Full report of the field study on Mental Health Care in East Africa 2007

Including:
The participation of Users and Survivors of Psychiatry at WSF 2007 Nairobi
And theories on East European psychiatry

Another World is Possible!

Europe's and Africa's common goals

The high needs of active social inclusion and support of users and survivors of psychiatry

Date: **April 24th 2007**
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Author: **Miss. Jolijn Santegoeds, Stichting Mind Rights, the Netherlands**

Post and contacts:
Organization: **Stichting Mind Rights**
Contact person: Miss. Jolijn Santegoeds
Address: Tellegenstraat 78
Postal Code: 5652 NT
City: Eindhoven
Country: the Netherlands
Website international: **http://www.mindrights.org**
Website Dutch: **http://www.mindrights.nl**
Email: tekeertegendeisoleer@hotmail.com
Telephone home: 0031 . 40 251 53 42
Telephone mobile: 0031 . 6 47 01 8432

Registry nr. of Dutch Chambre of Commerce (KvK) 17198277

Bank account Nr: **2762216**, Stichting Mind Rights, Eindhoven, the Netherlands
Name of bank: **Postbank NV**, Amsterdam, the Netherlands
IBAN number: NL 80 PSTB 0002 7622 16
BIC: PSTBNL21

I Introduction

This document contains the final report of a study trip through East Africa, on behalf of participation of users and survivors of psychiatry on the WSF 2007 January 20-25 Nairobi Kenya.

On behalf of the patients, we are representing ourselves in patient movements and we intend to give our point of view, as users and survivors of psychiatry, on improving mental health care worldwide.

This document is initiated by Miss Jolijn Santegoeds, initiator of the organizations:

- **Actiegroep Tekeer tegen de isoleer!** (translation: Action group Beat isolation cells) Dutch website: www.mindrights.nl (www.antiisosite.tk)
- **Stichting Mind Rights,** registered in the Dutch Chambre of Commerce, nr. 17198277, international website: www.mindrights.org

In this document, the use of the words 'illness', 'patient' and 'health' was inevitable for a correct correspondence. The author intends to keep away from the use of these words if possible, because often the responses are emotional and rooted in fear.

Before reading this document it is good to have a certain understanding on psychiatry and psychiatric problems.

I i Mental Health: a social issue

Mental health is about coping with life and feelings. Mental health is highly related to the **social background** of a person. Unequal social, sexual, economic power relations are very strong factors in causing psychological and psychiatric problems. For example violence, power abuse, child abuse, sexual abuse, traumatising events, loss of job, loss of friends, drug abuse etc. are all social circumstances which can lead to an outburst of psychic problems. Coping with these problems is **a very personal process**.

Across different cultures and different ages a variety of ways of dealing with grief, loss, insecurity, anger etc. has been developed. In all populated areas there are certain codes of conduct. (e.g. No shouting at nights etc). In general, society defines the boundaries of **acceptance** and tolerance on this individual behaviour. A mental health patient is generally in a way exceeding the favourable way of conduct and behaviour, which leads to a problem. When this problem is caused by one's personal mental issues it is called a mental problem.

A Mental Health problem therefore is a **social problem, closely related to one's social background and social circumstances, featuring social tension between the patient and society**.

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III Summary

This report "The high needs of active inclusion and support of users and survivors of psychiatry" , completed at April 24th 2007, is written by Miss Jolijn Santegoeds, founder of user initiative Actiegroep Tekeer tegen de isoleer! (Beat isolation cells) and Stichting Mind Rights, the Netherlands.

This final report comprises a description and the results of the field study trip on Mental health care through East Africa from January 7th to February 7th 2007, and it also contains my conclusions and views on psychiatry, which are altogether combined to an **overview on stigmas and (mis)perceptions** on mental health and treatments of psychiatric patients in West Europe, East Europe and East Africa.

The field study trip through Uganda, Kenya and Tanzania was self-organized by the following active (ex)users of psychiatry, representing Dutch user movements:

- **Miss. Jolijn Santegoeds**, Actiegroep Tekeer tegen de isoleer! / Stichting Mind Rights , www.mindrights.org
- **Mr. Jan Verhaegh**, Clienten Centrum Limburg, www.stichting-time-out.nl
- **Mrs. Marietje Lemmens**, Stichting Time Out, www.stichting-time-out.nl

The persons above formed the Dutch users delegation and were also representing the European Network Users and Survivors of Psychiatry in the participation on the self-organized user-based Workshop "Mental Health Care" at January 22nd 2007 at the World Social Forum 2007 in Nairobi Kenya.

Visiting psychiatric hospitals in Uganda and Tanzania, and meeting user groups in Uganda, Kenya and Tanzania showed me the true relations between psychiatry and poverty (or social economic chances), which made me realize very clearly that besides poverty, also culture, religion and politics are main themes related to the development of a good quality of psychiatric care, both in Europe and in Africa.
I have adjusted my theories on the horrific situation inside East European psychiatry, which is not only a matter of poverty, but appears in my opinion to be heavily political.

Summary on psychiatry per region:

i. West European psychiatry is distorted by neoliberalism and creatability.
Our impersonal, neoliberal West European world is ruled by the massive concerns, which are chasing **profits** and pursuing bureaucracy, leaving emotions out of decisions. Psychiatric patients suffer emotionally due to certain circumstances. West European psychiatry often features **'standardization into bodices',** with group activity schemes which are meant to train normal behaviour (drill instructions), including also a very narrow medical approach of the **inner soul as a range of chemical balances,** and technology claims to provide a cure for everything, as if all features are for sale. The profit oriented pharmaceutical industry has pushed these limits further and further, and nowadays being perfect and happy seems to be an own responsibility, which is achievable by getting your features repaired by pharmaceutical drugs or plastic surgery etc. Our society tends to **reject any imperfect features** of goods and also humans, with eg small breasts, wrinkles or grief, and our society seems to be convinced that **"we humans, with our technology are in control of all on Earth"**.

- But the complex human nature is more than bio-technology and social issues can not be replaced by pharmacy.
- **Mental health care should regard for the social life of the patient.**

ii. African psychiatry is suffering from poverty and general ignorance.
Mental health problems in Africa are generally seen as a **punishment or possession** from the spiritual world. Average Africans have never heard of psychiatry, they just **don't know** there is such help anywhere. Instead of psychiatry, patients often go to a

witchdoctor for rituals, e.g. (hostile) exorcisms. Only worst case patients reach psychiatry if they are lucky, because another problem is that most of the African population can not afford the transport to and from such a rare hospital if necessary.
Inside psychiatry the people were not dying in masses. There was food and drinkable water. It was a kind of **very poor** training camp with social intentions. Pedagogical violence is used, but the personnel does also show compassion towards the patients. They lack almost all means for any activities. In general, the Africans are using the cheapest treatments, based on our European **old-fashioned** repressive view on treatment, because their Nursery schools are using our old-fashioned psychiatry handbooks.

- African psychiatry needs investment: personnel, beds, activity means etc.
- **African psychiatry also needs to be included in developing better approaches of mental health care.** Africa offers us special experience on running mental hospitals without a history of political abuse, based on hospitality and a new temporary community life.

iii. In East European psychiatry, patients often don't survive the mental hospitals. This is the worst case of all three regions. Patients die in psychiatry due to severe **neglect (cold, malnutricion, bad hygiene, infections), wrong treatments (abuse of medication, ECT, and horrific and painful compulsory methods such as cage beds, shrink jackets and other torturous methods)**. At some institutions about 50% of the patients die within the first year of admission. At admission the patients are generally disowned from their property, and abandoned and forgotten by their relatives and most of them **never return to society again**.
This horror is not only due to poverty. In East Africa most of the patients survived.

In my analysis, this horrific situation in East European psychiatry is (as usual) caused by fear, related to several stigmas and taboos, such as: At first, the theories on **possession** (which includes fear, taboo and hostile exorcisms), and second, the lack of social security, which implicates **the threat of unemployment and dependence** when one speaks about personal sufferance.
Third, because patients don't fully assimilate, they are seen as dissidents, whom are feared, due to sharp examples in the past under the Stalinist regime (the Holocaust). After World War 2 a lot of East European countries were not free to develop due to other dictatorships, and these countries are in a way stuck with a harmful system, what is falsely named mental health care, although it was **designed to oppress and eliminate political opponents**.

- **East European psychiatry needs our help in breaking the taboo on psychiatry**. Since there are hardly any survivors nor user organizations in East Europe.

It seems that the Psychiatric Institution itself in general (worldwide), has never finished the history of ignorance and fear, resulting in taboo and neglect, enabling structural under investment, human rights violations and political abuse, which have resulted in a poor quality of mental health care and continuing misperceptions on mental health and mental health care.

The fear, stigmas and taboo on psychiatry, and the old-fashioned, ineffective and sometimes deadly treatments, combined with structural poverty of the patients (leaving patients with only little ability to participate), may lead to a world where **injustices** may rule everything, while the social victims are discarded from daily life by diagnosing their behaviour and perception as delusional and not realistic, and leaving those who represent our **society's general conscience** at the bottom of society.

We must care for feelings and care for one another.
It is now time to join the efforts to improve mental health care.
Another world really is possible.

