

EDITION 3 - June 2007

Dear WNUSP Friends,

Welcome to this edition of WNUSP-News. We are back, after the first and second editions which were dedicated to the Convention on the Rights of Persons with Disabilities (CPRD).

In this edition, our focus will be on our newly established continental organization, called the Pan African Network of Users and Survivors of Psychiatry (PANUSP). Also we are starting a regular slot on WNUSP reportbacks, where we give news and reports on activities and meetings, in which we were involved, as well as other important announcements relating to conferences, etc. In this edition, we will also, start a regular slot, which will provide updated information on progress with regard to the CRPD

1. PANUSP and MINDFREEDOM GHANA

Janet Amegatcher, chairperson of PANUSP, presented the following paper at a side event at the UN during the last the Ad Hoc committee meeting, on her involvement in the establishment of PANUSP and MINDFreedom Ghana

The UN Convention on the Rights of Persons With Disabilities: A Rights-based Approach to Development

INTRODUCTION

The World Network of Users and Survivors of Psychiatry (WNUSP), of which I am a board member, has helped to set up a regional wing of its organization, called the Pan African

Network of Users and Survivors of Psychiatry (PANUSP). In July 2004, the WNUSP held a General Assembly in Vejle, Denmark, where I was elected to join the board. It was agreed in that meeting, that there was a need for setting up a continental branch in Africa, and the name PANUSP was suggested. A co-ordinator, to facilitate this goal, was appointed from Uganda. A team from the same country was given the duty of working towards the establishment of PANUSP, as an organization. In November 2005, there was a conference in Kampala, Uganda, of representatives from various African countries, where PANUSP was inaugurated. I was also elected as chairperson for PANUSP.

In 2008, it is hoped that the General Assembly for WNUSP will be held in conjunction with that of PANUSP in Kampala, Uganda. I must also say that I am a director for Mind Freedom Ghana, a local NGO fighting for the human rights of persons with psychosocial disabilities. At Vejle, three delegates from Ghana were challenged to start a local user group and in 2005, this idea came to see the light of day.

Mind Freedom Ghana has the vision that one day there will be no more persons with psychosocial disabilities whose rights are violated in Ghana. Our mission is to offer education in mental health and human rights to the Ghanaian community in order to alleviate the suffering of persons with psychosocial disabilities in that community. Our goal is to give people with psychosocial disabilities the control, competence, potential and access they need to change their own lives, improve their own communities and influence their own destinies. Mind Freedom, for example, is building the capacity of persons with psychosocial disabilities and also helping to find a means of livelihood for them.

Basic Needs Ghana has also been involved in fighting for the human rights of persons with psychosocial disabilities. Earlier this month Basic Needs Ghana signed a memorandum of understanding with Mind Freedom Ghana to work together in the fight for the human rights and dignity of persons with psychosocial disabilities in Ghana. The project with Basic Needs Ghana involves outreach programmes to various communities where self-help groups have been formed. This will be a place where we will build their capacities and empower the individuals to be heard.

Mind Freedom Ghana is a membership organization. At the moment, there are about twenty registered members but because of the MOU with Basic Needs Ghana, their Self-Help Groups of about 240 individuals are going to become members of Mind Freedom Ghana. That is a big leap forward and also a great responsibility ahead. Since Mind Freedom Ghana came into being, we have helped raise awareness about human rights and dignity of persons with psychosocial disabilities. We have had a street march, radio / TV programmes and we have

written articles in the newspapers on the plight of persons with psychosocial disabilities. We have spoken to some government officials on behalf of persons with psychosocial disabilities in the count

Participation of persons with psychosocial disabilities is crucial when we talk about a rights-based approach to development. Participation in decisions that affect persons with psychosocial disabilities is important. We will meet with all new members and together chart the way forward. We want to find a way to have our voices heard when the Poverty Reduction Strategy Programme (PRSP) is being discussed. We will give necessary information to these new members so that right decisions will be made. We also want to empower our members so that they can be part of the decisions that are made concerning them in the area of drugs or incarceration.

I will give an example of my own life. Some time ago, I had some psychosocial problems and I was sent to a psychiatrist in Ghana who prescribed certain drugs including some injections. I refused to take the drugs and asked for a second opinion. I had the opportunity to go to my aunty who is a psychiatrist in London. She looked at the drugs and advised me that they were too strong and she gave me a substitute - milder capsules. I went back to Ghana after about four months.

