, International Center for Alcohol Policies, 1519 New Hampshire Avenue NW, Washington, DC 20036, USA; tel: +1 202 986 1159, fax: + 1 202 986 2080, mtesta@icap.org			

Session:	Symposium	SPEAKER 1	Code	
Title:	Official bans and hidden opportunities— Unregistered alcohol consumption in the European North of Russia			
Speaker	Andrey Soloviev Northern State Medical University, Arkhangelsk, Russia			
Abstract	The European North of Russia is historically a mostly “alcohol” but not “drug” territory due to its remoteness from major drug trafficking, the “dead-end” nature of its location, its low rankings on social and economic indicators, its adverse climate for producing plant-based drugs, and its lack of factories producing legal drugs. Drinking patterns in the European North of Russia are characterized by the northern style of alcohol consumption, involving mainly strong spirits consumed in large doses and with great frequency.			

	Despite the local administration's attempts to reduce official rates of alcohol abuse, legislative initiatives have sometimes had unexpected consequences, including a rise in the consumption of noncommercial alcohol. There are several features of the hidden marketing and illegal distribution methods of noncommercial alcohol: advertisement on the street; sale after 10:00 p.m.; services for the home delivery of alcohol with food, including at night; sale of alcoholic beverages in addition to other goods; promotions in shops, such as "3 bottles for the price of 2" and "additional bottle with discount"; the sale of alcohol in shops without a receipt at night; the sale of alcohol in taxis; advertisements in the free newspapers about technical fluids at a discount; and sale of industrial alcohol at home. At a broader level, other characteristics of the noncommercial alcohol market have been observed: a decline of home-produced alcohol for sale; mass consumption of beverages that are legal but not good quality; and high consumption of technical ethanol (hydrolysis, sulfite). In this situation the following opportunities for intervention may be suggested: continuing analysis of the features of cheap alcohol sales; ongoing checking of poisoning by alcohol surrogates, taking into account local climate conditions; improving toxicological techniques to identify poisonings by technical alcohol and technical fluids; evaluating of the impact of noncommercial alcohol on the overall dynamics of population alcohol consumption; and evidence-based proposals to support local legislative initiatives.
References	

Session:	Symposium	SPEAKER 2	Code
Title:	Summary of a three-year study of noncommercial alcohol production, sale, and consumption in China		
Speaker	Ian M. Newman , PhD Director, Nebraska Prevention Center for Alcohol and Drug Abuse University of Nebraska-Lincoln		
Abstract	OBJECTIVES: This presentation summarizes the results of a three-year study of family- or village-produced alcohol in rural China. The context of China's alcohol culture and the local environments of noncommercial alcohol production are also discussed. METHODS: The first phase focused on describing the methods used to manufacture distilled spirits. The second phase involved interviews with 259 village residents, including alcohol makers, sellers, and village leaders. The third phase involved chemical analysis of samples of the noncommercial alcohols sold in the villages where the interviews were conducted, in rural Hubei Province. The fourth phase involved interviews with a random sample of approximately 1,000 rural residents in each of three different provinces in China: Anhui, Hebei, and Hubei. RESULTS: Noncommercial alcohol producers were found to distill spirits from grain using simple and traditional methods. Producers and sellers expressed pride in their reputation, which they sought to protect by making or selling only quality products. Chemical analysis of 36 samples of spirits indicated alcohol content of 38.7% to 56.2% by volume and no evidence of extreme measures of harmful substances. All 3,268 persons surveyed in phase four had consumed alcohol in the last year. Among males, 35.1% reported drinking daily; among females, 11.8%. Consumers in Anhui and Hebei preferred commercial spirits; in Hubei, noncommercial beverages. Reasons cited for choosing noncommercial alcohol included cost (35.9%) and taste (27.1%). Males reported consuming 2.5–3.1 liangs per drinking occasion, while females reported 1.3–2.2 liangs per occasion (1 liang = approx. 50 g or 1 jigger). CONCLUSION: In China, informal alcohol production is not illegal, and the product and the makers are respected members of their communities. Making, selling, buying, or drinking noncommercial alcohol are considered normal, unremarkable behaviors. In rural communities alcohol production is part of a social network that ensures the safety of the product. Consuming indigenous alcohol is preferred by older rural men. As this population declines it is possible that noncommercial alcohol production will also decline, negating the need for additional regulations. If indigenous alcohol were taxed, it would be a source of revenue for the government, but demand would fall, as price advantage is one of the major reasons for purchase cited by consumers. This study suggests that the strategies promoted in the West to reduce alcohol-related problems may not be as effective in societies where commercial and noncommercial alcohol play a different role in family and community life.		
References			

Session:	Symposium	SPEAKER 3	Code
Title:	Study of noncommercial alcohol in the states of São Paulo and Minas Gerais, Brazil		
Speaker	Elisaldo A. Carlini Centro Brasileiro de Informações sobre Drogas Psicotrópicas (CEBRID), Departamento de Medicina Preventiva, Universidade Federal de São Paulo (UNIFESP).		
Abstract	INTRODUCTION: Commercial beverages, especially beer, account for most of the alcohol beverages consumed in Brazil. However, the formal beverage alcohol market coexists with an increasingly important noncommercial market. According to estimates by the Ministry of Agriculture, 95% of cachaça stills are thought to be clandestine, contributing 10% to 20% of total production. There has thus far been only limited research on the subject, especially on related aspects such as counterfeiting, tax evasion, and methanol poisoning. METHODS: Our research on unregistered alcohol beverages was divided into two stages: a study in two municipalities of the state of São Paulo (SP) in 2010, followed by a study in five municipalities in the state of Minas Gerais (MG), in 2011 and 2012. These studies utilized methods and techniques that included semi-structured interviews with consumers and producers, chemical analysis of alcohol beverages, and requests for institutional data. Interviewees were adults selected at random in public places. We also analyzed 2,808 news items that dealt with alcohol, drugs, or related policies in Brazil. RESULTS: Most participants (77.7% in MG, 96.5% in SP) stated that they were familiar with unregistered alcohol beverages. A high proportion of respondents (66.5% in MG, 80.5% in SP) stated they have consumed unregistered beverages, mostly cachaça; among this group, 19.8% in MG and 26.8% in SP stated they know they have consumed counterfeit beverages. Respondents cited the low price of unregistered beverages, the availability of such beverages, and cultural tradition (for homemade beverages) as factors in their consumption. A large majority of participants also stated that the effects of these beverages on health are negative. Chemical analysis of noncommercial beverages (mostly cachaça) revealed the presence of methanol and higher-chain alcohols in many samples but mostly in concentrations below the legal limit. Hydrocyanic acid, precursor of ethyl carbamate, was found in 85 of 87 samples from MG and 24 of 65 from SP. Data from three institutions indicated three distinct types of problems associated with production and sale of unregistered beverages: crimes against the economic system, crimes against public health, and subsistence production. Of the 2,808 media news items, only nine dealt with unrecorded alcohol. CONCLUSIONS: Further interdisciplinary studies on unregistered alcohol in Brazil are needed. Although many people perceive there are various health and socioeconomic disadvantages associated with unregistered beverages, consumption of these beverages is prevalent nonetheless. Future actions to promote public health in relation to registered and unregistered alcohol beverages should consider primarily access to information, cultural values, and income level.		
References			

Session:	Symposium	SPEAKER 4	Code
Title:	Noncommercial alcohol consumption patterns in Kenya		
Speaker	David Ndeti, University of Nairobi and Africa Mental Health Foundation		
Abstract	OBJECTIVES: Traditional noncommercial alcohol drinks, which include homebrews and home-distilled beverages, account for an estimated 74% of the total alcohol consumption in Kenya. Since these products are untaxed and can use low-cost ingredients and production methods, they tend to be cheaper (volume for volume) than their commercial counterparts. The consumption of noncommercial alcohol is highest among the poor, who cannot afford commercially produced beer or spirits. Because some of these beverages are produced illegally in hidden, unhygienic conditions, they are not always inspected for consumer safety. This study had the following objectives: to examine the patterns of production, sale, and consumption of noncommercial alcohol; to analyze the composition of noncommercial alcohol products; to examine the views and attitudes of stakeholders regarding the production, sale, and consumption of noncommercial alcohol; and to establish whether the people who consume noncommercial alcohol suffer from any mental or physical alcohol-related problems. METHODS: Consumers in a rural location (Kibwezi) and urban location (Kangemi) answered survey questions and kept diaries of their consumption for 30 days. Interviews were conducted with consumers, producers, and sellers of noncommercial beverages. RESULTS: Men made up 81% of the 320 consumers interviewed in the initial phase of the study. Most consumers were casual laborers, have only a primary-school education, and very low income. In the sample of consumers from across the Kibwezi District, two-thirds reported earning less than KES 4,000		

	shillings (USD \$47.60) per month. Among the positive effects reported were reduction of stress, ease in talking with others, meeting and making new friends, sleeping well, getting the energy to work, reducing pain, relaxing after a hard day's work, finding happiness, getting a good feeling, and providing a way of socializing and forgetting one's problems. However, half of all consumers showed signs of a major depressive disorder, according to the MINI Plus neuropsychiatric interview. Only 22.8% of consumers from the initial phase said that the alcohol they consumed had negative effects, such as family problems and medical problems. CONCLUSIONS: The study confirmed that poverty is a significant factor in the noncommercial alcohol market in Kenya. Most consumers have very low income and choose noncommercial beverages because they cannot afford commercial ones. These consumers face numerous physical and mental health risks from the daily consumption of beverages often produced in unsanitary conditions as well as from using other substances and having poor access to healthcare.
References	

Session:	Symposium	SPEAKER 5	Code	
Title:	Noncommercial alcohol consumption in three Indian states			
Speaker	Amit Chakrabarti, Sikkim Manipal Institute of Medical Sciences, Sikkim, India Currently: Regional Occupational Health Centre (ROHC), Eastern National Institute of Occupational Health (NIOH), Indian Council of Medical Research (ICMR)			
Abstract	INTRODUCTION: India has a rich tradition of noncommercial alcohol consumption and production. Because licensed alcohol beverages are considerably more expensive, home-brewed and illicit liquor are popular among people at lower socioeconomic levels. Such liquor is mostly produced in small batches by distillation or fermentation commonly using cereals as raw materials. However, with no legal quality-control checks in place, noncommercial alcoholic beverages can have alcohol content as high as 56% and may be adulterated. OBJECTIVES: A study to assess the nature and patterns of noncommercial alcohol consumption and production in India was conducted in two rural and two urban sites in Sikkim, two rural sites in Assam, and two urban areas in West Bengal. These states have distinct cultural characteristics as well as their own traditional alcohol beverages. METHODS: Across all sites, 1,207 subjects responded to a generic questionnaire to measure sociodemographics and alcohol consumption, the CAGE questionnaire to assess alcohol dependence, and the SF-36 questionnaire to measure quality of life; 1,137 participants kept a 30-day diary to record alcohol consumption and contexts of drinking. RESULTS: Differences in alcohol beverage preferences were observed among the study sites and among socioeconomic groups within some study sites. Participants had low socioeconomic status, with average monthly earnings ranging from 3,578 rupees (USD \$65) to 6,041 rupees (\$109). Average monthly expenditure on alcohol ranged from 436 to 976 rupees (\$7.87–\$17.62). A high percentage (66%–99%) had scores of 2 or more on the CAGE questionnaire. Most consumers drank daily, starting early in the day. Location of consumption (bars, homes, production facilities) varied by study site. Almost all study participants indicated that they felt no adverse effects of noncommercial alcohol; many reported some beneficial effects. Although 85% of all participants said that their current overall health was good, 26% said that their overall health was worse than it had been during the previous year. Chemical analysis was performed on 35 samples of noncommercial alcohol beverages collected from study sites in Sikkim and West Bengal. The samples contained moderate ethanol content ranging from 20% to 27% by volume. Methanol concentrations in all samples—even for distilled beverages known sometimes to be adulterated—ranged from 0.32% to 0.57% v/v.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	PSIQUIATRIA SOCIAL E REABILITAÇÃO PSICOSSOCIAL NO SÉCULO 21: MUDANÇAS DE PRÁTICAS, MUDANÇAS DE SISTEMAS E MUDANÇAS DE PARADIGMAS E FORMAS DE PENSAR A ATENÇÃO A CRIANÇAS E JOVENS NO BRASIL			
Chairperson	Ligia Costa Leite, PhD em comunicação, Professora do Instituto de Psiquiatria/ Universidade Federal do Rio de Janeiro (IPUB/UFRJ)			
Co-chairperson	Ana Maria Fernandes Pitta, MD, PhD, Universidade de São Paulo (USP), Universidade Católica de Salvador (UCSAL), World Association for Psychosocial Rehabilitation (WAPR) and Izabel Christina Friche Passos, PhD em psicologia Universidade Federal de Minas Gerais (UFMG), Associação Brasileira de Saúde Mental (ABRASME)			
Abstract	A proposta para este simpósio visa discutir as mudanças e transformações, que vêm sendo realizadas no Brasil, em três aspectos: (1) rede de cuidados em saúde mental; (2) práticas institucionais; e (3) ideias e conceitos. Estes aspectos estão presentes na atenção e reabilitação psicossocial para adolescentes sem privilégios, em quatro diferentes contextos e cidades brasileiras: Rio de Janeiro (Rio de Janeiro), Salvador (Bahia), Belo Horizonte (Minas Gerais) e Itapecuru-mirim (Maranhão). O intuito é partilhar estas experiências com outros países que vivenciam as mesmas questões de abandono e desesperança da juventude que encontra nas drogas, no abandono das famílias, nas escolas e políticas públicas negligentes, o estímulo para uma marginalidade/ criminalidade crescente. Estes trabalhos têm demonstrado uma evidência fundamental: a necessidade urgente de implantar políticas públicas de prevenção e proteção à saúde mental para essa juventude, uma precondição para o desenvolvimento da nação. Este é um tema de crescente importância para a saúde psíquica de adolescentes no mundo globalizado e individualizado atual, onde o sujeito jovem está cada vez fragmentado entre desejos e possibilidades. Os cinco apresentadores estão desenvolvendo ações e criando metodologias inovadoras ao longo dos últimos anos, que incorporam os adolescentes como protagonistas dessas ações, dando-lhes voz, para conhecer seu mundo e poder mediá-lo com o resto da sociedade e têm influído em mudanças significativas em algumas políticas públicas			
References				
Speakers	1. Ligia Costa Leite, PhD em comunicação Professora do Instituto de Psiquiatria/ Universidade Federal do Rio de Janeiro (IPUB/UFRJ), Brazil 2. Ana Maria Fernandes Pitta, MD, PhD Universidade de São Paulo (USP), Universidade Católica de Salvador (UCSAL) Brasil, World Association for Psychosocial Rehabilitation (WAPR) 3. Carlos Augusto de Araújo Jorge. Médico psiquiatra. Ex-diretor do Centro Psiquiatrico Pedro II, Secretário Municipal de Desenvolvimento Social e Sub-Secretário de Proteção Especial da Secretaria Municipal de Assistência Social do Rio de Janeiro, Brasil			
Contact:	Ligia Costa Leite, PhD em comunicação Professora do Instituto de Psiquiatria/ Universidade Federal do Rio de Janeiro (IPUB/UFRJ), Av. São Sebastião, 241, Urca, Rio de Janeiro, Brazil, 22291-070 Phone: 55 21 93220531 or 55 21 38735567 Fax: 55 21 25433101 ligia.cleite@gmail			

Session:	Symposium	SPEAKER 1	Code	
Title:	A abordagem da reabilitação psicossocial em grupos terapêuticos para jovens que acolhidos na rede de abrigos da municipalidade			
Speaker	Ligia Costa Leite, PhD em comunicação Professora do Instituto de Psiquiatria/ Universidade Federal do Rio de Janeiro (IPUB/UFRJ)			
Abstract	Esta apresentação objetiva descrever como a abordagem da reabilitação psicossocial é importante e válida no trabalho terapêutico com jovens que se encontram abrigados na rede de acolhimento municipal, em função de medidas de proteção especial determinadas pela lei brasileira. A falta de políticas públicas inclusivas e preventivas produz riscos psicossociais e sofrimento psíquico e gera diferentes formas de violência, em particular a silenciosa, esta expressa pela ausência de direitos civis e de cobertura em saúde mental para essa juventude. O trabalho reabilitativo, feito em grupos de jovens e seus cuidadores, provou ser um instrumento capaz de gerar mudanças no comportamento dos jovens, atuando em sua autoestima e autoconhecimento, de modo a que eles pudessem pensar em um projeto de vida para conviver em sociedade. Esta abordagem pode ajudar mediar conflitos e criar vínculos mais sustentáveis entre adolescentes, cuidadores sociais e a equipe terapêutica do IPUB. Ela também possibilita a perspectiva de um destino diferente para suas vidas. A experiência será ilustrada, neste simpósio, pela apresentação de um grupo clínico com nove meses de duração. Suas narrativas e avaliações finais do trabalho confirmam por suas próprias vozes, a transformação neles vivenciadas. Enfim este trabalho pode ser considerado uma evidência da necessidade urgente de implantar políticas públicas nesta área, de modo a fortalecer a saúde mental dessa juventude, uma pré-condição para o desenvolvimento da nação.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Projeto Capitães de Areia: Trabalhando em rede de cuidados para crianças e adolescentes no Centro Histórico de Salvador, Bahia			
Speaker	Ana Maria Fernandes Pitta, MD, PhD em Saúde coletiva Universidade de São Paulo (USP), Universidade Católica de Salvador (UCSAL), World Association for Psychosocial Rehabilitation (WAPR)			
Abstract	A equipe do Projeto Capitães de Areia iniciou suas atividades em 2008 e trabalhando no Centro Histórico de Salvador, Bahia com o objetivo de oferecer cuidados abrangentes para crianças e adolescentes que vivem em situação pessoal e social de vulnerabilidade (estão nas ruas e geralmente envolvidos com o uso e abuso de substâncias psicoativas, em especial o crack), através de ações de promoção, prevenção no processo de recuperação de sua saúde, assim como para sua reabilitação psicossocial. A parceria com o Projeto Axé, que vem atuando há vários anos nesse local, possibilitou mapear o território, identificar e abordar o grupo de usuários. Usamos a técnica de “pedagogia do encontro” como um recurso de aproximação e vinculação. Esta técnica consiste em ter sempre presente no território dois ou três profissionais da equipe, junto a educadores de rua já conhecidos pelo grupo-alvo, de modo que as crianças e adolescentes se acostumem com esta presença e gradualmente permitam uma aproximação. Depois desses contatos iniciais, adotaram-se estratégias de fortalecer os vínculos, buscando identificar as demandas emergenciais, facilitar o acesso aos serviços de saúde e, em uma abordagem intersetorial, estimular este público ao autocuidado e empoderamento para sua cidadania.			
References				

Session:	Symposium	SPEAKER 3	Code	
Title:	Embaixada de Liberdade: um verdadeiro acolher, Rio de Janeiro			
Speaker	Carlos Augusto de Araújo Jorge. MD Foi Secretário Municipal de Desenvolvimento Social e sub Secretário de Proteção Especial da Secretaria Municipal de Assistência Social do Rio de Janeiro			
Abstract	O objetivos desta apresentação é relatar uma experiência, desenvolvida entre 2008-2010, de acolhimento, a crianças e adolescentes que permaneciam, dias a fio, na chamada crackolândia nas ruas de Manguinhos/Jacarezinho, considerada a maior existente na cidade do Rio de Janeiro, em condições de extrema vulnerabilidade. Trabalho foi inspirado na compreensão de princípios das embaixadas: “Um território livre em outro território”. A liberdade, a aceitação do outro em sua própria condição, o respeito e o afeto constituíram suas principais matrizes, com embasamento técnico nos trabalhos e premissas de Nise da Silveira e Franco Basaglia. A Embaixada da Liberdade era um espaço de acolhimento, aberto, situado a poucos metros da chamada crackolândia. Seu funcionamento foi aos poucos sendo determinado pelos próprios usuários e, segundo narrativas dos próprios jovens, possibilitava mudanças em seus hábitos e maior segurança nas suas vidas (redução de riscos e danos). A experiência piloto foi pensada para atender diariamente vinte e cinco crianças e adolescentes, porém não demorou a passar a atender diariamente a uma média entre cinquenta a setenta pessoas. Funcionou por aproximadamente um ano e meio, sendo desativada, após mudança de gestores, para dar lugar a uma política de “recolhimento, internação ou abrigamento compulsório”.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	FROM THE PAST TO THE FUTURE: WHAT WE HAVE LEARNT FROM THE ITALIAN EXPERIENCE ON SOCIAL PSYCHIATRY			
Chairperson	A. Bellomo, Department of Medical science, Psychiatric Unit, University of Foggia			
Co-chairperson	Co-organizers: S. Rullo, Therapeutic community, Rome			
Abstract	Description and justification of the symposium or workshop: The Italian Law 180 determined the shift from an hospital-centred service to a model of community psychiatry, and thirty-four years have elapsed. The main principle stated by the Law 180 is patients' right to be treated in the same way as patients with other diseases. Moreover, according to the reform law, only voluntary treatments are allowed while compulsory treatments are strictly regulated. The main features and consequences of the Italian reform are discussed, national and local experiences are analysed in order to describe main objectives achieved by the Italian experience. In many parts of the country the implementation of community-oriented models of mental health care has been successful. In fact, mental health care has been made accessible to many people with mental needs who would have refrained in the past from any contact with old-fashioned system based on the asylums. The quality of care delivered is, however, still questionable in several areas of the country, and there is the room for improvement. Moreover, it is still difficult to provide an evidence-based reply to the question if the Italian model can be exported elsewhere. In particular, it will be discussed the effects of Italian reforms on specific topics such as early intervention services, addiction disorders, trauma-related disorders, migration.			
References				
Speakers				
Contact:	A. Fiorillo, Department of Psychiatry, University of Naples, SUN, Largo Madonna delle Grazie, Naples, Italy, telephone:0039 0815666531, fax: 0039 0815666523 anfioril@tin.it			

Session:	Symposium	SPEAKER 1	Code	
Title:	Community residential services without mental hospitals: the Italian Utopia			
Speaker	Santo Rullo. Therapeutic community, Rome			
Abstract	Italy was the first country 35 years ago which stopped psychiatric hospitals to focus on local services. The culture of the country was not ready for a so epoch-making step. Despite this, psychiatric revolution went forward resulting in a very uneven diffusion of good and bad practices. In particular the residential structures had to invent a new way to offer psychiatric assistance, doing care not to become new small asylums. This great change has been supported by a culture of social psychiatry clinical oriented and together by a very ideological attitude. This ambiguity has never completely resolved: today no one questions the closure of mental asylums, but social integration has not yet become collective heritage. Residential programs are far from being considered anything other than houses for social exclusion. Psychosocial interventions are the basis for a modern residential approach based on recovery and social integration.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Cultural adaptation and mental illness: language- proficiency among hospitalized immigrant psychiatric patients in Italy			
Speaker	A. Bellomo, A. Ventriglio			
Abstract	Lack of cultural adaptation may risk or worsen mental illness among immigrants, and interfere with			

	assessment and treatment. Language-proficiency (LP) seems essential for access to foreign environments, but the limited research concerning its effects on mental-health care encouraged this preliminary study. We reviewed clinical records of all immigrant psychiatric patients hospitalized at the University of Foggia in 2004–2009 (N=85), and compared characteristics of patients with adequate versus inadequate language proficiency (LP). Subjects (44 men, 41 women; aged 35.7±10.0 years) represented 3.62±0.94% of all hospitalizations (2004–2009). Most (60.0%) had emigrated from other European countries. Many were diagnosed with a DSM-IV unspecified psychosis (40.0%) or adjustment disorder (18.8%), and 45.9% were in first-lifetime episodes. Average comprehension and spoken language-proficiency (LP) was considered adequate in 62.4% and inadequate in 37.6%. In multivariate modeling, adequate-LP was more prevalent among women, emigration from another European country, receiving more psychotropic drugs at hospitalization, and having entered Italy legally. Findings support an expected importance of LP among immigrant psychiatric inpatients, and encourage language-assessment and training as part of comprehensive support of such patients, especially men.
References	Berry, J.W. (1976). Acculturative Stress in Northern Canada: Ecological, Cultural and Psychological Factors. Proceedings of the Third International Symposium on Circumpolar Health. Toronto: University of Toronto Press; pp 490–497. Berry, J.W. (1990). Psychology of Acculturation. Nebraska Symposium on Motivation, vol. 37. Lincoln, NB: University of Nebraska Press, pp 201–234. Bhugra, D. & Gupta, S. (2011). Migration and Mental Health. Cambridge: Cambridge Medicine Editions. Oberg, K. (1960). Cultural shock: adjustment to new cultural environments. Practical Anthropology; 7: 177–182.

Session:	Symposium	SPEAKER 3	Code	
Title:	Bio-psychosocial models: the self-help approach beyond addictions.			
Speaker	L. Janiri, G. Camardese. Catholic University, Rome, Italy			
Abstract	The role of the empowerment of personal resources in cooperative processes is becoming increasingly important in bio-psychosocial models. Particularly rooted in rehabilitation settings, self help activities include all initiatives an individual autonomously promotes to search for any external support (1). Alcoholics Anonymous groups were historically the first self help groups, early followed by other self help approaches to various forms of both chemical and behavioral addictions. In the last 20 years many thematic groups have been proposed to patients with somatic diseases, distress situations or psychiatric disorders, and yet to family members of problem subjects. In spite of such widespread variety of applications of the model, some common characteristics may be recognized: mutual support, empathetic links, sharing emotions and experiences, information, communication (2). Programs inspired to the social model of recovery involve non-professional figures and treatment sites other than hospitals or mental health facilities, thus providing not expensive therapeutic tools (3). Also in Italy this promising approach to mental disorders and distress, based upon practice and experience more than technical training or education, represents a sort of “from bottom” revolutionary turning in treatment philosophy. Data coming from a national survey on self help-based rehabilitative experiences in psychiatry will be presented.			
References	1) G. Camardese, L. Janiri (Eds.) (2012) Manuale di riabilitazione per i disturbi dell’umore. Alpes, Roma, pp. 161-167 2) L.H. Levy (2000) Self-help groups. In: J. Rappaport & E. Seidman (Eds.) Handbook of community psychology. Kluwer, New York, pp. 591-613 3) D. Barrows (1998) An historical and developmental analysis of social model programs. J. Subst. Abuse Treat. 15: 7-17			

Session:	Symposium	SPEAKER 4	Code	
Title:	New challenges in social psychiatry in Italy			
Speaker	A. Fiorillo. Department of Psychiatry, University of Naples SUN			
Abstract	The radical changes occurred to the Italian mental health care after the promulgation of the psychiatric reform law in 1978 caused the shift from a predominantly hospital to a predominantly community-based model of care, making psychiatry more social. Many challenges have been faced by social psychiatrists in the last 30 years, and some of them are still on the agenda of mental health professionals. One of these challenges is to fight stigma against mental disorders and to reduce social disadvantages of the mentally ill. In fact, despite anti-stigma campaigns have been conducted for more than 30 years, they seemed to be ineffective so far, as the public image of psychiatry is still detrimental. Sensitization campaigns are highly needed, but they should be targeted where stigma arises, i.e. in the school, the workplace, the media. One further challenge is to provide evidence-based psychosocial interventions in routine care. In recent multicentric Italian studies, the main obstacles to perform routinely psychosocial interventions in mental health centres were organizational difficulties, such as work overload and lack of time from professionals. Modern national policies should consider this when dealing with new guidelines and treatment plans in mental health care. Finally, the impact of migration cannot be ignored by Italian social psychiatrists. New users and new diagnoses are often coming to psychiatric consultation, but psychiatrists are not yet adequately equipped to treat them. Training on how to manage emerging psychiatric syndromes has to become a priority. Other challenges will arise in the years to come. This means that social psychiatry in Italy is still alive, and will continue to be.			
References				

Session:	Symposium	SPEAKER 5	Code	
Title:	Early intervention in the real world, between clinical and social needs: one five years Italian experience.			
Speaker	R. Pollice. University of L'Aquila, Italy			
Abstract	In recent years, enthusiasm has grown for the need to rapidly identify and treat patients at risk to develop psychiatric disorders in the earliest stages of the illness.^{1,2} The advantages of early intervention in any illness are well known, with additional benefits to be gained in severe and long-standing psychiatric conditions such as schizophrenia. It is known that people with an at-risk mental state are typically unwell for a considerable time before accessing effective treatment. In this regard, early recognition and initiation of treatment in its broadest sense is crucial in improving clinical outcome not only in subjects at increased risk for psychosis but also for those at risk of mood and anxiety disorders. Notably, early identification of people at risk to develop severe psychiatric conditions is paramount especially in young people.⁸ It is the mission of our experience to reduce the burden of mental suffering in young people by means of an earlier recognition of signs and symptoms, systematic evaluation of psychological distress and promotion of attitudes that encourage young people to seek care. We also aim to reduce the delays that young people at incipient risk of severe psychiatric illness experience in accessing appropriate psychiatric care. Our first five years experience at our service for Early Interventions in Psychiatry, clearly suggests that early recognition and treatment is feasible across of a wide range of psychiatric diagnoses and is not limited to psychosis. Moreover, our approaches for destigmatizing mental illness might enable better management in symptom control. Of interest is also the observation that considerable effort has been expended to ensure an adequate continuity of care by networking between our staff, hospital psychiatrists and primary care providers. In conclusion, our little experience has established a comprehensive early intervention service providing most of the mental health service requirements for young people, across a broad range of mental suffering states and overt psychiatric symptoms. Notably, it is a significant advance over what was provided before in Italy. Hopefully, the development of early intervention programmes for mental suffering will result in better linkages between child and adult psychiatry services and also with those involved in long-term care to ensure treatment of psychiatric disorders throughout the life cycle.			