IV Declaration: Mental Health : a social problem

We consider mental health as a cultural, spiritual, religious, medical, political and most of all **a social issue of all humans**.

1. **Patients are human beings with human feelings,** and they can feel pain, rejection, fear, grief, abandonment, just like anyone, at any time. And being forced (e.g. at a forced treatment) causes feelings of oppression, fear and loneliness. **Patients can also feel happiness, joy, compassion, love, friendship, humor, etc. which is certainly increasing mental health and the quality of one's life.**

2. Good mental health is about happiness and satisfaction, and maybe it is to be called **"mental wealth",** when one is able to continue his/her life happily without psychic problems. Some people don't have such "mental wealth", they suffer from their soul.

3. Psychiatric problems are on the patients mind or soul, and are mainly caused by social struggles in any form**,** from abuse, neglect and violence to social injustices, relationships, power imbalances, loss and unemployment, poor neighbourhoods, lack of chances or difficulties in expressing oneself etc. So mental problems mainly have **a social cause or trigger**.

4. A psychiatric problem disturbs the relationships of the patient and his/her environment, which leads to a **social problem or inconvenience**, and then mental health care is needed. So a mental problem is a social problem.

5. Professional Mental health care should aim for recovery and therefore regard and **focus on the social aspects of (the life of) the patient.** This means that treatments should be based on social educative activities and developing social skills. (so no breaking up of good relations, no exclusion and abandonment, no inequality and abuse of force, but equal relations and dialogue, like in 'normal' society)

6. The knowledge on recognizing and understanding mental health problems has to be promoted actively worldwide, **to renew traditional perceptions on these social struggles, and to develop a culture of socially good mental health care with dignity for the patients.**

So our priorities for another psychiatry are:
- **Combat stigma and fear**
- **Promote dignity and human rights for users and survivors of psychiatry**
- **Stop poverty**
- **Stop war, abuse and grief**
- **Accept and cope with imperfections of life**
- **Include and take care of one another**

Another world really is possible!

1. Going to the World Social Forum 2007 in Nairobi, Kenya

"Another World is Possible, Karibu to WSF Nairobi 2007" is the slogan of the WSF 2007, which means: "Another World is Possible, Welcome to WSF Nairobi 2007".

The 7th edition of the World Social Forum (WSF) brings the world to Africa as activists, social movements, networks, coalitions and other progressive forces from Asia-Pacific, Latin America, the Caribbean, North America, Europe and all corners of the African continent converge in Nairobi, Kenya for five days of cultural resistance and celebration; panels, workshops, symposia, processions, film nights and much much more; beginning on the 20th of January and wrapping up on the 25th of January 2007.

The World Social Forum is characterized by plurality and diversity, is non-confessional, non-governmental and non-party. It proposes to facilitate decentralized coordination and networking among organizations engaged in concrete action towards building another world, at any level from the local to the international, but it does not intend to be a body representing world civil society. The World Social Forum is not a group nor an organization.

The World Social Forum is an open meeting place where social movements, networks, NGOs and other civil society organizations opposed to neo-liberalism and a world dominated by capital or by any form of imperialism come together to pursue their thinking, to debate ideas democratically, for formulate proposals, share their experiences freely and network for effective action. Since the first world encounter in 2001, it has taken the form of a permanent world process seeking and building alternatives to neo-liberal policies. This definition is in its Charter of Principles, the WSF's guiding document.

The main venue for the World Social Forum 2007 was the Moi International Sports Centre in Kasarani - about 10 km. north east of the Central Business District of Nairobi. Opening and closing ceremonies were held at Uhuru Park in downtown Nairobi.

For information on the WSF visit http://www.wsf2007.org

1.1 Introducing user movements

The following user movements are actively participating in Social Forum movements:

- **Actiegroep Tekeer tegen de isoleer!** (action group Beat isolation cells!),
- **Clienten Centrum Limburg,** (User Centre of Limburg, district),
- **Stichting Time Out** (self helping women group Time Out)

These above user movements are based in the Netherlands, and their main activities are to support the *users and survivors of psychiatry* in the Netherlands and also to raise (international) awareness and solidarity towards people with mental problems.

Preceding this participation on the WSF, the same 3 organizations participated at the European Social Forum (ESF) 2006 in Athens, Greece, and at the Dutch Social Forum (NSF) in 2004 Amsterdam and 2006 Nijmegen.

The spokespeople of Actiegroep Tekeer tegen de isoleer!, Clienten Centrum Limburg and Stichting Time Out; resp. Jolijn Santegoeds, Jan Verhaegh and Marietje Lemmens decided to spend their private savings, to organize a workshop at the 7th World Social Forum about mental health care and patients rights, which we believe is necessary to do.

The Workshop, called Mental Health Care, took place at Monday January 22nd from 14.30 to 17.00 hours, at the WSF at Moi International Sports Centre, Kasarani, Nairobi.

1.2 Our aims and goals for going to Africa

On the activist assembly called World Social Forum, we intended to (1) expand our networks on patient rights and to (2) receive more views and opinions on psychiatry, and to actually (3) meet other users from Africa.

By putting the Workshop Mental Health Care on the WSF programme (ON THE AGENDA), we wanted to (4) make sure that psychiatry and its neglected patients rights are not forgotten. It is important to talk about psychiatry within the movement of Social Forums, which originates the modern reflections of freedom.

We wanted to (5) talk about patient rights violations, and to (6) lift the taboo, and to (7) share information, to (8) learn from each other how to deal with these problems, to (9) expand our views on the cause and the development of patient rights violations. Maybe we can (10) **analyse a solution**.

We did not only go to Africa for the WSF participation by a workshop, we also wanted to see the country, and especially (11) **find out how people with mental problems live and survive in East Africa**. So we also wanted to (12) see culture, and to meet users, and (13) discuss on perceptions on mental health. So we planned to go to East Africa for several weeks.

Some say: Africa now, is just like what Europe was, a 200 years back in history. So maybe going to Africa is like wandering in history, and maybe it will give us (14) a clear view on what is really going on.
Maybe afterwards I can (15) answer my big question, which is:

- **Why is force used on innocent patients worldwide, whom are suffering and need loving guidance?**

1.3 Preparation

We are connected to the European Network of Users and Survivors of Psychiatry (**ENUSP**, see also at www.enusp.org) and we were linking up with African Users by the World Network of Users and Survivors of Psychiatry, (**WNUSP**, www.wnusp.org) by sending an announcement of our participation on the WSF 2007 by the Internet. In this way we contacted African user organizations.

We were very happy to find out about the existence of African User movements and we were happy to link up with African Users, such as:

- **PANUSP** (Pan African Network of Users and Survivors of Psychiatry)
- **TUSPO** (Tanzania Users and Survivors of Psychiatry Organization)

Whom showed great hospitality to us and made the necessary contacts and arrangements for our journey through East Africa. We also did fundraising in the Netherlands to enable participation from African Users on the World Social Forum.

Jan Verhaegh and Marietje Lemmens were able to go to Africa to participate in this world social forum, because the mother of Jan passed away last year, and Jan had had a **heritage**, which he decided to dedicate to their users-efforts on improving psychiatry.
I myself, Jolijn Santegoeds, have won a **prize** of 2,500 euro with my graduation report on measuring sustainability of energy-supply, which enabled me to co-organize our trip and WSF participation.

Our thanks go to **X-Y solidarity fund** (www.x-y.org) **, PEACE Consumer organization** (www.peaceconsumer.org) **and other sponsors** for their **donations** to enable the transport, accommodation and participation of the 12 headed African User Delegation to the Wold Social Forum in Nairobi. Thanks to these donations we have had a successful meeting between European and African Users, which you can read about in this report.

2. Point of Departure : European psychiatry

We are Europeans (from the Netherlands), so in our efforts we try to consider all of Europe (the European Union). The activities of the Dutch delegation are based in Netherlands, but the situation of psychiatry is not the same throughout Europe.
Mental Health is attached to several economic, social and cultural problems and there are huge differences between Western and Eastern Europe.

2.1 East-West European overview

- **First world countries in Western Europe** are industrialized, capitalistic, and politically rather safe. The accessibility of health care facilities is very good, by decent infrastructures and good spreading of facilities, with lots of transporting means and communication. The quality of medical health care is very good, but **the average quality of Mental Health Care is not satisfying in West Europe,** with impersonal standardized treatments and lots of forceful measures. (see 2.2 West Europe). But still, in most Western European Countries, the users of mental health care generally **do get out of mental health institutions,** whether recovered from their crisis or just managed to get out in a short or a long term, and eventually they are able to participate in daily life of society again, sometimes with continuing medication or therapy or living in a community-based home. There is an increasing number of specialized facilities to support re-integration, employment, advocacy and inclusion of former users of mental health care in Western Europe.
- **In Second world countries in Eastern Europe** people are suffering much more from poverty, wealth differences and political power imbalances. The **quality of mental health care is extremely bad in Eastern Europe,** with deaths, diseases, abuse, ignorance, annoyance, prostitution etc. inside the institutions. (see 2.3 East Europe). Commonly, East European **patients/users/survivors are not seen at all** in society. Once they are admitted they are often 'forgotten' by their relatives, generally they don't return for the rest of their lives.

