EDITORIAL:
− 3.- Message from the President. May 2018. Ricardo Guinea. WAPR President.

ARTICLES:
− 8.- The Belgian Reform in Mental Health Care: where are we now? A short overview and state of progress. Bernard Jacob. Project Manager & Coordinator; Mental Health Care Reform, (based on Art. 107 Law of Hospitals). Belgium WAPR Section
− 10.- Implementing psychosocial evidence-based treatments in Italian mental health services: implications for organizational level and staff training. Paola Carozza Director of Mental Health Department of Ferrara (Italy) and Member of WAPR International Board.
− 15.- Recent Research. Reported by Barbara D’Avanzo.

REPORTS:
− 23.- Korea Republic. Report on Activity of Korean Association for Psychosocial Rehabilitation (KAPR)
− 24.- Canada. Activity Summary.
− 25.- India. Tamil Nadu. Carnival.
− 26.- Haiti. History of Haitian center for Psychosocial Rehabilitacion of Queensland University.
− 27.- India. Kerala Psychosocial Rehabilitation and the Role of Panchayath.
− 29.- Norway. Activity summary.
− 30.- Colombia. Psychosocial Consultation Centre, CAPsi, Icesi University. Cali.
− 32.- Saudi Arabia. An overview on mental health services in KSA.
− 33.- Australia. Establishment of WAPR Australia.
− 33.- Pakistan. Fountain House Psycho-Education Programme.

BOARD and Committees.
I am pleased to report that WAPR has continued its normal functioning with a good level of global activity and many local meetings.

This report will summarize my activity from Board Meeting in Seoul until now. The main points are:

REGISTRATION AS AN INTERNATIONAL NGO.
As I announced in Seoul, one of my priorities as President would be to strengthen our structures as an organization. So, as it was announced in our networks, after many bureaucratic actions, WAPR is finally registered as an International NGO in the Spanish Home Affairs Registry for Associations. This means now we have full legal capacity as an Organization, including the possibility to apply and receive funding from international donors for our activities. This is an important action that solves a previous vulnerability and gives us the possibility to face one of our pending weaknesses, that is our week financial structure. Now, after some conversations, we can face the creation of a Fund Rising Committee, with the target of create a more solid way of funding our activities.

WEBSITE AND SOCIAL NETWORKS.
As it was announced in Seoul, first Board Meeting of this term, we needed to renew the website. The rapid changes in technology, and the evolution of our structures made necessary to face that project. It was proposed that we would need to create a new site that could be easily managed by us, with latest and full compatible technology, and with the possibility to be easily transferred to another Webmaster when necessary, (i.e. when the presidency goes to India next term). Now this has been done. We have a new site, easy to handle, and highly connected with different networks (Facebook, Twitter and Google+).

The new site includes some very convenient features. First, a private section for members that requires password, so we can publish documents in restricted area, only for WAPR members. Second a secure payment gateway, so dues can be very easily paid, including the possibility of payment with a simple credit card transaction. We expect that this will ease our life in this aspect of our associative life. And third, the updates in the news sections of our site will be automatically published in Facebook, Twitter and Google+. This feature is already active, and our social networks are gaining dissemination and presence. Just as a simple example, the greeting video in the last Mental Health Day had more that 3000 hits.

For reference:
Website: www.wapr.org
Facebook: www.facebook.com/WAPR
Twitter: @wapr_amrp

COMMITTEES:
EDITORIAL COMMITTEE.
Under the direction of Marit Borg (Norway) chair of our standing Editorial Committee, and support of Barbara D’Avanzo, Tae Yeopn Hwang, Michael Amering and Ricardo Guinea, the bulletin
WAPR BOARD

is being released with regularity. Some other Board Members, have been collaborating. It should be noticed that the Bulletin is increasing its quality, and is very informative of the many activities that happen around WAPR and its branches.

We have had some conversations about how to coordinate the management of the website in the Editorial Committee, and we will probably have some agreements in the next future about this, to optimize our coordination and share the workload.

COMMITTEE OF TRAINING, AND GOOD PRACTICES.

Training is one of the most remarkable queries formulated in WAPR meetings in many countries. However, WAPR’s structure is still too weak as to be able to provide systematic training wherever it is requested, there is something we can certainly do: to agree in a basic training program in PSR, able to be delivered in a limited time, that would include the basic requirements to work in this field. This project has already been initiated, under the direction of Marianne Farkas (Boston, US), and hopefully will present in Madrid World Congress a consensual proposal.

HUMAN RIGHTS COMMITTEE.

This committee is a very important element of our agenda, since HHRR is one of the fields that have received more attention in the last years from several relevant international agencies. Michaela Amering, will be chairing the committee, assisted by Guadalupe Morales; a work plan has been sent. We are all aware that in our field, in many interventions there is an important risk of collision with HHRR principles, in issues like advocacy and protection, interventions on acute yards, interventions in forensic institutions, guardianship and other forms of substitute / supported decision making, etc. Moreover, the promulgation of the UN Declaration of Rights of Person with Disabilities has received a lot of attentions and some technical discussions. Again, therefore we will pay attention to this important field and will propose a Special Symposium in our World Congress specially dedicated to it.

TASKFORCE FOR WAPR-CCRT.

This taskforce has agreed in general criteria for accepting Collaborating Centers for research and training. Procedures and templates for applying for new centers, have been passed.

So far, we have the following accepted Collaborating Centers.

Chile: University of Concepción, Department of Psychology and Department of Psychiatry and Mental Health.

Colombia: Consultorio de Atención Psicosocial – CAPsi, Universidad Icesi, (Psychosocial Consultation Centre – CAPsi, Icesi University).

Kenia: Africa Mental Health Foundation (AMHF).

UAE: Psychiatric Rehabilitation Unit, Behavioral Sciences Pavilion, Sheikh Khalifa Medical City – PRU, BSP, SKMC.

Egypt: Institute of Psychiatry, Ain Shams University Hospitals, ASUIP.

Norway. Center for Mental Health and Substance Abuse (CMHSA), Dramen.

FORENSIC ISSUES.

Since psychiatry has a role in assessing the Legal system in many situations, forensic issues are in narrow connection with living conditions of

Lima, Peru.

Bogotá, Colombia-
many users. Legislation some many countries still need revision (i.e. to adapt to UN Convention of Rights of People with Disabilities). The situation of users under legal measures about mental illness (i.e. forensic mental hospitals) needs attention. Gabriele Rocca, WAPR DeP. Secretary General, expressed his interest in leading this committee.

CONFERENCES:
WAPR has been invited to sponsor to be part of the following conferences. In most of these Conferences, President has made himself available to present WAPR’s perspective on training and practice, based on community approach, human rights and recovery perspective.

- 2016, April. Johor; MALAYSIA. 20 – 22 APRIL 2016. Metamorphosis of Mental Health Services: an innovative approaches, 8th Johor mental health convention, Hospital Permai.
- 2016, May. Chiangmai, Tailand.
- 2016, Murcia, Spain; Dec. “Empleo y Enfermedad Mental”. Murcia (Spain).
- 2017, AbuDhabi, UAE; 24-26 March, AFPA World Congress.

NEW BRANCHES.
During this term, these are the branches that have reported and will be welcome to WAPR are:
- Australia.
- Chile
- Colombia.
- Egypt.
- Germany.
- Iran.
- Oman.
- Spain (AEN).
- Spain (Fundacion Manantial).
- UAE.
- Saudi Arabia.

WORLD CONGRESS MADRID 2018.
Organization is already started. (Committees, scientific program). The focus: “Recovery, Citizenship, Human Rights: revising consensus”. Main participation from WAPR is intended to be channelized by WAPR active committees.
Welcome to Madrid.
June 2018.
WAPR Editor Team.

The title of the 2018 WAPR congress is “Recovery, Citizenship, Human Rights; Reviewing Consensus”. We will meet in the Palacio de Municipal de Congresos, Madrid, Spain from 5th – 7th of July 2017. Emphasizing recovery, citizenship and human rights commits. Human rights are norms that help to protect all people everywhere from severe political, legal, and social abuses. The philosophy of human rights addresses questions about the existence, content, nature, universality, justification and legal status. We know that many fellow human beings with mental distress experience violation and abuses of their human and citizenship rights. Many also have difficulties in finding recovery-oriented services, where the issue of human rights respect is at the centre and which are characterised by humanity, partnerships and collaborative understandings and practises. We look forward to meet up with colleagues in Madrid with a variety of backgrounds and experiences - service users, family members, practitioners, volunteers, politicians, managers, and researchers. We invite you all to critical dialogues, discussions and actions in order to develop understandings and new insights of barriers and facilitators and to find ways of strengthening Recovery, Citizenship, Human Rights.