Four years later, I lost my father and it took a toll on me. I went to London for a holiday and there it was obvious that something was wrong somewhere. My aunty gave me three injections - on three different occasions. After that my mouth started dripping with saliva, I suffered from a stiff neck and muscle pulls very frequently - even when I was sleeping - and I was so confused. My aunty decided to stop the injections and gave me some tablets to take when necessary. I went back to Ghana and another psychiatrist wanted to continue with the injections so I called my aunty and she told my husband that the drugs are destructive and that if they continued the injections, it would destroy me. Gradually, my mind began to clear and I could understand when people talked to me and I could also go back to work. I believe that faith in the Almighty God played a part because although I could not pray much or read the Bible very much, I knew others were praying for me and God will answer.

I have a cousin who experienced some psychosocial problems some years ago. He was put on monthly injections and it has rather destroyed him. Since then, he has not been able to work again. He goes about laughing when nothing is funny and talking to himself or to people about non-existent things. His sisters are now sorry that they allowed him to be injected on a regular basis as they did. They encouraged me not to allow those injections.

CONCERNS AND CHALLENGES

In Ghana, some educators and parents have expressed concern that the introduction of students with psychosocial disabilities into regular classrooms may disrupt school activities or require excessive amounts of class time. They worry that inclusion slows educational progress both for students with psychosocial disabilities and for their peers with no psychosocial disabilities. It is the hope of WNUSP, PANUSP and Mind Freedom Ghana that with the new Convention on the Rights of Persons with Disabilities, things will change. Definitely, it will mean the public will have to be sensitized and educated in order to change their perceptions and attitudes. We believe that inclusive educational settings designed to address the individual needs of children offer expanded possibilities for educational, social, and emotional growth among all students.

Secondly, there is a dearth of information on mental health issues in Ghana and most African countries thereby making many ignorant claims about what to do when the need arises. Superstition is ingrained in the society hence some people tend to associate mental problems with this. Those who fall into such situations are thus ignored or left to roam about as a punishment for their supposed misdeeds or sent to spiritist churches or camps where they are chained and beaten on the pretext that evil spirits will leave them. Other people take them to institutions and abandon them there. So once they have been treated, they have no home or shelter to go to. This has led to overcrowding at the institutions and feeding is a very big problem. Sometimes, they are fed once a day and they go hungry for the rest of the day or they go out to beg for food or pick left over food around.

There is widespread stigma and discrimination against persons with psychosocial disabilities or even those who come out to do any form of work concerning them. Mind Freedom Ghana has a big task to deal with these challenges. We will have to develop educational materials on disability issues such as flyers, posters and banners to be displayed at public places as it has been done in the case of HIV/ AIDS. So far, this has not been done due to lack of funds and neglect both by officialdom and the public.

Another concern and challenge is that the country is celebrating its golden jubilee since independence this year. It is likely that persons with psychosocial disabilities - for example those who suffer from schizophrenia etc. - are likely to be collected from the road side and dumped at the institutions without the necessary supplies for them. This has been done before and we can almost predict that that will be done again.

WNUSP, PANUSP and Mind Freedom Ghana recognize that poverty is about more than just low income. The factors generating poverty and exclusion are wide-ranging and thus our work

on child poverty covers many areas including education, enterprise, health, justice and communities.

We believe that every child matters and, regardless of their family background, should have the best possible start in life. We also want to ensure that every young person has the opportunities, skills and support to make a successful transition to working life and active citizenship. We also believe that if parents with psychosocial disabilities are helped to take part in income generating ventures that will tackle poverty and exclusion headlong. Their children then can go to school and have a good education and training, so as to be marketable, thereby breaking the cycle of poverty.

In summary, Mind Freedom Ghana says that, if the UN Convention on the rights of persons with disabilities has a human rights approach to development, then it has to be one which:

- puts persons with disabilities first and promotes human-centred development, stresses liberty, equality and empowerment of persons with psychosocial disabilities
- recognizes the inherent dignity of every human being without distinction whether they have psychosocial disabilities or not
- promotes equal opportunities and choices for all, so that everyone can develop their unique potential and have a chance to contribute to development and society in spite of their psychosocial disabilities
- promotes national and international systems based on economic equity, equitable access to public resources, and social justice.

The UN's World Report on Disability and Rehabilitation (DAR)

A progress report, with some personal reflections

by

David Webb, Australia Deputy to the board of WNUSP, Asia-Pacific region

As a member of the International Disability Alliance (IDA), WNUSP is often called upon to represent people with psychosocial disability at international forums, and in particular at the United Nations and its various agencies. Following the significant contribution WNUSP made to the recently adopted UN Convention on the Rights of People with Disabilities (CRPD), we are increasingly recognized as the major international voice for users and survivors of psychiatry.