2.2 West Europe

2.2.1 West European culture

The countries in Western Europe are industrialized, capitalistic, and politically rather safe. Ratio and numbers are more valued than emotions and intuition. A lot of emotions are not shown in public (Eg 'male don't cry', be 'professional') and measurability is overrated. People suffer from impersonal systems (eg housing service) where they are treated like they are numbers on a row, and sympathy or exceptions are 'not in the system'. And finally perfectionism makes people strive to insane norms. (also see 2.2.2 West European psychiatry)
West European families are rather small, about 2 or 4 kids in a monogamy marriage. About 30% gets divorced. Houses are made of stone and all kinds of luxury are for sale.
A lot of psychiatric patients are obviously having a kind of problem and by that reason the patients are not accepted and **excluded from society**, regularly unemployed, living from welfare, suffering from annoyance because they can not fully participate (due to relative poverty and exclusion). Patients' opinions are often not taken very seriously into accounts, because they are **stigmatized as 'wrong', 'delusional', 'unreliable', 'dangerous', 'defect' and 'useless'**. Patients do often have a secondary position in West European society.

2.2.2 West European psychiatry

In the richer countries of Europe (First World Countries) the mental health care related problems are mainly cultural (with neoliberal perspectives), and less economic or religious. Commonly the citizens of West Europe have access to all kinds of health care facilities. Mental Health Facilities in rich countries are spread throughout the country and often look good, well painted and are put in a green surrounding, but often far away from 'normal society'.

In general, the care professionals in West European psychiatry are **improving their practices nowadays**.

The professionals were using an 'professional' and clean **impersonal approach** with standardized, universal 'equal' rules ('drill instructions') and medication for every diagnosis, leaving **no room for individual exceptions.** And lots of forceful measures were used for handling the patients and pushing through a certain behaviour. In general two 'Bodices' are responsible for the view on psychiatry in Western Europe.

2.2.2 A The old bodice of scheduled life

Life scheduling and forceful measures are old-fashioned practices, based on the idea that patients who show different behaviour than others, should be **trained to behave (A1)** themselves. In the past, mental health care has established **group-activity-schedules** for patients daily life, for example: to get up at 7, eat at 8, go to creative therapy on 9. When the patient could follow this scheme, he/she would be cured enough to go back to society. **If he/she does not follow the scheme, he will be forced or punished**. (eg with loss of freedom, isolation cells, extra medication etc.)

It is a well known fact that the patients social background is highly determining the mental state of health. For example child abuse, sexual abuse, traumatising events, loss of job or loss of friends, drug abuse etc. are all social circumstances which can lead to an outburst of psychic problems. Coping with these problems is a very personal process.

However, the group-activity-scheduling does not take any regard on the patients feelings. For example, the patient has to be creative at 9 am. In this way, the patients get drill-instructions, to fit into **a standardised daily life scheme** (a 'bodice'). There is no time to communicate on personal topics, because of the minimal amount of personnel. In general scheduling-treatment, the main attention the patients get, is the dictation of the rules of the institution. And when patients do not behave in accordance with the rules, they will be forced to do so. In the year 2006, a lot of psychiatric patients still have to become introvert by a mental-health-paralysing treatment, **adapting to the bodice**, otherwise they will not be dismissed from the mental health institutions.

The reason for this scheduling treatment is mainly, that mental health care institutions **cope with poverty:** a lack of personnel, lack of facilities and basically, a lack of investment and interests, which leads to a poor standard of mental health care. A group-activity-scheme is used as an easy way to claim the rules, and to keep the patients restricted, with the purpose underneath **to maintain order (A2)** inside the institutions without high costs, for example low expenses on personnel, and materializing mental health care. An other reason why group-activity-schemes are still widely used is the lack of experience on recovering psychiatric problems. Patients are kept busy with activities on a random basis, based on an **old-fashioned view on recovery**. ('the old Bodice')

2.2.2 B The new Bodice of perfection

In Western Europe, besides 'the old Bodice of scheduled life' also lays 'a new Bodice of perfection' which is a main cultural problem. The main theme is the definition of mental health, which is polluted by what we intend to call the neoliberal explanation of **'wealth'**, which makes the population unwanting to accept imperfective features of themselves or their surroundings. This neoliberal 'fashionable perfection' is chasing and exploiting **industrialized human features**, with various products for mood-improvements, breast-increasements and anti-aging etc. and this all leads to a stigma or even a responsibility which is based on not accepting any so-called imperfect features nor bad feelings of a human being, and that human beings are fully controllable, improvable and reproducible. But commonly, nobody is perfect and the complex human nature should be appreciated as a unique personal gift, and eventually we all get older.
Nowadays **the human differences, limitations and excesses** are not very much accepted, and research is done to control the human mind.

The **'perfection' view (B1)**, combined with the **capitalistic marketing motives** (neoliberalism), which makes concerns willing to conquer and broaden every inch of the market, leads to a society where more and more diseases are literally established (DSM IV). In this way, psycho oriented industry is creating a **market (B2)** for itself, and the interests of the market distorts to do what is best for us, the people, the patients.

Every unwanted feature of being different or feeling unhappy is nowadays analysed as a **chemical balancing disorder (B3)** (such as depression), which is a narrow view and also a very dangerous trend. Falling in love, grief and homosexuality also happen to be certain neurochemical processes in the brain of the human, but it is very dangerous to label these processes as illnesses.

Mentally caused chemical balancing disorders don't exist, because this would mean that someone's feelings would be 'not true' or 'wrong', (which is impossible, because feelings are a personal experience which can not be judged by another person). **Mental health is a social issue, with a social cause and social features** (also see 5. Declaration). It is no neurochemical, biological nor a medical based issue, but it is a social problem. But it is likely to assume that mental features do reflect on neurochemical balances in the brain. Medication can therefore be used to oppress symptoms and withdraw features, but **medication on itself is commonly not the cure for social inconveniences.**

The pharmaceutical drugs (B2/B3) are nowadays also for sale on commercial markets, and show us that we all have a choice or even a responsibility to be perfectly balanced and standardized, with none of the unwanted features and feelings**.** The pharmaceutical companies are striving to sell as much as they can, spending millions on promotional activities such as TV-commercials etc, and offering bonuses and rewards for psychiatrists who are prescribing their drugs. And to make optimal profits out of our 'diseases and sufferance', much efforts are done on the sales department, instead of on research and development. Also forceful compulsory medication is used more and more, which is mainly based on withdrawing the social inconvenience with medical repression.

Compulsory treatment for increasing mental health (B4) is a genuine paradox; increasing happiness and wellbeing ; by forceful obligations and violations of the right of self-determination. These treatments probably originate in 'the old bodice of scheduled life' and are in fact superseded, but forceful treatments are still widely used, and the terminology is an example of the side-effects of the psychiatric jargon.

The psychiatric jargon (B5) is very complex in its nature, mainly because it disguises all it really refers to. This jargon is in fact increasing the stigma, creating fear, misunderstanding and exclusion, instead of stimulating inclusion, support and understanding. This jargon is so mysterious, that it **can also be used to overrule legislations and human intuition**.

2.2.3 West European patients

Patients often feel lonely, abandoned and misunderstood. The main cause of death inside Western institutions is **suicide**. Patients state they suffer from loneliness, exclusion, and annoyance due to a lack of social participation, and an impersonal approach, forceful measures and violations of their human dignity and 'the Bodices' inside mental health care.

But nevertheless, in Western Europe, **most of the patients do get out** of the mental health care facilities after a shorter or longer period. Patients whether recovered from their crisis or just managed to get out. Eventually they are able to participate in daily life of society again, sometimes with continuing medication or therapy or living in a community-based home. **There is an increasing number of specialized facilities to support re-integration, employment, advocacy and inclusion of former users of mental health care in Western Europe.**

2.2.3 West Europe summary

- Generally, the quality of mental health care in West Europe is not satisfying.
- Patients are **stigmatized and secondary** in society, due to neoliberal explanations of wealth and perfectionism.
- Patients suffer from the **impersonal approach** (without emotion) and the **Bodices** (standardizing everything), and the use of **forceful measures** (without permission) which the patients refer to as **traumatizing.**
- **The pharmaceutical industry** takes advantage (profits) of the unclear system of psychiatry and is analysing every human feature as a neurochemical balance to be able to measure deviation as an illness, and to create a homogenous society with their medication.
- In this way the generally scaring 'illnesses' don't have to be faced, the true . of handling mental problems is delayed again and on the background the **traditional exclusion** continues (see 4.5 Coherence: Fear).

2.2.4 Our Dutch initiatives

We are Users and Survivors of Psychiatry and our views and involvements on psychiatry and patient rights are all due to our personal histories, with unpleasant and wrong treatments, with forceful measures such as isolation cells and medication. And we all discovered that **coping with mental problems is a social issue** where loving guidance and personal solutions are needed, instead of hostile standardized impersonal treatments.

In the Netherlands, we protest against violations of patients rights, by offering advocacy and support to the patients, and by increasing overall awareness of rights and equality and to stop torturous treatments by starting user groups, websites, self helping activities, promoting our initiatives by informative stalls, or activities such as, collecting signatures and handing out leaflets, street marches, exhibitions, media interviews and participating at Social Forums etc.