Marit Borg, Editor.
Barbara D’Avanzo, Editorial Committee.
Ricardo Guinea, President.
Mental health problems are as common in Belgium as in any other European country. Approximately 25% of the Belgians are experiencing some sort of psychological distress. The lifetime prevalence of at least one mental disorder can go up to 30% of the population. Furthermore, like in most other countries, there is a significant treatment gap that both encompasses people not getting treated or people receiving treatment far too late. Stigmatisation, financial barriers, lack of collaboration between primary care and specialized care, poor accessibility and waitings lists are only some of the factors named to account for this situation.

Until 2010, the Belgian mental health care strongly remained a hospital-based system. With more than 150 beds per 100.000 inhabitants, Belgium ranked in the global top three countries for numbers of bed per inhabitants. Although the late eighties and nineties gave rise to new housing initiatives nationwide, such as sheltered living and psychiatric nursing homes, this was only considered to be a first step in a further evolution towards a community-based approach. A transformation of a supply-driven residential mental health care towards a more differentiated demand-driven care was needed.

The 2002 Joint Declaration of all ministers responsible for Public Health on the future mental health policy was an important subsequent step. It stated that future acute and chronic care had to be organised through collaborating networks and circuits for 3 target groups (children and adolescents, adults and the elderly), bringing mental health care as close as possible to the needs and demands of people with mental health problems.

In May 2010, the Public Health authorities launched the ‘Guide towards a better mental health care’, thereby setting in motion the reform for adults. The Guide described a program and an organisational network model. A network coordinator was financed for each pilot project to facilitate the creation of the intersectoral networks, that had to establish 5 predefined sectors:

- **Sector 1:** prevention and promotion of mental health care, early detection, screening and diagnostic activities.
- **Sector 2:** ambulatory teams offering intensive treatment for both acute and chronic mental health problems.
- **Sector 3:** rehabilitation team focusing on recovery and social inclusion.
- **Sector 4:** residential intensive treatment for both acute and chronic mental health problems.
- **Sector 5:** specific housing facilities.
Given the high number of psychiatric hospital beds, the program implicated a bed reduction, to accomplish by a reallocation of the bed-bound financial means to new mobile treatment teams (function 2) or hospital intensification.

In 2016, almost the entire Belgian territory is Belgium is covered by different networks which include the 5 sectors. Approximately 55 newly created mobile teams (‘function 2’) are active, together with a chronic bed reduction of 20%. Several additional ambulatory rehabilitation and recovery centres, focusing on housing and employment, were founded. The important attitude change in the sector, combined with the new facilities in the community, have been associated with a significant reduction in the duration of hospital admissions. Furthermore, the accessibility of specialized care strongly benefited from the intersectoral collaboration (e.g. primary care, GP’s, housing corporation etc).

Nevertheless, important challenges remain for the nearby future. Three scientific teams monitor the reform, thereby making a process evaluation of the geographical implementation of the networks, network governance, establishment of the functions, continuity of care, patient satisfaction and recovery-oriented practices. It seems that the networks have established all functions, but an even more integrated approach is needed to further improve the accessibility and continuity of care. This requires a formalisation and rethinking of the governance structure of the networks. Furthermore, generalization of the reform model is needed over the areas that are not yet served, while the other regions are deepening the changes and reinforcing the resources in the community.

To conclude: the Belgian mental health care has, in a short period of time, undergone profound changes in an ongoing transformation process towards a community-based mental health care. Inter-organisational networks and a recovery-oriented practice can be considered as key aspects therein. Starting with the adult group, the aim is now to broaden and deepen the reform over the next years, for all regions and target groups. And last but not least, it is important to note that the professional sector, the authorities, the patient and family federations have undertaken this journey side by side.

Bernard Jacob
Belgium WAPR Section
Implementing psychosocial evidence-based treatments in Italian mental health services: implications for organizational level and staff training.

Paola Carozza
Director of Mental Health Department of Ferrara (Italy) and Member of WAPR International Board.

The need to integrate psychosocial treatments EB with psychopharmacology in the treatment of mental illness is based on the following considerations and contributions: eiopathogenesis of mental illness related to psychological, biological and social factor; mental illness impact on psychological, biological and social dimensions of human being; the contributions of neuroscience and in particular of social neuroscience and, at last, the spread of the concept of recovery for which the improvements of mental health is not only related to the symptoms but also to the ability to take a perspective of life again, to perform valid social roles, to increase the ability to choose and to drive own live, to improve cognition, to cope with stressors, to recognize and manage intense feelings and emotions.

As the brain is remarkably plastic, practicing promotes learning. When people repeatedly practice an activity or access a memory, their neural networks -- groups of neurons that fire together, creating electrochemical pathways -- shape themselves according to that activity or memory. When people stop practicing new things, the brain will eventually eliminate, or "prune," the connecting cells that formed the pathways. "More cells fire together, more wire together", meaning that if you perform a task or recall some information that causes different neurons to fire in concert, it strengthens the connections between those cells. Over time, these connections become thick, hardy road maps that link various parts of the brain -- and stimulating one neuron in the sequence is more likely to trigger the next one to fire. The more times the network is stimulated, the stronger and more efficient it becomes.

The brain's innate capacity to adapt to environmental demands and it's lifelong ability to reorganize neural pathways based on new experiences is named neuroplasticity. Even in middle or old age, brain is still adapting very actively to its environment. This adaptation can be as simple as learning a new skill or as complex as recovering brain function after injury. The brain responds to these challenges by becoming more efficient--by strengthening synaptic connections between neurons or by creating new neurons in the hippocampal region of the brain, a process known as neurogenesis.
Scientific foundations of psychosocial treatments

Within the context of the treatment, the mechanism of neurogenesis is the system through which interventions stimulating the same psychobiological mechanisms involved in the disease through the exercise of cognitive function, determine structural and functional changes in the brain. Because of neurons’ ability to be modified from experience, given that each type of therapy promotes a subjective experience, we could conclude that there is a reciprocity between therapy and neuroplasticity (impaired neuroplasticity determines conditions who need treatment, and all forms of treatments acts by affecting plasticity). The experiences of intensive psychosocial rehabilitation, similar to psychotherapy, could affecting the fundamental mechanisms of neuronal activity, and contribute to the development of new interconnections, starting up effective corrections on neuropsychological and neurophysiological dysfunction in psychosis.

Referring to the neuroscience, axis is shifted from the dysfunctional elements of mental illness to therapeutic role of social reciprocity (social cognition) and to the impact of social reciprocity on biological matrices of disorder. When the emotional / cognitive disconnection is caused by alterations of neuronal connectivity, you can think that reconnection between actions / emotions / knowledge depends on a more efficient synaptic connection. So the greater integration of the identity seems depending on greater synaptic integration.

Many studies have proven the effectiveness of psychotherapy proving the activation of specific brain areas to that specific disorder. Similarly for psychosocial treatments that are based on learning mechanisms, on empathic relationship favoring learning by imitation, on human experiences, on the repetition of skills etc. etc. In this scheme psychosocial treatments or medication are partners in the process of synaptic reorganization, called ‘care’.

Need of psychosocial treatments.

In the light of more than 60% of people with mental illness don't receive all appropriate treatments which would require (Lehman, Steinwachs, 1998 b); at least 70% of people with schizophrenia have already cognitive impairment concurrent or previous the onset, often resistant to the effects of drugs; acquisition of neuroscience and biopsychosocial consequences of mental illness is urgent to adopt treatment strategies that are effective on the psychological and social consequences of mental illness.

The main way to counteract the biopsychosocial consequences of mental illnesses the multidimensional integrated treatment (expected outcome in biological, psychological and social domains), that is Integrated (pharmacological and psychosocial), flexible (adapted to the needs, preferences and changes of the patients, adapted to the stages of psychosis), long term delivered, coordinated and based on the expertise of staff.