References	Klosterkötter J, Hellmich M, Steinmeyer EM, Schultze-Lutter F. Diagnosis in schizophrenia in the initial prodromal phase. <i>Arch Gen Psychiatry</i> 2001; 58: 158–64. Ruhrmann S, Schultze-Lutter F, Maier W, Klosterkötter J. Pharmacological intervention in the initial prodromal phase of psychosis. <i>Eur Psychiatry</i> 2005; 20: 1–6. Pollice R, Di Giovambattista E, Ussorio D, Di Pucchio A, Tomassini A, Mazza M, Roncone R, Casacchia M: The service for Monitoring and Early Intervention against psychoLogical and mEntal suffering in young people (SMILE) at the University of L'Aquila <i>Early Intervention in Psychiatry</i> 2007; 1: 271–275 Fiorillo A, Brambhatt P, Elkholy H, Lattova Z, Picon F. Activities of the WPA Early Career Psychiatrists Council: the Action Plan is in progress. <i>World Psychiatry</i>. 2011 Jun;10(2):159.

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	THE EVOLUTION OF SOCIAL PSYCHIATRY IN THE MEDITERRANEAN REGION IN THE XX AND XXI CENTURIES			
Chairperson	A. Guilherme Ferreira, President Mediterranean Sociopsychiatric Association			
Co-chairperson	Ramón Blasi i Ras, Me.Sp.A.			
Abstract	Social psychiatry appeared as an answer to the crisis of the Psychiatric Hospital, in the aftermath of World War II. Developed initially in anglo-saxonic countries, it spread, in a second step, precisely in the Mediterranean Region, before it reached practically all the World. It led to the construction of a preventive psychiatry which principal aim is naturally Mental Health Prevention The evolution of this approach in the Mediterranean Region is described and an example is given through the description of an intervention in Catalonia Two important problems rise in this moment in the Mediterranean Region: a) An important crisis reached the Mediterranean Region, firstly, in its European Shore and, in second step, in the Arabic Countries, after the emergence of a political struggle. Different ways to overcome this situation are analyzed. b) The problem of migration, very important in the European Countries, is studied as well as the development of an acculturation, which is the consequence of the individual trajectories of the migrants.			
References	A. Guilherme Ferreira, President Mediterranean Sociopsychiatry Association Av. Mouzinho de Albuquerque Lote B1 -7º - Lisboa, 1170-259 Portugal, Former Director and Chief of Service of Miguel Bombarda Hospital Tel. (+351) 218123438 Email: ag.ferreira@netcabo.pt			
Speakers	1. A. Guilherme Ferreira, President Mediterranean Sociopsychiatric Association, former Director and Chief of Service of Miguel Bombarda Hospital - Lisboa, Portugal, email: ag.ferreira@netcabo.pt - "Survey of social psychiatry evolution in the Mediterranean Region in the XXth and XXI centuries" 2. Ramón Blasi i Ras, Teaching and Research Centre C.D.D.R., ARAPDIS – Barcelona, Spain – email: rblasi@arapdis.org - "Social and Community psychiatric in Catalonia" 3. Rachid Bennegadi, chair of Network "Migration and Mental Health" – Paris, France - email: bennegadi@minkowska.com – "Why so much emphasis Odysseus to return to Ithaca" 4. A. Guilherme Ferreira, President Me.Sp.A. - "The socio-economical situation in the Mediterranean Region and its repercussion in Mental Health"			
Contact:	A. Guilherme Ferreira, President Mediterranean Sociopsychiatry Association Av. Mouzinho de Albuquerque Lote B1 -7º - Lisboa, 1170-259 Portugal, Former Director and Chief of Service of Miguel Bombarda Hospital Tel. (+351) 218123438 Email: ag.ferreira@netcabo.pt			

Session:	Symposium	SPEAKER 1	Code	
Title:	Survey of social psychiatry evolution in the Mediterranean Region in the XXth and XXI centuries			
Speaker	A. Guilherme Ferreira President Mediterranean Sociopsiquiatrie Association			
Abstract	After World War II there was a general contest to psychiatric hospital. Social Psychiatry movement appeared as a possibility to find new ways of psychiatric intervention. Born in Anglo-Saxon countries first as an intervention in hospitals and in patient units (therapeutic communities in Anglo-Saxon countries, institutional psychotherapy in France) and, in a second moment, in community itself through the support of out patients units and of self- help groups and networks that give support to individuals in risk. These kind of interventions were also developed in the Mediterranean Region, in a first step, in the Northern shore, composed by European and Christians countries and in Israel and in a second moment, in the Southern shore, constituted by African and Muslims countries. In consequence, a general movement developed conducting to a psychiatry centered in Mental Health promotion and, naturally, to Mental Illnesses prevention, in its three intervention areas. This evolution is analyzed and discussed and its results presented.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Social and community psychiatry in catalonia			
Speaker	Ramón Blasi, Teaching and Research Centre C.D.D. R. ARAPDIS			
Abstract	The evolution of "Social and Community Psychiatry" in Barcelona and Catalonia began 4 decades ago when a group of professional people formed a movement. This movement was in reply to the need to widen the field of work which up until then had been almost exclusively medical. It was also to serve as a union in the integration of the dynamic space with an open minded point of view, integral and integrating as regards the multi-disciplined concept of working in a team. All with the end in view of the future model "Psychosocial Comprehension of the Mentally Ill Patient and Community Intervention". More than 38 years ago, in 1971, the first "Day Centre (C.O.S.E.)" was set up. Then in 1973, with the first reform, some mental health clinics became "Mental Hygiene Centres". In 1981 the present day system with "Mental Health Centres" finalized the reform and settled the present day form with the "Psychiatric Reform in Catalonia" known as the "Catalan Model". 20 groups of postgraduates have obtained a "Master in Social Psychiatry" and we must look on the teaching of this subject as a valuable factor which is a basic and permanent support of our work. This work is continued and strengthened in our "Specialized Continued Training Programme" in "Integral Psychosocial Rehabilitation in the Community". It is organized by ARAPDIS "Document, Teaching and Research Centre". In 1982 an "Alternative Model of Postcure" was set up by Integral Reinsertion" (R.I). A combination of resources, techniques and interventions, created and interwinned progressively so as to be able to act on "deficits" at all "levels" as much as on the part of the "patient" as on the part of the "family" and also the "immediate environment". In "Catalonia the Psychiatric Reform" began officially in 1970 with a simple and futile sectorizing of the "Psychiatric Hospitals". In 1981 the "Real Reform" began with the development of a flexible, communicative, broad based and progressive model known as the "Catalan Model". In these almost 30 years of continuous evolution, we have undergone different stages with different policies from the varying political and administrative heads. As these varied, the course of these years has been unstable and variable. In some cases "Supply and Demand" has meant the collapse of the care system or fears of its disappearance. All this has meant that 1000 hospital beds are no longer necessary. The preset day budget is 450 million euros for "Psychiatric Health Care in Catalonia". In this exposition of past, present and future perspectives we present several works implemented at the CIS in SMC (Urban Therapeutic Community) in the district of Gràcia, with "24 hours Emergency Service, Sub-acute Admission, 2 Day Hospitals and Specialized Outpatient Consultation" with a multi-skilled team with 20 years of evolution (1994-2014).			

References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Why so much emphasis by ulysses to return to ithaca ?			
Speaker	R. Bennegadi Chair of Euromed Network "Migration and Mental Health"			
Abstract	The blind oracle, Tiresias, must have told him that apart from the pleasure of reuniting with his family, he would have a tragic destiny. Had Ulysses been practicing denial due to the fact that he knew he would perish by the hand of his own son? Obviously it is not Telemachus, the cherished son he had with Penelope, but rather Telegonus, the son he had with Circe, as she had never accepted that the Gods of Olympus, through Athena, separated her from the son of Laertes. Nostalgia is not what it once was, and Homer knew that we would be more interested in a heroic reunion rather than the miseries of reality. We will use the power of metaphor in order to discuss the work of acculturation and the changes it imposes, hence giving a less glamorous perception of migration trajectories.			
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	The socio-economic situation in the mediterranean region and its repercussion in mental health			
Speaker	A. Guilherme Ferreira President Mediterranean Sociopsychiatric Association			
Abstract	Since 2005, a severe economical crisis reached the Western World and, particularly, the Southern European Countries (In.E.U.) that constitute precisely the Northern Shore of the Mediterranean Sea. In these countries the GDP fall intensely (or at least rise very slowly) and, consequently, the personal income of their populations less also strongly. Similarly, in Arabic Countries of its Southern Shore, the so called Arabic Spring (as it is designated in Western Europe) developed and seems to lead to a similar situation. A research is proposed to be developed in all these countries (on at least in some of them, chosen aleatorilly) through structured clinical interviews in order to determine the repercussions this situation had on Mental Health and how it can be lessened through different preventive measures and which changes these facts should determine in the organization of Mental Health services and programs in order to answer to it.			
References				

Session:	Symposium	OVERALL ABSTRACT	Code	
Title:	Healing through cathartic experiences. Analogy between religious rituals and psychotherapies			
Chairperson	MARCOS DE NORONHA BRAZILIAN ASSOCIATION OF CULTURAL PSYCHIATRY , BRAZIL			
Co-chairperson				
Abstract	1. Joseba Achotegui, University of Barcelona, Spain 2. António Pacheco-Palha, Lídia Gouveia, aUniversity of Porto, Portugal 3. José Lopez Rodas, Instituto Nacional de Salud Mental “Honorio Delgado, Perú 4. Marcos de Noronha, Brazilian Association Of Cultural Psychiatry , Brazil			
References				
Speakers				
Contact:				

Session:	Symposium	SPEAKER 1	Code	
Title:	Stress Scale for Immigrants			
Speaker	Joseba Achotegui, University of Barcelona, Spain			
Abstract	This scale was designed as an instrument that structures information concerning migration related stress and mourning and facilitates welfare and psychosocial service provision as well as research. The scale can be used in the different social services that provide care to immigrants, not only in health services but also social and education services etc. The tale or narrative the immigrant brings us possesses an extraordinary phenomenological and anthropological value, but the provision of welfare and social services require trying to structure and make operative the information we possess such that it can be compared with that obtained by other professionals. The scale essentially serves a screening function; it evaluates the psychosocial situation of immigrants and measures risk factors. The approach would be similar to that of an insurance company: the scale evaluates the risk of problems. The scale is etic, that is to say it evaluates the facts from a conceptual framework external to an immigrant's own interpretation of his/her own experiences. The scale we present here applied to migration could be used in other situations of chronic stress, such as mobbing or bullying, etc., adapting the approach in relation to the types of stressors and mourning that is experienced in each situation.			
References				

Session:	Symposium	SPEAKER 2	Code	
Title:	Healing through cathartic experiences. Analogy between religious rituals and psychotherapies			
Speaker	Marcos de Noronha, Brazilian Association Of Cultural Psychiatry , Brazil			
Abstract	What societies, with their traditions that rely on rituals that come with catharsis. These practices, what kind of functions fulfilled in some societies? Catharsis has its importance to be used in a psychotherapy practice as a therapeutic resource? And in learning, even cathartic feature could make it easier? This presentation refers to the emotional aspects that make up the mental illness that could be considered for the treatment of the patient. The formula of emotion has a psychological basis and other physiological. But not just these two aspects. To understand its complexity also have to understand both the anatomical basis of brain function, such as the socio-cultural context in which this man entered.			

	Among these psychiatric treatments known some mobilize emotional aspects of the individual to try to cure him. Others do the same, but in a group. What are the advantages of individual treatment in relation to treatment group? Which type of treatment and how the resources of catharsis and appreciation of emotion can be used? As the affective and emotional appeal can be used by teachers who want to improve student learning? The author not only draws an analogy between the techniques of individual psychotherapy with the group, but also with both religious rituals. Even in the diversity of religious expression, which prevents us a generalization of the phenomenon, there is something in common, both in the formation of symptoms, and in manifestations of emotions. In this process comparing psychotherapeutic techniques and religious rituals the author walks a line of understanding that allows discriminatory actions less cooperative and more, integrating resources of mental health professionals and priests and shamans in the same population.
References	

Session:	Symposium	SPEAKER 3	Code	
Title:	Aspects of the mechanism dissociative psychopathology in a population of young Mozambicans - the purpose of the School case Quisse Mavota "			
Speaker	António Pacheco-Palha, Lídia Gouveia, University of Porto, Portugal			
Abstract				
References				

Session:	Symposium	SPEAKER 4	Code	
Title:	Meaning of communication and relationship with fellow friends of adolescents with potential suicide			
Speaker	José Lopez Rodas, Instituto Nacional de Salud Mental "Honorio Delgado, Perú			
Abstract	Through qualitative study, conducted between January and May 2013, determining the meaning of communication and relationship with partner friend for adolescents with "potential suicide" some whose parents had been living abroad and returned to Peru in recent years. These young people were identified in the mental health examination-2012, corresponding to 0 Suicide Program in secondary school level in the district of Independencia, Lima, Peru (district with population of 220,000 inhabitants., mostly middle and poor middle class; their migration and return flows are similar to national migration flows; with community mental health services for 33 years). After processing of semi-structured questionnaire, interviews will be conducted by members of the mental health team. The analysis will be done with the program for Atlas-ti qualitative research. The findings, apart from pointing out the many aspects to research to expand knowledge, must offer positive aspects to incorporate and strengthen, as difficulties to be avoided and overcome in the support strategy considered for young potential suicide. It also pursues the purpose to incorporate these findings into national academic curriculum of secondary.			
References				

29 June - 3 July 2013
Lisbon, Portugal

Workshops

HOW TO IMPLEMENT CLINICAL GUIDELINES

Principal organizer: Lars Lien, National centre for dual diagnosis, Hospital Innlandet Trust, Norway

Co-organizer: Barbara Reeger, Athena Institute, VU University Amsterdam, the Netherlands

Description and justification of workshop:

Governments and regional and local health authorities establish numerous clinical guidelines and in Norway seven clinical guidelines for substance misuse services are planned, in process or finished in the past few year. There is, however, limited experience in implementing clinical guidelines and there is a need for developing new and systematic knowledge concerning implementation. Clinical guidelines are not a "magic bullet" to improve healthcare and there is a need for more research and practice on how guidelines are successfully implemented.

The objectives of this workshop is first to give an insight to why clinical guidelines need to be evidence based implemented and that without an implantation plan and process guidelines in itself will not change health worker attitude and praxis. Secondly, we will give at least to examples, one from Norway and one from the Netherlands on how guidelines might be implemented and which tools that is necessary to reach your goals.

We think this workshop will be of great interest to first of all clinical leaders on all levels and officials who work with changing health worker praxis's and patient organisations that is eager to get evidence based treatment for their diseases. But most all this workshop is important for all mental health workers who need to know why there are several obstacles to change in praxis and how they can be solved.

Speakers

1. Anne Landheim, National Center for dual diagnoses, Hamar, Norway, Title: Norwegian Guidelines for persons with concurrent mental disorders and substance use disorders: assessment, treatment and rehabilitation - How to identify gaps between current practice and clinical guidelines?
2. Lars Lien: National centre for dual diagnosis, Hamar, Norway. Title: - How to bridge gaps between current practice and clinical guidelines?
3. Lia van der Ham: Athena Institute, VU University Amsterdam, Amsterdam, The Netherlands. Title: Participation of patients in the development of guidelines
4. Janwillem Renes: Altrecht Institute for Mental Health Care, Amsterdam, The Netherlands: Title: Treatment of Bipolar Disorder in the Netherlands and concordance with treatment guidelines
5. Barbara Regeer: Athena Institute, VU University Amsterdam, Amsterdam, The Netherlands. Title: Support by a shared research agenda

Other considerations: We plan to have ample time for discussion and debate also opening for examples from the participants.

INTERSUBJECTIVE AND CULTURAL DATA IN PSYCHIATRY: THEORETICAL FOUNDATIONS OF CLINICAL PRACTICE

Principal organizer: Maria Luísa Figueira, Dept. of Psychiatry. (Faculty of Medicine of Lisbon. University Hospital of Santa Maria. Lisbon. Portugal)

Co-Organizers: Luís Madeira Dept. of Psychiatry. (Faculty of Medicine of Lisbon. University Hospital of Santa Maria. Lisbon. Portugal), Ana Neto, Dept. of Psychiatry. (Hospital of Fernando da Fonseca. Amadora. Portugal)

Background information:

While searching for reliability (and strict operative definitions) researchers have deliberately stripped psychopathology of subjective experiences (Andreasen 2007). There is criticism that diagnostic criteria have too long “*wear the trousers*” and entertained the notion of a descriptive glossary for psychopathological experiences that one must memorize (Parnas, Sass, Zahavi, 2008). The fact is that operational definitions we now hold as equivalents for disorders have not brought us any closer to a full representation of meaning of mental disorder. When leaving such superficial objectivity we are confronted with a load of behaviors and experiences that stand as possibly relevant to understandings of the disorder. Facing this overload of data, much of it impervious to natural sciences objectification is a petrifying experience for both doctors and researchers. In recent years there were those (e.g. Fuchs, Zahavi, Parnas, Stanghellini) who again defied such impediments and delved into the description and characterization subjective aspects of mental illness. Specific to these conceptualizations is the acceptance that part of the meaning of our experience is embodied and so pre-reflexive. The role of the ecological and intersubjective meaning of falling mentally ill has been reprocessed into concepts as empathy, mirror-neurons, theory of mind, appraisal and enactivism.

On the other hand, psychiatric anthropology illustrates how contemporary psychiatry faces superficial objectivity that has failed to grasp the diversity and complexity of subjective experiences (Kleinman, 1997, Obeyesekere, 1990). More importantly they alert for the consequences of such neglect (Daas, 2000; Kleinman, 1991) and how taking into account this dimension not only helps to understand how cultural and social aspects are meaningful but also reshape the meaning of mental disorders and therapeutic paths (Jenkins, 2003).

The discussion regarding a cultural dimension of experience is intuitive in practice. The dialogical dependence of recollection of data and stigma as anthropological and social consequence are key subjects that demand consideration. As a whole, a full picture of mental illness must represent its affective, biotic, aesthetic and social dimensions.

Goals: This workshop aims to present how the inter-subjective experience and cultural data is imbued in the phenomenology, ethics and epistemology of mental illness

Objectives: at the end of the workshop the audience should be acquainted with the concepts of primordial inter-subjectivity and a model of the self-experience (that includes pre-reflexive experience). Also they should be able to recognize the modulation, of what is taken as disordered, by cultural variances, through the glens of anthropological assistance. The presentation is divided in 3 parts: Theoretical ~25min + Small group discussion (2 groups ~30 min) + Joint group discussion (30 ~min)

Speakers

1. Luís Madeira Dept. of Psychiatry. Faculty of Medicine of Lisbon. University Hospital of Santa Maria. Lisbon. Portugal
2. Ana Neto, Dept. of Psychiatry. Hospital of Fernando da Fonseca. Amadora. Portugal

PSYCHIATRY, RELIGION AND SPIRITUALITY: IMPROVING SKILLS

Principal Organizer: Peter J. Verhagen, WPA Section on Religion, Spirituality and Psychiatry

Co-Organizers: Sameer Malhotra, WPA Section on Religion, Spirituality and psychiatry

An understanding of religion and spirituality and their relationship to the diagnosis, aetiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development.

The aim of this interactive workshop is to enlarge knowledge and to improve skills. Four topics will be covered: 1) research data and controversies, 2) assessment, 3) cultural dynamics and culture and 4) therapeutic concepts.

By attending this workshop participants will be able to update their knowledge and improve their skills in the following ways. 1) Despite the information available it is still difficult to interpret and evaluate research data in an appropriate way. There are still a lot of controversies. What are the points for attention? 2) Psychiatrist (and mental health workers) are still hesitating with regard to assessment and religious/spiritual history taking. How to proceed? What are the points of attention? 3) The term culture can be applied to an individual, to families, to whole communities and even nations. Culture refers to a way of life common to a group. What are cultural dynamics? How do these dynamics relate to spirituality and religion, and to mental health? What is the meaning of a cultural assessment and case formulation? 4) Different cultures have different views on handling stress, counteracting what may be conceived as mental illness, and promoting well-being, spiritual development and recovery from crises. In that sense the western biomedical model turned out not to be 'soul-saving'. What can be learned from other cultures concerning the maintenance of mental health and counteracting problems that are seen as mental illness?

Short presentations will be alternated with discussions and exercises.

Speakers

1. Peter J. Verhagen MD, GGZ Centraal, Harderwijk, Netherlands, verhagen.p@wxs.nl
2. Sameer Malhotra, PhD, Max Healthcare, India, sameersankalp2003@yahoo.com

Other considerations

Max. participants 25.

“MANAGING MENTAL HEALTH PROBLEMS DURING , AND IN THE AFTERMATH OF, DISASTERS”

Principal Organizer: Professor Scott Henderson, MD, DSc, Emeritus Professor, The Australian National University, Canberra.

Description and justification of the symposium or workshop: Natural and man-made disasters are ubiquitous and recurrent. The purposes of the Workshop will be:

- 1) how to identifying those individuals and families in need of intervention for their mental health;
- 2) to determine what interventions are needed;
- 3) training of personnel for meeting these needs; and
- 4) contributing to the prevention of mental disorders in the aftermath.

Moderators: (Names, affiliations, city, country, email and tentative titles)

1. Prof Scott Henderson.
2. Dr Jaya Reddy, MB, BS, PhD. Consultant Psychiatrist, The Canberra Hospital, Canberra, Australia.

Preparation: We seek support from the Conference Organisers on recruitment of participants. The numbers will need to be estimated beforehand to ensure adequate accommodation.

As an Introduction, Dr Reddy and I will brief participants on the Aims of the Workshop. They will then be divided into groups of about 6 persons to tackle the specified topics.

Requirements:

One room for the whole group.

One or more rooms for the small groups to assemble. (According to numbers, one large room may itself be sufficient.

Clusters of six or more chairs for each group.

Butcher paper, easel, coloured feltex pens.

A4 paper and pencils for each group.

GLOBALIZATION OF CULTURE AND ITS IMPACT ON NON-WESTERN PSYCHE

Principal Organizer: Rama Rao Gogineni

Co-organizers: Prof Roy Abraham Kallivayalil

United Nations reports Globalization opened international borders and has the potential for both positive and negative effects on development and health. Many countries have profited from globalization including China, India, Uganda and Vietnam. WHO reports that globalization of health is contributing to growing number of health problems including trafficking of women, increased drug abuse/trade, increase in juvenile delinquency, etc. Globalization raising ethical problems in relation to autonomy, sovereignty, toleration, multiculturalism. The difficulty increases largely when we think of countries like India, a country with vast population diversity, and having numerous traditions.

Globalization Is Changing the World's Cultures, contributing to changes in family structures, hierarchies, relational dynamics, ethnic/caste systems, gender roles. Globalization contributes to exchange/expansion of music (rock n roll, jazz, Indian/Arab classical music), language, food habits (chicken tikka, masala, hamburgers, French fries, tacos, kung pao chicken), festivals (valentines day), art, traditions (yoga, relaxation, dating, marriage, sexual practices) etc. and opportunities for growth. The Diaspora in countries of Immigration have been vital in promotion of such cultural expansion and changes.

Unfortunately there is a downside to this rapid globalization- increase in crime, delinquency, violence, anxiety and depressive disorders, addictive disorders. Many of the traditionalists as well as people that love traditions have been experiencing much anxiety about changes with grief reactions of "giving up" some of the valued traditions, at times contributing to ethnocentric reactions.

Another aspect of globalization of culture is its potential impact on changing of psychic structures particularly superego and individuation. Freud, Erikson, Horney, Kohut and cultural anthropologists contributed a great deal in explaining role of culture in formation of superego. Kakar, Roland, Ramanujam, Gringerg, Akhtar and others explained the differences between Eastern and Western cultures, family traditions in the formation of psyche. So, globalization can, probably be influencing psychic formation and superego formation. This workshop presents these aspects of globalization, globalization of culture and its impact on Psyche.

-Professor Kallivalil will present on Globalization and its effects on Social Psychiatry

-Dr. Pennoose will present on Globalization of culture and its vicissitudes on South Asian culture/social psychiatry

-Professor Rataemane will highlight application to Sub Saharan Africa

-Gogineni will discuss Globalization of culture's impact on non-western Psyche.

Educational/Learning Objectives

At the conclusion of the presentation participants will:

1. Learn the socio-cultural impact of globalization on various national/ethnic groups
2. Understand the pros and cons of globalization of culture on mental illness and its contributions anxiety, mood, substance abuse, women, children and others.
3. Explore the vicissitudes of globalization of culture on psychology and psychic structures of individual, group, and nations.

Speakers

1. Rama Rao Gogineni, MD
2. Roy Abraham Kallivalil, M.D.
3. Professor Pennoose
4. Professor Solomon Rataemane

INTEGRATIVE COMMUNITY THERAPY: a participatory response to respond social suffering and ‘psychic misery’.

Prof. Dr. Adalberto Barreto
Federal University of Ceara Brazil

Keywords: community therapy, local knowledge, social participation Brazil,

Over the last 26 years the Community Health Department of Federal University of Ceará has been implementing a supportive project for addressing psychological suffering and “Psychic misery” of families and individuals who live in the Pirambu’s slums at the community of 4 Varas in north east of Brazil and present in all Brazilian states, and others Country.

The big challenges are:

- How to move from a model which generates dependency to another that promotes autonomy?
- How to disperse the concentration among elite professionals allowing it to flow freely among all who need help?
- How to *rescue* the knowledge from African and Indian ancestors? - How to *rescue* the knowledge from people’s life experience?
- How to move from individual/pathology oriented approaches to community-health oriented practices?
- How to move from therapeutic practices limited to *clinical* interventions (micro) to larger scale, that is *community-based*.

This is therapy for BUILDING SOCIAL WEBS OF SOLIDARITY. It focuses on and brings out the individual’s competencies and positive values. It mobilizes the therapeutic dimension of the group/community itself.

Community Mental Health acts on the human relationships networks. It includes family, neighbours, friends and community in order to support the most vulnerable individuals and families who are living in critical life situation. Through with a preventive perspective, it identifies and mobilizes competencies and community resources.