For more information on our points of view:

- See Chapter 5. Declaration

For information on our activities visit our websites:

- Stichting Time Out & Clienten Centrum Limburg: www.stichting-time-out.nl
- Actiegroep Tekeer tegen de isoleer! / Stichting Mind Rights: www.mindrights.org

2.3 East Europe

East Europe differs a lot from Western Europe. We could not find any client organization in Greece, when we were there for one week in May 2006, when we were participating at the European Social Forum 2006. We spoke to 3 psychiatrists and several other related persons of psychiatry in Greece, and they agreed: users in Greece are not organized. There is no organization for the rights of the patients in Greece, in Europe.

We do have some information as a result of our participation on the European Social Forum, May 5th 2006 in Athens, Greece. Such as the **report: Red Paper on improving mental health care in European member states- declaration of patient organizations** was written by this author, Miss. Jolijn Santegoeds and others, as an answering document on the European Commision's proposals in their Green paper. The Red Paper is mentioned on the official European Union website.
Mr. Jan Verhaegh made a field study journey through Eastern Europe which he describes in his **report Not on the Agenda** (2004, available on the following websites: www.stichting-time-out.org , www.enusp.org, www.mindrights.org see 7. Information).

The average situation of psychiatry in Eastern Europe is very bad, with features such as **no, or hardly any user movements** and **poverty, neglect, abuse and deaths.** In these poor countries there still is a high level of **taboo and stigma on mental health**.

We don't have very much information on East European psychiatry, especially because the East European users generally lack a voice. But still we can make an analysis of the facts we do know about Eastern European psychiatry and culture.
My first perceptions and a random analysis resulted in the theory that these mistreatments were mainly due to severe poverty. But after visiting Africa I needed some new theories (see 4.4 Theories on Eastern Europe: Dissident's prison).

2.3.1 East European culture

In countries in Eastern Europe people are suffering much more from poverty, wealth differences, political power imbalances and a low economic profile, than in Western Europe. The climate has a harsh severe winter and a hot summer. Houses are made of wood and stone. Unemployment rates are high and poverty is a real issue of the people. Food can be scarce. Heating can be too expensive. People are generally busy with surviving. Family and religion (esp. Roman catholic) are strong factors in East European society. **Users and survivors of psychiatry are not seen in society.**

In the Netherlands, we sometimes receive some news related to East European psychiatry in **the newspapers**. A news article (2006) from Italy was about a 54 year old, retarded woman, who had spend 36 years locked up in a bathroom, with only one dog-meal a day, washed weekly with cold water. Her mother did not want to show her to society or take her outside. In Greece similar things happen, and probably also in a lot more countries. And on February 20th 2007, two weeks after we returned from East Africa. An article in the Dutch newspaper (NRC) reminded us of the existence of religious perceptions in Eastern Europe. The article stated that a Romanian Priest got 14 years of jail because he had done a deadly exorcism, when he tied a nun onto a cross and left her there for 3 days, because, he stated "she was possessed by the devil" . The nun died of exhaustion, pain, dehydration and hunger. A documentary on TV (2006) was about a group of about 25 patients from Serbia or Croatia or Yugoslavia (Central Europe), who were taken to Hungary during the war. The patients were installed in a cloister ward and 14 years after the war still no one had come to pick them up or visit them. They were completely forgotten for over 14 years. A nun brought them food everyday and their families said in response they 'assumed they were dead'. In fact the families had never checked where their relatives were.

- **Having a mental problem in East Europe results in rejection by society, for life.**

2.3.2 East European psychiatry

In these poor countries there still is a high level of taboo and stigma on mental health.
The average **quality of mental health care is extremely bad in Eastern Europe.**
Psychiatric patients are **dying inside institutions**, This is a severe problem, and it is **violating every core right of the patients and the people.**
In some institutions (eg in Romania) about **50% of the admitted patients die within the first year of their admission**, due to malnutrition and lack of hygiene, severe neglect, abuse, wrong use of medication and therapies (ECT, fixation, violence etc.)
In some institutions in Central Europe the women patients of the hospital are sexually exploited for improvement of the financial situation of the hospital (!) with acknowledgements from the staff. **Poverty, violence and abuse is a huge problem**. There seems to be no control on these institutions.

- The **abuse and dying of the patients (E1)** (maybe even genocide) may be one of the contributing causes for the absence of client networks and organizations of users and survivors of psychiatry in Eastern Europe.

Reports of psychiatry in Eastern Europe are hard to find.
We know the torturous old-fashioned attributes and instruments (eg shrink jackets, straight jackets, cage beds, chains, lobotomy, ECT without anaesthesia) which in our Western culture is forbidden and such attributes belong to our historical museums. But these methods designed to destroy identities are probably still used in Eastern Europe, Russia, or China etc., and these methods are probably referred to as 'mental health therapy'. It may be due to our history that these methods are still used (see 4.4 Theories on Eastern Europe: Dissident's prison)

- These **frightening methods (E2)** are feeding fear and taboo, and may be another contributing cause for the absence of client networks and organizations of users and survivors of psychiatry in Eastern Europe.

2.3.2 East European patients

We don't have much information from the patients. Commonly East European users and survivors are **not seen at all** in society. Once they are admitted in a hospital they are 'forgotten' by their relatives, and generally **they don't return** for the rest of their lives.

Patient networks often can not, or hardly, exist in these poor countries with high unemployment and **low social security (E3)** (for example in Greece), because in such a social need people do not speak about their weaknesses, due to the threat of unemployment, social exclusion and dependency **(they fear to be 'stigmatized out').**
So there is a high level of **taboo**, and therefore also (too) little knowledge on patients' experiences.

- The **general exclusion by society (E4)** may be a third reason for the absence of client networks

2.3.4 East European psychiatry summary

- East European users are generally **not seen** in society, and often **don't return** from their admission in (sometimes deadly) mental health care institutions.
- Recovered patients (if returned) and their family **don't speak out**, because they fear a socially isolated and dependant position or religious perceptions (**Stigma**).
- In (some) countries in Eastern Europe mental health care is characterized by **deathly institutions (E1) with frightening methods** (E2) and poverty, malnutrition, lack of hygiene, severe neglect, diseases, wrong use of medication and therapies, abuse, violence, ignorance, and annoyance and prostitution etc. inside the institutions.

After going to Africa I also expanded my view on Eastern Europe, see 4 Conclusion and 4.4 Theories on Eastern Europe: Dissident's prison

3. Meeting East African psychiatry

3.1 The journey

We went to East Africa from 7th of January 2007 until the 7th of February 2007, which is 31 days. It was European wintertime, and African summertime (dry season) with average temperatures of 25-35 °C. We went to Uganda, Kenya and Tanzania, which are mainly covering the fertile zones around Lake Victoria. Only when we went inlands in Tanzania we experienced real heat (about 40°C. in Dar Es Salaam) and we saw areas that suffer from extreme drought (Dodoma).
We went to the following cities to visit mental health related facilities:

- Kampala, Uganda (January 8-18)
- Nairobi, Kenya (January 19-26)
- Dar Es Salaam, Tanzania (January 27-28)
- Dodoma, Tanzania (January 29-31)
- Arusha, Tanzania (February 1-3)

And back to Kampala, Uganda (February 3-6)

3.1.1 Kampala - Uganda

In Kampala we were seeing and experiencing African culture for the first time in our lives. We visited several places which are related to mental issues, such as:

- **Mental Health Uganda (MHU), Kampala Uganda** is a branche organization on Mental health in Uganda, owned by users, sharing their office with **PANUSP:** Pan African Network of Users and Survivors of Psychiatry.
  Mr. Julius Lutaakome Kayiira and *Mr Lukwago Godfrey* from MHU were telling us about the average situation of (East) Africa, with severe poverty, which keeps mental health facilities out of reach for the ordinary patients. And about common traditional tribes with *witchdoctors* doing ritual exorcisms, with sacrifices, chasing and hurting to "scare away" the evil spirits and possessive forces. MHU promotes and guards patients rights and quality of mental health care in policy and practice.
- **Butabika Hospital, Kampala Uganda** is the one and only psychiatric hospital of Uganda. We were welcomed by the commissioner and guided around the hospital by a psychiatric male nurse.
  - Butabika Hospital looks freshly re-constructed, but most of the patients asked us for food or money or to take them out of there (see 3.3.1 Butabika hospital)
- **The Comforter's Clubhouse (users meeting), Kampala Uganda** is a clubhouse near Kampala with a weekly gathering of users and survivors of psychiatry. *Mrs Sandra*, in charge of the Comforter's Clubhouse, took us there.
  - Users told us about the stigma and trouble of not being welcome in society. E.g. they are still looking for a buyer of their banana crafts, fruits and bricks, but it is hard to find any. They are rejected and abandoned, but the clubhouse is their new community.
- **Sanyu Babies' Home** and **National Children's Ministry of Uganda (NACMU), Kampala Uganda** are homes for abandoned children and babies.
  - A lot of babies and little children are 'thrown away', due to poverty and an inability to take care of these babies e.g. teenage pregnancies, loss of family (orphans) but also the stigmas on disabilities etc. lead to a huge number of abandoned childs and babies. There are lots of such homes in Kampala. *NACMU* is a children's home meeting European Standards: not as poor as the other homes.
- **Torrembe House, Kampala Uganda** is a teenage pregnancy centre for teenage pregnant girls. Run by the Christian organization *Youth for Christ*.
  - Teenage pregnant girls are often rejected by their community, because of strong religious convictions and judgements of 'wrong behaviour'. In this way the girls usually have to quit school and leave their homes, because they often get harassed and rejected. In the Christian Pregnancy Centre the young girl gets prepared for giving birth (abortion is illegal and not considered) and she gets support for building up her life as a young mother, by learning to take care of herself and the baby.