Last year, I was asked to represent WNUSP on another project of the UN that is to produce a World Report on Disability and Rehabilitation - sometimes abbreviated to WRDR, but I'll refer to it here as the World Report. This was the first time I have been directly involved in a UN project, so my report here includes some personal reflections on this challenging but illuminating experience.

In May 2005, the World Health Assembly (WHA) of the UN passed a resolution asking the World Health Organization (WHO) to produce a status report on disability and rehabilitation that would provide governments and civil society with a comprehensive description and analysis of disability around the world, and to make recommendations for action. This task was assigned to a group known as the Disability and Rehabilitation (DAR) team within the Violence and Injuries Prevention (VIP) department of the WHO - so it is sometimes known as the DAR project. The Director of VIP, Dr Etienne Krug, has said that he expects the World Report to be a "wake-up call" to the world on disability issues.

After a preliminary meeting at the Geneva headquarters of the WHO in 2005 (with just one representative from the IDA in attendance), I was asked to represent WNUSP at the next major DAR meeting in July 2006. About 50 people attended this meeting, including (only) two other representatives from IDA - Dan Pescod (UK) from the World Blind Union, and Sebenzile Matsebula (South Africa) from Rehabilitation International. There were a few other people with disabilities from other organizations, including Dr Federico Montero who, at the time, was the Coordinator of DAR though he has since resigned from this position. The remaining 45 (approx) attendees consisted of about fifteen WHO staff and a diverse mix of "international experts" on disability and rehabilitation.

These numbers are significant, in my view, as they reflect the WHO's excessive reliance and confidence in professional experts (rather than the expertise of people with disabilities themselves) that is not always shared by people with disabilities. I certainly felt rather overwhelmed at times to be among so many experts who I felt were frequently "talking about us without us". This was especially difficult when things were said that I - and WNUSP - vigorously disagreed with. There was little opportunity for me to express these concerns and on the two occasions when I did speak up at the plenary sessions, my comments were clearly not welcomed by most of the people there. It is difficult to speak up on such occasions when the numbers are so obviously against you. It is also easy for these lop-sided numbers to easily ignore one squeaky little voice from WNUSP. Overall, it was a disheartening, and at times distressing, experience so I would think very carefully before putting myself in that situation again.

The purpose of this meeting was to try and come to agreement on the definitions of (a) disability and (b) rehabilitation. Almost all of the two days, however, were spent on the definition of disability, but still without any agreement being reached. There's not space here to cover all the discussion of all the various proposed definitions, so I'll just mention my central concern on this issue, which remains my central concern with the entire World Report project.

Many people at this meeting supported a definition of disability that was developed and adopted by the WHO known as the ICF, which stands for the International Classification of Functioning, Disability and Health. The ICF is a large and complex document with quite a long history. In response to pressure from the disability community, the predecessor of the ICF was radically revised during the 1990s in an attempt to incorporate what is generally known as the social model of disability. Two central features of the social model of disability are (a) to recognize the social factors that contribute to the experience of disability and (b) to de-medicalise disability. This model, which was developed by people with disabilities themselves, therefore puts human rights - rather than health/medical issues - at the very centre of understanding disability. It is this approach to disability that has now culminated in the UN Convention on the Rights of People with Disabilities.

Despite the WHO's claim that the ICF incorporates the social model of disability, and despite the many good features of the ICF, I maintain that the ICF is in fact still a medical model, or as I called it at this meeting, a medical model in disguise. My reason for this is that at the heart of the ICF there is not a person who experiences disability but a person with a "health condition", which is an ICF euphemism for a medical diagnosis.

On both times when I spoke up at the plenary sessions, I said that users and survivors of psychiatry would never accept a definition of disability based on a psychiatric diagnosis. To emphasise this point, I added that a psychiatric diagnosis needs to be seen rather as a social factor that frequently contributes to a person's experience of disability - and indeed is often used as the rationale for human rights violations against people with psychosocial disability.

I need to briefly mention the other major topic of this meeting, the definition of rehabilitation, even though it was discussed only a little. Part of my homework in preparation for the meeting was to look at what the WHO and others were saying about rehabilitation. I was surprised to see that there seemed to be little awareness or understanding of what in the mental health world would typically be called the recovery-based approach to mental health.