In fact, we expect better outcomes when pharmacological and psychosocial treatments are provided in a multidimensional, integrated, coordinated and continuous way and are adapted to the stage of disorder; but also when the patient is motivated to treatment, the family is involved in the treatment, is actively involved in his treatment, is trained to the self-management of medications and is actively committed to reduce relapses. In the presence of these conditions is possible to achieve symptomatic and functional recovery, showing how to improve the traditionally pessimistic prognosis of mental illness.

The practice of rehabilitation includes psychosocial treatments EB

The practice of psychiatric rehabilitation includes four main treatments in order to protect from vulnerability to stress-induced relapses: pharmacotherapy adapted to the type and severity of psychopathology, in doses that do not produce sedation or side effects interfering with active
Involvement in rehabilitation process; programs for skill development so that the patient can deal with stressors and life situations that require adaptation and more independence; supported environment programs (employment, housing and education supported; economic aids, multidisciplinary treatment team, case-manager) and groups led by professionals mediated by activities or focused on specific topics.

As regards The support group is the preferred way to treat people with severe psychosocial dysfunction. The multiple stimuli and the unpredictability of events that individuals experience within the groups make these environments very similar to real life, because they:

- offer the opportunity to learn how to reduce stress symptoms and how to manage the illness;
- counteract social isolation and lack of relationships;
- provide an environment that facilitates social learning, through several examples, modelling and feedback;
- increase the self-awareness to the extent that groups give the opportunity to observe the behavior of others and learn from them;
- reproduce a social micro-context are a learning setting for specific skills;
- allow to work on individual goals;
- allow to feel a sense of belonging, reciprocity and collaboration, meaningful connections between tasks, the appreciation of others, constructive participation in a common cause, a greater social value.

The groups used in the psychosocial treatment of people with serious psychiatric disabilities are of two main types: 1) Groups mediated by activities (cooking, reading newspaper, shopping, etc.); 2) Groups focused on specific issues (managing medication, managing emotions, preventing relapses, coping with illness and her sequela, increasing motivation to change, etc.)

Building a mental health services system

Ebp and recovery oriented

Approved in 1978, the law 180 marks the “Italian Revolution” in the field of mental health, developing a radical process of change in services delivery: from guardianship to the beginning of the patient’s de-institutionalization.

Unfortunately, such objectives not only have been accomplished partially (in some areas of Italy the mental health public services aren’t existing yet), but also they have gradually lost their importance.

In fact, many mental health professionals think that serious mental illnesses are almost associated with a poor prognosis; the psychosocial practices have to gain a dignity of techniques, given that they have a marginal role if compared with biological treatments; there is an increased awareness of the inadequacy of the stabilization paradigm (intervention only in acute phase of mental illness, desired outcome: symptoms remission); the programs often lack of interventions aimed to provide the patients with abilities and support, so that they could get and maintain valid social roles in the community; the personnel working in the mental health services not always is been equipped with effective tools to link own practice to client’s goals, purposes and perspectives; many persons with severe mental disorders are replaced in psychiatric residential facilities, often reproducing a disconnected and isolated way of living, being onerous for the citizenship, disempowering people and increasing internal stigma.

We learned during these years that the traditional treatments, medication and crisis interventions, have shown their selves inadequate to met the different needs of people with psychiatric disabilities and insufficient to increase role functioning in the real world. There is an increased awareness of the inadequacy of the stabilization paradigm (intervention only in acute
The phase of mental illness, desired outcome: symptoms remission. It follows that it’s necessary to pay a greater attention to the tools and the methods with which to counteract the disabling effects of the mental illness on the individuals that suffer from it and that it’s necessary to pay a greater attention to highlight emotional, cognitive, functional and social outcomes more precisely and to make patient and families aware of them.

Mentioned above considerations have prompted the Local Health Authority of Ferrara to promote a radical services system’s change through a change of the paradigm (from biomedical paradigm to biopsychosocial paradigm). The purpose was to develop effective programs for people with severe mental illness that will strengthen their skills and capacities to live independently and meaningfully in the community as more as possible. In this view, the whole array of services, each for own specific field of action, should have the purpose to increase the personal and social functioning and subjective well-being of people with psychiatric disability, in order to be able to perform successfully a valid social role in the environment of choice (job, housing, education, meaningful activities in the community) with the least professional support.

The principles and values that inspired the services system change were the following:

- limiting disability’s impact through psychosocial treatment and social supports
- Encouraging client’s involvement in own treatment
- Strengthen successes; don’t blame person for his/her failures
- Building close relationship with person with mental illness, who is allowed to risk, to mistake and to have the same aspirations all human beings have
- Focusing on strengths; don’t amplify deficits.

(The actions we are doing to promote change are listed in table 1)

**Problems, barriers and contradictions, stemmed from process of system change.**

Unfortunately the process of change isn’t linear. Some results have been consolidated, but there are many critical points that have raised and need more examination.

To transfer EB principles in practice is a great challenge. It’s known in the field that introduce a scientific and methodological approach in daily clinical practice is very hard. Implementing EBPs requires a change in the usual organizational models and in the current policies, as well in the staff training and supervision.

Therefore, effective treatments are rarely available for the vast majority of people for whom they were thought, except for the new antipsychotic medication quickly accepted and prescribed by psychiatrists thanks to the efforts of the pharmaceutical market.

In fact, the implementation of psychosocial services is a very complex process because:

- Require multidisciplinary collaboration, coordination between different agencies
- Require a long period of time to acquire the skills to deliver them
- Require skills to face the resistance and inertia of the practitioners to change the way they deliver services
- Require commitment to teach staff new techniques and to learn from this
- Require a clear mandate from the leadership and its commitment to provide resources and support
- Require to familiarize practitioners with EBPs, fitting the workplace so that EBPs can be easily be used by the staff
- Require continuous on-site staff training, that staff who is learning the EB treatment evaluate
TABLE 1:

- Increasing practitioners’ knowledges, attitudes and skills about psychosocial evidence practices and concept of recovery, through a continuous training of workforce (interdisciplinary and involving the whole system) in the workplace.
- Helping to change the believes of many mental health professionals which think that:
  - serious mental illnesses have almost a poor prognosis associated with
  - the people who psychiatric disabilities cannot lead a meaningful life rich without the continuous support of psychiatric services.
- Encouraging the introduction of measure of recovery outcomes in the individual treatment plans’, that do not just concern:
  - remission of symptoms and of relapses
  - but also the personal and social functioning, quality of life and the subjective perception of a state of well-being.
- Training programs’ coordinators in order to learn leadership skills.
- Promoting the adoption of programs of supported housing, supported education and supported employment, that counteract:
  - De-socialization (reciprocal detachment between the individual and his environment)
  - Internal stigma (powerlessness, shame, worthlessness, inability to take over own life)
  - Giving-up hope, purposes and every effort to change.
- Reducing the use of psychiatric residential facilities and Increasing the number of people discharged from the psychiatric residential facilities through supported housing and vocational programs.
- Implementing person -centered programs for specific targets of population (Early Mental Disorders, Intellectual Disability, Dual Disorders).
- Orienting daily practices to scientific evidence and spreading culture of outcomes’ assessment.
- Favouring the overcoming of prejudices of many families about the concept of recovery , often rejected for fear either of painful hopes or of the implied challenges of the recovery process (increased relapses and hospitalization rates).
- Helping family members to recognize the outcomes of recovery, even those one minimal.
- Strengthening partnerships with families and with Associations of families.
- Encouraging the birth of Associations of Users and their participation in services’ quality assessment.
his training, the selection of patients to demonstrate the efficacy of new treatments.

Require the development of criteria for setting standards and measures of clinical quality that include the use of new practices.

Require the courage to eliminate inefficient practices often defended by many practitioners, families, politicians and other stakeholders.

Then, some issues raised from the process of system change: resistance to change, resistance to adopt a scientific method, resistance due to prejudices toward mental illness and obstacles due to the organizational model.

**Resistance to change own practices**

We know that the term "change" raises fears and expectations, developing resistances aimed at maintaining the status quo. Usually, in the psychiatric field, the resistances to change are motivated by the following arguments (Essock et al., 2003):

The scientific results not always may be used to meet the real and complex needs of patients, there are not reference points for most of the practitioners, as it is the "clinical wisdom" coming from his own experience.