The Project Goal : It works towards integrating the biological, sociocultural and political dimensions of the problems. Interaction starts from a “problem-situation” presented by a community member. The Community Therapist underlines the strategies used by other members in the group for resolving similar situations.

They ask reflective questions: to move the individual from a state of being overwhelmed by feelings (sensations) and be able to name and be cognizant of them (“when the mouth silences, the body talks”)

To move from an emotional state only to a reflective stance that brings a new understanding of themselves and experience and also individual and social change (*My husband continues being the same , but I’m not the same*”)

Emphasis is focused on group work for sharing problems and solutions. So it can serve as a shield for protecting the vulnerable ones. The group is also an important element for social insertion.

The intervention’s target is always the suffering of the people and not their pathologies/déficits.

We postulate that the solution must come from the group, through interactions, sharing of experiences, identification with one another, feeling of belonging, while respecting individual

diferences. The THERAPIST must be an integral part of this process of healing and social reconstruction. Both, THERAPIST and COMMUNITY benefit from each other. The community becomes more autonomous but also more integrated in the larger society, The THERAPIST is freed from his/her institutional and professional “autism” as well as from his/her alienating academic attitudes .

We believe that the best prevention is to link the individual to his/her cultural universe. It is by belonging to a group, to a set of cultural values that the individual nurtures him/herself and builds an identity. Culture for the individual is like a web for the spider.

We have helped the community rebuild its identity and renew its self-confidence; we have helped them to say ‘I can’.

TERAPIA COMUNITARIA INTEGRATIVA: Uma resposta participativa no acolhimento ao sofrimento e à miséria psíquica.

Palavras chave: Terapia Comunitaria, competencias e recursos culturais, participação comunitária Brasil

Nestes últimos 26 anos o Departamento de Saúde Comunitária da Universidade Federal do Ceara tem implementado um programa para acolher o sofrimento e tratar a miséria psíquica de indivíduos e famílias que vivem na favela do Pirambú na comunidade de 4 Varas no nordeste do Brasil, hoje presente em todos os estados do Brasil e em outros países. (www.abratecom.org.br - www.aetci-a4v.eu)

O grande desafio tem sido: Como passar de um modelo que gera dependência para um modelo que nutre autonomia e protagonismo?; Como romper com a concentração da informação e fazê-la circular numa linguagem acessível para que todos possam se beneficiar dela?; Como resgatar o saber dos antepassados indígenas, africanos, europeus, orientais e a competência adquirida por sua própria experiência de vida?; Como acolher o sofrimento sem ter que medicalizá-lo como se fosse patologia?; Como ultrapassar um modelo centrado na procura espontânea, na atenção individual, na cura medicamentosa, e possibilitar uma ação de promoção da saúde coletiva?

A Terapia Comunitária Sistêmica Integrativa é um ESPAÇO DE ESCUTA, PALAVRA E VÍNCULOS: uma prática sistêmica e integrativa de saúde e trabalho social comunitários, estruturado por regras precisas, permitindo a partir de uma situação problema, emergir um conjunto de estratégias de enfrentamento para as inquietações cotidianas devido a troca de experiências vivenciadas num clima de tolerância e liberdade, protegidos de projeções e desejos de manipulação.

Todos são convidados a serem corresponsáveis na busca de soluções e superação dos desafios do cotidiano saindo da posição de vítimas, objetos para corresponsáveis, parceiros, sujeitos. Atuamos numa perspectiva de promoção da saúde, que procura identificar e mobilizar as competências e recursos sócio culturais.

O ponto de partida é uma “situação-problema”, apresentada por alguém e escolhida pelo grupo. O animador procura estimular e favorecer a partilha de experiências possibilitando a construção de redes de apoio social. A pergunta que desencadeia a reflexão é:

« Quem já viveu algo parecido e o que fez para superar? »

A partilha de experiências mostra as possíveis estratégias de superação dos sofrimentos do cotidiano e permite a comunidade encontrar, nela mesma, as soluções aos seus problemas que a pessoa, a família e os serviços públicos não foram capazes de encontrar isoladamente.

Os objetivos da TCI são: Valorizar e reforçar o papel do indivíduo, da família e da rede de relações para que possam descobrir seus valores, suas potencialidades, tornando-se mais autônomos e menos dependentes; Favorecer o desenvolvimento comunitário, prevenindo e combatendo as situações de exclusão dos indivíduos e das famílias por meio da restauração e fortalecimento dos vínculos sociais e de encaminhamentos sócio econômico educacionais; Intervir nos determinantes sociais da saúde, em especial na redução do estresse e ampliação do apoio social.

Damos Ênfase no trabalho de grupo onde o foco da intervenção é o sofrimento jamais a patologia. Afirmamos que no lidar com o sofrimento, a solução está no compartilhar, no coletivo, nas identificações com o outro e no respeito às diferenças. Os profissionais são parte desta construção. Ambos tiram benefícios. A comunidade gerando autonomia e inserção social e nós profissionais nos curando de nosso autismo institucional e profissional bem como de nossa alienação universitária. “Ao cuidar do outro eu cuido também de mim”.

Nós acreditamos que a melhor maneira de promover a saúde, é ligar o indivíduo ao seu universo cultural. É pelo sentimento de pertença a um grupo e pela partilha dos valores culturais que o indivíduo nutre-se e constrói sua identidade. A cultura é para o indivíduo o que a teia é para a aranha. Temos ajudado a comunidade a reconstruir sua identidade e resgatar a confiança em si. Temos ajudado a comunidade a dizer : sim eu posso, eu sou capaz.

1. Prof. Dr. Adalberto Barreto

o papel do indivíduo, da família e da rede de relações para que possam descobrir seus valores, suas potencialidades, tornando-se mais autônomos e menos dependentes.

de redes de apoio social torna o indivíduo e a comunidade mais autônoma e menos dependente dos especialistas e instituições especializadas

BILINGUAL COMMUNICATION IN DIFFERENT SETTINGS: INCREASING PROVIDER-INTERPRETER COLLABORATION AND WORKING ALLIANCE

Principal Organizer: Betty Goguikian Ratcliff , University of Geneva

Co-organizers: Catarina Pereira, University of Geneva; F. Suardi, University of Geneva;
I. Fierro, Appartenances

Description and justification of the symposium or workshop:

In multicultural societies, with high rates of newcoming immigrants, it is of major importance that provider-migrant interactions are mediated by interpreters to facilitate communication in order to provide efficient and culturally sensitive assistance. However, the transition from a dyadic to a triadic encounter increases the complexity of the situation and leads to specific issues, not only in terms of roles, responsibility and power, but also in terms of interpersonal dynamics and processes.

Although interpreters' roles and functions in health care settings have been widely discussed, other areas such as school, social and legal contexts have received very scarce attention. Studies have actually underscored the importance of institutional norms and organisational structures on the dynamics of a bilingual encounter. Understanding providers' expectations and needs in different areas can provide important insight to interpreters' training, as the providers' preferences concerning the interpreters' degree of visibility (Invisible/interpreter-as-tool or conduit vs Visible/interpreter-as-mediator) may be very different. Therefore, the interpreters' ability to understand and adapt to provider's goals and expectations is essential to enhance the quality of provider-interpreter collaboration.

The three communications of the symposium will adopt a situational and interactional perspective, based on mixed-method studies. The first one will compare the views and practices of interpreters and providers collaborating in five different institutional contexts. The second one will analyse the impact of interpreters' training and providers experience in conducting bilingual interviews, on the quality of provider-interpreter collaboration. The last one will focus on the interpreters' contribution to therapeutic alliance in mental health setting.

Speakers (Names, affiliations, city, country, email and tentative titles)

1. Betty Goguikian Ratcliff
2. Catarina Pereira

Other considerations that you would like the Scientific Program Committee to know

TOBACCO SMOKING CESSATION/REDUCTION AND PERSONAL COMPETENCE IN PSYCHIATRIC PATIENTS: THE RECOVERY MODEL

Principal Organizer – Centro Hospitalar Psiquiátrico de Lisboa (Lisbon, Portugal). Tobacco smoking cessation/reduction program team.

Description and justification of the symposium or workshop:

Psychiatric and mental health services have evolved tremendously in the past few decades but much remains to be done to better the quality of care and quality of life for patients with psychiatric diagnosis. The tobacco smoking cessation/reduction program team, working in a large psychiatric hospital in Lisbon, Portugal, has had precisely this objective in mind and is now preparing multidisciplinary programs to address other health needs, like weight control and weight loss and exercise and physical activity, in this population of patients.

1. **Objectives:** to (1) Characterize tobacco smoking cessation/reduction interventions for psychiatric patients. (2) Discuss the recovery model in this context, focusing on the individual, competence, quality of life and a holistic view of human development. (3) Train active listening and counseling skills.
2. **Methods:** Based on a literature review, data analysis and clinical cases, the presentation will include models, concepts, practical interventions and clinical reasoning in clinical cases.
3. **Results:**(1) The majority of the participants in this program had diagnosis of anxiety and/or depressive disorders. However, many participants had substance abuse, bipolar or other psychotic disorders including several patients with residual schizophrenia.(2) Therapeutic effectiveness in this program was considered very significant.(3) The success of the program depends on the intervention model, dose-response relationship and communication and counseling skills.(4) The impact of these interventions can be extended to other risk behaviors and life objectives.(5) Strategies to minimize risks, low threshold interventions, relapse prevention and mobilizing social and caregiver support are fundamental.(6) Factors associated with positive outcomes are internal coherence, emotional and motivational stability, perception of control and differentiation of personal resources. Factors associated with negative outcomes are severity of illness, cognitive deficits, negative symptoms, co-morbid bio-psycho-social problems(ex. financial difficulties), cognitive biases and certain personality traits like impulsivity, low sociability and lack of flexibility.
4. **Conclusions:** Tobacco smoking cessation/reduction interventions for patients with psychiatric disorders should be considered an important opportunity to reduce a significant health risk and open the door to other initiatives in mental health settings like weight control and weight loss, exercise and increasing physical activity and self-regulation interventions. Effective management of motivational processes and harnessing personal competence are keys to change in lifestyle behaviors.

Speakers:

1. Miguel Trigo. Centro Hospitalar Psiquiátrico de Lisboa (CHPL). Tobacco smoking cessation/reduction program (CRRT). Lisbon, Portugal.. Clinical Psychologist
2. Isabel Ganhão. (CHPL). (CRRT). Lisbon. Portugal. Psychiatrist
3. Afonso Paixão. CHPL. CRRT. Lisboa. Portugal.. Clinical Psychologist
4. Noélia Canudo. CHPL. CRRT. Lisboa. Portugal. Clinical Psychologist

THE GENESIS OF PSYCHIC AND SOMATIC SYMPTOMS: PSYCHOSOCIAL PERSPECTIVE AND HOW TO IDENTIFY THESE PROBLEMS

Prof. Shridhar Sharma

MD, FRC Psy (Lond), DPM, FRANZCP (Australia), DFAPA (USA), FAMS;
Emeritus Professor, National Academy of Medical Sciences, and Institute of Human Behaviour & Allied Sciences, Delhi. Sr. Consultant & Head, Dept. of Psychiatry, PSRI Hospital & Research Centre, New Delhi.

The basic concept in a traditional illness is that the individual suffers from some pathology, which may be in an organ or a body system, which causes dysfunction, disability and pain to that individual. This basic premise is applicable both in the organic and psychiatric disorders. In psychosocial problems too the individual suffers from a disability, distress or pain but unlike the traditional illness, the primary pathology is outside the individual and due to this pathology, where one or the other organ or a system of a patient may be affected.

The symptoms originating from such psychosocial problems have certain basic characteristics. The physical symptoms in these cases are vague, ill-defined and often fleeting. They are changeable and present in one form or another for a short or long time. There is always an associated stressful precipitant factor. The symptoms become more marked with rising stress and are linked with continuation of stress. There is a clear time relationship between the initiation and continuation of the symptoms and the presence of psychosocial stress. The person suffering from these disorders may have an anxious, immature or a demanding personality. It is believed that behaviour resulting from such psychosocial problem can be differentiated from traditional illness behaviour. It is also known that all people with illness or illness feeling do not show same illness behaviour. Illness behaviour relates to those occasions or situations, where someone assumes that he is suffering from illness, adopts the role of a patient and thus seeks professional help. The workshop will discuss about these problems and also deal how these problems can be identified and managed in Primary health care setting.

SOCIAL PSYCHIATRY AND PRIMARY HEALTH CARE FOR MIGRANTS IN THE DEVELOPED COUNTRIES:

Auteurs: I. Biyong, R. Tempier, B. Kounou

Main objective: The promotion of mental health and prevention of mental disorders through promotion of primary health care according to WHO guidelines.

Specific objectives:

1. Show the inventory of primary health problems among the migrants in the developed countries.
2. To highlight mental health as part of overall health problems migrants.
3. Show the importance of integrating mental health care into primary health care to demystify psychiatric disorders educate and make prevention among these most vulnerable populations.
4. Demonstrate that this approach can overcome the lack of mental health specialists and psychiatrists to better promote social psychiatry for the right for mental care for everybody.

Affiliations of authors:

1. I. Biyong, Department of psychiatry, University of d'Ottawa, Canada
2. Dr. Raymond Tempier, B. Kounou, Processor of de psychiatry, University of Ottawa, Canada
3. Head Department of psychiatry/Mental health problem, Montfort Hospital, Ottawa, Canada
4. Laboratoire du Stress traumatique (EA 4560), Toulouse, France

SIGNIFICANCE AND TREATMENT OF BINGE EATING DISORDER IN OBESITY

Principal Organizer – Carlos M. Grilo, Ph.D. (Yale University School of Medicine)

Obesity is one of the world's leading health problems, and research has highlighted the clinical significance of a subgroup of obese persons with binge eating disorder (BED). BED is prevalent and is strongly associated with obesity and with increased psychiatric comorbidity and bio-psychosocial impairment. This presentation will provide an overview of controlled treatment research for obese persons with BED covering pharmacological, behavioral, psychological, and combined pharmacological-psychological interventions. A program of clinical research on the treatment of BED in obese patients across diverse clinical settings along with focused research on predictors and moderators of treatment outcomes will be also be presented. Recent studies have identified two reliable predictors of treatment outcomes for BED. One predictor is a patient characteristic reflecting body-image known as overvaluation of shape/weight and the second predictor is a treatment process known as rapid response. The significance of overvaluation of shape/weight has implications for refining and improved understanding of the BED diagnostic construct. Rapid response has clinical implications for informing stepped-care treatment approaches for BED and obesity. The broader implications of these findings for the dissemination of effective interventions and for informing social psychiatric and public health research will be presented.

Speakers

1. Carlos M. Grilo, Ph.D., Yale University School of Medicine, New Haven, USA,

AVATAR THERAPY: A NEW COMPUTER ASSISTED THERAPY FOR AUDITORY HALLUCINATIONS

Principal Organizer – Prof. Julian Leff (University College London, UK)

Objectives

To consider psychosocial processes that could explain the efficacy of a novel computer-based therapy for persecutory auditory hallucinations unresponsive to medication.

Methods

Patients were enabled to create a speaking image (avatar) of their supposed persecutor by means of a computerised system. They were encouraged to engage in a dialogue with the avatar which was controlled by the therapist. In the course of 6 sessions the avatar was altered by the therapist to come under the patient's control and to change its character from abusive to supportive and therapeutic. Each session was recorded and transferred to an MP3 for patients to use whenever they heard the persecutory voice. The efficacy of the therapy was evaluated in a randomised controlled trial.

Results

Assessment of patients before and after the therapy showed a significant reduction in the malevolence and omnipotence of the voices for the experimental patients, whereas there was virtually no change for the controls, who continued with treatment as usual. Three of the 16 patients who completed the therapy ceased to hear their voices altogether. A follow-up 3 months after the end of therapy showed that the experimental patients experienced a further significant reduction in the malevolence and omnipotence of the voices.

Psychosocial processes that could explain these results are: validation of the patients' experience by the therapist, increased control over the voices by the patients through creation of the avatar and its alteration to come under the patients' control, change in the nature of the avatar from persecutory to supportive and therapeutic. This could have enabled patients to reintegrate into their psyche the critical entity, formed from traumatic childhood experiences, that they could not tolerate and exteriorised as a persecutory voice.

Providing the patients with the recorded sessions on an MP3 probably explains the continued improvement in their hallucinations after the therapy ended.

Conclusion

The patients' experience in their dialogue with the avatar, which they had created, enabled them to oppose the actual persecutory voices vigorously and to take control of them. Some patients achieved an increase in insight during the therapy, recognising that the voices originated within their own mind.

This promising novel therapy is brief and efficacious. It needs to be evaluated in a large-scale replication trial.

Speakers

1. Prof. Julian Leff, University College London, UK

29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

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Oral Presentations

**Bio-psycho-social confluence
of psychiatric sciences**

NONSERIAL AND SERIAL SEXUAL HOMICIDE OFFENDERS IN CANADA: A COMPARISON OF TRAITS OF PERSONALITY DISORDERS AND PARAPHILIC BEHAVIOURS

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¹. City University of Hong Kong, Kowloon, Hong Kong, S.A.R.

². Simon Fraser University, Burnaby, British Columbia, Canada

³. Brown University, Providence, Rhode Island, U.S.A.

⁴. Rhode Island Hospital, Providence, Rhode Island, U.S.A.

Objectives: To explore the possible differences between nonserial and serial sexual homicide offenders (SHOs) in their manifestation of traits of personality disorders and paraphilic behaviours, and their potential influences in victim selection and perpetration.

Purpose: This paper aims to explore the possible differences between nonserial and serial SHOs in their manifestation of traits of DSM-IV-TR's ten (Cluster A, B, and C) personality disorders and paraphilic behaviours. In addition, the offending process by victim selection and perpetration methods of these two SHO groups is also examined.

Methods: Using a sample of incarcerated Canadian SHOs in a maximum correctional institution in the province of Quebec, between 1995 and 2005, 80 (73 nonserial and 13 serial) SHOs are examined.

Results: A number of important findings have emerged. Victims of serial SHOs ($M = 23.15$) are significantly younger than their nonserial counterparts ($M = 28.90$). In term of victim selection and perpetration methods, serial offenders are significantly more likely to engage in structured offense premeditation (62% versus 38%), to indulge in deviant sexual fantasies 48 hours prior to their offense (85% versus 48%), to hunt for strangers (69% versus 34%) with distinctive characteristics (46% versus 18%), and to verbally humiliate their victims during the offense than nonserial offenders. These differences may be partly due to the underlying manifestation of traits of personality disorders and paraphilic behaviours. Findings indicate that serial SHOs are significantly more likely to manifest traits of schizoid (62% versus 32%), narcissistic (69% versus 32%), and obsessive-compulsive (62% versus 32%) personality disorders than those who only sexually murdered one victim. Additionally, serial SHOs are also found to manifest significantly more paraphilic behaviours in the areas of exhibitionism (31% versus 8%), homosexual paedophilia (39% versus 16%), sexual masochism (62% versus 12%), voyeurism (23% versus 1%), and partialism (46% versus 19%) than their nonserial counterparts.

Conclusions: These findings underscore the potential influences of underlying manifestation of traits of personality disorders and paraphilic behaviours in victim selection and perpetration of nonserial and serial SHOs. Implications of the findings that may prove useful in criminal investigation are discussed.

Literature Reference

Chan, H. C., & Heide, K. M. (2009). Sexual homicide: A synthesis of the literature. *Trauma, Violence, and Abuse*, 10(1), 31-54.

RECENT DEVELOPMENTS IN THERAPEUTIC COMMUNITY WORK IN GRENDON PRISON

M. Brookes¹

¹. HMP Grendon, UK

Objectives: For the past fifty years Grendon prison has pioneered a unique, therapeutic community, approach to the management and treatment of severely personality disordered offenders. The offences committed by prisoners at Grendon include murder, manslaughter, grievous bodily harm, rape and sexual abuse of children and young people. Recently, externally imposed directives combined with internal management changes have altered the structures which surround how the therapeutic communities operate. This paper will explain how Grendon has adjusted to these developments whilst still maintaining the integrity of therapy delivered.

Methods: Described will be Grendon's treatment regime and the various government, national and local initiatives that prison managers have had to navigate and respond to over the past five years. These include an offender personality disorder strategy, market testing policy, healthcare and substance misuse funding arrangements, the accreditation of each therapeutic community, prison service audits and, revised management and grading arrangements.

Results: Outcome data will be presented to demonstrate Grendon's efficacy as a treatment intervention along with the views of Her Majesty's Inspector of Prison and findings from Community of Communities/HM Prison Service therapeutic community accreditation reports.

Conclusion: Grendon prison has been able to successfully operate as a series of therapeutic communities adjusting and adapting to an ever changing external world while maintaining the core and core and essential elements of its internationally recognised treatment programme.

ENHANCING CARE PROCESSES AND MANAGEMENT OF OMDs (OFFENDERS WITH MENTAL DISORDERS) UPON RELEASE FROM PRISONS – 1st YEAR OF SINGAPORE INITIATIVE.

B. Saluja¹, J. Goh¹, L. Lee¹, M. Gunasilan¹, R. Tan¹, C.H. Ang¹

¹Institute of Mental Health, Singapore

Objectives: Institute of Mental Health (IMH) is the only tertiary care psychiatric institute in Singapore. All the offenders with mental disorders (OMDs) when released from prison are given a follow-up appointment at IMH. Most of these OMDs don't turn up for their appointments and subsequently relapse and re-offend and end up in prison again – a typical revolving door phenomenon. Our data base (April 2010 to August 2011) indicates that 79% of the OMDs referred to IMH did not turn up for their scheduled first appointments. The average time to first appointment upon release during this period was 65 days. 70% of the remand admissions during this period consisted of OMDs who had re-offended and had been remanded at least once in the past.

Purpose: Establish a Specialist Forensic Community Services to support ex-offenders with mental disabilities (ex-OMDs) in their reintegration into the community, encompassing psychiatric treatment and social support in collaboration with partners.

Outcome Measures: 1) Default rate for the first visits, 2) Time to first psychiatric appointment and 3) Recidivism

Methods: A team consisting of psychiatrist, social workers and case coordinators was formed in 2011. A formal structured referral letter and triage process was put in place. Regular meetings were held with all the stakeholders including prisons, general psychiatric services, department of addictions services, after care services and voluntary work organizations. Pre-release assessment for risk and needs were done using CANFOR and HCR-20, and a multidisciplinary management plan formulated for each OMD. The family members of the OMDs were engaged in their management plan.

Our hospital IT system captured the data for the default rate for the first visits and time to first psychiatric appointment. Our case coordinators regularly contacted the prisons, remand wards, ex-OMDs and their family members to find out any recidivism. We were unable to obtain the data directly from criminal records office.

Results: 76 OMDs who fulfilled the inclusion criteria for our services were released from prison in Year 2012. 80% of OMDs engaged with mental health services upon release from prison within 14 days of their release. 5 (7.1%) ex-OMDs re-offended within 1 year of starting of the service.

Conclusion: Singapore model of care for ex-OMDs is in early stages of development. The initial data is encouraging and provides a good nidus for future development of the services.

EFFECT OF A LOW-IMPACT EXERCISE PROGRAM ON LEBANESE MARGINALIZED POSTMENOPAUSAL WOMAN WITH PSYCHOLOGICAL DISTRESS: A RANDOMIZES CONTROLLED TRIAL

B.R. Saab, M. Chaaya , N. El Ayoubi , T. Itani

¹.American University Of Beirut (AUB)

Objectives: Although physical exercise is generally recommended by physicians to relieve Psychological distress (PD) among older adults, substantial evidence does not yet exist to fully support this recommendation. *Aim:* This study examines the effect of a low impact exercise program on marginalized postmenopausal Lebanese women with psychological distress.

Methods: Community-dwelling women with a mean age of 56 years were randomized to either a low impact exercise program for three times a week over 6 weeks or a control group who received daily calcium tablets. The 12-item General Health Questionnaire (GHQ-12) was used to assess PD, the main outcome measure, and intention-to-treat analysis was performed. A focus group discussion was then conducted with a group of women who completed the exercise program.

Results: Sixty nine women were enrolled. Psychological distress was significantly lower at the completion of the study when compared to baseline levels in both intervention and calcium groups. This decrease in the GHQ-12 was noted across all 69 women, but did not differ significantly between the two groups.

Conclusion: This study shows that light impact exercise does not result in significant improvement of PD though the postmenopausal women who participated in the exercise program reported improvement and asked to sustain this activity.

THE INTERVENTION OF CASE MANAGERS FOR PATIENTS WITH SEVERE MENTAL DISORDER IN *CENTRO HOSPITALAR DE SÃO JOÃO*

S. Fonseca^{1,3}, C. Pinto¹, R. Melo², A. Ribeiro¹, I. Ferraz¹, R. Curral^{1,3}

¹ Centro Hospitalar de São João, Porto, Portugal

² Hospital Divino Espírito Santo, Ponta Delgada, Açores, Portugal

³ Faculdade de Medicina da Universidade do Porto, Porto, Portugal

Educational Objectives: The organization model of mental health services in Portugal includes strategies to promote integrated programs for patients with severe mental disorders. These programs are based on case management and its major goals are: assessment of individual problems and needs; definition of a care program approach; and monitoring progress.

Purpose: To characterize patients on Case Management Program in Psychiatry Department of Centro Hospitalar São João, Porto (CHSJ) and to evaluate the efficacy of this intervention.

Methods: Longitudinal retrospective study of patients included in the program more than 12 months before. We performed data analysis of socio-demographic and clinical variables and compared utilization of inpatient, day hospital, emergency and ambulatory services up to three years before and after the beginning of the intervention.

Results: We identified 40 patients. Most were included in the program following discharge from Day Hospital. Most patients were single (75%) and lived with parents (63%). Most patients were retired (49%) or unemployed (39%). Schizophrenia was the most common diagnosis (80%) followed by schizoaffective disorder (15%). Utilization of inpatient and day hospital services significantly decreased after entering the Program, both in number of days and number of admissions. Emergency department visits also significantly decreased. No significant differences were found between the ambulatory clinic visits and rate of attendance before and after starting the intervention.

Conclusions: Case Management Intervention was associated with decrease in the inpatient, emergency and day hospital service utilization but not outpatient clinic visits. More prolonged assessment of this intervention is required.

IMPACTS OF SOCIOECONOMIC, FAMILY, SCHOOL, BEHAVIORAL AND MENTAL DIFFICULTIES ON SUICIDE ATTEMPTS IN YOUTH

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Educational Objectives: This study may help participants to recognize factors influencing suicide attempt which have to be assessed/monitored in boys and girls.

Purpose: To assess the impacts of socioeconomic factors, alcohol/tobacco/cannabis/hard drugs uses, repeating a school-year, sustained physical/verbal violence, sexual abuse, depressive symptoms, and involvement in violence on suicide attempt among boys and girls in early adolescents.

Methods: The sample included 1,559 middle-school students from north-eastern France (778 boys and 781 girls, mean age 13.5, SD 1.3), who completed a self-administered questionnaire including gender, birth date, father's occupation, parents' education, nationality, income, social supports (9-item scale), and lifetime history reconstruction of parents' separation/divorce/death, alcohol/tobacco/cannabis/hard drugs uses, repeating a school-year, sustained physical/verbal violence (20-item scale), sexual abuse, depressive symptoms (Kandel scale), involvement in violence (11-item scale), and suicide attempts. Data were analyzed using Cox regression models.