This is not an area that I claim any great expertise in, so I asked two of my colleagues in WNUSP who I regard as experts in this area, Judi Chamberlin and Chris Hansen, for some background information on recovery to take to Geneva. In Geneva, my surprise became shock when I attended the one small-group session to discuss rehabilitation. I was so offended by what I heard that I was unable to speak - sorry, folks, I was not a very good representative on this occasion. What I heard that so offended me was a consensus among the professional experts - mostly rehabilitation service providers - that rehabilitation is something that "they", the experts, do to "us", the disabled, in order to "fix" us. Rehabilitation was spoken of in terms of "restoring lost function" with the only exception being when a person has never had the desired function, such as being blind from birth, which is then called "habilitation". There was no suggestion at all that either (a) we might not want to be rehabilitated or (b) that rehabilitation (recovery) might come through personal growth and transformation into an entirely new state of wellbeing never previously experienced. People with disabilities were clearly seen by this group as "broken" and in need of their expert skills to "fix" us. I was stunned. I'm afraid I was unable to present to this brief meeting the information I had from Judi and Chris.

Following this meeting in July 2006, there was a period when the discussions were continued using a WHO website and email list. And for a while, I hosted an email list of people with disabilities that included representatives of almost all the member organizations of the IDA. Although we were a new group where many of us were meeting each other for the first time, and despite the tight deadlines imposed by DAR, we were able to reach consensus on a few key points, which were communicated to D

- a definition of disability based on a health (i.e. medical) condition is not acceptable
 - it is better to have no definition at all than a bad one that would exclude some people
 - the World Report needs to recognize the UN Convention as a "paradigm shift" in how we think about disability that includes:
 - human rights as central to the understanding and definition of disability
 - the need to de-medicalise disability
 - the need to put rehabilitating societies on an equal basis with rehabilitating individuals
- I am not at all convinced, however, that DAR have heard, far less heeded, this unequivocal message from this group.

For most of 2007, I have heard little from DAR. I heard that Dr Montero had resigned. I heard that there were some concerns about his resignation and that some people close to the WHO had called for the World Report project to be moved out of the DAR team. I heard that DAR were proceeding to put together two committees to oversee the project - an Editorial Committee to supervise the writing of the report and an Advisory Committee to support its launch and implementation. And I heard that Venus Ilagan was to represent IDA on the Editorial Committee. I have not met Venus and have no complaint whatsoever with her being on the Editorial Committee, but I am skeptical that one person is able to represent the entire disability community. In particular, and based on my experience of DAR thus far, I am concerned that the key issues for people with psychosocial disabilities are simply not being heard by DAR.

Very recently, I received copies of two bulletins from DAR. One is Issue 1 (April 2007) of a newsletter that you can subscribe to (for free) by sending an email to saiton@who.int. The other is Issue 1 (May 2007) of what they call an "update" for participants on the project, which includes the IDA.

Again, these two bulletins do not reassure me at all that DAR has heard our concerns. Although there is a discernible shift in these bulletins towards greater recognition of the Convention, this seems to mostly be around the right to health and access to rehabilitation services. Contrary to the Convention, DAR and the WHO still seem to see disability as primarily a health/medical issue. I do not see any real sign that DAR understands the central message of the Convention that for people with disabilities the core issues are human rights issues like the right to self-determination, full recognition before the law as a person, including legal capacity, the right to free and informed consent for any medical treatment or rehabilitation, and access to justice. For users and survivors of psychiatry in particular, this includes the right to refuse medical treatment and unwanted "rehabilitation" that are routinely imposed on us all around the world. DAR also seems to still be endorsing the ICF as a model/definition of disability, which I still say is bad news for people with psychosocial disability and may now even contravene the Convention as discrimination against a person because of medical diagnosis.

At the time of writing, DAR has identified the chapter headings for the World Report and is appointing the principal authors for each chapter. They plan to have a first draft of the report early in 2008 which, after extensive peer review, they hope to launch worldwide sometime in 2009.

I want to believe, but am doubtful, that there is still time for people with disabilities to have rather more input into the production of this World Report than has been the case so far. And in particular, I hope that people with specific disabilities, such as psychosocial disability, do not find themselves marginalized and discriminated against in this World Report because of insufficient consultation by the DAR team with all relevant sectors of the disability community. It would be a sad day for the UN if one of its first major projects on disability after the ground-breaking Convention failed to get the endorsement of people with disabilities themselves.