Many practitioners have invested time and energy in training with low or minimal effect on the everyday practice; then, skepticism to devote more time and energy to learn new approaches.

Even if no one is satisfied with the quality of the services we currently have, it is difficult for the system to incorporate new approaches. Practitioners are aware that the change could be just "window dressing", especially when innovation is linked to leader unreliable or transient, and that some changes are often introduced more to the fashion of the moment or to comply with the will of the administrators than to actually improve the effectiveness of treatments and their outcomes. Therefore, they don’t engage themselves in adopting new ways of working.

The EBP cannot address the problems of the real world, being applied to patient samples other than those who usually turn to public services.

**Resistance to adopt a scientific method**

The resistance to adopt a scientific method is indicated by the fear that techniques, procedures, outcomes cause a sort of "methodological cast" which resets the human component, creativity and flexibility; by the belief that the possession of the rehabilitative techniques deliver the same service for all, denying individual needs and characteristic, by the difficulties in transforming a job for certain aspects idealized, because essentially based on human components, to a measurable job; by the tendency to abstraction and generalization paying little attention to the objective data; by paying little attention to identify and to evaluate the results; by the resistance to change interventions in the light of achieved, outcomes (fully, partially or not at all achieved and, at last, by the tendency to repeat the same action over and over again even if proved largely ineffective.

Resistance due to prejudices toward mental illness

The resistance due to prejudices toward mental illness is indicated by the belief that people with serious psychiatric disabilities are not able to choose appropriate roles and environments and do not wish to change their situation for the better; by the pessimism about their ability to learn and grow and by the belief that the mental illness destroys the desires, goals, dreams and perspectives.

**Conclusions**

My own experience, supplied with data from the literature, indicates that the some factors are critical to introduce the psychosocial evidence based practice (EBP) in our services system: a leadership seriously committed to promote change; building consensus within the organization on the advantage and the opportunity to use EBP, reminding that familiarity with the usual way of working can be a set of behaviors difficult to change; assessing

**Background:** Since the 1960s the quality of life of people with psychosis has received increasing attention. Because of the prevailing concern that outcome assessment should include the patient's perspective, attention was paid to the development of measures, and subjective quality of life (SQOL) is an established patient-reported outcome in psychosis. A distinction is made between objective QOL (patients’ life circumstances in various life domains) and subjective QOL (satisfaction with life in general and in major life domains). This has stimulated a search for new models and methods for assessing SQOL in daily life, with concurrent assessment of individual preferences and experience, ‘daily or momentary QOL’.

**Methods:** The Experience Sampling Method (ESM), a structured, random time sampling diary technique, offers a strategy for measuring moment-to-moment variation in patients’ subjective experience of life in general and major life domains. This was done in 56 patients with psychotic disorder and 71 controls. Self-reported QOL was assessed with the WHO-QOL, momentary QOL and real life experiences were assessed with the Experience Sampling Method (ESM).

**Results:** SQOL and momentary QOL measures were significantly associated in patients and controls, and associations with emotional experience were most relevant, momentary QOL being a stronger predictor than self-reported QOL. Overall, momentary QOL was more consistently associated with affect, social interaction and activity, while self-reported QOL displayed a more narrow association with affect. The association between momentary QOL and negative affect was stronger in patients than in controls.

**Discussion:** SQOL is not necessarily reflected in experiences in the respective domains in daily life. Most associations with real life were of similar magnitude in patients with psychotic disorder and in healthy controls, except for a stronger association between momentary QOL and negative affect in patients. Further, momentary QOL may more closely approximate real-life experiences than self-
reported QOL, by showing a strong association with affect and with social interaction and activity. For clinical care, this means using momentary QOL can help us develop more targeted interventions to improve QOL in patients.

**Conclusion:** By placing more emphasis on feelings of guilt, insecurity and anxiety can improve subjective QOL in psychosis. Moreover, our findings suggest treatment plans should be personalized and tailored to individual levels of social contacts and activities in order to optimize subjective QOL.


**Background:** After having fled from the home country, refugee children they request protection in a new, host country. If those children are not able to explain why the authorities should provide protection, they risk being deported without a proper assessment of the threats they might encounter upon return. The migration authorities have the obligation to assess the best interests of the child and to make sure that these interests are a primary consideration in the decision making process. Assessing the best interests of the child is not possible without hearing the child in an adequate manner. Mental health problems may hamper the ability of children to talk about their life stories. Research on the situation of recently arrived refugee children in the host country shows that they have experienced a large number of stressful life events. Interviewers of traumatized refugee children can be confronted with the same difficulties as forensic interviewers who speak with abused children. The effect of traumatic experiences may impede the refugee child’s ability to produce a coherent, chronological story. Inconsistencies are an important reason for rejecting children’s asylum claims. It is important to ensure that migration decisions are based on reliable information about the children’s needs for protection.

**Methods:** A systematic review was conducted in academic journals, collecting all available scientific knowledge about the disclosure of life stories by refugee minors in the context of social work, guardianship, foster care, asylum procedures, mental health assessment, and therapeutic settings.

**Results:** The main barrier that impedes refugee children’s ability to disclose their experiences lies in the mistrust children feel against authorities in general, including caretakers, researchers, migrations authorities, and interpreters. Refugee children may choose to keep silent because they think it might harm them to talk about their experiences. Nondisclosure helps them to manage stress or cope with serious disturbances. The barrier “disrespect” refers to the child’s perception or expectation of limited trust or respect by others in the host community. In the context of asylum hearings, refugee children say, they felt confronted with disbelief, nonunderstanding, and superiority. Facilitators were showing interest in the child by seeing them as young people who have to reinvent their lives instead of as “asylum seekers” and by offering reliable and enduring companionship. Spending time with the children was necessary to facilitate the disclosure of the children’s stories. A skilled interpreter is not only enhancing the refugee children’s sharing of their life stories during asylum hearings but is also crucial for the accuracy of the children’s answers. Moreover, the validity of the information children share can be negatively affected when the interpreters ignore or “improve” the minors’ own terms and style.
Discussion: The facilitators for disclosing life stories were a positive and respectful attitude of the interviewer, taking time to build trust, using nonverbal methods, providing agency to the children, and involving trained interpreters.

Conclusion: Social workers, mentors, and guardians should have time to build trust and to help a young refugee in revealing the life story before the minor is heard by the migration authorities.


Background: Individual Placement and Support (IPS) was developed in the early 1990s in an environment of disenchantment with sheltered workshops and other segregated day programs. IPS is an alternative approach in which a “place-train” approach replaces the practice of training people with disabilities in protected work settings in preparation for regular community jobs. More than 20 randomized controlled trials have demonstrated increased employment among IPS recipients. However, despite ongoing interest in employment protection laws (legislation that shields existing employees from dismissal after a probationary period) and disability benefit policies (which may discourage recipients from seeking employment), research focusing on the interaction between IPS and the local regulatory environment has been minimal.

Methods: Mixed-effects meta-regressions were used to assess the impact of site-level moderators on the likelihood that IPS recipients, compared with recipients of alternative vocational services, achieved competitive employment, using data from 39 studies.

Results: From 21 randomized controlled trials in 12 countries (33% in the United States), IPS recipients were 2.31 (95% CI 1.99–2.69) times more likely to find competitive employment than recipients of alternative vocational rehabilitation services. The significant competitive-employment rate advantage of IPS over control services increased in the presence of weaker employment protection legislation and integration efforts, and less generous disability benefits. Potential moderators were change in gross domestic product, local unemployment and unionization rates, employment protection regulations, level of disability benefits compensation, and efforts to integrate people with disabilities into the workforce. Regulatory moderators represent facilitators and barriers to employment that may reinforce or detract from the effectiveness of IPS.

Discussion: IPS was consistently more effective at placing recipients in competitive employment than alternative vocational services. IPS was more effective in the presence of less interventionist employment protections, a less generous disability benefit structure, and less aggressive state efforts to integrate people with disabilities into the workforce.

Conclusion: The effect of IPS is robust across a wide range of economic, labor, and regulatory conditions. However, IPS programs function in contexts defined by local conditions, and it is more effective, compared to alternative forms of vocational rehabilitation, when local regulatory environments neither inhibit the hiring practices of employers nor create an incentive structure that reduces motivation to find work.