Results: Lifetime suicide attempt affected 7.2% of boys and 12.5% of girls ($p < 0.001$). Among boys, the factors with significant crude hazard ratio cHR were: insufficient income (2.29), alcohol use (2.33), tobacco use (3.76), hard drugs use (4.48), depressive symptoms (3.60), sustained physical/verbal violence (2.72), sexual abuse (4.30), involvement in violence (3.16), and lack of social support (2.64 for score 1-2, 3.08 for score 3+, vs. score 0). Full model including all factors retained only insufficient income (adjusted hazard ratio aHR 2.11), alcohol use (1.99), depressive symptoms (3.29), and involvement in violence (2.64). Among girls, the factors with significant cHR were: parents' separation/divorce (2.44), insufficient income (2.23), low parents' education (1.86), repeating a school-year (2.56), alcohol use (2.04), tobacco use (5.19), cannabis use (3.72), hard drugs use (11.65), depressive symptoms (3.51), sustained physical/verbal violence (1.71), sexual abuse (8.09), involvement in violence (2.04), and lack of social support (3.46 for score 1-2, 6.92 for score 3+, vs. score 0). Full model retained only parents' separation/divorce (aHR 1.56), repeating a school-year (1.98), alcohol use (1.58), tobacco use (3.60), depressive symptoms (1.86), sexual abuse (6.60), and lack of social support (2.62 for score 1-2 and 4.38 for score 3+, vs. score 0). Compared with boys, girls had a significant cHR of 1.74 which decreased to 1.57 when controlling for all covariates (contribution 23%).

Conclusion: This study has achieved our objectives to identify a wide range of socioeconomic, family, school, behavioral and mental difficulties generating suicide attempt among boys and girls in early adolescence. Our findings are original. They reported their causal relationships, the knowledge of which may help public policy preventing suicide attempt.

Keywords: Adolescents, violence, socioeconomic factors, school/behavioral/mental difficulties, causal relationships.

CAN A BIO-PSYCHO-SOCIAL MODEL HELP IDENTIFY SELF-HARM REPEATERS IN ACUTE PSYCHIATRY?

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Educational Objectives: 1. Report findings from an investigation of a bio-psycho-social risk model for self-harm repeaters. 2. Focus on patients characterised by both suicide attempts and non-suicidal self-injury (SA+NSSI).

Purpose: To explore whether a biological marker could improve risk assessment of self-harm behaviour during the first year after discharge from an acute psychiatric department.

Methods: All (489) patients acutely admitted to a psychiatric ward during one year (2006-07) were asked to participate in this prospective observational study. Written consent was given by 254 patients. The following baseline variables were measured during hospital stay: lipid levels¹, the MINI suicidal scale² and psycho-social risk factors. Self-harming episodes were recorded at 3 and 12 months after discharge (n=199, dropouts=55) and compared with baseline measures.

Results: The SA+NSSI group (n=25) was characterised by triglyceride (TG) levels above mean (1.37, 1.28-1.47 mmol/litre). This group had more re-admissions and significantly more severe attempts compared to patients with only suicidal (n=36) or only NSSI (n=9) behaviours. TG remained a significant predictor of SA+NSSI in multivariate analyses at 3 and 12 months. The values of the area under the receiver operating characteristic curve (AUC) at 3-months were: MINI suicidal scale: 0.88, MINI suicidal scale + psycho-social factors: 0.93, MINI + psycho-social factors + TG: 0.94. AUC values after 12-months were 0.82, 0.83 and 0.86, respectively. The Odds ratio of TG for self-harm was significant for both men (OR=3.3, p=0.050) and women (OR=7.5, p=0.020), and significantly better for women than for men (p=0.037).

Conclusions: Triglyceride level above mean was a significant predictor of SA+NSSI behaviours in multivariate analysis at 3 and 12 months. Compared with a psycho-social model, the bio-psycho-social model increased the predictive effect sizes (AUCs) of post-discharge self-harm in this group. Limitations of the project were a small sample size and recruitment from only one hospital. Body mass index was not controlled for, but controlling for diabetes, alcohol abuse and medication did not change results. There were minor differences between the study group (199) and all target patients (489), and naturally other methodological problems pertaining to the observational study design may have biased the results. Still, even with these shortcomings results may be of significance.

One possible explanation of the results is that high triglyceride levels reflect increased nor-adrenergic activity caused by psychological distress. If confirmed by more extensive research our finding may open up for new treatment and management approaches.

¹ Roaldset, JO; Bakken, AM; Bjørkly, S. A prospective study of lipids and serotonin as risk markers of violence and self-harm in acute psychiatric patients. *Psychiatry Research* 2011; (186), 293-299

² Roaldset JO, Linaker OM, Bjørkly S: Predictive Validity of the MINI Suicidal Scale for Self-Harm in Acute Psychiatry: A Prospective Study of the First Year After Discharge *Archives of Suicide Research* 2012; (16), 1-15

DOES RELIGION STILL PROTECT AGAINST SUICIDE? A LONGITUDINAL STUDY OF 1 MILLION PEOPLE.

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Educational Objective/Purpose: This study addresses the question, why, given the increasing secularisation of society does the relationship between religion and suicide persist? If it is attributable to the increased social capital associated with church attendance, as suggested by Durkheim, then the risk should be lowest for Catholics, intermediate for Protestants and highest for those with no religious affiliation. If religiosity in terms of the relevance of religion in personal life is important, risk should be lowest for the more fundamental/Conservative Christian faiths.

Methods: This is a 9-year follow-up study of 1,106,104 people aged 16-74 enumerated in the 2001 census divided into four groups; Catholic, mainstream Protestant, Conservative Christians, and those with no religious affiliation, with Cox proportional hazards models adjusting for a wide array of cohort attributes identified at the census.

Results: The cohort experienced 1,119 suicides; 74.4% to males and 64.8% to people aged <45 years. The usual relationships between suicide risk and age, sex, marital status, social isolation and socio-economic standing were confirmed. In fully adjusted models there was no difference in risk between Catholics, and Protestants or those with no religion (HR 0.94; 95%CI 0.83, 1.08 and HR 1.00; 95%CI 0.84, 1.20 respectively); the risk for the Conservative Christians was about 30% lower than Catholics (HR 0.71; 95%CI 0.52, 0.97). Further analysis showed that the relationship between religious affiliation and mortality risk varied by age (Chi-sq 25.2; P = 0.047) but not by sex (Chi-sq 3.72; P = 0.294). Stratified analysis shows that between 16 and 34 suicide risk is about 25% highest for either Catholics or those with no religious affiliation than for Protestants or Conservative Christians. At 35-54 there is no appreciable difference between Catholics, Protestants and those with no religion, but lower for Conservative Christians (HR 0.50; 95%CI 0.29, 0.85 compared to Catholics). At 55-74 years, the absolute risk is low and there are no significant differences between the four groups.

Conclusions: The relationship, and suggested mechanisms, between religion and suicide risk established by Durkheim do not pertain in modern societies. The risk is similar for those with and without a religious affiliation and the higher Church attendance amongst Catholics does not protect against suicide risk. Religious affiliation is a poor measure of religiosity, except for a smaller group of Conservative Christians, though their lower risk may be attributed to factors other than religion such as lower risk behaviour and alcohol consumption.

THE EARLY INTERVENTION STRATEGIES (EIS) FOR THE SOCIAL INCLUSION OF CHILDREN WITH AUTISM SPECTRUM DISORDERS (ASDs)

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Objective: ASDs are characterized by impairments in social interaction, behavior, and communication and are often the cause of disability in children. So far there is no global consensus on what strategies of treatment, education, and social support are most effective for patients with ASDs [1-2].

Methods: We evaluated samples of 400 children with ASDs. We applied Autism Diagnostic Interview Revised, PEP-R, Ritw-Freeman and Vineland Adaptive Behavior Scales. The EIS included a consistent, if necessary, combined use of several rehabilitation trainings: of sensory stimulation and integration, special cognitive trainings (general perception, imitation, special school skills), behavioral trainings, trainings of social functioning (social perception, emotional cognition, basic social functioning skills (food intake, personal hygiene, peers communication, household appliance use, behavior in class, etc.), in case of need (expressive speech absence or on the first stage of speech development) the elements of methodology of alternative communication (facilitated communication, labels, icons). EIS comprised an average of 25 hours of therapy per week for 200 children of the main group. The rest of the children with ASDs were available chaotic aid correctional educators and speech therapists in special pre-schools.

Results: SEI in the study group has provided the best, compared with the control group, changes in cognitive function, speech formation, the formation of daily living skills and the formation of adaptive behavior. We have not received sufficient evidence to assess special behavioral interventions to determine which ones are most effective for individual children with ASDs. Parameters of cognition and social behavior of in-group of children with ASDs, receiving medication on a background of active rehabilitation were on the higher level, than in groups of comparison.

Conclusions: There may be several potential benefits of EIS: reduced disability, a better prognosis, most likely restore normal development and recovery of psychosocial skills.

ARE THE NEEDS OF YOUNG PEOPLE WITH EARLY MENTAL HEALTH PROBLEMS IN RURAL AUSTRALIA BEING MET OR IGNORED?

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Educational Objectives: At the conclusion of this presentation participants will be able to identify some ecological systems that influence the mental health well-being of some young rural Australians.

Purpose: To understand how young rural people with emergent mental health problems could be helped early following the onset of a mental health problem.

Methods: A mixed methods case study was conducted in rural Northern NSW, Australia, to understand how young rural people with emergent mental health problems could be helped early following the onset of a mental health problem. An ecological framework was used to see how systems and relationships have influenced the early help seeking behaviours of young rural people, their families and their communities.

Rural people were interviewed to gain real life accounts, and a survey was conducted to describe mental health helping experiences. Descriptive and thematic analysis took place and the findings indicated that young rural people, and their families, require a broad range of locally available community-based support systems to assist their uptake of early mental health professional care.

Results: Findings will be presented which describe the difficulties experienced by young people, and their families, associated with understanding the language and processes related to initial access to mental health services. A range of issues identified by respondents' which hindered access to early mental health care will be discussed. These included access to adequate food, shelter, safety and transport in combination with geographical isolation as well as the perception of quality and usefulness of first appointment experiences.

Conclusions: The findings of this study indicate that the capacity for translational mental health promotion and early intervention in rural communities is scant, and that future efforts should focus on locally-based holistic community approaches to improve the mental health of young rural people.

COMPARING PARENT RATINGS OF ADHD SYMPTOMS BETWEEN CHINA AND US: PSYCHOMETRIC ASSESSMENT WITH THE CHINESE ADHD RATING SCALE - IV

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Educational Objectives: This is the first study investigating the psychometric properties of ADHD Rating Scale-IV: Home Version (DuPaul, Anastopoulos, et al., 1998) in an ethnic group outside western countries. The participants will understand better the cross-cultural universality and specificity of the manifestation of the ADHD symptoms between schoolchildren in China vs. US.

Purpose: To assess the psychometric properties of the Chinese ADHD Rating Scale – IV: Home Version and to explore parent ratings of ADHD symptoms in a large sample of Chinese urban schoolchildren.

Methods: Parents of a representative sample of 1,616 schoolchildren (aged 6-17) in 12 Chinese cities completed the ADHD RS-IV: Home Version. Reliability, validity and factor structure were calculated.

Results: The Chinese ADHD RS-IV: Home Version demonstrated good internal consistency ($\alpha \geq 0.85$), moderate test-retest reliability ($r_s = 0.45 - 0.72$ over 4 weeks) and low parent-teacher correlation ($r = 0.32$). The scale showed good discriminant validity between children with and without ADHD ($p_s \leq 0.0001$, Cohen's $d_s \geq 1.84$), with ROC analysis showing optimal sensitivity (91%) and specificity (93%). The scale was significantly correlated with the Attention Problems ($r_s \geq 0.62$) and Externalizing Behaviors ($r_s \geq 0.58$) subscales of the Child Behaviour Checklist, and with the Abbreviated Conners Rating Scale ($r_s \geq 0.68$). Factor analysis revealed the *DSM-IV* two-factor model with 'inattention' and 'hyperactivity-impulsivity' dimensions, accounting for equal variances. Parent ratings revealed lower/similar scores for Chinese schoolchildren compared with the U.S. study.

Conclusions: The Chinese ADHD RS-IV: Home Version is a reliable and valid ADHD screening tool for ADHD assessment among Chinese urban schoolchildren. The factor structure is similar but not identical to the U.S. study. Normative data reveal cultural differences in some aspects of the parent ratings. Considering its clinical implications, the Chinese ADHD RS-IV is not only a useful instrument for identifying ADHD in Chinese youth, but can also be adopted to supplement the clinic diagnosis, supervise the treatment effect, and assist the epidemiological investigation of ADHD in China.

Literature Reference: DuPaul, G. J., Anastopoulos, A. D., Power, T. J., Reid, R., McGoey, K. E., & Ikeda, M. J. (1998). Parent ratings of ADHD symptoms: Factor structure, normative data, and psychometric properties. *Journal of Psychopathology and Behavioral Assessment*, 20, 83-102.

DEPRESSION, DISABILITY AND CHRONIC DISEASE AMONG ELDERLY

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Educational Objectives: Relationship between depression and chronic disease is mainly explained by disability, all or not related to chronic disease. Especially GPs should be aware of cognitive and physical impairment among elderly and its risk for depression

Purpose: To analyse the relationship between depression and physical impairment among elderly

Methods: Cross-sectional survey in a sample of 378 depressed and 138 “healthy” (no CIDI disorder) elderly from a general practice population of 60 years and older. Psychiatric disorder was assessed with CIDI. Impairments and disability with WHO-DAS. During the interview, social demographic characteristics and chronic diseases were assessed. Data were analysed using bivariate and multivariate statistical techniques (logistic regression).

Results: Depression is significantly related to physical functioning, cognitive functioning and presence of somatic disease. In multivariate analysis it appeared that the latter is not a modifier for the relationship between physical functioning and depression. The reverse however is true: the relationship between somatic disease and depression disappears after controlling for physical and cognitive function.

These results are especially found among “younger elderly”. For persons above 70 years cognitive function is the only disability factor that remains related to depression.

Conclusions: The relationship of depression and chronic disease, often found in the literature for many chronic diseases, disappears in general after controlling for impairment and disability. Although for a number of chronic diseases (e.g. Parkinson disease, some kinds of cancer, CVA) a specific link with depression will exist, we were not able to demonstrate this due to too small numbers of patients with such diseases.

PREDICTING RECURRENT DEPRESSION AMONG PRIMARY CARE PATIENTS: THE IMPORTANCE OF SOCIAL CONNECTEDNESS PERCEPTIONS

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Educational Objectives: At the conclusion of this presentation, participants should have an increased understanding of how social factors may be used to identify which patients are at greatest risk of experiencing recurrent or persistent depressive symptoms.

Purpose: To investigate the role of social connectedness in predicting recurrent or persistent depression among primary care patients at 12 and 24 months when multiple confounding variables were considered.

Methods: This was a two year prospective cohort study of 789 people recruited from 30 primary care clinics. Participants completed a baseline questionnaire on current depressive symptoms, three dimensions of social connectedness (perceptions, integration and available attachments), neuroticism, health care use, self-rated health, self-reported chronic illness, alcohol intake, partner violence, childhood physical or sexual abuse, socio-economic status and demographic characteristics. The analysis tested for a potential moderating effect of gender and age, and a potential mediating effect of health care use, on the relationship between social connectedness and depression outcome. Multiple logistic regression analysis was used to identify significant predictors of depressive status at 12 and at 24 month follow-up. Generalised estimating equations were used to control for clustering and multiple imputation was used to handle missing outcome data.

Results: At 12 months, 655 (83%) participants were followed up, 40 percent of whom were depressed. At 24 months, 495 (63%) participants were followed up, 30 percent of whom were depressed. Perceptions of social connectedness, baseline depression severity, and neuroticism were significant ($p < 0.01$) predictors of depressive status at both 12 months and 24 months. Self-rated health significantly predicted depressive status at 12 months only and health care use predicted depressive status at 24 months only. Social integration and available attachments did not predict depression outcome. Neither gender nor age moderated the association between social connectedness perceptions and depression outcome and health care use did not mediate the association.

Conclusions: People who perceive that their social connectedness is inadequate are significantly more likely to continue to experience recurrent or persistent depression. The ability of social connectedness perceptions to predict depression outcome is independent of other factors such as initial depression severity, neuroticism, chronic illness, problem drinking, partner violence, child abuse, SES and demographic characteristics. This study shows that the pathway between social connectedness and depression outcome is through an individual's subjective appraisal of the adequacy of their social connectedness and not through objective levels of social integration or available attachments. These results suggest that social connectedness based interventions for depression should concentrate on changing perceptions rather than on increasing objective levels of connectedness.

ACCEPTABILITY TO USERS OF MOODGYM VERSUS INFORMATIONAL WEBSITES IN DEALING WITH DEPRESSION

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Educational Objectives: To present the potential advantages and disadvantages of on-line self-help using a Cognitive Behavioural Therapy (CBT)-based intervention, and open up discussion of how such websites, which are proliferating, may be delivered to greater effect.

Purpose: To investigate views of two on-line approaches to self-help for depression among adults in employment: computerised cognitive behaviour therapy (cCBT) and informational websites. CCBT offers an inexpensive and accessible alternative to face to face therapy, depending on its acceptability to employees.

Methods: Qualitative data were collected within an on-line RCT whose participants had diagnosable depression. The experimental intervention was a five week cCBT programme called MoodGYM, the control condition was five informational websites about mental health. There was no evidence of the superiority of either in terms of treatment outcomes. Here we look at the relative acceptability of each approach over time, including perceptions of cCBT compared to seeing a healthcare professional. We also present analysis of qualitative comments on the process of on-line self-help.

Results: Most people valued the advantages of cCBT at the outset and retained favourable attitudes towards it when they had used it. The control participants found the informational websites somewhat less acceptable over time. Barriers to use fell into four categories: intrinsic, intra-personal problems; extrinsic technical problems; generic issues mostly pertaining to perceptions of cCBT; and specific issues about the intervention or control condition.

Conclusions: As first-aid for mild to moderate mental health problems, evidence-based computerised approaches have broad acceptability. This could be increased by attending to the barriers noted here and by managing users' expectations at individual and organisational levels. The findings have implications for occupational health providers and others addressing the needs of working-age adults with depression.

SOCIAL RELATIONSHIPS AND DEPRESSION: TEN-YEAR FOLLOW-UP FROM A NATIONALLY REPRESENTATIVE STUDY

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Educational Objectives: At the conclusion of this presentation participants should be able to: 1) identify quality of social relationships as a risk factor for major depressive episodes; 2) appreciate the degree of effect poor quality of social relationships on depression risk; and 3) recognize how to assess individuals' quality of social relationships.

Purpose: Social relationships have long been associated with mental health, but the long-term ability to predict depression based on features of social relationships has been less explored. We determined whether quality of social relationships and social isolation predicts the development of major depression ten years later.

Methods: This is a longitudinal cohort study of 4,642 community-residing adults who participated in the Midlife in the United States study. Participants age 25-75 completed surveys at baseline in 1995-1996 and at ten-year follow-up. Weighting adjustments were applied to make the sample nationally representative. Quality of relationships was assessed with multi-item scales of social support and social strain. Social isolation was measured by presence of a cohabiting spouse/partner and reported frequency of social contact with family, friends, and neighbors. The primary outcome was past year major depressive episode ascertained at follow-up. Multiple logistic regression was conducted, adjusting for the presence at baseline of major depression, psychiatric comorbidity, sociodemographics, and other potential confounders.

Results: Risk of depression at 10-year follow-up was significantly greater in those with social strain (OR, 2.03; 95% CI, 1.49 - 2.76), lack of social support (OR, 1.79; 95% CI, 1.36 - 2.36), and poor overall relationship quality (OR 2.65; 95% CI, 1.86 - 3.76) with spouse/partner, family, and friends. Poor quality of relationship with spouse/partner (OR, 1.47; 95% CI, 1.16 - 1.87) and family (OR, 1.45; 95% CI, 1.10 - 1.90) each independently increased risk of depression. Those with the lowest overall quality of social relationships had more than double the risk of depression (14.1%; 95% CI, 12.0-16.1; $p < .001$) than those with the highest quality (6.6%; 95% CI, 5.2-8.0; $p < .001$). Social isolation did not predict future depression, nor did it moderate the effect of relationship quality.

Conclusions: Poor quality of social relationships is an important risk factor for major depression. Interventions aimed at preventing depression should consider addressing social relationships and targeting individuals with low quality of social relationships.

DEPRESSION IN BRAZILIAN ADULTS: A CROSS-SECTIONAL POPULATION-BASED STUDY

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Educational Objectives: Update on the prevalence of Major Depressive Episode (MDE) in Brazil. At the conclusion of this presentation, the participants should be able to know the prevalence and factors associated with MDE in Brazilian adults.

Purpose: The present study aimed to assess the prevalence of MDE and to describe demographic, socioeconomic and behavioral factors associated in adult.

Methods: A population-based cross-sectional study was conducted in Pelotas, southern Brazil, in 2012 using a sampling design of two-stage conglomerates with probability proportional to size. All adults aged 20 or more living in the selected households were invited to participate in the study. MDE was assessed using the Patient Health Questionnaire-9 (PHQ-9) with a cutoff ≥ 9 . Demographic, socioeconomic and behavioral variables were evaluated.

Results: The study sample comprised 2,925 respondents. The prevalence of MDE in the sample studied was 20.4% (95% CI 18.9;21.8). After adjustment for confounding factors according to a conceptual analysis model the following variables were associated with a higher prevalence of depression: female gender; younger age; white skin color; lower socioeconomic condition; lower education; smoking; being single or separated; being unemployed; and reporting a heart condition. Alcohol use, arterial hypertension, and diabetes mellitus were not found to be associated with depression

Conclusions: Our findings support the relevance of depression as a prevalent condition among adults. It also provided evidence of the factors associated with depression, and that some are potentially modifiable risk factors may have implications for policy and health service planning.

DEPRESSION SELF-MANAGEMENT SUPPORT GROUP: OUTCOMES OF A PILOT STUDY

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Educational Objectives: At the end of this presentation, participants should be able to recognize depression self-management support as a promising approach in primary care.

Purpose: The objective of this 1-year pilot study was to evaluate the effectiveness, acceptability and feasibility of a depression self-management support group among primary care patients with depressive symptoms.

Methods: Using a pre- and post-intervention prospective design, 40 patients with depressive symptoms received a weekly self-management group intervention lasting 10 weeks. Inclusion criteria were: a) ≥ 18 years old; b) major depressive episode in the previous two years, based on the SCID; c) score ≥ 6 to Quick Inventory of Depressive Symptomatology-Clinician (QIDS-C) and ≥ 8 to Hamilton Rating Scale for Depression (HDRS). Exclusion criteria were: a) bipolar disorder; b) psychotic disorder; c) pregnancy or $\leq$ six months postpartum. Clinicians blind to the intervention completed pre-intervention and post-intervention telephone interviews assessing participants' depressive symptomatology (QIDS and HDRS) and antidepressant adherence (MMAS). Knowledge about depression, self-efficacy and self-management behaviors were measured by self-administered questionnaires. Participant satisfaction and perceived usefulness of the intervention were also evaluated at post-intervention.

Results: Participants had significantly lower levels of depressive symptoms after the group intervention. Self-management behaviors also improved. Based on these findings, patients' feedback and rates of retention, the self-management support group intervention was acceptable. Feasibility is high because our recruitment was quicker than expected.

Conclusions: Providing self-management support to depressive patients seems to be a promising intervention in primary care. This study demonstrates the acceptability and feasibility of a group intervention. A randomized controlled trial is needed before we can recommend implementing the program.

DOSE-RESPONSE RELATIONSHIP BETWEEN EXERCISE AND CLINICAL DEPRESSION. A SYSTEMATIC REVIEW

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Educational Objectives: To inform mental health professionals about dose-response issues related with the prescription of exercise to clinically depressed adults.

Purpose: To determine the optimum dose-response relationship between exercise and clinical depression.

Methods: A systematic literature review of randomized controlled trials (RCTs) on exercise intervention was conducted (1980 to 2011-June). Inclusion criteria included adult patients (18-65) diagnosed with major depressive disorder. The dose-response relationship in each RCT was assessed with the Cribbie and Arpin-Cribbie (2009) method that clarifies if treatment changes (reduction in depression) are equivalent to the normal population at the 0.5, 1.0, and 1.5 standard deviation (SD) intervals. Based on the 10-item Physiotherapy Evidence-Based Database Scale (PEDro), two independent raters evaluated the internal validity qualities of each RCT to control for the confounding impact of systematic errors of bias as these are related with larger treatment effects. Due to inability to blind patients/therapists in exercise RCTs, the two related PEDro items were excluded. Thus, the maximum quality score was 8. Interrater agreement was calculated as Cohen's kappa.

Results: Fourteen RCTs met the inclusion criteria. Aerobic exercise compared favourably to other exercise modes (relaxation, low intensity, stretch or strengthening exercise) in three RCTs and equally in two RCTs. Aerobic exercise showed higher effects than traditional treatments in eight RCTs and equally in one RCT. PEDro scoring ranged from 1 (lowest) to 8 (highest) with substantial interrater reliability (Cohen's kappa=62). RCTs were hierarchically classified on the basis of top PEDro scoring to identify the optimum dose-response relationship toward the most proximal equivalence interval (0.5SD) to the normal population. One RCT (PEDro score=4), and two RCTs (PEDro score=5) with low-moderate intensity exercise delivered three times/week (for 3, 8, or 9 weeks) reflecting on the patients' preferred mode/intensity exercise brought about an improvement in depression scores equivalent to the normal population (0.5SD, and 1.5SD intervals, respectively). The 4 and 5 PEDro scoring is moderate pointing unfulfilled key design criteria including random/concealed allocation, blinding assessor.

Conclusions: Both short- and longer-term (3, 8, or 9 weeks) aerobic exercise protocols at low-moderate intensity delivered three times/week reflecting on the patients' preferred intensity/mode exercise improved depression to a state of normalcy. However, the optimum dose-response relationship between exercise and depression cannot be determined due to moderate methodological qualities of the RCTs. Robust methodological RCTs focusing on the patients' preferred mode/intensity exercise are needed to establish the optimum dose-response relationship between exercise and clinical depression.

CHANGING PSYCHIATRIC PERCEPTION OF AFRICAN- AMERICANS WITH MOOD DISORDERS, 1788-2012

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Educational Objectives: At the conclusion of this presentation, the participants will 1) understand the link between historical stereotypes and low reported rates of mood disorders in African Americans and 2) recognize the importance of historical perspective when assigning psychiatric diagnoses to members of minority populations.

Purpose: This presentation will explore the origins and implications of the underdiagnosis of mood disorders in African-Americans.

Methods: To facilitate this historical inquiry, the author 1) searched MEDLINE, American psychiatric journals, and old collections using relevant key words; and 2) reviewed references from the bibliographies of articles that were collected by this procedure.

Results: The historical record indicated that the psychiatric perception of African-Americans with mood disorders changed significantly during the last 200 years. In the antebellum period, the mental disorders of slaves mostly went unnoticed. By the early 20th century, African-Americans were reported to have high rates of manic-depressive disorder compared with whites. By the mid-century, reported rates of manic-depressive disorder in African-Americans plummeted, and rates of depression remained virtually nonexistent. In recent decades, reported suicide and rates of diagnosed depression and bipolar disorder, whether in clinical or research settings, were inexplicably low in African-Americans compared with whites. Regardless of year, whether early last century or as recently as 2012, studies 1) linked mood disorders in African-Americans to severe mental disorders, such as schizophrenia or organic psychoses; 2) judged psychotic symptoms in African Americans to be more severe in their own right; and 3) deemed affective disorders without psychotic features in African Americans to be more severe and debilitating.

Conclusions: Given these results, American psychiatry has come to perceive that blacks are prone to severe psychotic disorders, such as schizophrenia, rather than mood disorders. Low reported rates of depression and suicide in African Americans may be influenced by past stereotypes that portray blacks as being insusceptible to or unaffected by depression. Psychiatry, as a whole, needs to appraise the deep-seated effects of historical stereotypes on the diagnosis of minority populations and exercise appropriate caution in clinical and research settings.

THE INTERRELATIONSHIP BETWEEN RESILIENCY AND PSYCHOSOCIAL MEASURES FOR PRETERM BIRTH

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Educational Objective: To understand how maternal psychosocial measures are related to the risk of early or late preterm birth.

Purpose: To investigate the relationship among composite pregnancy anxiety and the risk of early preterm (EP; <34 weeks) and late preterm (LP; 34-36 weeks) compared to term delivery (>37 weeks) and to further examine this relationship among women with high perceived social support and optimism.