Moosa Salie (South Africa), WNUSP co-chair reports on the launch of the Global Forum on Community Mental Health (GFCMH)

On 30 and 31 May 2007, I attended the launch of the Global Forum on Community Mental

Health, which was held at the WHO headquarters in Geneva. I, along with only a handful of people from the user/survivor movement attended this forum on invitation from the WHO. They included Dan Taylor, of MINDFreedom Ghana, Eliezar Mdakilwa of our Tanzanian group, TUSPO, Sylvester Katontoka of the Mental Health User Network of Zambia, Jolijn Santegoeds of the Dutch advocacy group, Stichting Mind Rights, and Dejan Stevanovic, ENUSP member and founder of WAPR Macedonia.

As with other WHO sponsored conferences, the User/Survivors, were a distinct minority, most delegates attending being MH professionals from all over the world. Admittedly though, this was not your typical group of professionals. It seems that the WHO went to great lengths to invite people to this forum who have had a proven track record of alternative approaches to MH service delivery.

The main sponsor groups for this forum were the WHO's Department of Mental Health and Substance Dependence, the World Association of Psychosocial Rehabilitation (WAPR), the British charity Basic Needs, and an organization called Christoffel Blindenmission (CBM).

As far as I could gather, the stated goal of establishing a Global Forum on Community Mental Health was to promote the moving of MH services into the community and to have a forum in which this discourse can be continued. I was pleasantly surprised to find so many professionals acknowledging the failure of the institutionalisation model. What came out clearly was the need to explore new and alternative models for community based interventions. What was also very obvious was the predominance of the service provider perspective, not really taking into account the very real and successful projects which have been run by organizations in the user/survivor movement for many years.

Dr. Saraceno, the head of the WHO Department of MH and Substance Dependence was also very outspoken against the abuses that have always been taking place in mental institutions, and in fact he seemed very sincere when he said the following: "We are not promoting psychiatry in the community, but we are promoting mental health in the community"

I hope that this new direction of promoting mental health or mental wellness, as opposed to deinstitutionalisation, merely being just a cost saving measure, really takes off. Unfortunately a few days later, while visiting with user/survivor groups in Italy, I was rudely awoken by a press release coming from the UN, on the conference, and I realised that what was said in closed session, might not be easily attainable in practice, if this kind of doublespeak continues.

The following is a small extract of from the UN press release:

"The call for community mental health services came during WHO's Global Forum for Community Mental Health, which concluded in Geneva yesterday and which, for the first time, included the participation of people living with mental disorders. In addition to the nearly 54 million people suffering severe mental disorders such as schizophrenia and bipolar affective disorder, WHO estimates that 154 million suffer from depression".

For the full text of the actual WHO press release, please follow the following link:
<http://www.who.int/entity/mediacentre/news/notes/2007/np25/en/index.html>

You can also access the website of the Global Forum at the following link:
www.gfcmh.com

The following update on progress on the CRPD is written by Tina Minkowitz , WNUSP co-chair and chief delegate to the Ad Hoc Committee

On March 30, 2007, the Convention on the Rights of Persons with Disabilities (CPRD) was opened for signature by governments and a ceremony was held at United Nations headquarters in New York. WNUSP representatives Tina Minkowitz and Amita Dhanda were there, along with our Mind Freedom colleagues Celia Brown, Myra Kovary and Kate Millett.

A record 82 countries plus the European Union signed the Convention on opening day, indicating their intent to ratify and become legally bound. 44 countries signed the optional protocol authorizing the treaty monitoring committee to hear individual complaints and investigate grave or systematic violations. One country (Jamaica) became the first to ratify the Convention. Following the opening ceremony, additional countries have signed, bringing the total to 89 for the Convention and 48 for the optional protocol as of May 1. Check <http://www.un.org/esa/socdev/enable/conventionsign.htm> to see if your country is among them.

UN High Commissioner for Human Rights Louise Arbour gave a speech outlining challenges for implementation, and legal capacity was first on her list, as a right without which none of the others can be exercised.

We are facing challenges in some countries over the translation of "legal capacity". The correct

translation in countries with a Roman legal system is "capacity to act," which means the right to make our own decisions.

In a recent meeting with WNUSP board member Gabor Gombos, users and survivors of psychiatry in Croatia reached a consensus that guardianship should be abolished. Gabor also visited institutions where our peers are being de facto detained through legal incapacitation, i.e. guardianship. Gabor says, "It was reassuring to see how persons with disabilities from very different backgrounds and individual experiences share the very same feelings/thoughts when reflecting on legal capacity."