**Background:** In low- and middle-income countries (LMICs), mental, neurological and substance use (MNS) disorders contribute significantly to the burden of disease. Yet they are characterised by huge treatment gaps and the health systems often fail to meet the needs of people with MNS. Service user and caregiver involvement has been proposed as an essential means of strengthening weak mental health care systems and of improving mental health quality of care. Yet at present it is still the case that service users are often denied the right to health, to full citizenship and meaningful participation in clinical decision making.

**Methods:** A cross-country qualitative study was conducted in Ethiopia, Nepal and Nigeria, interviewing 83 stakeholders of mental health services. The study design was a cross-sectional, using qualitative individual in-depth interviews with service users, caregivers, policy makers and heads of mental health services. The sample selection method was purposive sampling, based on the close knowledge of researchers of the local communities. The content of the interview guide addressed existing level of involvement and its potential benefit in mental health policy-making, mental health planning and service development, monitoring the quality of mental health services.

**Results:** Service users and caregivers reported very limited access to direct participation, and in the involvement in the health system strengthening process. Stigma and poverty were described as the main barriers for involvement. Several strategies were identified by participants to overcome existing hurdles to facilitate service user and caregiver involvement, such as support to access treatment, mental health promotion and empowerment of service users. This study suggests that capacity building for service users, and strengthening of user groups would equip them to contribute meaningfully to policy development from informed perspectives.

**Conclusion:** Involvement of service users and their caregivers in mental health decision-making is still in its infancy in LMICs. Effective strategies are required to overcome existing barriers, for example making funding more widely available for Ph.D. studies in participatory research with service users and caregivers to develop, implement and evaluate approaches to involvement that are locally and culturally acceptable in LMICs.
Practical Implementation of Psychosocial Rehabilitation in Rural Kenya

Professor D. M. Ndetei.
Africa Mental Health Foundation

Introduction:
Given the poor mental health service provision and mental health seeking behavior in rural Kenya, psychosocial rehabilitation is hardly ever discussed let alone implemented. Machakos County, as at 2015, had one psychiatrist serving at the County referral hospital, which received patients from more than 6 neighboring counties and did not have a single peer support group for people living with mental health issues. However, through the implementation of the CREATE program in Machakos Kenya, which worked with people recovering from serious mental illness, the first formal peer support group was formed.

Under the program, a toolkit of psychosocial rehabilitation was designed, locally reviewed, adapted to suit local context and needs and piloted with 7 people recovering from serious mental illness in Machakos Kenya. The recovery oriented psychosocial rehabilitation toolkit is a 256 paged document divided in 2 sections: Section A – Psychoeducation for understanding mental illness and Section B – Workplace Wellness.

Implementation:

Pilot
Prior to the pilot period, 6 local mental health care workers (including occupational therapists) were trained on effective delivery of the toolkit. 2 healthcare workers volunteered to facilitate the toolkit with the first 7 people with lived experience; who also happened to be the first employees of Point Tech Solutions, first social business offering meaningful work for equally pay for people with lived experience in rural Kenya. Facilitation took 14 weeks, one session per week lasting 2.5 hours on average to complete the entire toolkit. One session included care-givers who were also keen to learn and share the noticeable changes in their loved ones since starting the classes. People with lived experience also had the opportunity to co-facilitate these sessions.

Expansion Study:
A further expansion study was conducted to test the efficacy of the toolkit in a hospital setting. Learning from the pilot study, a second ToT session was done with interested mental healthcare workers from the target hospital and 3 people with lived experience/peer co-facilitators who had shown interest in facilitation during the pilot. An additional
24 people living with serious mental illness from the hospital showed interest in the classes. Caregivers were also invited to participate, as was in the pilot. 4 healthcare workers and 2 peer co-facilitators conducted the 14 week sessions in 3 groups i.e. each with 8 participants.

**Findings and Conclusion:**

Following the conclusion of the PSR Toolkit sessions (i.e. pilot and expansion studies), participants formed and registered the first ever social group comprised of people living with mental illness in Machakos County under the department of social services, Ministry of Public service, youth and gender affairs.

The members of the group attribute their unique bond and different approach in life to knowledge and skills learned from the PSR Toolkit. The psychosocial rehabilitation increased their understanding of their mental health condition and various wellness strategies, which in turn, reduced their levels of self-stigma and mitigated their concern over social stigma. They intend to continue regular reviews of the toolkit within their new group and are currently working with the CREATE Kenya project team (under the guidance of Dr. MacDougall, Dr. R. Casey and Prof. Ndetei) to adapt the current PSR toolkit to include more sessions for caregivers.
KOREA REPUBLIC

Report on Activity of Korean Association for Psychosocial Rehabilitation (KAPR)

1. Introduction to Korean Association for Psychosocial Rehabilitation (KAPR)

-KAPR is a nonprofit corporation aiming to improve the quality of life for persons with mental illnesses through psychosocial rehabilitation, promote their return to society, and promote academic exchanges and development among members.

- This association has been playing a pivotal role in the development of psychosocial rehabilitation for more than 20 years after being founded in 1995 by mental health professionals such as psychiatrists, nurses, social workers and clinical psychologists who gathered their will and strength.

- Major activities of KAPR include academic conferences, program development and dissemination, research and book publications, public relations, advocacy projects, networking and collaboration with related organizations at national and international level. In particular, in the fall of 2015, this association successfully held the 12th World Congress of WAPR for the first time in Asia.

2. Report on major activities in 2017

1) Board meetings and an executive meeting

- The meetings of the board were held twice, once in Seoul in the first half of the year and once in Daejeon in the second half of the year. In the meeting of the board in the first half of the year, business reporting and reporting on the settlement of accounts were carried out and business plans were approved. In the meeting of the board in the second half of the year, training of family support activists for mental health, autumn conference plans, and revisions of the articles of incorporation were discussed.

- The executive meeting was held for one night two days on February 3 and 4 and during the meeting. MOU was signed with Gongju National Hospital, department meetings and general meetings were held.

2) Spring and autumn conferences and a day hospital symposium

- The spring conference was held on March 24 at Pusan National University Hospital. During the conference, education on human rights, workshops, and symposiums were held under the theme of "Prospects and Tasks of Support for Welfare Services for Mental Patients Following the Complete Revision of the Mental Health Act" and a total of 154 persons participated in the conference.

- The autumn conference was held on September 15 at National Center for Mental Health in Seoul. During the conference, workshops and
symposiums were held under the theme of "Mental Health Made by Solidarity and Collaboration" and a total of 70 persons participated in the conference.

- The day hospital symposium was held on December 1 at the C & V Center in Choongbuk Province under the theme of "Opening of day hospitals and a plan for successful management" and a total of 141 people participated in the symposium.

3) FL(Family Link) and SDM(Shared Decision Making) projects

- A basic course for family link (March-September, 446 mentally disabled persons from 31 institutions participated in the course and 294 persons completed the course), a regional intensive course (October-November, 125 mentally disabled persons from seven institutions participated in the course and 97 persons completed the course), a family instructor refresher training course (a total of 85 persons participated in the first and second sessions), and a specialist workshop (March 13, 54 mental health specialists participated in the workshop) were implemented.

- An SDM training course (215 mentally disabled persons from 24 institutions participated in the course and 164 persons completed the course) and a specialist workshop (March 13, 101 mental health specialists participated in the workshop) were implemented.

4) Operation of a public campaign booth and workshop at the Gongju Mental Health Academic Festival

- In the Mental Health Academic Festival held for one night two days on August 25-26, 2017, a workshop under the theme of 'Family Members of Mentally Disabled Persons' was held. Public campaign booth was operated, family member counseling was provided, and movies were screened.

CANADA

Psychosocial Rehabilitation (PSR)
Réadaptation Psychosociale (RPS) Canada
Activity Summary

PSR/RPS Canada is Canada’s lead organization promoting the dissemination and adoption of evidence based, best and promising recovery oriented practices. Accordingly, most of our activity involves the education and training of mental health practitioners as well as administrators, family members and clients/service users.