- All nights in Kampala we slept at **the Comforter's Centre, Kampala Uganda,** a Guesthouse run by *Miss. Veronica Nakyewe*. In the near future this guesthouse will be used to host pregnant women, but now mainly consultancy takes place.

3.1.2 Nairobi - Kenya

After Uganda, we went to Nairobi in Kenya by buss to participate at the 5 day WSF-gathering.

- **World Social Forum (users meeting), Nairobi Kenya** : international 5 day conference for activists on a better world. (3.4 Workshop Mental Health Care)
  - With a workshop including survivor testimonies on wrong treatments by witchdoctors and institutions, and statements on improvement.

3.1.3 Dar Es Salaam, Dodoma and Arusha - Tanzania

After the WSF, we went south by buss to Tanzania with *Mr. Eliezer Robert Mdakilwa* from TUSPO, to meet Tanzanian users and survivors in Dar Es Salaam and to visit a saddening neglected hospital in Dodoma.

- **TUSPO (users meeting), Dar Es Salaam Tanzania** : users meeting at Eliezer's place.
  - about 10 people from the neighbourhood came to the meeting and told us about the mental problems they experienced in their lives, such as confusion, depression and sexual abuse. (see 3.2 East African psychiatry)
- **Mirembe Hospital, Dodoma Tanzania** : psychiatric hospital , where we were welcomed by *Dr Jennings Nkya* (administrator) and guided around by two male nurses *Mr. John G Lyimo* (patron Isanga) and *Mr Balthazar Hgomyani* (social worker), meeting a nice female social worker *Mrs. Elizabeth Emanuel Mwari* who also talked and walked with us.
  - At Mirembe Hospital we witnessed a very bad situation, with a lack of dignity for the patients. (see 3.3.2 Mirembe Hospital, Dodoma Tanzania)

After visiting Mirembe Hospital in Dodoma, we wanted to go west to Rwanda, but the roads (and a village) were vanished by severe rainfall, so buss traffic going west was impossible, and there were no affordable international flights to Kigali, Rwanda departing near Dodoma. So we changed our plans and we took a buss north to Arusha, Tanzania, what was on the way heading back to Kampala via Nairobi.
In Arusha we discovered something interesting to compensate on not going to Rwanda, and we visited:

- **Rwanda Tribunal AICC, Arusha Tanzania** international court of Rwanda war crimes
  - traumatizing events, such as the Rwanda war and the brutal genocide are causing collective mental problems. Special mental support to these (former) warzones is needed.

Then after all these impressive visits, we went on a one day **Safari to Lake Manyara**, to ease our minds and to enjoy Africa's beauty. It was very relaxing.
After that we headed back to Kampala by airplane and on our last day we visited:

- **Kireka home, Kampala Uganda**, a place for children with special educational needs (disabled), where *Miss Tara,* our Canadian home-mate, is volunteering.
  - There we saw a young disabled girl, who had been locked up for several years from birth on. She had never learned to communicate or move herself. It is a result of taboo and stigma.

After all these visits we had a rather clear view on what it is like to have mental problems in Africa.

3.2 East African psychiatry

Psychiatry is always connected to culture and economic aspects of the country.

3.2.1 East African culture

Poverty of the African continent means a lot of deaths due to hunger, infections and diseases, and a general lack of system, with bad infrastructures and little facilities, with lacks of transport and communication. This leads to a shattered organization of the country (and the continent).
One of the results is a serious gap on the people's knowledge on illnesses and possibilities to reach a hospital. People with mental health problems in the villages often are not recognized and don't reach any hospital at all. They stay at home and need to survive in their own community*

* **The lack of knowledge on mental illnesses** in the traditional communities (in villages) has, fed with fear, resulted in theories of **possession by evil spirits** and this is often resulting in hostile treatments (such as exorcisms) varying from e.g. sacrifices, ritual bondage and herbal medicines, to violent rituals, confinement (and hiding out of shame, taboo) and even homicide in some tribes. Without any other knowledge or guidance on mental problems these exorcisms will remain the only resort in these communities for someone with mental problems.
  The African Users/Survivors of Psychiatry state that the stigma of possession is very severe and exorcisms are experienced by patients as **violent and hostile**.

Within different tribes there are a lot of differences and **variety of rules**. In some tribes one man can marry five women and easily have about 30 kids. Some tribes prefer monogamy.
It is common in East Africa to bring children up with some **pedagogical violence**, and so this also happens on psychiatric patients to educate them.
In some tribes like the Maasaai abandoning the maternal home (eg for going to school) is contrary to the rules, and kids need to stay at home.
The Maasaai also seem to **kill all of their disabled and mental patients**, because the patients can not take care of themselves.
I think in our country, the Netherlands, we would call e.g. the Maasaai tribe uncivilized.

3.2.1 Typical East African mental problems

Poverty of the citizens and traditional cultures lead to special mental health problems in Africa, such as:

- **Confusion** due to a lack of education, in the third industrializing world.
- **Depression** due to poor livelihoods, sickness and deaths and lack of perspectives for the next generation.
- **Fear of the unknown**
- **Women, youth and children** in a secondary position, dominated by the Man of the House.
- **Trauma's of war and violence** in (former) war zones with collective distrust and trauma's of (former) power imbalances, with not any form of mental health care.

These problems above are the outcomes of the user meeting of TUSPO in Tanzania, January 27th 2007, and we consider these themes very likely to assume.

Officially **schizophrenia and epilepsy** are the most common mental health problem, according to the hospital's documents. But we know that schizophrenia and epilepsy do show very severe and obvious symptoms, and we assume that problems first need to get completely out of control before someone gets into African mental health care (**only "worst cases", which means in the "worst stage" of their problems**). Most people, with less obvious symptoms, or in an early stage, do not reach the mental health facilities/hospitals, which is due to **lack of knowledge and general poverty**.

3.3 East African psychiatric hospitals

Poverty of the country results in poverty of the hospitals, which means lacks and shortages, such as insufficient personnel or improper facilities or no medication or transport, which results again in **a low quality of care** and also **no improvement of accessibility.**

3.3.1 Butabika Hospital, Kampala Uganda

We visited Butabika Hospital in Kampala, Uganda and the situation was not as bad as we had expected. Mental Health in Uganda is best developed from all Africa and mental health is in the top 5 of key issues on national health care and policy, and mental health care gets full priority, because nothing can develop without mental health.

Butabika Hospital was built between 1950 and 1956 to look after dangerous patients. In that period mental health was understood better due to the recommendations from the WHO, which stated that patients need to go back into their community. The vision of Butabika is that mental health care should be close to the community and that it is better to have several small facilities than one big institution, and they are realizing mental health care units in every district of Uganda. Butabika hospital can host about a 1000 patients, but now has about 700 inpatients, and a 100 outpatients a day. Butabika hospital has also completed some specialized superservices, such as child/adolescent, drugs and alcohol, psychotrauma and war, forensic, rehabilitation and a mental health community project to avoid relapses. The hospital is run by the government, which pay for the basic needs, such as housing, food, medication etc. and the patients pay nothing. Butabika cooperates with MHU on developing expertise.

Patients wear green uniforms, a dark green uniform means one is an inpatient of the admission or closed ward, a bright green striped uniform means continuation patient. Outpatients and staff wear regular clothes. There are only a few occupational therapies, who are related to occupations in the outside community, such as creativity (banana arts, music and sports) hand craft (tailory, carpentry and mechanics) and jobs such as cleaning the uniforms etc. There was some playing equipment, such as a table-soccer, a few animals and a small playground for kids. There were 15 people waiting to go home after their dismiss. Once a runaway girl had no place to go to when she was ready for dismiss, and she was admitted for 4 years, before she was found by her family and taken back home. Family and relatives (and e.g. priests) are allowed visit the patients as much as they want, because family and community is very important in Africa.

Mental heath Care in Uganda has always been **friendly and humanitarian**, and never been abused for military or political imprisonment. Generally because psychiatry has never been thought about at all. It was left out, and **it has always been a hospital**.
At nights there is only one night nurse on a 70 patient ward, which is possible with huge social control and solidarity from the group.

There is a shortage of nurses, but new nurses are being recruited actively. There is also a nursing school attached to the Hospital. In a poor country such as Uganda, no trendy pharmaceutical drugs are used, because these are too expensive, so old-fashioned drugs are used in hospitals, such as haloperidol and promazine (largatil). There is sufficient medication since a 2003-2004, when the hospital looked awful and a loan was obtained from *the African Development Bank* to clean and rebuild the hospital.
The main ward is the admission ward, with 100 patients and 6 isolation cells. A lot of wards were not fully operational, had just been opened or were still under reconstruction. Rarely ECT is done, when the patients does not respond on the pharmaceutical drugs, but that is only occasional, maybe once a year, and with the use of narcotics.