Methods: We used data from the All Our Babies study, a prospective community-based pregnancy cohort in Alberta, Canada (n=3388). Composite pregnancy anxiety included excessive symptoms of state anxiety in early pregnancy, history of abuse and feelings about timing of pregnancy. We performed bivariate and multinomial logistic regression to examine the effect of composite pregnancy anxiety on preterm delivery after controlling for demographics, lifestyle and pregnancy-related factors.

Results: Pregnancy anxiety was an independent risk factor for LP birth (Odds ratio (OR) 1.72; 95% CI: 1.06, 2.79), but not for EP birth (OR 2.45; 95% CI: 0.96, 6.38) after adjusting for known risk factors. However, pregnancy anxiety was not a significant risk factor for preterm birth among women with high perceived social support or high optimism.

Conclusions: The results suggest that that both external and internal resiliency factors mitigate psychosocial risk for shortened gestation. In specific, high social support and high optimism buffer the effect of pregnancy anxiety on the risk for delivering a late-preterm infant. Being connected to others and the perceived availability of social support is a coping mechanism related to resiliency, while optimism is related to a sense of control or mastery over life. Our findings add to the accumulating evidence that self reported measures of stress-related emotions are related to adverse pregnancy outcomes, and suggest the importance of effective prenatal screening to identify anxiety. In addition, the important role of spouses, families and communities in providing support is highlighted.

CHILDREN'S MENTAL HEALTH AND PARENTING AMONGST MULTICULTURAL CANADIAN FAMILIES: ASSOCIATIONS WITH UNIQUE PROFILES OF ENVIRONMENTAL RISK

D. T. Browne¹, J. M. Jenkins¹

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Educational Objectives: To illustrate the fact that distal environmental risk factors for mental health problems in children (e.g. neighbourhood quality, immigration status, poverty, marital conflict, maternal history of abuse, etc.) combine in unique and distinct profiles amongst urban and multicultural Canadian families. These risk profiles are differentially associated with both child psychopathology and parent-child relationships. To date, only one study has explicitly addressed this issue in the context of academic and behaviour problems (Lanza et al, 2010).

Purpose: To statistically identify prototypical patterns (Latent Classes) of environmental risk and examine the corresponding patterns of child psychopathology and parent-child relationships amongst 501 diverse urban families from Ontario, Canada.

Methods: Participants came from the Kids, Families & Places Study, which is largely representative of the urban Canadian population with the exception of slightly higher education and less divorce. A Latent Class Analysis was conducted across 33 multi-informant risk factors, which concerned maternal history/functioning, household characteristics, socioeconomic indicators, and neighbourhood quality. The optimal number of classes was selected based on statistical fit indices (the Akaike and Bayesian Information Criteria, Entropy, and the Lo-Mendell-Rubin Likelihood-Ratio Test). Subsequently, the identified classes were compared on psychiatric screening measures derived from the Canadian National Longitudinal Survey of Children and Youth (hyperactivity-inattention, physical aggression-conduct disorder, emotional disorder-anxiety), interviewer observation of child behaviour, and psychometric and observational measures of parenting (parental positivity and negativity).

Results: A four class solution for the Latent Class Analysis was selected: (1) intact families with low risk (43%), (2) intact immigrant families with low-SES living in disadvantaged neighbourhoods (28%), (3) intact families with maternal history of adversity (16%) and (4) single-parent families with multilevel risk (13%). Differential associations with child psychiatric problems and parenting practices were observed across risk profiles.

Conclusions: Distal environmental risk factors are distributed in a nominal fashion similar to the risk profiles previously described by Lanza and colleagues (2010). This is with the exception of the low-SES immigrant group living in disadvantaged neighbourhoods, which is reflective of the Canadian urban landscape. Findings suggest that scientists should not only be concerned with the amount of psychosocial risk children experience, but also the pattern of risk and the way these patterns differentially correlate with child mental health problems and family relationships.

THE MENTAL HEALTH IMPACT OF ABORTION

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². King's College London, UK

Educational Objectives: At the conclusion of this presentation, the participants should be able to understand the evidence regarding mental health problems following an elective abortion.

Purpose: To review the best available evidence assessing the link between mental health problems and elective abortions.

Methods: We undertook a comprehensive and systematic review of the associations between abortion and mental health.

Results: Most of abortions carried out in the UK and commonwealth countries are undertaken on the grounds that continuing with the pregnancy would risk physical and/or psychological harm to the woman or child. However, there has been some concern in recent years that abortion itself may lead to an increased psychological risk and negatively affect the woman's mental health. Indeed, two recent meta-analyses have claimed that abortion leads to a deterioration in mental health. Neither of these meta-analyses was done systematically, nor did they comprehensively review the field of abortion and mental health in terms of prevalence and factors associated with a poor outcome. Previous reviews concluded that the mental health outcomes following an unwanted pregnancy are very similar whether the woman gives birth or has an abortion. One of these was comprehensive but not systematic; the other was systematic but not comprehensive. The review highlighted multiple flaws in the evidence base currently available to assess the question. findings suggested that there may be a link between mental health problems and an unwanted but this risk is unchanged by going to abortion or giving birth.

Conclusions: Mental health problems are associated with an unwanted pregnancy regardless of pregnancy resolution e.g. abortion or live birth. Meta-analysis is particularly susceptible to bias in this area. The physical health outcomes for women with an unwanted pregnancy have improved greatly by making abortion legal. To further improve the mental health outcomes associated with an unwanted pregnancy we should focus practice and research on the individual needs of women with an unwanted pregnancy, rather than how the pregnancy is resolved.

THE ADDITIVE EFFECTS OF EXPOSURE TO VIOLENCE, SOCIOECONOMIC STATUS, AND POVERTY ON AFRICAN AMERICAN YOUTH DELINQUENCY AND VIOLENCE: A STRAIN THEORY APPROACH.

A. A. Seixas¹

¹. City University of New York, NY

Educational Objectives: The objective of this paper is to highlight a new etiological framework, called chronic cumulative community strain, on youth delinquency. Chronic cumulative strain (CCS) considers the additive and chronic effects and processes of risk factors across an individual's many environmental systems, which insidiously erodes potentially buffering factors. This new paradigm has the potential to inform multi-level and multi-systemic community interventions programs and policy.

Purpose: The project provides a unique etiological model on youth delinquency, one that incorporates risk and protective factors in a general strain theory perspective.

Methods: The current study examined the relationship between chronic cumulative community strain (CCCS), an additive construct of exposure to violence and poverty stressors, and delinquency and violence in a sample of 74 African American adolescent boys. In addition, the study investigated the risk and protective properties of coping, family environment, parenting styles, peer affiliation and male identity on the putative relationship between CCCS and delinquency and violence.

Results: Results demonstrated a significant positive correlation between CCCS and juvenile delinquency, specifically a positive correlation between exposure to violence and juvenile delinquency, and a negative correlation between SES and juvenile delinquency. In addition, the moderational effects of positive coping, family cohesion, authoritarian parenting styles, prosocial involvement and male identity on the relationship between CCCS and delinquency were examined. Findings from moderation analyses showed that negative coping strategies and a conflictive family environment were positively correlated with juvenile delinquency, but the relationships were no longer significant after controlling for exposure to violence. More importantly the study found that some male identities moderated the relationship between CCCS and juvenile delinquency. Specifically, reference group nondependent (RGND) and no reference group (NRG) male identities, adolescent boys who either base their male identity on non-traditional masculine ideology or do not subscribe to any male ideology, weakened the positive relationship between violence victimization and delinquent behavior.

Conclusions: The study's unique socio-ecological perspective on risk and protective factors has the potential to revolutionize youth delinquency interventions. It offers a comprehensive understanding of a vexing social issue: the contribution that long term community strain has on endemic delinquency among male African American youth.

WESTERN-TRAINED HEALTH CARE PRACTITIONERS' BEHAVIORAL INTENTIONS TO WORK WITH TRADITIONAL HEALERS: IMPLICATIONS FOR INTEGRATION OF TRADITIONAL HEALING AND WESTERN HEALING

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Educational Objectives: This study was informed by South Africa's proposal to integrate traditional African healing and Western medicine in state health care institutions.

Purpose: The study aimed to investigate how Western-trained health care practitioners' opinions, attitudes, knowledge and experiences with traditional healing could predict their intentions to work with traditional healers in the future. Participants were 319 Western-trained healthcare practitioners at state hospitals and clinics in Gauteng and Limpopo provinces in South Africa.

Results: Results of standard multiple regression analysis revealed that the predictor variables (opinions, attitudes, knowledge and experiences) explained 51% of the total variance of health care practitioners' intentions to work with traditional healers in the future. Attitudes made the strongest unique contribution to explaining health care practitioners' intentions to work with traditional healers in the future when the variance explained by other variables in the model was controlled for.

Conclusions: In conclusion, it would appear that the current potential to integrate the two health care models is remote and can only be realised with considerable effort from all stakeholders.

THE MANIFESTATION OF ANXIETY AMONG SESOTHO SPEAKERS

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Educational objectives: Many aspects of mental health may be influenced by culture, including how individuals manifest and express their symptoms, their support from the family and communities, coping styles, and willingness to seek treatment. Diagnosis, treatment and service delivery are also influenced by the cultures of the service system and clinician. This is also true for anxiety. Anxiety is a universal phenomenon. However, cross-cultural studies have shown that there are significant differences in the way anxiety is described and experienced.

Purpose: This study investigates the way in which anxiety is clinically manifested among Sesotho speakers in Mangaung, Free State, South Africa

Methods: The participants consisted of 101 Sesotho speakers from Mangaung, South Africa, diagnosed with anxiety disorders. They were drawn from consecutive patients presenting at various health establishments. The participants were between 18 and 65 years of age. Written informed consent was obtained from each participant. The study was approved by the research committee of the University of the Free State. A semi-structured interview, based on the Psychiatric Interview Questionnaire (PIQ) was used to elicit the information. The PIQ consists of two types of data collection: open-ended interview and clinical observation.

Results: About 64.0% of the participants were between 26 and 45 years of age. Almost 50.0% of the participants were single. Although anxiety is found across cultures, its expression, in terms of interpretation and experiences, is influenced significantly by cultural factors. Furthermore, it was found that the core symptoms of anxiety among Sesotho speakers are similar to those that have been reported in other cultures except for the prevalence of perceptual disturbances and physical symptoms. There was also culture-specific expression of anxiety among Sesotho speakers.

Conclusion: The present study strongly confirms other research reports that anxiety is a universal psychological or emotional disorder. However, the way in which anxiety is experienced and interpreted, and how people respond to it, is strongly influenced by cultural forces. Another important finding of this research is the marked variation in manifestation of the symptoms of anxiety among Sesotho speakers in comparison with Westerners. The main differences were observed in perceptual disturbances, specifically the prevalence of hallucinations, which are regarded as indicative of psychosis in the western world. Although this study revealed important findings, the results should be interpreted with caution, especially as far as generalization is concerned.

PSYCHOSOCIAL SUPPORT IN MENTAL ILLNESS: CREATING CHANGE TO IMPROVE SERVICES

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2. UnitingCare Wesley Port Adelaide, South Australia

Educational Objectives: Participants will recognise uses of change management models and measurement tools in putting improvements into practice in psychiatry-related services such as psychosocial support.

Purpose: Many best practice recommendations in biopsychosocial psychiatric care are not delivered to patients, often because planned practice changes are not properly implemented. This project identified and assessed a change management tool in implementing improved psychosocial support delivery in community mental health.

Methods: *Background:* Psychosocial support is a key element of biopsychosocially oriented mental health care, but one with a continually evolving evidence and theoretical basis. To maintain alignment with current best practice, providers must continually adapt their services. Such service changes are notoriously difficult to put into practice therefore leaders need appropriate and proven implementation tools.

Setting: The study setting was the introduction of a new program, the Flinders Chronic Condition Management Program (Flinders ProgramTM), to underpin 15 recovery-based psychosocial support programs delivered by a non-government organisation in South Australia, UnitingCare Wesley Port Adelaide (UCWPA). The Flinders Program had been assessed by UCWPA as empirically tested and consistent with the client-partnership and recovery orientations of the organisation. The research team assessed the usefulness of a health service change tool in implementing this planned change.

Literature review: A literature search and review was conducted to select a health service implementation model which had corresponding measurement tools and face applicability for psychosocial support services in community mental health.

Application of the tool: The selected measurement tools were applied early in the implementation (T1) and 9 months later (T2). Changes in scores for the 3 domains of the model were matched against change strategies used between T1 and T2 (such as worker training and awareness, measurement systems, and integration with performance management) and against organisational measures of practice change.

Results: The literature review found few implementation models which had corresponding tools that were easily accessible for service practitioners. Of those found, the Promoting Action on Research Implementation in Health Services (PARIHS) model and corresponding Organizational Readiness to Change Assessment (ORCA) tool were selected for the project.

Lowest scoring subscales of the ORCA tool at T1 pointed to domains of the PARIHS model which could be strengthened through change strategies. Changes in subscale scores at T2 showed good alignment with strategies applied and with greater use of the Flinders Program.

Conclusions:

The PARIHS model and aligned ORCA tool were found useful in showing gaps, guiding strategies, structuring change processes, and reflecting progress in implementing change in psychosocial support services in our setting. We believe that such models and tools warrant further use by psychiatrists and other service leaders wishing to implement improvements in biopsychosocially oriented mental health care services.

IMPLEMENTATION OF MODERN MENTAL HEALTH CARE PRINCIPLES IN LITHUANIA: ANALYSIS OF OBSTACLES FOR MAKING SHIFT OF PARADIGM POSSIBLE

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Educational Objectives: At the conclusion of this presentation, the participants should be able to identify factors which might facilitate or impede implementation of evidence-based mental health policies and services.

Purpose: Main objective was to identify basic obstacles impeding so far implementation of modern mental health policies.

Methods: Multidisciplinary group of researchers, representing social and biomedical sciences, analyzed steps undertaken in attempt to transform mental health services in Lithuania during two decades (1990-2010). Analysis of dynamics of public mental health indicators, mental health system performance indicators and documents reflecting formulation and implementation of national mental health policy during 1990-2010 was performed, as well as a qualitative study of interviews with representatives of major stakeholders.

Results: Several stages in the area of mental health policy formulation and implementation have been identified. Enthusiastic development of innovative preventive and clinical services during the 1990's has faded away during the second decade of transition, with increasing tendencies to keep investing in traditional system based on biomedical model, with overuse of institutional long-term care and drug treatment. The following basic needs for change in mental health care system have been identified as priorities:

- a) substantially invest in modern psychosocial interventions and to reduce over-reliance of mental health care system on drug treatment and long-term institutional care;
- b) introduce a broad spectrum of sustainable evidence-based modern interventions in the area of prevention and mental health promotion, including suicide prevention;
- c) move from „self-feeding“ tradition of evaluation to independent monitoring of performance of mental health care system;
- d) introduce independent monitoring of human rights in mental health care system;
- e) facilitate public discourse among general population, academic and other groups about how to transform culture of mental health services from the model based on paternalism and stigmatization, to the one based on principles of autonomy and participation.

Conclusions: Contextual and attitudinal factors, including low level of tolerance to vulnerable groups among population, and lobby of interest groups supporting tradition of overuse of institutional care and biomedical treatment, and lack of political will to invest in modern community-based psychosocial interventions, have been blocking so far the shift of paradigm in mental health care system in Lithuania. Analysis performed on challenges for implementation of modern principles in Lithuanian mental health care system, may be used as a template for identification of factors, which might facilitate or impede reforms, in other countries of Eastern Europe and other regions.

THE PATHWAYS TO CARE OF ACUTE PSYCHOSIS IN A DEPARTMENT OF MENTAL HEALTH IN NORTHERN ITALY: A RETROSPECTIVE STUDY.

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Educational Objectives: To study the pathways to care for patients affected by acute psychosis in the Department of Mental Health (DMH) of Modena (Northern Italy).

Purpose: To describe the pathways to care of patients presenting with acute psychosis in the Department of Mental Health (DMH) of Modena during the year 2011 and to examine the demographic, clinical and social factors influencing routine integrated treatment for acute psychosis.

Methods: Through both retrospective charts review and interviews to specialists working in the 8 out-patient clinics of the DMH of Modena, we collected demographic, clinical and social characteristics of all patients who presented with an episode of acute psychosis (affective and non affective) from January 1st to December 31st of 2011 at the DMH of Modena. We compared patients who underwent NON psychopharmacological intervention (psychotherapy, social inclusion, supported employment, psychoeducational and family intervention) versus subjects who did not.

Results: 47 subjects, 68% males, 77% single, with a mean age of $27 \pm 5,4$, were included in our analysis. 40 patients (89%) received a psychopharmacological treatment as a part of usual care; 19 (41%) received a NON psychopharmacological treatment. We observed that subjects with lower education and foreign nationality were less likely to receive a NON pharmacological treatment, with a statistically significant difference ($p=0,036$ and $p=0,013$ respectively). Comparing Italian patients (29, 62%) vs foreigners (18, 38%) no differences were observed in terms of numbers of admission to the psychiatric hospital and in terms of disengagement from the out patient clinic.

Conclusions:

- According to literature, our data confirm that psychopharmacological treatment is the predominant treatment in acute psychosis attending MHD but 41% of the total sample attended non pharmacological treatment as well.
- Our findings are consistent with international and national guidelines for interventions in acute psychosis: pharmacological treatment is the first line intervention, whereas non pharmacological ones are strictly related to the stage of illness, particularly indicated when acute psychosis symptoms are decreased.
- Foreigners and subjects with lower level of education were less likely to attend non pharmacological interventions, this may be due to social, linguistic and cultural barriers.
- Our findings are preliminary data and more analysis are needed to explore pathway of care in the different local and national mental health systems.
- Our study, despite its limitations of a small sample and the retrospective design, could be useful to achieve a higher quality of service through specific patient-centered programs that should take into consideration cultural, social and linguistic features.

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29 June - 3 July 2013
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Oral Presentations

**Life-Span perspectives of
mental health**

MULTI-FACTORIAL MEASURE OF PARENTING AND CHILDREN'S PSYCHOLOGICAL DISORDERS: A CROSS CULTURAL RESEARCH

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Background: Studies on parenting typically focus on one or two parental factors such as authoritarian, authoritative, and permissive parenting or acceptance-rejection factor.

Methods: Based on the understanding that parenting is a complex process and on that parenting factors may overlapping (such as authoritarian and rejection), the author (Dwairy) has suggested a multi-factorial method of research and has developed a scale that measures seven different factors: *Punishing in the name of love, addressing the child's conscience, addressing the child's rational thinking, conditional love, inconsistent parenting, unconditional acceptance, and authoritarian parenting*. The questionnaire in addition to another questionnaire that measures psychological disorders among children was administered to 900 teenagers (15-17 years old) in three cultures: Palestinians, British, Lebanon, and Algerian. The results shows that the scales were valid and reliable and revealed four different patterns (profiles) of parenting each consists from seven factors. Each pattern was associated with different level of psychological disorders. Interesting cross-cultural and gender differences in parenting patterns were found.

Results: To our knowledge, this is the first study of parenting that is based on a multi-factorial scale of parenting. Based on further research the Dwairy Multi-Factorial Parenting Scale (DMFPS) may contribute a lot to parenting research and to clinical work with families.

SCREENING FOR RISK OF LATER MENTAL HEALTH PROBLEMS: A LONGITUDINAL STUDY

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². Mater Medical Research Institute, Brisbane, Queensland, Australia.

Purpose: This is one of the first studies to report that the Achenbach internalising scales were much more effective at identifying those with current comorbid depression and anxiety, rather than individual mood disorder.

Introduction: The Achenbach behaviour checklists (YSR, YASR) are widely used, low cost screening tools used to assess problem behaviour. Several studies report good association between the checklists and psychiatric diagnoses; although with varying degrees of agreement. Most are cross-sectional studies involving adolescents referred to mental health services; few are in large community-based studies. This study examined the usefulness of the Achenbach internalising scales in the primary screening (both predictive and concurrent) for depression and anxiety.

Methods: The sample was 2400 young adults from an Australian population-based prospective birth cohort study. The association between the empirical anxiety and depression scales were individually assessed against DSM-IV depression and anxiety diagnoses. Odds ratios and diagnostic efficiency tests report the findings.

Results: Adolescents with internalising symptoms were twice (OR 2.3, 95%CI 1.7 to 3.1) as likely to be diagnosed with later DSM-IV depression. YASR internalising scale predicted DSM-IV mood disorders (depression OR = 6.9, 95% CI 5.0–9.5; anxiety OR = 5.1, 95% CI 3.8–6.7) in the previous 12 months. The internalising scales were much more effective at identifying those with comorbid depression and anxiety.

Conclusions: Adolescence and early adulthood are key risk periods for the onset of anxiety and depression. This study found that young people with internalising behaviour problems were more likely to have comorbid depression and anxiety DSM-IV disorder.

Literature Reference:

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PATTERNS OF ANXIETY ACROSS THE REPRODUCTIVE LIFE COURSE OF A COHORT OF WOMEN FOLLOWED OVER 27 YEARS

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Educational Objectives: At the conclusion of this presentation participants should demonstrate an understanding of reproductive life course variations in anxiety in women.

Purpose: Anxiety is a major source of morbidity particularly for women, this long term, prospective study aims to describe the natural history of anxiety disorders over women's reproductive life course.

Methods: Two thousand, four hundred and fifty-six women from a prospective mother-child birth cohort study (Mater-University of Queensland Study of Pregnancy (MUSP)) were followed over 27 years from 1981 through to 2012. These women were interviewed seven times over this period: at first hospital antenatal appointment, a few days after the birth of the index child, then at 6 months, 5, 14, 21 and 27 years after the birth. Mental health was measured at each phase using the Delusions-Symptoms-States Inventory (DSSI, a validated and reliable measure of anxiety and depression symptoms).

Results: Of the women surveyed 1021 (41.6%) reported at least one episode of severe anxiety symptoms over the 27 years of follow-up. Nearly half of women (48%, n=490) had severe anxiety during the index pregnancy or in the immediate post-partum period, they had a mean age of 25 years (SD=5.3 years, their ages ranged from 14 to 42 years old). Of the 490 women anxious either at the time of the index pregnancy or in the post-partum period nearly a third (n=140) reported anxiety only in this period, whilst the remaining women reported additional episodes to 27 years. The remaining 531 women reported first measured episode of severe anxiety symptoms after the index pregnancy. These women were on average 39 years of age (SD=8.5 years, their ages ranged from 21 to 65 years old) when assessed. Just under a half of the women with anxiety symptoms (48.7%, n=494) experienced only anxiety, the other half reported comorbid depressive symptoms: 24.6% (n=250) experienced concurrent anxiety and depressive symptoms, 22.4% developed anxiety before depressive symptoms, whilst only 4.3% had depressive symptoms followed by later anxiety. The majority of women reporting no anxiety (n=1369) also had no depressive symptoms, less than five per cent (4.5%, n=64) of women without anxiety reported lifetime depressive symptoms only.

Multivariate analyses adjusting for socio-demographic and life style factors as well as life stressors at initial assessment, found that poverty, incomplete schooling, and severe stress during the index pregnancy remained significant predictors of anxiety regardless of time of onset. Women experiencing severe stress during pregnancy had 19 times the odds (95%CI 12.3,30.1) of severe symptoms of anxiety than women reporting few or no stressors.

Conclusion: This study provides one of the first long term, population based studies of anxiety across a woman's reproductive life course. It shows that there is a high level of continuity of anxiety symptoms with severe stress during the pregnancy remaining a consistent, major, contributing factor.

UNDERSTANDING THE IMPLICATIONS OF THE PHILOSOPHY AND PRACTICE OF RECOVERY FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS

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Educational Objectives: At the end of the presentation, participants should be able to understand the implications of recovery for older people and will hold an awareness of the issues involved in undertaking evaluation of recovery training within older people's mental health services.

Purpose: The purpose of the project is to understand the philosophical and practice implications arising from the concept of recovery for older people with mental health problems and upon service delivery.

Methods: A qualitative study was undertaken with 28 service users and 10 carers, using grounded theory techniques to produce a conceptual framework of recovery for older people with mental health problems (Daley et al, Int J Geriatr Psychiatr, in press). This framework was used to develop the RECOPE model comprising an intervention (a 3-day team-based recovery training package for staff working within older people's mental health services) and intended effects. The RECOPE intervention was delivered to 203 staff working in clinical teams in South London, UK. The primary and secondary hypotheses were that the RECOPE intervention would improve recovery and quality of life for service users.

The primary outcome evaluation used a controlled pre/post design, with service user participants (n=65) across three time points, using the Illness Management and Recovery Scales (Meuser et al, 2004) and two quality of life measures, the DEMQOL (Smith et al, 2007) for people with dementia and the Short Form Health Survey (SF12) (Ware et al, 1996). Process evaluation comprised: qualitative interviews with staff (n=19), pre-post staff ratings (n=176) of recovery knowledge and attitudes using the Recovery Attitudes Questionnaire (Borkin, 2007) and the Recovery Knowledge Inventory (Bedregal et al, 2006), and review of longitudinal care plan data (n=250) over seven time points.

Results: The results from the primary outcome evaluation will be presented. The process evaluation highlighted that:

- a) The fit between trainer and team, and team organisational culture was a significant mediator in the successful delivery of training and transfer of learning into practice
- b) Significant change was found in measures of staff knowledge and attitudes, and team and professional group membership were found to impact upon the results.
- c) Change in the behavioural intent of staff was evident through the review of care plans

Conclusion: The need to develop recovery measures for use with older people is indicated. The need to tailor pre and post intervention implementation strategies to the local team context to maximise effectiveness is required.

THE LISBON STUDY ON FAMILIES OF PEOPLE WITH DEMENTIA (FAMIDEM)

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Educational objectives: At the conclusion of this presentation, the participants should be able to discuss some findings of the FAMIDEM study in Portugal, namely on the importance of caregiver knowledge in dementia and the risks of being a non-primary caregiver.

Purpose: Important issues remain unanswered regarding family caregiving in dementia (e.g. the importance of disease-related knowledge, or the risks of non-primary caregivers). Many international findings should be locally replicated, and measures cross-culturally validated. A comprehensive study of families of people with dementia (FAMIDEM) was conducted in Lisbon (Portugal), with international collaboration. We aimed: 1. to understand how caregivers' knowledge about dementia could relate to particular aspects of the caregiving experience, including burden; 2. to compare the experience of caregiving in primary caregivers and other less directly involved relatives; and 3. to contribute to the validation of some caregiving measures in Portugal.

Methods: FAMIDEM was a non-randomised cross-sectional study, conducted in three waves. Patients were in contact with outpatient neurology or psychiatric services in Lisbon. Dementia diagnoses were confirmed (ICD-10 Diagnostic Criteria for Research), and demographic and clinical data were collected. Caregivers' assessments included: Zarit Burden Interview, Caregiver Activity Survey, Positive Aspects of Caregiving, General Health Questionnaire, Social Network Questionnaire, Sense of Coherence Questionnaire and Dementia Knowledge Questionnaire. The translations of these measures or previous validation studies in Portugal were documented.

Results: In wave II, 116 caregivers were studied. No associations were found between caregivers' knowledge and their burden, positive aspects of caregiving or psychological distress (1). In another wave II study, two related samples of caregivers of the same patient (primary caregivers versus others) were compared (n=41 in each sample). Primary caregivers were older and tended to live with the patient. They reported less emotional support and higher objective burden, according to the Caregiver Activity Survey. Regarding other domains, no significant differences were found between groups (2). Finally, psychometrics of the Portuguese translations of two questionnaires were established, the Burden Interview and the Positive Aspects of Caregiving scale, which allows for further comparative research.

Conclusion: A large proportion of caregivers in wave II FAMIDEM, albeit informed about dementia, were at risk of high burden and distress. As would be expected, risks for primary caregivers were greater, but our findings suggest further exploration is needed, given the importance of secondary caregivers in Portugal. For the moment, it is prudent not to assume that only key-relatives are at risk. Wave III results are now under analysis.