The Dresden Declaration was made by movement groups on the occasion of the World Psychiatric Association's, conference on Coercive Treatment in Psychiatry, which was held in Dresden, Germany from the 6-8 June 2007

Declaration of Dresden Against Coerced Psychiatric Treatment Dresden (Germany), June 7, 2007

The European Network of (ex-)Users and Survivors of Psychiatry (including its German member-organisation Bundesverband Psychiatrie-Erfahrener) together with their sister organisation the World Network of Users and Survivors of Psychiatry, and working closely with MindFreedom International, are issuing this statement to make clear our coordinated position on force and psychiatry at the time of The World Psychiatric Association (WPA) Conference, "Coercive Treatment in Psychiatry: A Comprehensive Review," being held in Dresden, Germany, June 6 to 8, 2007. Our organizations are in a unique position to speak on this issue because we have experienced forced psychiatry and know the damage it has done to our lives and those of our members, colleagues, and friends.

Our organizations will have representatives from a number of countries participating in the WPA conference, with the intent of putting a human face on this practice. We believe that people who have been coerced by psychiatry have a moral claim to making the definitive statement concerning such coercion.

We stand united in calling for an end to all forced and coerced psychiatric procedures and for the development of alternatives to psychiatry.

We especially point to the recent adoption by the United Nations General Assembly of the "Convention on the Rights of Persons with Disabilities" which was drafted with the participation of human rights activists who had personally experienced the mental health system. We believe that the people of the world and their elected representatives should ratify this Convention without reservations, affirming that all people ought to be treated equally and that no one should be denied liberty based on a label of disability, disease or disorder. We all have a right to refuse psychiatric procedures, since this Convention recognizes the right to free and informed consent with no discrimination based on disability. Even more important, the Convention guarantees to people with disabilities the right to make our own decisions (legal capacity) on an equal basis with others, and requires governments to provide access to non-coercive support in decision-making, for those who need such support.

We note that the World Health Organization (WHO) has stated its opposition to all involuntary electroshock, which is also known as electro-convulsive therapy (ECT). Involuntary electroshock is increasing internationally, including in poor and developing countries where it is most likely to be used without anaesthesia. In particular, we call for the abolition of involuntary ECT in every country.

WHO and the European Commission have also stated the need for the development of new non-stigmatising and self-help approaches for people in emotional distress. Organizations of people who have experienced psychiatric treatment have taken the lead in developing self-help programs that are based on equality and choice, rather than on coercion, and have been successful in helping people lead integrated lives in the community. We know that healing can only occur when people are respected as humans with free will and when there are alternatives beyond psychiatry which are based on ethical approaches, which see the whole person, and which support recovery, while force makes recovery impossible.

We note that in many countries of the world, there is an increasing use of forced psychiatric procedures, including court ordered treatment which requires that people living in their own homes take psychiatric drugs against their will or lose their freedom. This practice is a violation of our human rights as set forth in the UN Convention.

We invite all supporters of human rights to join and support us in demanding a world free of forced and coerced psychiatric procedures, and we call for adequate funding and support for voluntary self-help services and for alternatives to psychiatry which respect our humanity and dignity.

Signed by

Judi Chamberlin and Peter Lehmann

On behalf of

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- Bundesverband Psychiatrie-Erfahrener (BPE), Wittener Str. 87 44789 Bochum, Germany, www.bpe-online.de

SAVE THE DATE !

The next WNUSP General Assembly is scheduled to take place during the week of the 6th to the 12th of October 2008 in Kampala, Uganda. The WNUSP Board along with the local organisers, Mental Health Uganda, are working on structuring the days of the conference as well as the logistics. We will keep you updated as the plans get more concrete. We expect the GA to be a smashing hit with programming on the Convention and other exciting workshops. Save these dates on your calendar! For more news about the GA, contact the WNUSP at admin@wnusp.net

MEMBERS' NEWS NOTICE

The WNUSP Newsletter aims to present the global struggles and achievements of users and survivors of psychiatry. We invite all members of the WNUSP to write in, sharing your views and giving news about your activities. News reports must be in English, brief (250 words) and giving your name and contact details. You may also submit ideas or proposals for articles to be considered for publication in the newsletter. Write to the Editor, WNUSP-News at newsletter@wnusp.net
Moosa Salie, Facilitator WNUSP newsletter Co-Chair WNUSP Secretary PANUSP