Butabika wants to decentralize it's facilities, and they want the facilities to be managed by the people who own it. The key statement of Butabika Hospital's practices is:
"Patients belong to the community, and not to a hospital".

3.3.2. Mirembe Hospital, Dodoma Tanzania

In Mirembe Hospital in Dodoma, Tanzania's capital, we saw a lot of sufferance.
Dodoma suffers frequently from drought, unlike Kampala. The hospital compounds were dry and barren, with exception of garden which was surrounding the head offices and the reception. The buildings and wards for the patients were **old, showing bursts.**
The poorly neglected, dry and sad sight of this hospital struck us.

Mirembe hospital consists of 5 parts:

1. **Isanga** : forensic psychiatry,
2. **Mirembe** : main regular psychiatric hospital
3. **Mirembe annex** : ward for people who are recovered, but not completely, e.g are on medication or wait for an escort home.
4. **Hombolo village** : village of rejected people, who need a new community.
5. **the Nursing school** : educating nurses.

Mirembe hospital also offers a **regional general medical hospital service** and a **dentist service** and services **300 outpatients a day**.

In Mirembe hospital all mental patients are wearing dark blue uniforms, similar to the staff, but patients don't have a long pants, only robes and shorts. There is no real occupational therapy, only 5 sewing machines and one iron-heater to make uniforms for 700 patients. There is **not any equipment to avoid annoyance,** no music, sports, plays nor any material. Sometimes language lessons are given to patients on a voluntary basis. Patients are very annoyed, hanging around, sitting and laying everywhere on **insufficient and dirty mattresses** on the floor, often without any bed and sometimes shared by a group of patients. It seems common to have e.g. 7 beds and 13 patients (with a part of mattresses on the floor between the beds). Some of them looked sick from detox or medication, but fortunately medical care is also present.

The admission ward (ward 13) consists of 20 isolation cells, and hosts about 70 patients. This means that during the nights **isolation cells are shared by 3 or 4 patients**. The average period on the admission ward is 3 weeks, before continuation.

The bad salaries of the staff, and the improper facilities, and a general lack of interest in psychiatry, are resulting in **poor non-attractive facilities**.
There is only about **50% of the needed personnel and professionals**. (1 out of 4 psychiatrists, none of 2 occupational therapists, 42 out of 167 nurses grade B, 29 out of 66 nurses grade A)

Patients were dazed and quiet. Communicating with them was not easily, and probably the patients complaints were a kind of prohibited. One confused and sedated boy came to us curiously, but the ordinary security guard took a branch from the tree, pulled the leafs off, and **hit the patient**, to make clear to him that he should go back to his ward. The guard hit the patients a few times, before the boy understood what was expected.
And we were guided along a naked women, who had just been washed according to our guide. It was painful that **she was exposed to us in such a disgraceful position**.
These are severe violations of the human rights and dignity of the patients.

There is an **ECT room**, with dirty mattresses laying outside in the sunshine. We have no information on the frequency of the use of ECT or the use of narcotics.

It is a fact that only the worst cases, or the elite, come to a mental health hospital. There is also a private part of this hospital, with single and more luxurious rooms (which can also be found in Butabika hospital) and these rooms are also available for the staff when they fall ill.
This hospital was very **disastrous and sad.**

A general description of the situation inside an African psychiatric hospital:
*Patients are wearing a **uniform** and sitting or laying in the shadow. Sleeping a lot. Having 3 meals a day. There's no real range of therapy, only very **few practical occupations** with therapeutical side-effects, such as cleaning the uniforms. Patients are annoyed and waiting for their release. Some dismissed patients are waiting for months before they have money or means to go home (if possible**).*
*There are sometimes not enough beds in the hospitals. The buildings are often old. Fences and isolation cells are common. Hardly any visitors come to the hospital. There is only some (to us old-fashioned) medication. And an ECT-room. There is a shortage on the needed personnel and professionals, due to a general lack of interest in psychiatry, resulting in **poor non-attractive facilities**. There are ordinary private security guards without specialization in mental health care (armed with hitting sticks). In some institutions patients are beaten and shown in disgraceful situations (which is in fact: **lack of human dignity for patients**)*
Inside psychiatry is not much spoken about the spiritual world.

3.3.3 Mental Health patients in East Africa

Outside the institutions the patients are **misunderstood**, and fear of the unknown is resulting in the stigma of "control by spiritual forces", which is solved by chasing the scare away, by exorcisms, violence, homicide and holocaust, or taboo, shame, hiding and confinement for life).

Inside the hospitals without therapy, it is almost like the patients are just waiting for a miracle. And in this way the traditional perceptions of mental health care, still effects the quality of care, and patients are again neglected by these **traditional attitudes**, when social aspects are not recognized (see 5. Declaration: mental health: a social problem)
Also the **use of pedagogical violence** harms the patients.

** And even after being treated, and if you managed to survive having a mental problem in Africa, it is **very hard to get back into the society**, and you probably won't get much respect from the community. Patients often remain unemployed and dependant, or run off to another village or region.

So we know that patients are commonly rejected and unemployed, which means **no income**, dependency (due to "uselessness", not working class), often resulting in a poor life-standard and poor livelihood, and they often have only little ability to change the situation (eg to start usergroups). Their chances are declined, because their behaviours and emotions are not taken seriously into account (**stigma**). This is a worldwide problem.

We don't know if most patients survive, or whether most of them die. We don't know how many people are in need. They are unknown to us, and they are somewhere out there "on their own".

The situation of East African psychiatry can be summarized:

- All of Africa suffers from poverty.
- Mental health facilities in East Africa are **very poor**
- And the mental health facilities are **out of reach for the mass.**
- And patients are very badly stigmatized:
- **Patients are chased and rejected** because of traditional explainations of possession.
- Patients are subjected to **hostile exorcisms and witchdoctors.**
- And they are **not welcome in society.**

3.4 The Workshop Mental Health Care at the WSF 2007
At Monday January 22nd 2007, the workshop Mental health Care took place from 2.30 h. until 5.00 h. at the 7th World Social Forum in Nairobi Kenya.
This workshop was initiated by the persons named on the list of contacts at page 2.
More than a 100 people attended this workshop of the Users and Survivors of Psychiatry.

There were **testimonies** from the Dutch delegation about wrong and forceful treatments in rich countries. And the African delegates also gave very good testimonies on poverty, the stigma of mental problems and hostile treatments done by witchdoctors in Africa.

At the end of our workshop we also discussed and talked about our **WSF Statements**, which can be found at chapter 6 WSF Statements.

A very interesting **contribution** on our workshop came from a Miss from the organization *Conselho Federal de Psicologia, Brazil* who told us about the successful abolishment of psychiatric asylums in Brazil. She said: ***"An asylum free world is possible"*** . For information on this initiative see www.pol.org.br (in Spanish)

We also met with the British-based organization *Basic Needs* (www.basicneeds.org) who also work on improving mental health care. This organization is very rich and may possibly be funded with pharmaceutical money, which we think is always leading to 'coloured activities' (not neutral). They also pleaded for the use of medication. But nevertheless this organization does a lot of good de-stigmatizing work all over the world, such as e.g. in Kenya.

There were also several workshops on ***Frantz Fanon***, a revolutionary thinker and psychiatrist, whom played a great role in decolonization of Algeria. Our meeting was attended by some French psychiatrists involved with the Frantz Fanon working space as a subgroup of the Marxism's space. They agreed with our statements (see chapter 6).
Our delegation of users and survivors has also attended some workshops on Frantz Fanon and listened to the liberating views on equality and unity. From one of those French psychiatrists, B. Doray, we also got a book called 'Frantz Fanon, a portrait', as a gift of friendship in our struggle for solidarity.

A day after our workshop, at the Basic Needs workshop, we heard a women testify, with tears rolling down, that she had never heard about psychiatry, and her 9 year old daughter was very hard to handle. She cried that she had beaten her child, because she did not know what to do. She testified that she had entered our workshop at a random basis, just one day ago, and now she had another view on her daughter. She would go and look for help, and she would not beat her daughter anymore. She thanked God for leading her to the meeting on psychiatry and we were all very moved by this precious moment.

Another detailed report on our Workshop Mental Health Care on the WSF will be made by the African delegates and will be available at: www.mindrights.org

4. The Conclusion

By summarizing all previous information an overview of the different situations in Europe and Africa can be obtained.

4.1 East African psychiatry:

- All of Africa suffers from poverty.
- Mental health facilities in East Africa are **very poor**
- And the mental health facilities are **out of reach for the mass.**
- And patients are very badly stigmatized:
- **Patients are chased and rejected** because of traditional explainations of possession.
- Patients are subjected to **hostile exorcisms and witchdoctors.**
- And they are **not welcome in society.**
- African hospitals have never been abused as a political / dissident's prison.