References:

Gonçalves-Pereira et al, International Psychogeriatrics, 2010; 22(2): 270-280
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29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

**Natural Disasters/Man-made
(including Fukushima) and
mental health**

AGONY OR ACTUALISATION? HOW GLOBAL WARMING MAY AFFECT MENTAL HEALTH. A CASE STUDY FROM AUSTRALIA

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Purpose: Continued global warming will mean systemic climatic changes and, consequently, more intense, unpredictable and (possibly) frequent weather-related disasters. There are immediate psychiatric impacts and sometimes severe longer-term sequelae from such disasters. To help predict future impacts and adaptive responses, a program of research at The University of Canberra, Australia, aims to identify possible causal mechanisms and explanatory models and to test these models.

Methods: Data matching with large panel and cross-sectional studies to quantify selected interacting causal parameters in a proposed explanatory model. *Drought* impacts were examined by matching precipitation records from the Australian Bureau of Meteorology to data from Waves 1-8 of the Household, Income and Labour Dynamics in Australia Survey, a nationally representative panel study, N~15,000 participants, collected annually from 2001. To investigate *flood* impacts, we partnered with Queensland Health to include our *Brief Trauma Exposure and Impact Screen* (N~5,500) in that State's routine screening which, in the summer of 2010-11, coincided with extreme flooding. Statistical techniques: prevalence estimates; regression modelling approaches; cluster analysis; path modelling.

Results: Study 1. We identified five types of drought exposure: zero-to-moderate; constant; very dry; very prolonged; constant and very long. Those experiencing very prolonged and constant drought had worse mental health than did other categories. Those in the very prolonged category had the worst outcomes of any group – but only if they lived in rural locations. For city-dwellers, prolonged drought was slightly associated with *better* mental health compared to zero-to-moderate drought. Study 2. Over 14% of adults felt terrified, helpless or hopeless, with a further 3.9% thinking they might be badly injured or die. The prevalence of each of these two symptoms of post traumatic stress varied markedly with the extent of physical impact of the disasters and by two other factors: rurality; and dis/advantage. Poorer circumstances were associated with greater exposure and, separately, with greater impact.

Conclusions: 'Drought' and 'floods' require careful definition. Experiencing such an event does not automatically confer a psychiatric exposure. 'Drought' *as an exposure* is a period of long cumulative dryness *relative to the local norms*, particularly if it culminates in a recent very long period of extreme dryness. Floods may be an exposure if people experience two or more forms of damage (e.g., their home *and* their business is flooded). Further, disasters seem to have specifically traumatic impact with little impact on general mental health. However, if traumatic impact is of sufficient magnitude, general mental health can also be affected. These findings suggest that climate change adaptation planning, including disaster preparedness policy, must engage with systematic differences between sub-populations as well as with climate modelling.

AN UPDATE OF OUR EVIDENCE-BASED CARE MODEL FOR PSYCHOLOGICAL SUPPORT FOR DISASTER VICTIMS. INTEGRATING THE EXPERIENCE (SYMPOSIUM)

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Background: In 2010, our group proposed a model of disaster response, based on systematic reviews and meta-analysis, which was based on five stages. (Reference 1) I. Diffusion, II. Social support, III. GP Management, IV. General psychiatric management and V. Psychiatric management experts. Each of these levels is implemented in different physical locations and with different objectives, beneficiaries, duties, executors and referral criteria to the next level, which will determine the flow of patients from centers of low to high level of expertise.

The whole community should be informed about the disaster and receive psychoeducation and offer counseling through the media. We try to keep psychotherapy and pharmacotherapy only for patients with psychiatric disorders, because it is the only group that has shown benefit from these treatments. For the rest of those affected, including those with subclinical distress, we recommend limiting attention to so-called psychological first aid

Results: This model was been tested and evaluated in the multiple disasters that occurred in our country after its publication. The main ones were the earthquake and tsunami of February 2010 and the rescue of 33 miners in September 2010. These disasters allow us to gain experience on their effectiveness in real life as well as their strengths and weak points of our model.

Conclusions: Our goal is to show and comment our model and our experience of implementing it in a South American country with a history of major natural disasters. The importance for listeners will hear the experience of applying a model of evidence-based trauma but also is designed to be applied in health systems with limited resources.

NATURAL DISASTER AND MENTAL HEALTH: EFFECTS OF FLOODING ON A POPULATION IN SE SPAIN

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Introduction: Post-disaster mental health problems may affect population in different ways.

Population exposure to a natural disaster has been associated with psychological distress, in particular, in the development of Posttraumatic Stress Disorder (PTSD).

Most people experience distress after their exposure to an extreme event.

For people with good psychosocial resilience and access to social support, mental health problems can be relatively less important since supporting relationships and inner capabilities may begin the adaptation processes. Mental disorders occur often, but less commonly than distress, and in some cases they may require intensive and long term continuing interventions and treatment(1).

Objectives: The aims of this study were to investigate the effects of flooding on mental health population, particularly on the general health and the symptom's emergence of PTSD.

Method: A random sampling method was conducted in a population affected by a flood occurred in September 2012, an area of 20.000 inhabitants in the North of Almería (Spain).

A sample of 52 individuals were screened with a socio-demographic questionnaire, 12-item General Health Questionnaire(GHQ-12) and the Questionnaire to rate Traumatic Experiences(TQ). We also counted the distribution of stress exposure among people with various kinds of exposures (physical risk or/and economical losses).

Results: The mean age of the individuals was 53, 02 years, sd 16, 35. Distribution by sex was 34,62% men – 65,38% women. There were no statistical differences between genders in TQ scores and GHQ scores.

An association between age and TQ scores was demonstrated, increasing TQ scores by age. Also, there were no statistical differences between individuals that suffered physical risk in the flood versus people that didn't suffered in TQ scores. On the other hand, a multiple regression model was adjusted by age and sex. Significant differences were found in the TQ scores mean values for individuals that suffered economical losses (9,51 TQ score) versus individuals that didn't suffered it (2,94).

Conclusions

1. Older people were more likely to develop PTSD
2. It's necessary to consider secondary stressors, such as economical losses, in the develop of PTSD.

References:

1. Lock S, Rubin GJ, Murray V, Rogers MB, Amlôt R, Williams R
Secondary stressors and extreme events and disasters: a systematic review of primary research from 2010-2011.
PLoS Curr. 2012 Oct 29;4

THE ASSOCIATION BETWEEN SLEEPING HOURS, SMOKING, HEALTH AND NUTRITIONAL STATUS WITH DEPRESSION

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Objectives: Depression is associated with increased rates of disability and mortality. There are very few studies looked at the association between nutritional status and depressive symptoms.

Purpose: The main purpose of this study was to look for if there is any association between nutritional statuses, sleeping hours, smoking, and having headache or hair loss with depression.

Method: Cross-sectional study was conducted from 787 subjects in different age groups, who had participated in a major campaign in Riyadh, Saudi Arabia during March 2012. The questionnaires that had been distributed among subjects contained specific questions regarding the nutritional status, sleeping hours per day and smoking habit. Blood pressure (BP), random blood glucose (RBG), Serum hemoglobin (Hb), self-rated health status questionnaire and depressive symptoms using Beck Depression Inventory Scale (BDI) had been measured. Covariates included age, sex, and being ex-smoker or not.

Results: We classify the sleeping hours into different categories; most of subjects were present in 3-6 hours of sleeping per night (42.7%). Its association with depression appears clearly that extreme groups have high prevalence of depression, the group with less than three hours of sleep showed (40.5%), and more than nine hours of sleep (46%) compared to groups who sleep 3-6 hours (28.6%), and 6-9 hours (26%). The prevalence of smoking among male was (21%), and among female (2%). The presence of severe and extreme depression among smoker was (4%) compared to non-smoker (3.5%). Among non-smoker the depression among ex-smoker was (3%). Hair loss was present among (60.4%) with prevalence of depression (34.3%) compared to subjects with no hair loss (24.3%). Headache was less common (38.5%) with the presence of depression (38.6%) much higher than subjects with no headache (25.2%). Regarding the nutritional behavior, most of subjects had 2-4 meals per day (82.2%) and only (26.8%) of them with fixed time in the day. Subjects who used to drink a coffee or tea had less depressive symptoms (27.7%) than who didn't (34.4%). Drinking soft drinks or energy drinks was clearly associates with presence of depressive symptoms (38.8%) compared to subjects who didn't drink them (29%).

Conclusions: Nutritional status profile of the population has a significant association with the depression and depressive symptoms. Certain type of food has differences with its association with BDI score of the subject. The lower the sleeping hours, the most likely to develop depressive symptoms. Being smoker or an ex-smoker has a strong association with depression. Hair loss and Headache have another strong association with depression especially among female. Certain Socio-Demographic differences and their association with the depression have been clarified in this study. Further studies will be conducted to find the strength of depression associated with those Socio-Demographic differences.

THE ASSOCIATION BETWEEN EXPOSURE TO TRAUMATIC EVENTS WITH ANXIETY DISORDER: RESULTS FROM A CROSS-SECTIONAL COMMUNITY STUDY IN THE POST-CONFLICT SOUTH SUDAN

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Background: The negative effect of exposure to traumatic events on mental health is well known. Most studies of the effects of trauma on mental health in war-affected populations have focused on posttraumatic stress disorder (PTSD) and depression. Although some studies confirm the existence of anxiety symptoms in war-affected populations, to what extent exposure to traumatic events are independently associated with anxiety diagnosis (other than PTSD) is less investigated.

Purpose: The study aimed to determine whether having an anxiety diagnosis was associated with experiencing traumatic events in a post conflict setting, after controlling for demographic and socioeconomic variables.

Methods: In this cross-sectional community study (n=1200) we applied the Harvard Trauma Questionnaire (HTQ) to investigate the extent of trauma exposure. MINI International Neuropsychiatric Interview (MINI) was used to investigate the prevalence of anxiety disorders (Generalized anxiety disorder, panic disorder, agoraphobia, and obsessive-compulsive disorder). Multinomial logistic regression analyses were conducted to examine the association between these disorders, previous trauma exposure, and socioeconomic factors.

Results: 41.4% of the participants had an anxiety diagnosis. 25% reported more than eight traumatic events during the war and 9.8% reported to have experienced more than 4 recent traumatic events. Exposure to traumatic events and socioeconomic disadvantage were significantly associated with having one or more anxiety diagnoses. After controlling for age, sex, rural-urban setting and socioeconomic position, exposure to trauma was independently associated with anxiety diagnosis.

Conclusion: in individuals with history of war-related trauma exposure, in addition to PTSD and depression symptoms, attention should be given to symptoms of anxiety disorder (Generalized anxiety disorder, panic disorder, agoraphobia, and obsessive-compulsive disorder).

EXPOSURE OF PALESTINIAN ADOLESCENTS TO PROLONGED AND CUMULATIVE MILITARY VIOLENCE: A STUDY OF ITS PSYCHOLOGICAL EFFECTS AND RESILIENCY FACTORS

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BACKGROUND: The mental health consequences of living in war zones and exposure to military violence have been investigated extensively over the past six decades. However, there is a dearth of research on the consequences of Palestinian children's exposure to chronic, cumulative, and prolonged military violence. Furthermore, there is a lack of research on intergenerational transmission of those consequences on the one hand, and on protective and resiliency factors that buffer the consequences of exposure to military violence among children and their parents on the other.

METHODS: In an attempt to fill this gap, self-administered questionnaires were utilized among a random systematic cluster sample of 2,934 Palestinian adolescents and their parents from the West Bank and East Jerusalem, who live under conditions of prolonged and chronic exposure to military violence. For adolescents, the study included measures about their exposure to military violence during the previous year as well as between the last year and September 2000, i.e., since the outbreak of Al-Aqsa Intifada. For parents, the study related to the following periods: (1) during the last Intifada (i.e., from late September 2000 to the day of filling-out the questionnaire); (2) from end of the first Intifada (around the signing of the Oslo accords in September 1993) until the outbreak of the last Intifada (i.e., September 2000); and (3) from the June 1967 war until the period of the first Intifada (i.e., between June 1967 and September 1993). This time frame of exposure to military violence provides a basis for examining the consequences of multiple and cumulative risk factors. Thus, the main objective of this study was to investigate the psychological consequences (e.g., anxiety, depression, aggressive behavior, attention and thought problems, PTSD, etc.) of adolescents' and parents' exposure to prolonged military violence as well as intergenerational transmission of those consequences from the perspectives of parents and their offspring. Concomitantly, the study aimed to investigate the contribution of protective and resilience factors among parents (e.g., self-efficacy, family environment, parenting styles, and social capital) and their adolescent offspring (e.g., ego resilience, self-esteem, and support from family and friends) to mitigating the effects of exposure to prolonged and cumulative military violence.

RESULTS: The results of this study revealed that the more the Palestinian adolescents had been exposed to military violence the higher the levels of all psychological symptoms, i.e., withdrawal, somatization, anxiety and depression, attention problems, thought problems, social problems, delinquent behavior, aggressive behavior, and post-traumatic stress disorder. The results also revealed that significant amounts of the variance in all of these symptoms could be attributed to adolescents' exposure to military violence, over and above the variance in these psychological states that could be explained by participants' gender, self-esteem, parents' loving and intimate parenting styles or rejecting and hostile parenting styles, parents' self-efficacy, positive family environment, parents' perceptions of their social capital. The results also revealed that the parents' exposure to military violence during the three above-mentioned periods was significantly related to their symptoms of post-traumatic disorder (PTSD) and psychological distress. More specifically, the results revealed that the higher (or more frequent) the parents' exposure to military violence, the higher the levels of these symptoms were. Significant positive relationships were also found between these symptoms among parents and the above mentioned psychological states among the adolescents. Interaction analyses revealed that *none* of the protective and resilience variables examined in this study (either among adolescents or among their parents) was found to contribute significantly to moderating the relationship between the exposure of adolescents to military violence and the above-mentioned psychological states.

CONCLUSIONS: This particular finding yields at least to two possible conclusions. First, the exposure of Palestinian adolescents to military violence has very serious long-term mental health consequences, which are so severe that they cannot be moderated by any protective and resilience factors. Second, the exposure of Palestinian adolescents and their parents to military violence had detrimental effects on resilience and protective factors among both groups, to the extent that those factors could not mitigate the severe consequences of exposure to military violence.

The strengths and limitations of the study are discussed in detail. Furthermore, the implications of the results for future research, practice, and service delivery are delineated.

29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

**Co-morbid mental and
physical illnesses**

CO-MORBIDITY OF DEPRESSION AMONG CANCER SUBJECTS AND ITS IMPLICATION TO OVERALL TREATMENT OUTCOME: A PERSPECTIVE FROM A DEVELOPING COUNTRY

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Educational Objectives: Co-morbidity of depressive symptomatology is a common indication for use of mental health services in oncology. At the end of this presentation the participants should have an understanding of the burden of depression among cancer patients in this context and see its implication on cancer treatment.

Purpose: This study is set to evaluate the burden of depression in cancer and describe its cancer treatment implications.

Methods: A designed questionnaire, Centre for Epidemiological Studies Depression Scale Revised (CES-DR) and the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) were administered by the researchers on 200 participants made up of attendees of a Nigerian hospital with histological diagnoses of cancer. The data were analysed with statistical package of social sciences version 15.

Results: Majority of participants, 85.5% were females. The mean age for the participants was 51.48(±11.45) years. The largest proportion of them (35.5%) belonged to age group of 51 to 60 years and one hundred and thirty (65.0%) were married. The commonest type of malignancy was breast cancer (51.0%), cervical cancer 59(29.5%), colon/rectum and prostatic cancers were 21(10.5%) and 18(9.0%) respectively. Slightly less than half (49.0%) of subjects had advanced cancer. Most participants (36.5%) had symptoms for between 1 to 2 years. Two-thirds (66.0%) had pain and 104(52%) had weight loss while 20.0% had external ulcer resulting from complications of the cancer

Ninety-eight (49.0%) participants had significant depressive symptomatology (CES-DR scores of ≥16) as against the diagnosis of depression in 55(27.5%) of them following SCAN interview. A substantial proportion of subjects 36(65.5%) had moderate depression, 15(27.3%) were mildly depressed and 7.2% had severe depression. In this study, the diagnosis of depression among cancer patients was significantly associated cancer stage ($p=0.006$), duration of cancer ($p=0.048$), pain ($p<0.001$), physical complication ($p<0.001$) and past family history of mental illness ($p=0.002$). However, only pain and duration of cancer were predictive of depression.

Conclusions: A significant burden of depression was observed in cancer patients. Prompt identification and treatment of cancer, mental disorders like depression, management of psychosocial problems and care for pain should be integrated into cancer care in this part of the world. The development as well as popularization of screening instrument(s) with good diagnostic and administration property to ensure prompt identification of mental disorders to improve overall treatment outcome in cancer care are implied. Furthermore, replication of similar research is warranted.

THE ASSOCIATIONS OF RELATIONSHIP QUALITY WITH PHYSICAL FUNCTIONING AND DEPRESSIVE SYMPTOMS ARE MEDIATED BY SOCIAL SUPPORT PROCESS AMONG CANCER CAREGIVERS

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Educational Objectives: This study provides one of the first preliminary data on the social relationship and supportive experience of cancer caregivers and suggests interpersonal intervention for improving caregivers' physical and mental health.

Purpose: This study aims to study the mediating effect of perception of provided support and patients' supportive needs in the association between relationship quality and physical and psychological functioning of cancer caregivers.

Methods: A total of 44 caregivers of people newly diagnosed with colorectal cancer (time since diagnosis < six months) were recruited and administered a questionnaire set. Relationship quality (i.e., intimacy in and commitment to the relationship) with their ill family members was assessed using the Social Relational Quality Scale (Hou et al., 2009). An adapted Chinese version of the Berlin Social Support Scale (BSSS; Schwarzer & Schulz, 2000) assessed provided support and perceived supportive needs in the past two weeks. Sample items: "Did you show him/her how much you cherish and accept him/her?"; "Do you think your care-recipient wants you to show him/her this?" Physical functioning was measured using the 10-item version of the Chinese MOS 36-item Short-form Health Survey, which has been validated among Hong Kong Chinese (Lam et al., 1998). Depressive symptoms were measured using the Chinese version of the 21-item Beck Depression Inventory II (Byrne et al., 2004).

Results: Regression analyses showed that controlling for the effect of demographic variables, levels of provided support significantly mediated the inverse association between relationship quality and depressive symptoms, whereas levels of perceived supportive needs significantly mediated the positive association between relationship quality and physical functioning.

Conclusions: Your conclusions should address the following questions:

- Higher relationship quality could increase caregivers' (1) perception of support provided for their ill family members, resulting in lower levels of depressive symptoms, and (2) perception of patient supportive needs and, in turn, contribute to higher self-reported physical health.
- Patients' perceived social support and physical and psychological functioning should also be assessed and compared with their caregivers' report in order to gain a holistic picture of the support process.
- Interpersonal intervention could be implemented for improving physical and mental health of both caregivers and patients.

Literature Reference:

Reynolds JS, Perrin NA. 2004. Mismatches in social support and psychosocial adjustment to breast cancer. *Health Psychol* 23:425-30

ACUTE MEDICAL COMPLICATIONS OF PATIENTS IN PSYCHIATRIC UNITS. A LITERATURE REVIEW

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People with severe mental illness (SMI) have increased rates of physical illness compared to the general population. Physical medical problems have been associated with an increased burden on psychiatric patients resulting in poorer outcomes. People with SMI have a life expectancy that is up to 25 years shorter compared to the general population.

Yet the physical needs of inpatient psychiatric patients are neglected, underdiagnosed and undertreated. Nurses play a key role in prevention and early intervention in the physical wellbeing of people with SMI. We suppose that not only the chronic diseases need to be focused on but also on acute medical complications in inpatient psychiatric settings.

Purpose: to identify the most common acute medical complications in inpatient psychiatric settings. To discuss interventions that increase acute physical care in people with SMI.

Method: literature was reviewed between June and August 2012 by utilizing 'MEDLINE' and 'CINAHL' databases. The key words used were „mental health“ or “psychiatry”, “acute medical comorbidity“ or “physical comorbidity”, “referral” or “admission”. The broad search strategy focused on publications in German, French and English.

Results: Five studies correspond to the research questions. They evaluate the reasons for required transfers from a psychiatric ward to a medical-surgical unit. The most common acute medical complications in inpatient psychiatric settings are cardiovascular or endocrine causes, respiratory failure, electrolyte imbalances and infections. Acute medical complications in people with SMI are mostly overlooked. Incidence and prevalence are unknown. Interventions require more skilled nursing and qualified physicians.

Conclusion: Although more and better prevalence data are needed the existing data call for more attention to be paid to the general medical needs of inpatients with SMI. Regarding inpatients there is an additional reason for addressing active medical comorbidity. However there are many studies describing chronic medical illness in people with SMI.

Professionals must be better trained in managing acute medical problems and must be made aware of the possibility that their patients may also have physical (acute or chronic) diseases in addition to psychiatric diagnosis.

In addition this review has demonstrated that structural cooperation between acute medical wards and psychiatric wards is necessary.

INVESTIGATING THE CO-MORBIDITY OF ANXIETY AND DEPRESSION IN A COMMUNITY SAMPLE WITH TYPE 2 DIABETES

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Educational Objectives: Diabetes is associated with an increased likelihood of being diagnosed with depression or anxiety, however little research explicitly examines both anxiety and depression. This presentation will demonstrate why it is important to screen for both anxiety and depression in diabetes research and clinical practice.

Purpose: Establish the association of anxiety alone, depression alone and co-morbid anxiety and depression with self-care indicators and clinical outcomes.

Methods: Data for this study is taken from 2,028 community-based individuals who took part in the Quebec EDIT study. Participants in this study were required to have a doctor diagnosis of type 2 diabetes for less than 10 years, be insulin-naïve and aged 40-75. All participants took part in a telephone survey and answered questions pertaining to psychological well-being, self-care, sociodemographic characteristics, physical complications and functioning. Groups with elevated anxiety symptoms, elevated depression symptoms, and elevated co-morbid anxiety and depression symptoms were compared to a reference population with below threshold anxiety and depression using logistic regression analysis.

Results: Those participants with elevated anxiety alone were more likely to report more physical complications, report poor eating habits and report poorer functioning. Those participants with elevated depression alone were more likely to report more physical complications, were more likely to be overweight/obese, were more likely to be a current smoker, were less likely to be physically active and report more problems with functioning. The group with co-morbid depression and anxiety reported similar problems to the depressed group but also were more likely to report non-adherence to medication. They also reported the highest frequency of problems with functioning.

Conclusions: Those people who meet criteria for elevated anxiety and/or depression symptoms are more likely to report physical complications, non-adherence to self-care recommendations and more problems with functioning. These associations are particularly marked in those people with co-morbid depression and anxiety symptoms. To our knowledge this is the first study that has explicitly examined anxiety and depression co-morbidity in people with diabetes and the association of this co-morbidity with important clinical outcomes. Furthermore, this study has important clinical implications indicating that along with screening for depression in people with diabetes, that screening for a co-morbid anxiety may be important.

PSYCHOLOGICAL MORBIDITY AND PAIN IN SUBJECTS WITH SPINAL CORD INJURY

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Educational Objectives: Spinal Cord Injury (SCI) is one of the most clinical and physical severe condition, often associated with high levels of anxiety and depression. With this presentation, the participants should be aware for the incidence of psychological morbidity in this condition and specially its association with SCI's secondary complications.

Purpose: Spinal cord injured individuals are at risk of developing additional health problems - physical or psychological - which can result in secondary complications to his disability and, consequently, additional functional limitations. The aim of this study is to assess the psychological morbidity associated with this clinical picture of spinal cord injury and its probable association with the most frequent SCI's secondary complications.

Methods: This study was conducted Nationwide during the year 2012 in collaboration with: Centro Hospitalar do Porto (HSA); Sul and Rovisco Pais' Rehabilitation Center; Gaia's Professional Rehabilitation Center, Salvador Association and Portuguese Association of Disabled People. 168 subjects with Traumatic Spinal Cord Injury participated in this study. The Hospital Anxiety and Depression Scale was used to evaluate the Anxiety and Depression symptoms and a clinical, socio-demographic questionnaire to identify the SCI's secondary complications.

Results: SCI subjects present anxiety symptoms (73.8%) in which 26.8% have moderate/severe Anxiety. On other hand 71.4% of the SCI subjects present depressive symptoms and 20.8% of those have moderate/severe depression.

When questioned about secondary complications, subjects with SCI report: 66.7% urinary tract infections, 48.8% Bladder and sphincter complications, 42.3% pain, 42.3% sexual dysfunction, 19.6% pressure ulcers and 16.7% respiratory complications.

To verify dependence between the anxiety and depression symptoms and SCI secondary complications we used the Chi-squared test. The results show that the depression symptoms don't vary with SCI secondary complications, however anxiety symptoms vary with pain. In this sense the incidence of anxiety symptoms are greater for those who have pain as a secondary complication ($p = 0.00$).

Conclusions: This study calls attention to the high levels of anxiety and depression symptoms in subjects with SCI as well as the presence of pain in a considerable part of the sample. Pain in Spinal Cord Injury (SCI) it's a high prevalent clinical secondary condition and difficult to treat. This complication is seen as debilitating as the injury itself. The results suggest the need to consider multidisciplinary teams capable of managing multiple and integrated treatment. The ultimate goal is to restore the biopsychosocial balance of the subject with SCI and the reintegration into the society.

PHYSICAL, EMOTIONAL AND SOCIAL OVERLOAD OF INFORMAL CAREGIVERS OF SUBJECTS WITH SPINAL CORD INJURY

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Educational Objectives: Traumatic spinal cord injury (SCI) is perhaps one of the the most devastating orthopaedic injuries. In this dynamic process of the rehabilitation the informal caregivers (IC) live tremendous challenges: - to promote the maximization of physical functioning, the prevention of secondary complications, the reintegration into the community of the people with SCI, - to the challenge to deal with their one personal needs.

With this presentation, the participants should be able to recognize the importance of evaluating the experience of IC and whose overload can cause psychological, emotional, social and financial damage, that can seriously affect the patient and IC's well being.

Purpose: The aim of this study it's to evaluate the physical, emotional and social overload expressivity in Portuguese IC of people with SCI.

Methods: Nationwide and during the year 2012, 160 IC of subjects with Traumatic SCI participated in this study. The physical, emotional and social overload was evaluated by the QASCI (Caregiver Burden Questionnaire).

Results: 83,1% of the informal caregivers are female and 16.9% are male, with a mean age of 51.2 years (SD = 14.3). The results suggest that the informal caregivers of people with spinal cord injury present moderate overload levels (mean values ranging from 26 to 50) especially relative to: Financial Overload (M=48.70; DP=35,10), Implications in the personal life of caregiver (M = 39.68, SD = 25.54), Family Support (inverted sub-scale with M = 33, 06, SD = 31.53) and Emotional Overload (M = 29.15, SD = 25.38). The three sub-scales that present low overload levels (mean values ranging from 0 to 25) are: Satisfaction with the paper and the relative (inverted sub-scale with M = 16.85, SD = 15.62), Reactions to demands (M = 21.71, SD = 20.70) and Mechanisms of effectiveness and control (inverted sub-scale with M = 24.89, SD = 20.46).

Conclusions: Caregiving can be an overload experience especially with personal implications in daily life, emotional and financially. Mental health professionals should consider the IC as a vulnerable group and embrace strategies to promote their well being. Doing so they are not only contributing to enhance IC's quality of life but also the quality of care, quality of life and preventing the institutionalization of their relatives.

29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

**Mass movements of
populations: migrants,
refugees, others**

IMMIGRATION, DISCRIMINATION AND MENTAL DISORDERS (SYMPOSIUM)

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Background: Unfavorable health conditions as well as adverse morbidity and mortality data have been consistently reported across minority ethnic groups both in the US and the United Kingdom (UK) (Sorlie, 1995; Marmot, 1984). In recent decades, the experiences of racism and daily encounters with different forms of discrimination and prejudice started to be recognized as a major burden in the lives of ethnic minority individuals. As a result, there is a growing concern about the negative impact of racism and discrimination on the health standards of unprivileged individuals.