During 2017, activities included:

- Improved communication and sharing of resources through a greatly improved web page: www.psrrpscanada.com
- Implemented a national credential for PSR practitioners, the Certified Psychosocial Rehabilitation and Recovery Practitioner (CPRRP)
- Established a national Registry of CPRRP’s and appointed a Registrar
- Published a revised edition of Competencies of Practice for Canadian
Recovery-Oriented Psychosocial Rehabilitation Practitioners. These competencies, including performance indicators, are intended to serve as the basis for education and training programs as well as guiding the development, implementation and evaluation of recovery oriented services and systems. This document may be accessed through our web page: www.psrrpscanada.com

- In partnership with our Chapters, PSR British Columbia in Vancouver and PSR Atlantic in Halifax held two education conferences
- Participated and presented at mental health conferences in Victoria, Winnipeg and Toronto.
- PSR/RPS Canada is a partner with the Mental Health Commission of Canada in presentations and educational events focusing on best and promising practices and recovery. We are currently working with the Commission to plan a “Recovery Day” event in the Province of Alberta in May, 2018.

INDIA

Tamil Nadu. Carnival

WAPR (IC) and KFCMD jointly conducted a one week programme of rehabilitation carnival at Maria Sadan, Palai from 19th to 26th May 2017.

The programme was inaugurated by PC George MLA. Mr. Santhosh Joseph welcomed the gathering. Dr. C. Ramasubramaniam (President WAPR (IC)) chaired the session. Dr. V.K Radhakrishnan, (Vice President WAPR) delivered the keynote address. Prof. George Varghese proposed the vote of thanks. Dr. Roy Abraham (WPA Secretary General) spoke during the occasion.

The carnival was arranged in an open ground. Various stalls were arranged by psychosocial rehabilitation centers from different parts of the state and a few stalls by government and semi government agencies. Stalls exhibited varieties of products manufactured in the rehabilitation centers by patients. These stalls were managed by mentally ill persons who were now healthy and recovered.

There was a range of products like handicrafts, readymade garments, pillow covers and bed sheets with art works, bakery products, jams and various juices. One stall was exclusively for Jack fruit products, from Jackfruit pakora to Jackfruit halwa. Jack fruit is a very common and cheap edible fruit of Kerala.

There were three tea stalls and one hotel. One stall was exclusively for herbal medicines and herbal products. One mentally ill person who has now recovered is a Black Smith handling one stall with household items like Knife, chisel and pickaxe which he makes himself and delivers as per order. One stall was for low cost water management. More than three thousand people visited the stall in a week.

Every evening there were cultural programs staged by patients and professionals. In between people from various walks of life delivered lectures on destigmatisation and community participation.

The valedictory function was inaugurated by Mr. Jose K Mani M.P; Dr. T. Murali (WAPR President Elect) chaired the session. Mr. Santhosh Joseph welcome the gathering, Dr. V.K Radhakrishnan delivered the key note address. Local Media covered the events in a big manner. It was an eye opening experience for all the concerned participants.
HAITI.

History of the Haitian Center for Psychosocial Rehabilitation (CHARP) of Queensland University (UQ). Haitian Center for Psychosocial Rehabilitation (HACEPR) of Queensland University

A dynamic institution at the service of social rehabilitation in rural and urban areas of Haiti

The Haitian Center for Rehabilitation Psychosocial (CHARP) of Queensland University (UQ), it is more than three (3) years of work, commitment, volunteerism for the well-being of the users of health services in rural and urban areas of Haiti. We find many people who have together supported and support the institution in its development and influence throughout Haiti.

Created on June 20, 2010 in Haiti by Queensland University (UQ), at the end of a workshop on mental health and psychology on the partnership between the various intervention agencies promoting community integration for children. Victims of the Earthquake of January 12, 2010 where the majority of children, young and adult victims who lost their father and mother, their brothers and sisters began to have mental disorders, the CHARP-UQ affirmed from the beginning his will to bring together actors from community organizations, private institutions, from the regions of Haiti and urban and rural centers of the Republic of Haiti.

His biggest challenge was to arouse the interest of being tamed, to regroup the different tendencies victims of the earthquake of January 12, 2010. Once assembled, we had to develop a common conception of the psychosocial rehabilitation, equip ourselves with a common language by the Queensland University Board of Trustees (UQ) to found the UQ's Haitian Center for Psychosocial Rehabilitation (CHARP). Followed the incorporation, the establishment of a structure, the recruitment of the members and the search for a technical and financial means that can help us to start.

From 30 members in June 2010, the CHARP-UQ now has 50 individual and corporate members. Founded by Queensland University (UQ) Haiti, the Haitian Center for Psychosocial Rehabilitation (CHARP) is an institution belonging to the Queensland University (UQ) therefore, the Haitian Center for Psychosocial Rehabilitation (CHARP) has not need an Operating Authorization of the Haitian Government, it is an institution accredited by Queensland University (UQ) registered and recognized by the Ministry of Foreign Affairs and Cults, the Ministry of Commerce and Industry, the Ministry of National Education and Vocational Training. The CHARP-UQ conducts its various activities thanks to the low financial contributions of its members, it does not receive funding from any National and International Organization, nor from the Government of Haiti for the organization of national events such as its Symposium and Thematic and Training Days.

The Haitian Center for Psychosocial Rehabilitation (CHARP) at Queensland University (UQ) is thus the only mental health institution in Haiti that stands out for its ability to mobilize a wide range of actors in the same agora: the various categories private and public establishments in the country; the special and original contribution of the community groups; the multiple disciplines and sectors of intervention; each of the different stakeholder groups, including those who use mental health services and their close victims of the January 12, 2010, earthquake.

Our symposium, the rendezvous par excellence in Haiti in the field of mental health, brings together during the years 2011 and 2012, under a new theme hundreds of participants, among whom a significant number of people using
services in the field of mental health field of psychosocial rehabilitation of rural and urban areas of Haiti.

The Haitian Center for Psychosocial Rehabilitation (CHARP) at the University Queensland (UQ) is a real crossroads of information and action in mental health in rural and urban areas of Haiti, the Haitian Center for Psychosocial Rehabilitation (CHARP) at the University Queensland (UQ) has for mission to gather all the people concerned by psychosocial rehabilitation and recovery. In rural and urban areas of Haiti, it promotes the concerted action of a multitude of actors, including people living or having experienced a mental health problem and their relatives, to promote and improve practices and services in mental health during the passage of the earthquake of January 12, 2010.

www.uqstegnetwork.org

INDIA

Kerala. Psychosocial rehabilitation and the role of the Panchayath

WAPR Indian Chapter and Kerala Federation for the care of mentally disabled jointly conducted a One Day Symposium on Psychosocial Rehabilitation – The Role of the Panchayath at Lourd Bhavan Trust Auditorium, Pallickathodu on Dec. 4th 2017 at 10 A.M. Mr. Santhosh Joseph (KFC MD General Secretary) welcomed the gathering. Dr. V.K Radhakrishnan (WAPR Vice President) chaired the inaugural function. Dr. N Jayarat MLA inaugurated the function. Mr. Oommen Chandy, Ex- Chief Minister of Kerala blessed the programme. Shri. Jose Antony (Director, Lourd Bhavan) proposed the Vote of Thanks. Following the inauguration function, the seminar started with an introduction of the topic by the moderator Dr. V.K Radhakrishnan. He briefed the audience about the various areas where the Three Tier Panchayath Raj system could coordinate with psycho social rehabilitation centres.

Dr. Prameela Devi, Ex- Member of Womens Commission, spoke about the legal facilities provided for the marginalized women by the womens commission. Shri. Mathachan Thamarassery (President District Panchayath) told Panchayath is ready to take up the rehabilitation projects with limited resources. But they need a well prepared project. Smt. Sasikala Nair (District Panchayath member) told that the District Panchayath is providing funds for Rehabilitation centers. Smt. Sandhya Devi (Block Panchayath Vice President), Shri. Giji Anchani (Grama Panchayathu President Pallickathodu), Shri. Kunju, (Panchayathu President Kooropada), Shri. Tomy Mathew (President KFC MD) shared their views.