4.2 West European psychiatry:

- Generally, the quality of mental health care in West Europe is **not satisfying**.
- Patients are **stigmatized and secondary** in society, due to neoliberal explanations of wealth and perfectionism.
- Patients suffer from the **impersonal approach** (without emotion) and the **Bodices** (standardizing everything), and the use of **forceful measures** (without permission) which the patients refer to as **traumatizing.**
- **The pharmaceutical industry** takes advantage (profits) of the unclear system of psychiatry and is analysing every human feature as a neurochemical balance to be able to measure deviation as an illness, and to create a homogenous society with their medication.
- In this way the generally scaring 'illnesses' don't have to be faced, the true . of handling mental problems is delayed again and on the background the **traditional exclusion** continues (see 4.5 Coherence: Fear).

4.3 East European psychiatry

- East European users are generally **not seen** in society, and often **don't return** from their admission in (sometimes deadly) mental health care institutions.
- Recovered patients (if returned) and their family **don't speak out**, because they fear a socially isolated and dependant position or religious perceptions (**Stigma**).
- In (some) countries in Eastern Europe mental health care is characterized by **deathly institutions (E1) with frightening methods** (E2) and poverty, malnutrition, lack of hygiene, severe neglect, diseases, wrong use of medication and therapies, abuse, violence, ignorance, and annoyance and prostitution etc. inside the institutions.

After visiting African psychiatry my conclusion is that poverty is not the only contributing factor to the excessive use of force on patients in Eastern Europe. In Africa we saw a **rather poor though pretty friendly institution** (Butabika hospital).

4.4 Theories on Eastern Europe: Dissident's prison

The use of force and the taboo on mental problems in Eastern Europe may possibly orient from the oppressive regime in World War 2, when Stalinist/communistic forces (not real communism) held Europe in a clamp of fear and death. 'Equality' was explained in a very wrong way (a bodice) and **genocide** on mental health patients was very common. The **dangerous theories of inferiority** were established by psychiatrists, who in that way prepared the world for the killing of thousands of mental patients, Roma's, Jews etc. In these days some people really believed in inferiority of certain human species to others (eg black skin, disabled, retarded, Jews etc.) and the 'inferior people' were deported to horrifying death-row working-camps, and very horrible and cruel experiments were put on them and almost all of them were killed (the Holocaust).

It is also known that within these false-communistic, oppressive regimes psychiatry was abused for ruling out political opponents by diagnosing them with delusional thoughts, creeping schizophrenia and paranoia conspiracy theories. In the name of psychiatric treatment the **dissidents were tortured and oppressed** (e.g. drugged, confined and shocked with ECT), and in this way the state prevented the dissidents to participate in society and to cause rumours and uprising movements. (e.g. in China this still happens)
In 1945 Western Europe was freed from the Stalinist/communists by the Americans and the Englishmen (ending World War 2, enabling democracy and capitalism), but the Eastern part of Europe remained under Stalinist regime, suffering from poverty and oppression and **not free to develop**. Now, after 62 years, some Eastern European countries have just recently made it to democracy and the 'free world economy'. But maybe the burden of the past has kept wrong behaviour, having its roots within the Stalinist culture, **maybe unchanged**.
In the report Not on the Agenda is stated that in Eastern Europe, under Stalinist regime, psychiatry was part of the ruling system. It was (and still is) **forbidden to talk** to other people, which is quickly seen as *subversion*. As a result people could stay in hospitals for years, and being exposed to series of electroshocks without having any possibility to speak. Patients do body movement therapy or painting. Some therapists in Eastern Europe don't know anything about giving therapy, but are just ordered to give therapy.
Traumatizing events such as wars, are causing fear and distrust and therefore blocking the rise of psychotherapy in Eastern Europe.

4.5 Coherence : Fear

So considering all the previous, there is a coherence on worldwide psychiatry practices, which are at best: not satisfying or worst: deadly. In general, all these practices are based on 3 different misperceptions of mental health (care):

- **Possession** is the African stigma (see 3.2 African psychiatry) and maybe also be applicable to Eastern Europe (see 2.3 East Europe). Then the 'possessive force' or 'spirit' will be chased, harmed and scared (an eye for an eye)
- **Imperfection** is the Western world stigma (see 2.2.2 West European psychiatry). Then the patient gets a medical prescription to adapt.
- Political abuse of psychiatry as a **dissidents' prison** may be a third contribution to stigma in certain countries. (see 4.4 Theories on Eastern Europe: Dissident's prison). Then psychiatry is very scaring.

All these (mis)perceptions are stigmatizing and excluding patients away from society.
The coherence of all the previous is: **fear is leading to this traditional exclusion.**
And in a way, the 3 misperceptions are all related to fear, misunderstanding and taboo, which is quite reasonable without any advanced knowledge or education on mental health. Some aspects are:

1. Fear of the unknown: mental illnesses are not a common development but a **rarity, which is hard to handle**.
2. Fear of illnesses: mental illnesses are **frightening**, because no one would like to lose his mind and become dependant and vulnerable**.** It can happen to anyone.
3. Fear of imperfection: everyone would want to believe that anyone can be perfect and we don't like to **accept our human limits** in the year 2007.
4. Fear of psychiatry: Psychiatry and mental health care is **scaring on itself** (e.g. big old-fashioned buildings, taboo and mystery, superseded treatments), and especially fearful when it's abused as a **political prison** with excessive exclusion, violence, neglect and torture.

But frightening things do happen, so we have to deal with it.
We can say: **things get less frightening when you get to know them.**

We conclude that a persistent **taboo** and a general **lack of knowledge** on mental health (probably worldwide) has never been completely lifted, due to **fear. And therefore patients are still traditionally and structurally excluded from society.**

5. Declaration: Mental Health : a social problem

We consider mental health as a cultural, spiritual, religious, medical, political and most of all **a social issue of all humans**.

1. **Patients are human beings with human feelings,** and they can feel pain, rejection, fear, grief, abandonment, just like anyone, at any time. And being forced (e.g. at a forced treatment) causes feelings of oppression, fear and loneliness. **Patients can also feel happiness, joy, compassion, love, friendship, humor, etc. which is certainly increasing mental health and the quality of one's life.**

2. Good mental health is about happiness and satisfaction, and maybe it is to be called **"mental wealth",** when one is able to continue his/her life happily without psychic problems. Some people don't have such "mental wealth", they suffer from their soul.

3. Psychiatric problems are on the patients mind or soul, and are mainly caused by social struggles in any form, from abuse, neglect and violence to social injustices, relationships, power imbalances, loss and unemployment, poor neighbourhoods, lack of chances or difficulties in expressing oneself etc. So mental problems mainly have **a social cause or trigger**.

4. A psychiatric problem disturbs the relationships of the patient and his/her environment, which leads to a **social problem or inconvenience**, and then mental health care is needed. So a mental problem is a social problem.

5. Professional Mental health care should aim for recovery and therefore regard and **focus on the social aspects of (the life of) the patient.** This means that treatments should be based on social educative activities and developing social skills. (so no breaking up of good relations, no exclusion and abandonment, no inequality and abuse of force, but equal relations and dialogue, like in 'normal' society)

6. The knowledge on recognizing and understanding mental health problems has to be promoted actively worldwide, **to renew traditional perceptions on these social struggles, and to develop a culture of socially good mental health care with dignity for the patients.**

So our priorities for another psychiatry are:
- **Combat stigma and fear**
- **Promote dignity and human rights for users and survivors of psychiatry**
- **Stop poverty**
- **Stop war, abuse and grief**
- **Accept and cope with imperfections of life**
- **Include and take care of one another**

Another world really is possible!

6. WSF Statements, 22 January 2007, 2.30 hr - 5.00 hr,

Actiegroep Tekeer tegen de isoleer! – Stichting Mind Rights www.mindrights.org

1. Nobody is perfect. People can have good feelings, but they can also suffer from bad feelings, like sadness, anger or confusion. Those bad feelings are also HUMAN feelings and they should be accepted as a part of the human nature. It is NO possession by evil spirits, nor a mental illness. It is only sufferance of the soul with main causes in power imbalances, such as abuse, violence and poverty.

a. **Referring to bad feelings as evil Spirits, and practicing exorcisms is very hostile** towards human beings, and it denies the existence of bad feelings in the human nature. The stigma of being possessed is almost unbearable, and causes unnecessary fear, confusion and grief for those who already suffer.
   Exorcisms should be replaced by treatments with regard for the patients inner life and should be aiming for social inclusion and empowerment.

b. **A rather similar stigma is created by Modern perfectionism**, with various products for mood-improvements, breast-increasements and anti-aging. This is established and exploited within commercial means. and is also based on not accepting any so-called imperfect features nor bad feelings of a human being.

Being different or feeling unhappy is nowadays analysed as **a chemical balancing disorder** , which is a narrow view and also a very dangerous trend. Falling in love, grief and homosexuality also happen to be certain neurochemical processes in the brain of the human, but these are not illnesses.

c. **By reducing human feelings to Chemical balances the human right to have feelings is again diminished**, which is in fact a severe crime towards humanity. The **pharmaceutical drugs** are nowadays also for sale on commercial markets, and show us that we have a choice or even a responsibility to be perfectly balanced and standardized, with none of the unwanted features and feelings.

By calling bad and unwanted feelings a possession, an illness or a balancing disorder, a very important part of the complex human nature is neglected and this gives possibilities to create a harmful and cruel society where human emotions are no longer valued. This is very dangerous to our society.
Having feelings and handling feelings is a very social issue. Therefore mental health is a very important issue for all human beings.