It is now understood that the experiences of social disadvantage, racial discrimination and marginalization tend to progressively accumulate over the life course (Williams, 2002). Racism plays a role as a social force that agglutinates additional detrimental factors such as socio-economic deprivation; restricted access to jobs, education and leadership roles in society; aesthetic marginalization from mainframe cultural life; residential exclusion to peripheral and dilapidated neighborhoods; and a consequent increment of exposure to violence and criminal influences. Research evidence demonstrates that members of minority groups not only earn less than members of dominant groups in society, but also work in less desirable occupations and present longer periods of unemployment (Krieger, 1993). Racism is fundamentally involved in the structuring of social-economic opportunities and the quality of health and social services that minority individuals receive.

The limited research conducted in the US and in UK to investigate the impact of racism on health status and well-being suggests that racism is an unrelenting societal hazard that remains unaddressed and neglected. Results from a study in which the interplay between blood pressure and racism was investigated among African-Americans revealed that 80% of individuals within this group experienced racial discrimination at some point in their lives (Krieger, 1996). Similarly, a national survey conducted in the UK revealed that more than 12% of respondents experienced at least one incident of harassment during the preceding year (Virdee, 1997). Immigrants frequently suffer additional lifetime distress as a result of the forcing factors towards migration that occur in source countries such as social upheaval, economic hardship, environmental catastrophe, war and famine. Such adversities are also known to produce long lasting psychological effects (Toar, 2009).

Several studies have demonstrated a relationship between self-reported experiences of racism and a series of adverse health outcomes, such as psychological distress, hypertension, diabetes and inferior levels of self-rated health (Krieger, 1993; Krieger, 1996, Karlsen, 2002, Gravlee, 2009). Racism and discrimination tend to be directed at migrant groups, resulting in high levels of anxiety (Thompson, 1996), which may evolve to the status of post-traumatic stress disorder (Ritsner, 1997). It has been observed in longitudinal studies that 'everyday encounters with discrimination are casually associated with poor mental and physical health outcomes' (Schulz, 2006).

A timely research agenda: The evidence presented above substantiates the need for additional research on the association between discrimination and mental disorders. This symposium proposes an international approach to the interplay between immigration and discrimination, and consequently mental disorders. There is now an outstanding opportunity for consolidating this theme as a priority research agenda. This initiative should also create the opportunity for additional research consortiums to be created around the core areas of mental health, social justice and international migration.

3 YEARS OUTCOME IN FIRST-EPISODE PSYCHOSIS AMONG MIGRANTS IN PARIS

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Background: Migration is known to increase the risk for psychosis in western countries but studies show that there is low use of mental health services by this population.

This is the second part of a retrospective study based on case files of all first admissions for psychosis in the 20th district of Paris between 2005 and 2009. One hundred and thirty six native patients and one hundred twenty two migrant patients met the criteria. In the first part of the study we found higher risk for psychosis in the migrant group (IRR 2.9, 95% CI 0.9-9.8) compared to patients born in France. Among migrants, incidence was higher in patients from sub-Saharan Africa compared to natives (IRR=7.1; CI95%= 2.2-21.8) whereas the incidence was similar for those from Europe (IRR=1.2; CI95%= 0.3-5.1) and from North Africa (Algeria, Morocco, and Tunisia) (IRR=1.4; CI95%= 0.4-5.6).

In this second part of the study we will compare the outcome of native and migrant patients with first admission for psychosis.

Methods: We will study all re-admissions between the two groups. At one and three years we will analyse rates, gender, age, country of birth, type of admission (compulsory or voluntary), clinical diagnosis, use of outpatient services, and treatment at discharge.

MENTAL HEALTH STATUS AMONGST RURAL-TO-URBAN MIGRANT WORKERS IN GUANGZHOU, CHINA: COMPARISON TO PERMANENT URBAN WORKERS AND AGE MODIFICATION EFFECT

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Objectives: The last three decades have seen a dramatic increase in rural-to-urban migrant workers in China; in 2011 the number reached 160 million. In Guangzhou, the largest city in southern China, the 7.3 million migrant population accounted for half of the city's population. Past studies of mental health status amongst Chinese migrant workers showed conflicting results; some found poorer mental health in migrant workers than in permanent urban workers whilst others showed the contrary. There is also a recent concern about the poor mental health in young migrant workers. The aim of this study is to investigate the mental health status of young and older migrant workers in comparison to their urban counterparts in Guangzhou.

Methods: A cross-sectional survey was conducted amongst 914 migrant workers and 814 urban workers recruited from four districts in Guangzhou city between May and July 2012. The World Health Organization Five-item Well-Being Index Scale (WHO-5) and the 36 Item Short Form Health Survey (SF-36) mental health scale were used to assess mental well-being. Linear and logistic regression models were used to investigate differences between migrant and urban workers and factors related to poor mental health.

Results: The mean age was 30 and 36 years for migrant and urban workers respectively. Migrant workers showed modestly higher scores than their urban counterpart for both WHO-5 (12.94 vs 12.40; difference = 0.54, 95% Confidence Interval [CI] 0.04-1.04) and SF-36 mental health scale (73.12 vs 71.06; difference = 2.06, 95% CI 0.56-3.56), whilst there was some evidence for age modification effect (p for interaction = 0.16 and 0.10). Higher scores in migrant workers than urban workers were mainly seen in people aged 30 years or above but not in the younger group aged <30, and the difference attenuated to some extent after controlling for income satisfaction. Amongst migrant workers factors that were independently associated with poor mental health included younger age, being male, longer working hours, lower income, and unsatisfactory income, whilst very good / good self-reported general health and more use of social support resources were associated with reduced risk of poor mental health.

Conclusion: Older Chinese migrant workers showed better mental health than their urban counterpart, and this was partly attributable to greater income satisfaction, whilst younger migrant workers did not show similar advantage over young urban workers. Measures to improve mental health amongst migrant workers may be usefully targeted on the younger group.

DIFFERENTIAL MODERATING FACTORS OF DISTRESS, PSYCHOPATHOLOGY AND SOMATIZATION AMONG NATIVE-BORN AND IMMIGRANT FEMALES: A CROSS-SECTIONAL STUDY IN AN OBSTETRIC UNIT

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Objectives: The present study aims to compare the relation of psychosocial distress, quality of life, psychopathology (anxiety and depression symptoms) and somatization with socio-demographic data, coping strategies and spirituality among female native-born and Latin American immigrant patients.

Methods: We present a cross-sectional, comparative study, based on the description of 222 female patients (73 natives, 149 immigrants) admitted in an obstetrics unit.

Clinical, socio-demographic characteristics and quality of life were registered using an ad-hoc questionnaire. Structured interviews were carried out using the PHQ to evaluate somatization, HADS for anxiety and depression symptoms, CAE for coping strategies, PSS10 for psychosocial distress and SSRS for spirituality.

Following a stratified design, Pearson correlation coefficients and linear regression were used to measure the strength of linear dependence between independent, moderator and dependent variables in both samples.

Results: After carrying correlational analyses, statistically significant variables were used to perform regression analyses, using as dependent variables psychosocial distress, quality of life, somatization, anxiety and depression symptoms. For immigrants, a negative self-focused coping strategy directly predicted all dependent variables except for quality of life, which was indirectly predicted by this strategy. Overt (hostile) emotional expression predicted anxiety and depression symptoms. Furthermore, positive reevaluation indirectly predicted depression and psychosocial distress. For native women, positive reevaluation indirectly predicts only depression symptoms. Depression, anxiety and psycho-social distress were also predicted by negative self-focused coping. No variable was found to predict somatization.

Conclusions: Firstly, in both groups, resignation, feeling undefended and guilty (negative self-focused coping) is related to higher scores of depression, anxiety, psychosocial distress and poorer quality of life. Furthermore in both samples a positive reevaluation of the conflict tends to decrease depression, but only in native-born this strategy is related to higher quality of life. Secondly, among immigrant females is seen that a hostile style of coping (overt emotional expression) raises both levels of anxiety and depression symptoms. Interestingly, only in this group, to actively practice a religion is related to a better quality of life.

Finally, negative self-focused coping conditions higher rates of somatization in the Latin American sample. This relation has not been confirmed in the native sample, in which a moderator could not be identified.

We have not found evidence of spirituality being associated with the dependent variables in any of the groups.

It can be concluded that there is a different structure of relations between coping strategies and our dependent variables among native-born and Latin American females.

AN INVESTIGATION OF MENTAL HEALTH STATUS OF ECOLOGICAL MIGRANTS IN WESTERN CHINA

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Educational Objectives: At the conclusion of this presentation, the participants should be able to develop a brief knowledge of the mental health status of those ecological migrants who were expected to benefit from the massive “ecological migration project” initiated by the Chinese government.

Purpose: To compare the mental health status of those ecological migrants with local residents; and, to explore the predictors for better mental health status among ecological migrants.

Methods: The survey was conducted in Ningxia Hui Autonomous Region, Western China. Multi-stage cluster sampling method was used to identify individuals from households in randomly selected villages. Symptom Checklist-90 (SCL-90) Chinese version was used for evaluating mental health status. Information on demographic characteristics was also collected. Comparison was made between ecological migrants and local residents by using X^2 test; logistic regression was used to identify the predictors for mental disorders.

Results: There were 684 people being recruited into the study among which 626 of them completed the survey (response rate 91.2%), including 365 ecological migrants and 319 local residents. The proportion of Hui ethnicity people was significantly larger among the migrants than the local residents (65.7% vs. 53.5%, $P=0.002$). The proportions of people having low education level and low family income were significantly larger among migrants comparing with the local residents (73.0% vs. 63.1%, $P=0.008$; 64.8% vs. 50.4%, $P=0.001$, respectively). Among male participants, migrants has significantly higher depression score and psychoticism score than local residents ($P<0.05$ and $P<0.01$, respectively). Among female participants, migrants had significantly higher somatization score and anxiety score than local residents ($P=0.01$ and $P<0.05$, respectively). Among the Hui ethnic participants, almost all SCL-90 subscores, except phobic anxiety, were significantly higher among the migrants than local residents. The proportion of SCL-90 positive psychiatric cases among Hui ethnic migrants was significantly larger than that among Hui ethnic local residents (79.3% vs. 47.4%, $P<0.001$). For these migrants, female, being older and Hui ethnicity had higher probability to have SCL-90 positive psychiatric status.

Conclusion: Overall, the ecological migrants were more vulnerable to mental disorders, especially for the elderly, women and Hui ethnic people. Comparing with local residents, migrants had lower education level and family income. In order to achieve the goals of “ecological migration project” and ensure those migrants to have better lives in the new places, the Chinese government and health sectors should take specific consideration of ethnicity and gender in their work.

29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

Suicide and its prevention

SUICIDE: NEW DIMENSIONS OF SOCIAL DISORGANIZATION WITHIN THE MILITARY AND AMONG CIVILIAN SURVIVORS OF WAR

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Objectives: Suicides among coalition forces, notably American service personnel, serving during the “wars on terrorism” played out in Iraq, Kuwait, Pakistan, and Afghanistan, and among the survivors of the Balkan Wars (1991-2002) is a compelling challenge for the veterans administrations and mental health service agencies within the former Yugoslavia and the NGOs serving these new nations. What is baffling among the U.S. population is the fact that a greater incidence of suicide occurs among military personnel who did not serve in a combat area. Male and female differences and socio-economic status also are factors for consideration in the prevention of military-related suicides and suicide-attempts. In the former Yugoslavia sample, untreated Post-traumatic Stress Disorder (PTSD) among displaced and interned victims and secondary PTSD among their off-spring appear to represent the bulk of untreated individuals with a potential for suicide or suicide-attempts.

Methods: Any viable analysis of this phenomenon requires comparisons and contrasts with the Vietnam-era veterans, the cohort upon which the Post-traumatic Stress Disorder (PTSD) was based in the 1980 Diagnostic and Statistical Manual-Third Edition (DSM-III). A review of Slavic-language medical and clinical articles, as well as personal observations, account for the Balkan War sample.

Results: Military suicides are at a record level among U.S. service personnel actually outnumbering battlefield casualties for those deployed in the Gulf War and Afghanistan. This phenomenon is similar to that which occurred during the Vietnam conflict where, in the long run, it is estimated that more veterans died from suicide than that died in combat (58,000+). A similar picture has surfaced from the victims of the 1991-2002 Balkan Wars involving the former Yugoslavia. Where economic hardships have relegated mental health services to the bottom of the social and political agenda in all of these break away nations. Our clinical assessment looks at both of these populations with the indication that suicide is often the result of untreated or otherwise unresolved personal conflicts that are not adequately addressed within the person’s family, religion, or subculture.

Conclusions: War trauma suicide often reflects a significant detachment from the person’s social existence while suicide, and suicide attempts among children and youth are often the result of impulse-control dysregulation. Another dimension of suicide today is that of the suicide bomber – a reflection of intense group solidarity contrary to suicides due to social disorganization. On-going research seeks out a better understanding of the neuro-chemical processes involved in mental illnesses that are prone to suicide ideations -- and medications and other treatment protocols that may be helpful in suicide prevention among those directly, or indirectly, affected by war trauma.

CHILD SUICIDE IN RUSSIA: CHARACTERISTICS, CAUSES, PREVENTION METHODS

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Educational Objectives: The purpose of this presentation is to reveal the findings of a recent study conducted by our Centre for the Ministry of Education and Science of Russia on the social and psychological causes of child suicide.

Characteristics of suicide in Russia: There are 19-20 suicide cases for every 100,000 teenagers in Russia. This is 3 times more compared to the global rate. In recent years, mass suicide has become a serious issue and the most common way to commit suicide has been jumping off tall buildings. 60% of all suicide cases take place in the spring (when mental illnesses are more common) and summer periods (at the time of school exams). In only 10% of adolescent suicide cases there is a true desire to commit suicide, the other 90% - are considered "cries for help." Often suicidal behaviours of adolescents take on a demonstrative nature, in the form of "suicide blackmail" (when a child threatens to commit suicide to gain attention). Further, the rate of failed suicide attempts often triggered by punishments, which the teenager considers unfair, is 10 times higher than the actual number of suicides committed.

Some causes found to trigger suicidal ideation and attempt:

- **specific personality traits:** vulnerability, immaturity, a tendency to self-analyse, shyness, sensitivity, lack of self-control, impulsivity, under-developed value system, the inability to adequately process conflicts, etc.
- **specific mental states** - depression, anxiety, fear, apathy, hopelessness, guilt, shame and disgrace, trouble sleeping, loss of appetite, alcohol and drug abuse, etc.
- **damaged pride**, the loss of valuable attention, rejected love, etc.
- **necessity to get out of a serious situation** - debts, obligations that are impossible to meet, communication problems, etc.

Suicide prevention interventions are based on an understanding of the child's developmental situation, the social and psychological problems of his environment, the implementation of appropriate methods of prevention, the potential use of the mass media, etc. The main conclusion we drew from our findings is that love and compassion help young people value their lives, and that the opportunity to speak "heart-to-heart" with someone who will listen, sympathize and understand can prevent young people from taking that desperate step.

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1. Official Government Statistics, 2011. Russian Federation.
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SUICIDE IN PRISON: THE ONSET OF DEPRESSION AS THE FOLLOW- UP OF THE VICIOUS CIRCLE “OFFENDER TO VICTIM”

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Background: Suicides in prison reflect how incarcerated men/women enter the vicious circle of “offender-victim-offender”. Current prison policies are traumatizing formerly normal prisoners and making them angry, violent, and vulnerable to severe emotional problems. The above, along with psychological factors of personal identity induce the transition of an offender to a victim and vice versa, forming a vicious circle followed either by recidivism or self-destructive acts. It is of fair interest to detect, rationalize and in cases predict the vicious circle.

SPACE statistics on suicides in prison reveal a rate above 10 per 10,000 in 10 European countries. Thus, can be seen that correctional services do not offer chances for reform other than the feeling of exclusion through punishment and they offer no clinical evaluation of suicidal symptoms.

Method: This study explores the patterns by which incarcerated men/women enter the vicious circle of offender-victim-offender. A prototype self-completion Test and personal interviews of 270 incarcerated men/women in penal institutions in Greece and Iran were used. The survey constructs a conceptual framework for understanding the progression and transition from offender to victim and back to offender, assessing how this dual-role change can motivate the onset of mental disorders during incarceration, such as depression disorders which are more often linked to suicide. We explore the relationships between prison quality, prisoner well-being and distress causing emotional breakdown.

All data are extracted from a survey on offending behavior, victimization, punishment and other sensitive objects, through self-completion questionnaires and interviewing. During this stage, the participating incarcerated men/women were attending inside-prison educational programs. Their ages were from 19 to 58 years old the eldest. Penalties varied from 5 years to life sentences with the exception of death penalties in Iranian prisons. The substantive field work took place between March of 2011 and September of 2011. Surveys were completed by inmates in seven (7) public sector prisons in Greece (with a multinational convicted population) and two (2) in Iran.

Conclusion: As we begin to define the relation between offending and victimization among people involved in crime, we cast light on inmate's “emotion-perception- behaviour”; identifying signs and symptoms of role changing between offender and victim; recognizing, dealing with, and understanding the motivations behind suicidal behaviour aiming to prevention. Last, offering recommendations to change prisons into institutions that respect human life and the constitutional rights of all citizens.

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29 June - 3 July 2013
Lisbon, Portugal

Oral Presentations

**Stigma of mental disorders
and psychiatric institutions**

THE LIVED EXPERIENCE OF INVOLUNTARY PSYCHIATRIC TREATMENT IN THE COMMUNITY

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Objectives: There is limited research examining the lived experiences of consumers and carers subject to involuntary psychiatric treatment in the community via the use of community treatment orders (CTOs). Several studies provide some insight into the lived experience of involuntary community mental health treatment, but no such research has been conducted in Australia. This researcher sought to describe the lived experience of CTO's from the perspectives of patients and their carers.

Purpose: To described the lived experience of involuntary psychiatric treatment in community mental health care settings.

Methods: Eleven participants – five patients and six carers – participated in the research project by taking part in in-depth interviews about their experiences. This interview data set was analysed using qualitative methodologies – specifically a Grounded Theory analysis of the data.

Results: The lived experience of consumers and carers of CTOs in NSW had five themes: 'access', 'isolation', 'loss and trauma', 'resistance and resignation' and 'vulnerability and distress'. These spoke to the experiential components of the losses and trauma associated with a severe mental illness, the compromises associated with the assumption of the sick role, and the challenges of managing the relationships and engagements necessitated by these processes.

Conclusions: The distress, isolation, grief and loss experienced by those affected by CTOs appeared to be a part of the experience of a severe mental illness. Putting aside instances where CTOs were implemented poorly, the kind of illness and level of disability experienced by those who needed such treatment interventions was an intrinsic source of distress. The need for a CTO emerged from that illness and, by extension, that distress. In essence, the experience of distress around a CTO seemed to be indistinguishable from the distress of the severe illness that necessitated it. From these data the study proposed a model of experience of being subject to a CTO in NSW is one of a core distress, emerging from the distress of the illness, communication gaps, difficulty accessing services, and the perceived benefits of CTOs.

SELF-STIGMA AND ORGANIZATIONAL EMPOWERMENT IN COMBINED-COMMUNITY MENTAL HEALTH AND CONSUMER-RUN SERVICES: TWO RANDOMIZED CONTROLLED TRIALS

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³Kaiser Permanente of Northern California, USA

Objectives: Participants should recognize the importance of meaningful participation in treatment planning as a factor in both positive and negative patient outcomes.

Purpose: Self-help agencies (SHAs) are consumer-operated service organizations, managed as participatory democracies involving members in all aspects of organizational management. SHAs assume that organizational empowerment promotes recovery. Hierarchically organized board-and-staff-run consumer-operated service programs (BSR-COSPs) while led by consumer management and boards, accord less decision-making powers to their membership. This study considers the relative effectiveness of SHAs and BSR-COSPs working jointly with community mental health agencies (CMHAs) and the role of organizational empowerment in reducing self-stigma, a key to recovery.

Method: Weighted-samples of 505 and 139 new clients seeking CMHA services were randomly assigned in separate randomized control trials to, respectively, regular county-CMHA vs. combined SHA/CMHA service, or regular county-CMHA vs. combined BSR-COSP/CMHA-service. Self-stigma and organizational empowerment were assessed at baseline and eight months in each RCT using the Attitudes towards the Mentally Ill Scale and the Organizationally-Mediated-Empowerment Scale. Outcomes were evaluated with fully-recursive path analysis models.

Results: Combined-SHA/CMHA-service-participants experienced greater positive change in self-stigma than CMHA-only participants, a result attributable to both participation in the combined condition ($b = 1.20$; $p = .016$) and increased organizational empowerment ($b = .27$; $p = .003$). BSR-COSP/CMHA-service participants experienced greater negative self-stigma change than CMHA-only-participants, a result attributable to participation in the combined service ($b = -4.73$; $p = .031$).

Conclusions: *Opinion of authors.* Differential organizational empowerment efforts in the SHA and BSR-COSP appeared to account for the differing outcomes. Persons with mental illness experience reduced self-stigma when they are engaged in responsible roles with other consumers. When placed in positions implying they are less responsible, participants place more stigmas on themselves and others with similar disabilities.

Project objectives. The study successfully demonstrated the role of meaningful participation in treatment planning as a factor in both positive and unexpectedly negative patient outcomes.

New knowledge and implications. The study provides a better understanding of the contributions that can be made by consumer-run services to improved outcomes and shows the need for more discriminating endorsement of such care based on the service's commitment, organization, and ability to empower participants in a true self-help experience.

MOVING TOWARDS PSYCHO-SOCIAL INTEGRATION IN MENTAL HEALTH THROUGH THE ARTS: A PERSPECTIVE ON COMMUNITY ART INTERVENTIONS AT A SOCIO-OCCUPATIONAL FORUM IN PORTUGAL

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Educational Objectives: at the conclusion of this presentation the participants should be able to recognize the effects of community art projects in individuals with severe mental illness as well as to understand their implications in the engagement against social stigma regarding mental illness.

Purpose: Being exclusion and stigmatisation of individuals with severe mental illness, not a geographical but a social/political/economical/cultural and even a collective psychological problem- it is the main objective of this presentation to illustrate the work and the art projects that have been developed by an art therapist/fine artist and a group of individuals with severe mental health problems in diverse community (cultural and mental health) settings.

Methods: The methods being used include multiple case studies presented within a heuristic perspective of the therapist, artist and researcher in relationship with the phenomena. As the majority of the artworks being presented were born of collective collaborations in between persons with mental illness and an art therapist (in a time frame of nine months) - the systemic and dynamic field within interaction, as well as the effects that this kind of interaction produces in both sides, will be the main focus of this presentation.

Results: Within this context the arts played a significant role supporting the attainment of some of the major objectives of psychosis rehabilitation and personal development, as they also produced significant subjective experiences in the art therapist which supported her personal development as well as an enhancement in the relationship established with other fellow human beings.

Conclusions: Some of the most significant results include the development of capabilities and self-esteem through the training and application of technical competencies as well as expressive and creative ones. There was a reinforcement of cognitive rehabilitation, through 'abstract exercises' and metaphors inherent to 'quality' art productions. The arts provided a container for a safe exteriorization, contemplation - a safe mirror for potential acceptance of the internal parts being created and transformed into an art object. They enhanced the readiness for change, re-connection with the city and community structures, socialisation and social re-integration through regular visits, workshops and community art studios created in relevant art museums in the community. Another relevant aspect of this work is that it was particularly focused and directed to the community, raising questions regarding the phenomena of psychosis and mental health in general, as well as a deconstruction of the myth of normality in a world which, regarded and contemplated by an attentive observer, becomes rather chaotic, dehumanized and tremendously diseased.

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NOT IN MY WORKPLACE! ATTITUDES AND PRIORITIES OF HUMAN-RESOURCE PERSONNEL IN NIGERIA TOWARDS WORKPLACE MENTAL HEALTH

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Educational Objectives: At the conclusion of presentation, participants should have some insights into the degree to which mental health is prioritized in workplace health-promotion initiatives among human-resource personnel in Nigeria, as well as their attitudes towards employee and potential employees with mental illness.

Purpose: To determine the attitude of human-resource personnel in Nigeria towards current and prospective employees with mental illness, and assess the degree to which mental health is prioritized in workplace health promotion initiatives.

Methods: In the course of work-place health and safety seminar for human resource personnel in Nigeria, questionnaires assessing their attitudes towards employees and potential employees with mental illness, as well as the health promotion priorities of their workplaces were assessed. Attitude questionnaires were on a 5-point Likert scale with a score of 4 or 5 on the negative scale taken as poor attitude.

Results: A total of 90 human-resource personnel returned completed questionnaires. They were mostly (62%) managerial-level. About 16% reported having handled the case of an employee with a suspected mental health problem in the preceding year. Attitudes toward employees and prospective employees with mental illness were largely poor. For instance, more than 65% of respondents would feel uncomfortable to share same office or socialize with someone with a history of mental illness, while about 55% of respondents considered it unreasonable to place someone who is returning to work after treatment for mental illness at their previous post. More than 70% were likely to consider for employment someone with a pre-existing physical disability than for someone with a history of mental illness. The key concern for not wanting to employ someone with a history of mental illness was workplace safety. In terms of workplace health promotion priorities, 88% of respondents' workplace have organised physical health and safety seminars for their employees in the preceding year, while only 6% have organised a seminar addressing common signs and symptoms of mental ill-health.

Conclusions: Study suggests that discriminatory attitudes and social distance from employees and prospective employees in Nigeria may be very high. Mental health-promotion initiatives in the workplace also appeared lower in the priorities of employers compared with physical health initiatives. Being the first study to examine the potentials for stigma in the workplace in Nigeria, this study has the potential of setting an agenda for combating discrimination on mental health grounds in the Nigerian workplace.

FIGHTING STIGMATIZATION OF MENTAL DISORDERS IN PORTUGAL - THE ROLE OF PATIENTS' ASSOCIATIONS: TWO CASE STUDIES

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The stigma of mental disorders is widely recognized as a major problem in the mental health field and it represents a very negative issue for patients and their families.

This paper analyses the role of mental patients' associations in the fight against stigma and discrimination by examining the way these organizations approach the problem in Portugal.

Case methodology was applied using mainly qualitative data gathered through qualitative interviews and document analysis.

We studied two organizations. The first one, with 3,800 members nationwide, aims to support people suffering from depression or bipolar disorders. The second one is a 120 member organization that operated between 2001 and 2010 in Lisbon for the development of educational programs and support of people living with schizophrenia.

Our study shows that both organizations targeted their members and families to avoid self-stigmatization. This study also shows that both tried to reach larger audiences through the internet, leaflets, brochures, by organizing open debates and through media advocacy.

Although these organizations did not assess their own activity, both seem to be effective and their methods very appropriate for fighting the stigma of mental disorders.

THE STIGMA OF MEMORY LOSS AND DEMENTIA: HOW IS THE MEDIA HELPING?

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Objectives: The media, including printed papers, television and radio stories, have a powerful way to communicate and perpetuate community attitudes and beliefs about health conditions. Ageist attitudes are reflected in sensational reporting of events involving older people, especially those involved dementia and other mental conditions. Our objective was to understand how dementia is reported in the media and whether stigma associated with the condition is being perpetuated through reporting.

Methods: We analysed changes in the quantity and quality of media reporting about dementia in Australian media between two time periods. A media retrieval service collected all news items related to dementia in a sample of reports. Quality ratings based on previously developed criteria were made for a stratified random sample of items - 1,129 items for 2000/01 and 1,606 for 2006/07. Nine items of quality were assessed. A summary score for quality was constructed. The content of the sampled media items was also coded.

Results: We found that the quality of media reporting improved over the study period. Overall, the mean total quality score for dementia related items significantly improved over the study period. There were very large improvements in quality of reporting of 'sensationalism' 'language' and 'provision of information about help services' and some small deterioration in quality for 'medical terminology' and 'illness versus person'.