Dr. V.K Radhakrishnan requested the agencies to present their experience with the panchayath system. Mr. Johny Vazhavatta started the presentations and explained about the medicine cover and note book manufacturing unit in his center. Vazhavatta Grama Panchayath has sanctioned Rs. Five Lakhs for the projects. DMHP conducted fifteen camps and distributed medicine for six thousand patients. Mr. Tomy Thodupuzha told the district panchayath sanctioned Twelve Lakhs rupees for a building in his center. Mr. Mathew, Little Flower Mercy Home, Chengalam stated that Idukki District Panchayath has allotted Seven Lakhs for a building in his center. Shanu Sankar, Standing Committee Chairman of Pallickathodu Panchayath told the Panchayath is quickly clearing the project presented to them. Mr. Joji from Marayoor told that he was getting Rupees Two Lakhs for medicine from Block Panchayath. But now it is stopped due to audit objections. They are also having problems to get proper ration cards. Sr. Navya Maria, Assisi Bhavan, Kattapanna is getting Rupees Twenty Lakhs from Block Panchayath for a permanent building. This
seminar was concluded by summarizing the procedures by the moderator. He also requested the members to conduct similar programs in different parts of the State and offered full technical support by the WAPR Indian Chapter.

Dr. V.K Radhakrishnan  
Vice President WAPR  
Director, C N K Hospital (P) Ltd  
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ISRAEL

Psychiatric medication among people with severe mental illness: research, lived experience, attitudes and choice

ISPRA, Israel Psychiatric Rehabilitation Association was founded in 2009. As one of its varied activities it holds an annual conference focusing on topics relevant to the local psychiatric rehabilitation community. The 2017 annual conference focused on the usage of psychiatric medications among people with severe mental illness. In order to encourage a comprehensive discussion ISPRA collaborated with the Community Mental Health Department at the University of Haifa, the Israeli Psychiatric Association and the Community Mental Health Society. 400 participants represented the varied stakeholders in the field - psychiatric rehabilitation providers, persons with lived experience, psychiatrists, policy makers and academics. The program included three keynote speakers- Professor Donald Goff, M.D. Director of the Nathan S. Kline Institute for Psychiatric Research and Vice Chair for Research in the New York University Langone Medical Center, Mr. Robert Whitaker, Journalist and Author of "Anatomy of an Epidemic", 2015; and Professor Lisa Dixon, M.D., M.P.H, Columbia University. In addition, two people with lived experience and two-family members of people with lived experience shared from their experience with psychiatric medication.

Prof. Goff who is a psychiatrist and a well-known researcher in the field of psychopharmacology revealed a complex picture of whether medication is helpful or harmful. On one hand, according to recent research, long term use might be toxic to the brain and reduce people's functionality. On the other, long DUP (duration of untreated psychosis) is known for predicting poor prognosis.

Mr. Robert Whitaker argued in his presentation that not only the brain imbalance theory was never proven scientifically but also that research which demonstrated the toxicity of psychiatric medications to the brain has been hidden from the public . According to him, the pharmacological industry played a main role in this game. He explained that the relapse phenomenon when discontinuing medications is actually a phenomenon created by the medications themselves because of the brain compensation process they dictate.

People with lived experience and family members presented different angles and explained why they decided to comply or not to with treatment prescriptions. Shira described how she couldn’t accept the flattening of her emotions and personality by using antidepressants. Before she decided to quit medication, she didn’t see the way out and actually was looking for the right roof to jump from. Since then she has finished her master's degree in the community mental health department at the University of Haifa, got married and is raising her two daughters together with her husband. David, an experienced physiotherapist and the chairperson of 'Lishma' (The Israeli Consumer Movement Organization) shared his story and described how he unsuccessfully tried several times to quit medication without consulting his psychiatrist and eventually found himself relapsing and hospitalized. Gadi, a Hi-Tec entrepreneur described how his family saved his
sons life by getting him off medication in a gradual and responsible process. His son developed anxiety after being in a stressful environment and treating him with a growing amount of medications only worsened his situation and caused him to develop psychosis and akathisia. After quitting, his son went back to play the violin, returned to his studies and his life as he lived before the crisis. This process has been possible only because of the knowledge the family acquired, courage and available resources. Nily, a Board member in 'Ozma' (Families Advocacy Organization) emphasised that not all families have the resources required to help support their family members through such a withdrawal process and that we have to make sure that society will take over this responsibility in order to create the adequate environment for all people interested in similar processes.

A model of shared decision making was introduced by Prof. Lisa Dixon in order to address the confusion among the participants in the audience. The three steps model includes Choice talk, Option talk and Decision talk developed by OnTrackNY. The purpose of the model is to help people make informed decisions after processing the information with a professional.

The contents of the conference were very confusing for the professionals and even more so for tens of people with lived experience and their families. Some people felt guilty for having let their relatives take medications for many years and were looking for immediate answers to their private situation. The majority of the people felt that this was an eye-opening event which will have a major impact on their future decisions in relation to medications intake.

Another model which was mentioned is the 'Soteria' home in Jerusalem. The Soteria home has been opened in September 2016 and has been adopted by the Ministry of Health as a legitimate service for hospitalization prevention. At Soteria people with acute psychosis are treated in an intimate home atmosphere using as little medications as possible and with the informed consent only of each client after a shared decision process.

The ISPRA chairperson, Mrs. Sylvia Tessler-Lozowick, emphasised the obligation of ISPRA to promote further discussion on the issue of psychiatric medications and invited all stakeholders to take part in a cooperative effort. Following the conference Prof. Haim Belmaker, the Israeli Psychiatric Association appointed a professional committee in order to formulate guidelines for tapering psychiatric medication whenever possible.

It is important to note that ISPRA doesn't take a stand pro or anti medication. The goal of the conference was to raise awareness to the use of medications and to initiate a fruitful discussion with the message that psychiatric drugs are not only a medical matter but also a matter relevant to psychiatric rehabilitation providers and of-course to the rehabilitation service users.

Oren Derhy, ISPRA National Coordinator

Prof. Max Lachman. ISPRA Board Member and Community Mental Health Department at the University of Haifa

NORWAY

2017 was a very good year for our activities in WAPR Norway. The board is based in Bergen where all the board members live. This makes it practical to cooperate. Contact with members in the national level is maintained through mail, skype and particularly through the annual conference. There is also close cooperation with the most central competence and research centers for mental health and substance abuse services and recovery in Norway.

2017 WAPR Norway Conference in May had the theme “Recovery oriented mental health
services - what does it really mean?” This theme was much appreciated by WAPR members, service users, family members, students and professionals. The conference beat all previous records of participants. There were about 250 persons from all over Norway. A wonderful, exciting and educational day for all those involved in supporting a person’s recovery processes. You can read more about it the last edition of Bulletin.

Our next national conference May 2018 will focus on the themes human rights, belonging and social inclusion and shared decision making. In Norway a new law gives users of mental health services a right to choose pharmacology-free treatment also for psychosis. We will present how this right is implemented in the local services in a region of Norway. A pilot study using the recovery tool INSPIRE will also be presented. And last but not the least examples and initiatives of belonging in the community is on the agenda. Experiences from “On the Ball” projects about football and mental health from Nottingham, UK, and local initiatives from Bergen will be offered.

One of our local projects – a one year Peer support training program – has been invited to several conferences lately. In 2017 the program was presented in St Petersburg, Russia and in Abu Dhabi, UAE. In January 2018 it was presented in Manila, The Philippines. The leader for the national WAPR branch, Audun Pedersen, was also in Russia on a 10 days internship in March 2017. It gave opportunity to networking there, despite challenges with languages. After the presentation in October in St Petersburg Phoenix Centre in St Petersburg has asked for having the program translated in order to implement it in their centre. It is a centre with some similarities to Fountain houses. It is really excited to build this network with colleagues in Russia. Immediate Past president Afzal Javed has been very supportive in this process, and will continue to be during his work in WPA as a president now.

On national level there is also a lot of activity related to peer support work. Two studies about peer support work have been carried out by the Center of Mental Health, University College of Southeast-Norway on behalf of the Center of experience-based knowledge. One focusing on service users experiences of help and support from peer support workers and the other on how peer support workers use their experiences in helping others. There is also established a national interestgroup for peer support works. They will attend areas like working conditions, wages, roles etc.

Our national branch has established an option for support to persons who like to have internship in Norway, especially for colleagues from middle and low income countries. In August a young social worker from a psychiatric hospital in Tbilisi, Georgia stayed in Norway for two weeks, in order to study our community based mental health services. He met also some from a local LGBT organization. He was special interested in human rights and how we worked against stigma and discrimination. It was very successful, and he is now taking a master degree in a master program from WHO.