Because of the social basis of mental health and mental health related problems, the community plays a very important role in mental health care.

- **We have to claim that there are no mentally ill people, but just people who suffer in personal ways, who are not to be subjected to exorcisms or a medical regime in virtue of their ideas and behaviours.**

2. Mental health is highly related to the social background of a person.
In warzones and former warzones people suffer from mental health problems. Within poor areas the psychosis-rates are higher, compared to the number of psychosis in richer areas.
A lot of psychiatric disorders are caused by violence and the abuse of power. A main theme is child abuse. And a second theme is violence against women. Also housing problems, unemployment, under developed neighbourhoods, loss of friends and drug abuse are all social circumstances which can lead to an outburst of psychic problems.
Coping with mental problems is a very personal process, but this can not be distinguished from the community, because mental health is a social issue.

Patients need to be loved and not be feared, stigmatized, rejected and treated wrong.

- **To be welcome, and to belong to the community (or a family or any group) is a key issue in establishing recovery from mental health problems. Patients belong to the society, not to a hospital or prison. So society must embrace those who suffer from their emotions.**

- **Networks on self-support, such as usergroups, can provide support and guidance and information on Best Practices, to prevent the abuse of power and the violation of vulnerable groups, such as children, women, poor people and people in warzones or former warzones.**

3. Within neoliberal culture, like in the Netherlands in Europe, the lack of knowledge about mental issues is growing, because the community is shattered and replaced by money making and working 24-7. This is accompanied by **social neglect, individualism and loneliness**. Patients still are seen and treated as useless, secondary humans and there is hardly any space left for personal issues or family-love. Most emotions are rejected and feared.

- **But there is no health without mental health. Emotions should be appreciated.**

4. The psychiatric jargon is a powerful tool within psychiatry. The psychiatric jargon is very complex in it's nature, mainly because it disguises all it really refers to. Sadness is called a depression and overwhelming confusion is called a psychosis. These labelling words do not cause more understanding nor affection within the community, and they are not solving any problem for the patients. Instead they just stigmatize the patients which causes even more trouble than they already had.

- **Words play a very important role in the mental health system, and we must be sure to call "things" with their real name.**

5. Within the psychiatric hospitals worldwide, the average situation is very bad, with poverty, neglect and torture.

In Eastern Europe 50% of the patients die within the first year of their admission, due to poor hygiene, lack of food and improper treatments with psychiatric drugs, violence and ECT.

In Africa most patients do not even reach the few psychiatric hospitals, and their problems are often ritually chased by churches and witchdoctors in the villages.

In rich countries wealth has replaced social life, and advanced repression is often very common. **Real helpful psychiatry still has not really been established yet.**

6. Neoliberal strategies of making money should not be implemented in the Mental Health Care sector. Privatizing Mental Health Care leads to a cutting down of the expenses on the care itself, or higher fees.

a- Higher fees mean that the patients are pointed at an Own Responsibility for their illnesses and that they have to pay more for their treatments. And in fact it means that the Rich part of the population does not want to pay for the poorer citizens

- **We need international solidarity towards those who suffer. Make sure that the psychiatric patients are no longer forgotten.**

b- Cutting down the expenses leads to a situation where people don't get the help they need, because the cheapest option is not always the best option. For example, the description of pills is cheaper than psychotherapy, in special when the bonuses and mass discounts from pharmaceutical industries are taken into acccount. But pills only repress the symptoms of the social emotional struggle, and they usually don´t cure the core of the problem, which lies in social aspects..

- **The expenses and profits may never become the guidelines of mental health care.**

- **By privatizing Mental Health Care, a positive development of the Quality of Mental Health Care is under a threat. Mental Health Care should be a public service to offer the Best Care for the lowest price, without making private profits.**

7. The most highest rate of isolation cell usage within European member states can be found in the Netherlands (about 75% of all patients gets isolated for a shorter or longer period during admission). Other forceful repressive means, such as fixation with chains or straps, drugging and electroshocking are also well known by the psychiatric patients, disabled and elder people (with Alzheimer etc) These methods are traumatizing on itself.
These compulsory treatments are mainly used because the inadequate number of employed professionals in psychiatry, which is due to the lack of investments.

But also the psychiatric professionals are constrained to do their job in accordance with the rules, and they cannot freely decide what to do. (for example with regard to the legislation and the abilities and means which they have or don't have, such as money and facilities or even insurance policies).

- **More efforts should be made to give the patients the care and attention they need and to avoid exclusion. The Human species are one worth to take care of.**
- **Caring for one another is not only the job of professionals, but it is a task of all human beings, especially in society. Another world is possible.**

- **All patients must have the right and abilities to address complaints about their treatments at any time.**

8. Large scaled psychiatric hospitals, with a high population of psychiatric patients, do show a lot of poverty, annoyance, prostitution and drug abuse. This, combined with the usually impersonally approach and the imbalance of power within psychiatry, and the stigma and exclusion of psychiatric patients, makes the problems of a psychiatric patient even worse than they already are.

- **Large scaled psychiatric hospitals should be replaced by smaller community-based service facilities, to give better personal care to the patients, and to give the patients the opportunity to participate in the daily life of the society.**

9.

- **Good Quality of mental health care means that the patient and their surroundings are both satisfied.**
- **The wellbeing of the patients and recovery of their inner peace must be the key issue at all time.**

The quality of care depends highly on the social awareness, efforts and abilities of a specific area or country to invest in the quality of mental health care.

10. Freedom, patient and client movements, psychic and psychiatrical problems and mental health care are closely related to one another. The practice of the Own Responsibility of psychiatric patients means to organise and establish all kinds of networks on self-support.
Governmentally founded initiatives on the social participation of psychiatric patients, generally imply the influence of psychiatric professionals, which may lead to the old-fashioned habits where patients have a secondary position.

11. It is important to talk about psychiatry within the movement of Social Forums, which originates the modern reflections of freedom.

7 Information

The following documents contain valuable information for this report:

- **Not on the Agenda (2005) – including reports from the field study trip on psychiatry in Central and Eastern Europe**
  By Jan Verhaegh
  (available on www.stichting-time-out.nl, www.enusp.org, www.mindrights.org)

- **Red paper on improving mental health care - Declaration of Patient Organizations on mental health care (May 2006)**
  By Jolijn Santegoeds and others
  (available on www.stichting-time-out.nl, www.enusp.org, www.mindrights.org)

- **Green paper: Improving the mental health of the population: towards a strategy on mental health for the European Union (February 2006)**
  By the European Union- European Commission on Health

8 Contact list

Contact list (Email) of initiating participants:

European participants:

- **Actiegroep Tekeer tegen de isoleer! /Stichting Mind Rights**
  Miss. Jolijn Santegoeds, Eindhoven, the Netherlands (author of this report)
  email: tekeertegendeisoleer@hotmail.com
  website (English): **www.mindrights.org**
- **Clienten Centrum Limburg (CCL)**
  Mr. Jan Verhaegh, Valkenburg a/d Geul, the Netherlands
  email: jhaverhaegh@gmail.com
  website (Dutch/English) **www.stichting-time-out.nl**
- **Stichting Time Out**
  Mrs. Marietje Lemmens, Valkenburg a/d Geul, the Netherlands
  email: marietjelemmens@gmail.com
  website (Dutch/English) **www.stichting-time-out.nl**

Representing the European Network of Users and Survivors of Psychiatry ENUSP (**www.enusp.org**) and the World Network of Users and Survivors of Psychiatry WNUSP (**www.wnusp.org**)

Connecting to African Participants:

- **Pan African Network Users and Survivors of Psychiatry (PANUSP) East; and Comforter's Centre & Comforter's Clubhouse, Uganda**
  Miss. Veronica Nakyewe, email: vnakyewe@yahoo.com
  Mrs. Lydia M Munabi, email: munably@yahoo.com
  Mrs. Patricia Athieno, email: patriciathieno@yahoo.co.uk
  Mr Paul
  Mr Robert
- **Tanzania Users and Survivors of Psychiatry Organization (TUSPO)**
  Mr. Eliezer Robert Mdakilwa , email: a_efound@yahoo.com
  Mrs. Agatha Sanga , email: a_efound@yahoo.com
- **Network Organization of Users and Survivors of Psychiatry Rwanda (NOUSPR)**
  Mr. Sam Badege , email: badegesam@yahoo.fr
  Mr. Moses Mukono, email: moseserek@yahoo.co.uk, nousprwanda@rwanda.com
  Miss Rose
  Miss Petronilla
- **Mental Health Uganda (MHU)**
  Mr. Julius Lutaakome Kayiira , email: ugmhu@yahoo.co.uk

In solidarity with those who were not able to come to Nairobi:

- **Comforter's Clubhouse,** Mrs Sandra, macagic@yahoo.com
- **Mindfreedom Ghana,** Mr Dan Taylor, mindfreedomghana@yahoo.co.uk
- **PANUSP South section / WNUSP,** Mr Moosa Salie

Other psychiatry organizations:

- **Butabika Hospital**, Kampala (UG): buthosp@infocom.co.ug
- **Mirembe Hospital**, Dodoma (TZ)
  Dr Jennings Nkya, email: jennings1948tz@yahoo.com

Don't hesitate to contact us, please

The end of this report.