Conclusions: Generally the quality of reporting dementia improved over the period studied. However further work needs to be carried out on guidance for media outlets in reporting stories about dementia and other mental illnesses.

UNDERSTANDING STIGMA AMONG HOMELESS PERSONS: PATHWAYS INTO HOMELESSNESS

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This study examined how homeless individuals with mental illness make meaning of pathways into homelessness. Study participants are currently enrolled in the *At Home/Chez Soi* project, a Pan-Canadian, mixed methods Randomized Controlled Trial comparing the *Housing First* approach with Treatment as Usual interventions for homeless adults with mental illness in five Canadian cities.

Educational Objectives: At the conclusion of this presentation, the participants should be able to better understand how stigma and discrimination are pervasive in the lives of people who are homeless and have a mental health problem.

Purpose: The purpose of this research was to understand the lived experiences of participants through life story interviews. Our aim was to explore at baseline: (a) pathways into homelessness, (b) life on the street or in a shelter, and (c) experiences of mental health issues and mental health services.

Methods: In all 225 qualitative baseline interviews were conducted with homeless persons between December 2009 and June 2011. Sampling was purposeful in order to ensure diverse representation of participants (e.g., gender, ethnicity, age, sexuality, etc.). The interview guide focused on pathways of participants into homelessness, life on the streets, experiences with mental health services, and key life events. Interviews were between 45-90 minutes in duration and were audio recorded and transcribed verbatim. Data analysis involved thematic analysis and content coding. Researchers sought and identified “common threads” throughout the data, drawing out significant concepts that emerged from individual interviews along with cross-cutting themes and concepts that occurred across interviews.

Results: The experience of stigma and discrimination was among the most salient theme across the five sites. Participants described being stigmatized by their families, in shelters, and on the streets. For many participants, the experience of stigma caused them to avoid accessing services. Discrimination limited opportunities to obtain work, education, and stable and safe housing, contributing to continued marginalization. Issues of stigma and discrimination were so pervasive one site recommended that programs and services raise awareness by implementing training and strategies for lessening stigma and discrimination

Many participants internalized the stigma they routinely experienced. Stigma adversely impacted their identities, leading to further social isolation, poor self-esteem and worsened mental health. Participants describe the accumulation of stress from stigma and marginalization, as they perceived widespread discrimination due to homelessness, mental illness, and lost identities.

Conclusions: The widespread experience of stigma and discrimination underscores the need for interventions and services to support participants in developing social relationships and in becoming integrated into their communities as valued members. From a policy standpoint, this finding suggests the need for campaigns to address and minimize stigma and discrimination. Further, it is essential to understand the neighborhood, community, social, and cultural contexts in which the participants are embedded. Chronic homelessness is not just a problem faced by individuals, but is heavily influenced by structural injustices and economic inequalities.

YOUTH DESIRE FOR SOCIAL DISTANCE FROM PEOPLE WITH SCHIZOPHRENIA

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Objectives: Social distance is one of stigma facets. It represents the degree in which an individual is comfortable being close or around a mental ill person. The desire for social distance can be influenced by various factors, including the perceived dangerousness and unpredictability of a person suffering from a mental disorder and the incurability of the disease. We intend to evaluate the desire for social distance in Portuguese youth, in order to design an intervention to increase their mental health literacy about schizophrenia and reduce their desire for social distance from people who suffer from this disorder.

Methods: This study is based on a questionnaire, administered to a representative sample of 4938 adolescents and young Portuguese (43,3% males and 56,7% female), living in the central region of Portugal in the districts of Aveiro, Castelo Branco, Coimbra, Guarda, Leiria and Viseu. Their ages range from 14 to 24 years (mean age of 16,75 years; standard deviation of 1,62 years). They attend schools circumscribed in the Regional Direction of Education – Center.

To evaluate the desire for social distance, a vignette describing a boy named Miguel suffering from schizophrenia according to the diagnostic criteria for this disorder of DSM-IV was presented. The following question was asked: “In what extent would you...” followed by these options: To go out with Miguel on the weekend?; To work on a project or group work with Miguel?; To invite Miguel to go to your house?; To go to Miguel’s house?; Be happy to develop a close friendship with Miguel?. The respondents had to mark a number from 1 – No way to 7 – Without any problem, using a Likert type scale.

Results: All of the items had a low mean, revealing a higher desire for social distance. The item with the higher mean (3,18) was ‘Go out with Miguel on the weekend’, the situation in which the desire for social distance was lower. The item with the lower average (2,59) and with the higher desire for distance was ‘Be happy to develop a close friendship with Miguel’.

Conclusion: There are no other studies in Portugal that measure social distance concerning schizophrenia in youth. However, there is evidence that social distance can be reduced through planned interventions.

If intervention programs modify youth attitudes and beliefs about mental illness and schizophrenia, they can stop them from becoming adults who stigmatize and desire social distance from mental ill.

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Oral Presentations

Investing in mental health

AMERICA'S CLINICAL/LEGAL DIVIDE REGARDING THE ADJUDICATION VERSUS CLINICAL TREATMENT OF JUVENILES: A MODEL OUT OF STEP WITH THE EU

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Objectives: Societal reactions toward the treatment of troubled juveniles, many who suffer from some degree of psychological distress, vary throughout the world. The United States of America has long subscribed to a more punitive versus treatment orientation setting it aside from other Western societies. Here, we address the discord between the USA and the UN and EU perspectives as well as the slow progress being made in providing better care for youth in the United States.

Methods: An analysis of current laws and programs within the USA in comparison with UN standards and EU practices.

Results: Remarkable progress has been made within the past decades in the treatment of juveniles worldwide with the adoption of UN-recommended clinical and legal standards by the European Community and other industrialized societies, including those standards promulgated by the UN Convention on the Rights of the Child; UN Standard Minimum Rules for the Administration of Juvenile Justice – the Beijing Rules; and the Standard Minimum Rules for Non-Custodial Measures – the Tokyo Rule. These legal standards plus the advances in brain mapping topography and clinical interventions has led to a movement toward clinical versus punitive efforts regarding the behaviors of children and youth. Yet, the United States stands out as a Western/industrialized society that still resorts to extreme punishment for certain youth, at the expense of clinical treatments and interventions. A problem with a “republic” system like the U.S.A. is that uniform standards are difficult to ascertain, relying instead on the often slow process of the U.S. Supreme Court, which, in itself, is not usually in concert with UN and EU standards.

Conclusions: As it stands now, many states treat juveniles as harshly as adults despite the 1967 “*In re Gault*” Supreme Court decision advocating a “due process” format. More recently, in 2005, the Supreme Court, in “*Roper v. Simmons*,” outlawed the death penalty for youth under age 18. Even then, mandatory life sentences without the possibility of parole were quickly adopted in place of execution for juvenile offenders. This changed in 2012 when the U.S. Supreme Court ended the *mandatory* life without parole administered in certain states, not the possibility of continuing this practice per se, -- in its “*Miller v. Alabama*” decision. This clinical/legal dilemma continues to plague the treatment of youth, especially minorities, in the U.S.A. with emphasis often on punishment over clinical treatment protocols despite their obvious efficacy.

SECONDARY TORTURE VICTIMS: THE IMPACT OF DETENTION ON FAMILY MEMBERS OF PALESTINIAN POLITICAL PRISONERS IN ISRAELI PRISONS

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Objectives: The main objective of the study is to identify the impact of the head of household (HOH) being imprisoned in Israeli detentions on their well-being and socioeconomically status, and their mental health.

Methods: The study was performed on the West Bank in Nov.2011 amongst 358 families, who were selected from the database of the Ministry of Detainees and Ex-detainees who's HOH were detained as political prisoners for one year or more. Of all families the replacing HOH as well as up to four other family members filled in a special designed questionnaire to identify the conditions of the arrest, and the impact on the family. Moreover the PTSD, BDI, BSI, FAD were used to measure the socio-economic and mental health impact.

Results: In total 35% men and 62% women were interviewed. The impact of the (conditions of) arrest on the family mentioned: almost 60% reported severe damage to the house; 40% mentioned their houses had been repeatedly raided after detention and they felt scared and intimidated and, 42% reported that their family members had been verbally insulted and abused during the arrest. 89.3% of the study sample out of 358 reported that the HOH detainees were tortured or ill-treated during their detention. When visiting their relatives almost 90% were harassed and intimidated and subjected to excessive physical searches. Over three quarter reported being detained on the checkpoints. A third reported they were strip searched.

The socio-economic impact of detention of the head of the family meant that > 85% of the families suffered from financial hardship, the most severe suffering was amongst newly married women whose husband were detained. More than half of the families reported that they lost the source of protection. The mental health assessments revealed that > 60% of children suffered from recurrent nightmares; both men and women showed signs and symptoms such as sadness, anxiety, stress, sleeping disorders, loss of appetite and headaches. Moreover, diagnoses of PTSD (57%), depression (22%), anxiety disorder (44%) and physical pains of psychological origins (33%) were assessed.

Conclusion: The impact and effect on family members of the arrest and detention circumstances of political Palestinian prisoners is enormous, both in socio-economic as well as mental health terms. Families of detainees are repeatedly exposed to ill-treatment, collective punishment and sometimes torture.

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**Mental health care in
developing countries**

THE SETUP AND VALUE OF AN EXPERIMENTAL MODEL OF COMMUNITY PSYCHOLOGICAL COPING INTERVENTION

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Objective: To set up the experimental model, seek the methods and value of community psychological coping intervention, and provide the basis of psychological theory and practice for the work of community mental health.

Methods: The scale of crisis fragility and BCQ were employed to evaluate and compare the mental state before and after intervention.

Results: 1) Crisis fragility of residents was negatively correlated with positive coping, positively correlated with negative coping. 2) After intervention, scores of scale for crisis vulnerability and negative coping dropped. 3) Through the regression model analysis, the linear relationship between positive coping factor and the crisis vulnerable is closest.

Conclusion: The intervention of psychological coping in community is an effective method, and the setup of experimental model has provided the theory and the practice basis for development psychology counseling in community.

Key Words: Community; Crisis fragility; Coping style; Intervention model

SUBCORTICAL EXISTENCE: SOMATIZATION AS THE MAIN MODE OF COMMUNICATION IN SOME CULTURES

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Objective: In some cultures, direct explanation of inner world is inhibited. Talking about emotions is prohibited and evaluated as a sign of weakness. In these cultures, somatization is the main outlet for emotional discharge. In this paper, with reference to Maclean's theory of "Triune brain" and sensorimotor approach of Ogden to the treatment of trauma and dissociation, we suggest a hypothesis about the function of the brain in such cultures and convey the impression that the behavior of some people are mediated by subcortical areas of the brain rather than cortex. They employ a bottom-up approach for information processing. The therapist has to consider this mode of thinking in the treatment of psychiatric problems of such patient.

MENTAL HEALTH POLICY AS PROCESS IN A GLOBAL CONTEXT: EVIDENCE-BASED RESEARCH IN PARTICIPATORY DEVELOPMENT

R. Hayward¹, P. Cutler

¹ InterAction

Objective: The future of mental health systems and services relies on the ability of all stakeholders to work together to address the challenges posed by globalization and rapidly changing social environments. For developing countries this is a priority as there is a vacuum in mental health policy. A gap exists between those at the grassroots and those charged with the responsibility to develop effective and equitable services. The situation is exacerbated for people who have mental health problems and their families as they are further excluded from policy processes by stigma, power differentials and lack of information.

Methods: This paper reports on five years of work and research by staff from an international mental health agency, InterAction, in many countries including Estonia, Kyrgyzstan, Armenia, Cuba, Bosnia, India and Romania using the Pathways to Policy model. This model is theoretically based on policy-as-process and public action concepts and has successfully enabled grassroots stakeholders, including service users, carers, psychiatrists and members of local communities, to work together to develop services and address local issues such as rural livelihoods, gender and transparency / corruption.

Results: The model has developed local and national policy forums that are run by service users and other stakeholders. By providing the training, support and resources for these grassroots lead forums, the model provides evidence that bottom-up approaches can build partnership and collaborative activities based on mutual respect and trust. The research draws on data including participatory analysis, semi-structured interviews, focus groups and reflective records.

Conclusions: By addressing the twin questions of how people at the grassroots can shape mental health services and how they can have a voice in the policy debate, the paper demonstrates that real outcomes are possible in countries where poverty, conflict and low funding of services are common. The implications of this work are significant for the wider development of mental health policy as it challenges accepted orthodoxies and indicates the need for more inclusive responses to the problems of long term mental health needs.

Key words: Policy / Participation / User Involvement / Globalization

EVALUATION OF SOCIAL PSYCHIATRY PROGRAMMES IN KERALA USING THE RE-AIM FRAMEWORK: A PRELIMINARY STUDY

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Background: The state of Kerala, in South India is unique with high morbidity and comparable mortality rates. It has a history of very progressive social movements and non governmental organisations making inroads into health care. This is especially so in the mental health care sector. These organisations in the voluntary sector serve to supplement and fill in gaps in the provision of mental health care. Most of these organisations receive little funds and are subserved by a group of caring volunteers.

Objective: To evaluate the impact of social psychiatry programmes in Kerala.

Methods: This was a preliminary study to look at the feasibility of using the RE-AIM framework to study the performance and impact of two voluntary organisations working in the field of mental health in Kerala. The study collected data using a structured interview. The directors of two programmes were asked to complete a 15 item questionnaire assessing domains on the RE AIM domains and a checklist of good practices. This was followed by an in depth interview with the director of the programme which was recorded, transcribed and analysed. RE AIM profiles were compiled for the two programmes.

Results: The two programmes, one providing support and empowering parents of children with a learning difficulty (dyslexia, Dysgraphia and dyscalculia) and the other providing support for adults affected by learning disability (mental handicap) had been functioning for more than 10 years in Kerala. Several good practices such as the spirit of volunteerism, involvement and empowering of carers, low cost techniques were identified. Some areas for improvement were identified similarly.

Conclusion: We have demonstrated, on a small scale the feasibility of using RE-AIM framework to look at voluntary organisations in a developing country. The approach is replicable and ensures that the scope of involvement is widened. The RE AIM domains provide a good framework to study public health interventions and to identify good practices as well as areas for improvement.

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**Creating alliances to respond
to mental health challenges**

MENTAL HEALTH POLICY AS PROCESS IN A GLOBAL CONTEXT: EVIDENCE- BASED RESEARCH IN PARTICIPATORY DEVELOPMENT

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¹. InterAction, Canterbury, United Kingdom

². Mental Health & International development, London, United Kingdom

Objective: The future of mental health systems and services relies on the ability of all stakeholders to work together to address the challenges posed by globalization and rapidly changing social environments. For developing countries this is a priority as there is a vacuum in mental health policy. A gap exists between those at the grassroots and those charged with the responsibility to develop effective and equitable services. The situation is exacerbated for people who have mental health problems and their families as they are further excluded from policy processes by stigma, power differentials and lack of information.

Methods: This paper reports on five years of work and research by staff from an international mental health agency, InterAction, in many countries including Estonia, Kyrgyzstan, Armenia, Bosnia-Herzegovina, India and Romania using the Pathways to Policy model. This model is theoretically based on policy-as-process and public action concepts and has successfully enabled grassroots stakeholders, including service users, carers, psychiatrists and members of local communities, to work together to develop services and address local issues such as rural livelihoods, gender and transparency / corruption.

Results: The model has developed local and national policy forums that are run by service users and other stakeholders. By providing the training, support and resources for these grassroots lead forums, the model provides evidence that bottom-up approaches can build partnership and collaborative activities based on mutual respect and trust. The research draws on data including participatory analysis, semi-structured interviews, focus groups and reflective records.

Conclusions: By addressing the twin questions of how people at the grassroots can shape mental health services and how they can have a voice in the policy debate, the paper demonstrates that real outcomes are possible in countries where poverty, conflict and low funding of services are common. The implications of this work are significant for the wider development of mental health policy as it challenges accepted orthodoxies and indicates the need for more inclusive responses to the problems of long term mental health needs.

Literature Reference: Hayward R. & Cutler P. *"Evidence-based Policy in Mental Health"* in Knapp M., McDaid D., Mossialos E. & Thornicroft G. (2005) *Mental Health Policy and Practice Across Europe*. Milton Keynes: Open University Press.

Key words: Policy / Participation / User Involvement / Globalization

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Others

IMPACT OF THE PHYSICAL ACTIVITY ON THE MODERATION OF THE SYMPTOMS AND THE REMEDIATION AMONG SCHIZOPHRENIC PATIENTS: CASE OF TUNISIAN PATIENTS

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Objectives: This research is part of studies that highlighted the effectiveness of the Pilate method in the relief of certain organic attacks such as the fibromyalgia or the breast cancer (Altan et al., 2009). The aim of our research was to check the impact of the Pilate's method, that's a method of physical activity which refers to soft exercises, on the moderation of the negative and positive symptoms among schizophrenic patients and its effectiveness of a better psychological balance of the patient (Eyigor et al., 2010).

Methods: The sample of our study consisted of N=20 patients of the medico-legal service of the care and readjustment unit of psychiatric hospital "ERRAZI" in Tunis. All patients were males have the same type of schizophrenia (paranoia) and they were between 21 to 63 years old (average age 42 years). Most of them were of elementary level of schooling. The sample is divided into two groups: an experimental and a control group. Because of the reduced size of manpower we chose the case study with directing maintenance by calling upon two scales of appreciation of the negative and positive syndromes "the SAPS and the SANS" (Andreasen, 1982, 1986).

Results: The quantitative and qualitative analysis of the results has shown that the physical activities based on the Pilate method have a positive impact on the moderation of the negative symptoms such as emotional poverty and the attention. Moreover, our analysis reveals a certain improvement of the moderation of the positive syndromes and a significant influence on the management of the disease of the psychotics and the schizophrenics in particular while acting on the reduction of the negative symptoms of schizophrenia. However, it is obvious that the physical activity based on the Pilate's method cannot replace the traditional treatments of serious psychiatric diseases, but it can be considered as an important additional therapeutic. The Pilates method can be also a useful method to keep the positive symptoms under control.

Conclusion: The positive effect of the Pilate's method on the moderation of the negative and positive symptoms among Tunisian schizophrenic patients has been checked. Furthermore, this method tends to develop active strategies of coping which allows a compensation of the side effects of drugs and treatments (i.e. obesity, passivity). Finally our study makes it possible to open the way with future research on the improvement of the construction functions of the psychotic oneself.

Key words: physical activities, schizophrenia, Pilate's method, positive and negative symptoms

AN INTERPERSONAL COGNITIVE PROBLEM-SOLVING STRATEGY ON CHILDREN WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER: A ONE-YEAR FOLLOW-UP

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Objective:

To evaluate the efficacy, predictability, and stability of an Interpersonal Cognitive Problem-Solving Strategy / “I Can Problem Solve” (ICPS) program on behavioral and emotional problems in all children with Attention Deficit Hyperactivity Disorder (ADHD), it was completed a 1-year follow-up study on 32 children of the totally 33 children with ADHD into the study. The results of this follow-up are presented.

Methods: The researcher taught ICPS to 33 children with ADHD ranging between 6 to 11 years old over a 14 week period. The ICPS was associated with significant reductions in behavioral and emotional problems (attention problems, hyperactivity problems, anxious/depressed, withdrawn/depressed, oppositional defiant problems, rule breaking behavior, and aggressive behavior).

The “Child Behavior Checklist for Ages 6-18 (Teacher Report Form/TRF)” and “*DSM-IV based screening and assessment scale for Attention Disorder and Disruptive Behavior Disorder* (parents’ and teacher’s forms)” were used to evaluate the efficacy of the program. The scales were applied to mothers, fathers and teachers of the children before and after ICPS and 1 year after training ended.

Results: The results of this follow-up have shown that the improvement in behavioral, social and emotional adjustment lasted 1 years after training ended. Findings indicated that the measured pre-training scores for behavioral and emotional problems (attention problems, hyperactivity problems, anxious/depressed, withdrawn/depressed, oppositional defiant problems, rule breaking behavior, and aggressive behavior) were significantly decreased for all children post-training. In addition, children’s total competence scores increased (working, behaving, learning and happy) after the ICPS. On both the DSM-IV based screening and assessment scales and TRF, the comparison between initial ratings and at 1-year follow-up was significant ($p < 0.05$).

Conclusion: According to the results of this study, it is likely that the ICPS program would be a useful tool to decrease certain emotional and behavioral problems associated with ADHD. Specifically, to increase the competence level of the children with ADHD in the following areas: working, behaving, learning and happy. An additional benefit of the program might be to empower children to deal with problems associated with ADHD such as attention problems, hyperactivity-impulsivity, and Oppositional defiant problems.

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INCREASE IN CHILD BEHAVIOR PROBLEMS AMONG BRAZILIAN PRESCHOOLERS: A COMPARISON OF THE 1993 AND 2004 PELOTAS BIRTH COHORTS

A. Matijasevich¹, A. Stein², L. Anselmi¹, A. M. Menezes¹, I. S. Santos¹, A. J. Barros¹, D. P. Gigante¹, F. C. Barros^{1,3}, C. G. Victora¹

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Educational Objectives: At the conclusion of this presentation, the participants should be able to understand time trends in preschool behavioural/emotional problems among children from a middle-income country.

Purpose: To investigate trends in preschool behavioral/emotional problems in two birth cohorts from a middle-income country born eleven years apart.

Methods: We analyzed data from the 1993 and 2004 Pelotas birth cohort studies from Brazil. A sub-sample of four year olds from the 1993 cohort (634) and all four year olds from the 2004 cohort (3750) were assessed for behavioral and emotional problems through mother report using the same measure, Child Behavior Checklist (CBCL). Similar methods were used in these two population-based cohorts, and response rates were above 90%.

Results: We found a significant increase in CBCL total problems and externalizing mean scores over the eleven-year period: mean values (SE) CBCL for total problems scores were 27.9 (0.8) and 34.7 (0.3) and for externalizing scores, 12.4 (0.4) and 15.5 (0.1) in 1993 and 2004 Pelotas cohorts, respectively. Aggressive behavior syndrome score showed the largest increase: means (SE) of 9.7 (0.3) and 13.0 (0.1) in 1993 and 2004 studies. Changes in familial, maternal and child's characteristics did not help to explain the observed increase in child behavior problems during the study period.

Conclusions: this study provides evidence of a substantial increase in psychological problems, particularly behavioral ones, among preschool children over a recent 11 year period. Given the potential long-term effects of childhood psychological problems on an individual's social and psychological life course, early identification of such problems must be a key priority for mental health services.

NEEDS ASSESSMENT OF PATIENTS TREATED IN COMMUNITY PSYCHOSOCIAL CENTERS IN SÃO PAULO, BRAZIL

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². Hospital Alemao Oswaldo Cruz, Sao Paulo, Brazil

Educational Objectives: at the conclusion of this presentation, the participants should be able to estimate the needs of care of patients treated in community psychosocial services in a large city in Brazil and to compare them with results of previous studies conducted in Europe

Purpose: To describe the needs of patients treated at community psychosocial centers in Sao Paulo, Brazil.

Methods: We performed a cross-sectional study with 373 patients who were attending psychosocial care activities at least three times per week in community psychosocial centers in São Paulo, Brazil, during 2007-2008. Needs were assessed using the “Camberwell Assessment of Need” (CAN). Psychotic symptoms were assessed using the “Positive and Negative Symptom Schedule” (PANSS).

Results: Mean age of patients was 40.0 years (standard deviation, SD = 12.6 years); 57.6% were male, 57.9% had fundamental education, 40.5% have schizophrenia, 15.9% have worked during last 12 months, 14.7% were living alone and 21.9% have no previous psychiatric hospitalizations. Median time attending in community psychosocial centers was two years (range of 15 days to 30 years) and mean number of weekly therapeutic activities was 3.6 (SD = 2.3). The mean score for the total number of needs was 7.1 (SD = 2.8), with a range of 0 to 15 (maximum = 22). Mean scores of PANSS positive, negative and general scales were 13.4 (SD = 4.8), 14.9 (SD = 5.7) and 29.0 (SD = 8.7), respectively. Basic needs (accommodation and food) were reported by 38 (10.2%) patients; at least one social need was reported by 90.9% and 18.8% have needs related to company, intimate relations and sexual expression. At least one functioning need (self-care, child care, basic education, looking after home, daytime activities, money) was reported by 94.4% patients; 85.5% have at least one health need (physical health, psychological distress, psychotic symptoms, safety to others, alcohol abuse, drug abuse) and 86.3% have at least one service need (information, telephone, transport, benefits). Women showed higher number of needs than men ($p = 0.02$) and educational until fundamental level was also associated with more needs ($p = 0.02$). We did not observe associations between weekly activities, unemployment, age, diagnosis and number of needs. Patients with higher PANSS scores showed more needs ($p < 0.001$).

Conclusions: We managed to estimate needs of care of these patients. We observed higher number of needs than in studies conducted in Europe, in all conceptual domains assessed by CAN. Many patients showed needs related to health and services, despite the time that they were attending in community psychosocial centers. Patients' needs should take in account in order to improve the quality of care offered in mental health services.

EMPATHY IN NURSING STUDENTS: RELATED SOCIO-DEMOGRAPHIC CHARACTERISTICS AND FAMILY FUNCTIONING

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Objectives: This study was designed as descriptive to evaluate the socio-demographics and family functioning related to the empathic skills and tendency of nursing students.

Methods: The study was conducted in a School of Nursing and all the registered students (all students were female and the average age was 19-21) were asked to participate into the study. Of the totally 731 students, 689 students participated (94.3%) into the study. A socio-demographic questionnaire (including family types, number of siblings, birth order, parental educational status, parents' profession, the number of persons living in the same house, income level and parents deceased or alive), Empathic Communication Skills Scale (ECSS), Empathic Tendency Scale (ETS), and Turkish version of McMaster Family Assessment Device (FAD) were used to collect data. ECSS measures affective and cognitive components of empathy and verbal response dimension of communication. ETS was developed in order to measure the potential of persons' ability to establish empathic relationships in daily life. The FAD measures "Problem Solving", "Communication", "Roles", "Affective Responsiveness", "Affective Involvement", "Behavior Control" and "General Functioning".

Results: There were statistically differences among the groups on measured ECSS, and ETS scores in terms of some characteristics of students such as number of siblings, birth order, professions of fathers, and the number of persons living in the same house. There was a significant negative correlation both between FAD scores and ETS ($r=-0.343$, $p<.001$) and between FAD scores and ECSS ($r=-0.090$, $p=.020$) of students. The higher scores on the FAD showing unhealthy/pathology functions of the families were increased in parallel with the decrease in ETS and ECSS scores of students. Multivariate analysis have shown that students who were raised in families showing high levels of unhealthy "Communication", "Roles" had lower ETS and ECSS scores ($p<0.05$).

Conclusion: The negativities in family functioning affect students' empathic tendency and skills. Also some characteristics of family system such as the increase in the number of siblings and the number of persons living in the same house seem related to lower both empathic tendency and skills the status of being the first child in a family seem related to higher empathic tendency and people-oriented professions of fathers seem related to higher empathic skills.

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INFORMATION SYSTEMS: DO THEY IMPROVE THE QUALITY OF MENTAL HEALTH CARE?

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Objectives: Participants will understand the importance of collecting clinical data in order to improve the quality of care. Participants will be more familiar with the Resident Assessment Instrument for Mental Health, a data collection instrument made in Canada.

Information systems allow clinicians to understand better clinical activities helping informed decisions taking. The Minimum Data Set for Mental Health (MDS-MH) has been in use in Ontario since 1999, initially as a research instrument, now part of normal clinical practice. Since 2005, the MDS-MH, the basis of the Ontario Mental Health Reporting System (OMHRS), is used for patients hospitalized in mental health beds. The OMHRS is designed for outcome measurement and quality improvement. It collects 21 domains of care including mental state indicators, substance use or excessive behaviour, service utilization and treatments, etc. We are using MDS-MH-based results in a Teaching Hospital, the Montfort Hospital, in Ottawa, Canada.

Some clinical indicators that MDS-MH and OMHRS bring to those clinicians interested by improving the quality of care. Pros and cons of using such tools to improve services will be discussed.

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