I September several from the national branch participated on Refocus Recovery 2017 in Nottingham, and got inspiration for establishing a Recovery college in Bergen. A group of six
persons visited Nottingham Recovery College and Central North West London Recovery College in December. WAPR Norway is now supporting an initiative to establish such college in Bergen.

In Norway there is good climate now for promoting recovery oriented services, and WAPR can be a part of a bigger national movement. WAPR Norway try to link local initiatives to international experiences and to bring impulses and experiences from interesting program to Norway.

Audun Pedersen. Chair of the National Board.

COLOMBIA

Psychosocial Consultation Centre.
CAPsi, Icesi University. Cali, Colombia.

Training and research activities:
- In the month of September 2017, the CAPsi team organized a 16-hour training workshop on mental health concepts and referral criteria for non-formal adult education teachers working in the World Women’s Bank Foundation in Cali, Colombia. In total, 18 teachers were sensitized and trained to detect, intervene in a crisis situation and refer adequately persons who may suffer from chronic mental health conditions.

- In the months of October and November 2017, we organized mental health brigades addressed to the city’s most vulnerable population. This activity is planned in the framework of the Psychology undergraduate clinical training programme. In total, 26 Psychology students we trained during the brigades.

- Between the months of August 2017 and May 2018, a Canadian-Colombian social worker, Rosa Delgado, is working as an Intern in CAPsi. This internship programme is possible thanks to a collaboration agreement between CAPsi and a Canadian NGO CUSO International. Rosa is leading a research project on psychosocial barriers in an employment inclusion programme financed by CUSO in Cali. In the framework of this research project, approximately 85 persons from poor neighborhoods in Cali have participated in Psychosocial Consultation Centre. CAPsi, Icesi University. Cali, Colombia.
collective therapeutic workshops and individual and family psychosocial counselling.

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SAUDI ARABIA.
An overview on mental health services in KSA

Up until the early 1950's, there were no psychiatric hospitals anywhere in KSA. Progress began with the building in 1952 of the Taif Mental Hospital in Shahr, an hour's drive southeast from Mecca; the cradle of Islam. By the early 1980's, however, there were still only two psychiatric hospitals to serve the Kingdom's population of 6 to 8 million.

Much indeed has changed over the last few decades. The number of psychiatric hospitals in KSA has expanded nearly 10-fold over the past 30 years to 21 specialty hospitals today. These include three facilities, called "Al-Amal" hospitals, located in feddah, Riyadh, and Dammam that specialize in the treatment of addictions. The Ministry of Health is the main provider of mental health services throughout the Kingdom of Saudi Arabia. Under the umbrella of MOH, the General Directorate of Mental Health and Medical Social Services helps in planning and developing, coordinating, evaluating and monitoring mental health services.

In 2015 mental health act was approved and aimed to improve access to mental health care and provide treatment in level restrictive environment with clear mechanism for monitoring of human right in mental health. There are approximately 94 public outpatient mental health facilities available in the MOH, of which 20 are for children and women located in Children and Maternity Hospitals. Mental health care services costs the government around 40% of total health budget.

Community mental health and integration of mental health in primary care is very limited and need extensive work. A national strategic plan to improve the mental health services was introduced with clear objective to change the current services from being hospital based physician oriented and drug dependent to community based, team oriented and biopsychosocial social model.

The national committee for mental health promotion was established on 2014 to work as facilitator body to help intersectoral cooperation and develop national program for mental health promotion.

Future:

There has been remarkable progress in the recognition and treatment of mental health disorders over the past 60 years in Saudi Arabia, especially in the last two decades. The mental health system is making long strides toward addressing the mental health needs of its individual. There is still a way to go in extending care to the entire population including expatriates, in developing training programs in Saudi medical centers and academic institutions particularly fellowship training in psychiatry subspecialties, and in conducting research to guide efforts to modernize the mental health care system.

Currently, there are plans in process to systematize, standardize, and expand mental health services across the country.

CONTACT INFO: National Committee for Mental Health Promotion Kingdom of Saudi Arabia

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AUSTRALIA

Establishment of WAPR–Australia.

An interim committee has been formed with members from four Australian States and Territories, representing wide-ranging expertise and skills (including academic, advocacy, clinical and NGO sectors, education and training). The former Australian branch has been inactive for several years. Therefore, the interim committee has been setting up the structures necessary to enable the branch to function effectively. WAPR-Australia has been registered as an Incorporated Association. External assistance is being sought to help the committee to develop a social media business plan and on-line presence by mid-2018. Committee members have also written a position paper that describes the current focus of WAPR-Australia activities and outlines key psychosocial rehabilitation issues across Australia and ways in which WAPR-Australia may contribute to the global objectives of WAPR, particularly in the Asia-Pacific region.

The interim committee’s immediate goals for 2018 are to:

- finalise legal establishment of WAPR-Australia by mid-2018
- recruit members from July 2018 (i.e. the start of the next financial year in Australia)
- attend and contribute to the WAPR International Congress in Madrid in July 2018
- co-produce a consumer and carer participation strategy in the third quarter of 2018
- organise and convene the inaugural Annual General Meeting alongside a half-day symposium in the fourth quarter of 2018
- continue to identify and respond to opportunities to advocate for, and enhance the profile of, psychosocial rehabilitation across Australia.

Prof Carol Harvey, Secretary and A/Prof Harry Minas, President, WAPR-Australia

PAKISTAN


Ms Lisa Cherry (UK) delivered lecture on emotional health and self care in Fountain House In collaborations with WAPR on November 15, 2017 in which Mental Health Professionals, students, stable members.

He also welcomed the guest speaker and participants and spoke on the Psycho Education Program and how it’s making difference in the community.(patients) and caregivers participated.

Dr. Syed Imran Murtaza Medical Superintendent Fountain House, Representative voluntary organisation WAPR is addressing the
## EXECUTIVE COMMITTEE

<table>
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MORE INFO IN www.wapr.org

Members of the WAPR Board 2015-18 in Seoul, Rep.Korea,
## WAPR COMMITTEES

### Congress Committee
- Co-Chair: T Murali (Pres. Elect)
- Solomon Rataemane (Sec. General)
- Tae-Yeon Hwang (Chair Org. Com previous congress)
- Antonio Maone (VP Region next congress).
- Ricardo Guinea, Chair Org Com. Next Congress.

### Nomination committee
- Co Chair: T Murali (Pres. Elect).
- Solomon Rataemane (Sec General)
- Afzal Javed (Immediate Past President)
- Alberto Fergusson (VP)
- V. Radhakrishnan (VP)

### Membership committee
- Co Chair: Solomon Rataemane (Sec. General)
- T Murali (Pres Elect)
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### Publications Committee
- Co Chair: Marit Borg.
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- Peter Yaro.
- T.S. Sathyanarayana Rao
- Barbara D'Avanzo.
- Michaela Amering.

### Constitution Committee
- Co Chair: T Murali (Pres Elect)
- Afzal Javed (Immediate Past President)
- Solomon Rataemane (Sec. General).

### Ethics and Human Rights.
- Co Chair: Michaela Amering.
- Guadalupe Morales.

## WAPR TASK FORCES

### Users & Carers involvement in Treatment and Rehabilitation Planning
- To be created.

### Ethics & Human Rights for persons experiencing mental illness
- Michaela Amering

### WAPR-Collaborating Centres for Training and Research (WAPR -CCTRs)
- Co-Chair: Harry Minas.
- PresElect. Murali Thylloth
- SecGen. Solomon Rataemane.
- Treasurer Carmen Ferrer
- VP Alberto Fergusson.
- VP V Radakrishnan
- VP Europe: A. Maone.
- VP Africa: Monique Mucheru.
- VP Americas. Pedro Delgado.
- VP EastMedit. Medhat Elsabbahi.
- VP SEast Asia Pichet Udomratn.
- David Ndetei.
- Tae-Yeon Hwang.

### Taskforce for Activities in Latin America.
- Co-Chair: Pedro Delgado.
- Anel Garcia.
- Georgina Fumero.

### Forensic Implications in PSR
- Co-Chair: Gabrielle Rocca.

More info in [www.wapr.org](http://www.wapr.org)