



WAPR World Association for Psychosocial Rehabilitation

Asociación Mundial de Rehabilitación Psicosocial | Association Mondiale pour Réadaptation Pshycho sociale

“A Global NGO in advocacy for people experiencing mental distress”

WAPR e-bulletín



*Responding to complex emerging needs in mental health
with new WAPR leadership,
after the World Congress
in Madrid 2018*

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WAPR Bulletin. Contributions

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EDITORIAL

by Marit Borg and Michalis Lavdas



At first we would like to thank our colleagues in Spain for organising a successful and highly inspiring world congress. We are very impressed of the scientific program and grateful for all the friendliness, hospitality and good discussions. WAPR is based on the principles of psychosocial rehabilitation being a term continually re-examined and re-defined in the light of lived experience and recovery-knowledge. Recent evidence also indicates the need for community and culturally-informed psychosocial rehabilitation practices.

In this WAPR Bulletin we are honoured to present you a presidential message from Murali Thyloth who has taken up leadership after the WAPR World Congress in Madrid (July, 2018). In the spirit of his message for an “updated” mental health promotion, we are also hosting critical reviews of recovery, the value and need choice in mental health, service user involvement and reports from WAPR branches worldwide interlinked with social and political changes. The global mental health movement is growing along with relevant criticism that is being developed and highlighted among different stakeholders. If we are to move forward in mental health adjusted to a “changing world” as also emphasized at the message for the World Mental Health Day in 2018, it should be done in a dialogic way where lived experience has a central role in planning, research and interventions. Evidence has been documented and presented that peer support workers are equally or more effective to any other expert by profession in community and clinical settings.

Collaborative research including service-users’ and peers’ participation is also of vital importance. Person-centred care is being included in the training programs in UK guidelines while recovery-oriented services are being introduced and developed continually. WAPR has been and is evolving with active participation from its worldwide network. Our network has moved forward in the context of promoting the psychosocial dimensions in mental health through different voices. This constitutes a reality that is shaped through “polyphony” and “heteroglossia” with Bakhtinian terms. Engaging in a dialogue with multiple voices, was part of the process that facilitated editing of this current issue; Marit as lead editor worked together with Michalis, a mental health professional from Greece honoured to be invited into the editorial committee. Michalis has a central role in editing of the WAPR Bulletin. Greece has been into the spotlight several years; harsh socio-economic conditions and austerity measures that have been taken as well as the refugee and forced migration crisis that has taken a global dimension bring into question current socio-political practices and their impact in mental health.

WAPR has been holding on to a worldwide inclusion of lived and practice-experiences and civil and human-rights. It is in our hopes that WAPR principles continue to reach out to service users, professionals, family members and societies facilitating needed changes.

Michalis Lavdas & Marit Borg

Presidential Remarks. *Murali Thyloth, President of WAPR*



Murali Thyloth
President of WAPR

At the outset I would like to thank all the members of our esteemed association for electing me as the President to serve the Association from 2018 to 2021. Under the leadership of Ricardo Guinea and his team, we had a very successful and well-organized 13th Congress in Madrid Spain, in July 2018. I am happy to inform all of you that the 14th World congress will be held in Abu Dhabi. World Association for Psychosocial Rehabilitation (WAPR) has grown from strength to strength over the last few years and today it has become well known all over world. This is largely due to the efforts of many of our past presidents and active members, among them notably is Afzal Javed. We now have many branches across the globe, with presence of WAPR in all continents, and active branches in many countries. It is due to the untiring efforts of Ricardo Guinea, Carmen Ferrer, and the Spanish team, that we were able to formally register WAPR in Madrid. We are now a fully registered organization with a good legal standing as an International not for profit organization.

Another significant development is the formation of “The Collaborating Centre for Training in Rehabilitation” (CCRT) in Asia, Africa and South America. Any mental health facility that wishes to

be a CCRT can now apply to WAPR for recognition. During the International and National conferences of other mental health associations, we have been cosponsors along with these agencies. As a result, we have been able to highlight the role of Psychosocial Rehabilitation (PSR).

WAPR has been a part of the “Rehabilitation 2030: Action Plan by WHO”. Representatives from WAPR have been present in the meetings held by the WHO. As a result, a number of international organizations have decided to form a global alliance on rehabilitation and WAPR has been actively involved in this.

The earlier board has worked towards the collection of dues and there by strengthening the base of WAPR in many countries. We have a strong accounting system in place made possible by our previous treasurer - Carmen Ferrer.

Going forward, what is it that we envisage for WAPR? The present geo political situations with natural calamities, climate change, migrants, refugee issues and work place mental health tensions taking a predominant focus, the progress of PSR is likely to be hampered as it is not one of the high priority areas. However the current day realities outlining the geo political situations will also be the thrust areas for WAPR, going forward. In order to realize our ambitions, WAPR needs to mobilize resources. With a shoe string budget that we have, it would be a challenge to sustain all our initiatives in the coming years. Hence there is an urgent need for financial resource mobilisation, which needs to be a collective approach with innovative thinking.

There is a need to increase CCRT’s that are locally relevant in terms of the culture and ethos of the community and this in turn will help to improve human resources for PSR.

Currently only few of our office bearers are active, and inputs from the regional representatives are not adequate. The National Secretaries are

not sufficiently propagating PSR in their respective countries. We will focus on strengthening and providing support to the existing branches as well as look at the development of new branches . We need to concentrate on LAMIC countries to reduce the mental health gap.

The activities are not regularly and systematically reported in the WAPR bulletin. While our network is wide, in many countries it is not active. Focus will be given to improve communication between the national branches and the WAPR board. Also the national branches will be encouraged to report their activities in the WAPR news bulletin. The website is currently in transition phase and will soon be available to all members.

We need to continue and manage with equal rigour some of the currently successful activities of the WAPR like active participation in Rehabilitation 2030 action plan of WHO.

Considering that the longevity of the population is increasing, rehabilitation is an important component for healthy living. Hence, I believe we are at the right time in the right place to deliver health care. I look forward to a continued support from the board and active collaborative participation from the national branches to bring to realization some of the dreams outlined for the period of my presidency

Murali Thyloth
President WAPR



MH
NEWS

The Mental Health & Psychosocial Support Network

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When talking about mental health we should keep in mind the different context that mental health responses should be developed in a culturally sensitive way. In the words of the MHPSS.net “A growing global platform for connecting people, networks and organizations, for sharing resources and for building knowledge related to mental health and psychosocial support both in emergency settings and in situations of chronic hardship. The network functions as an online community of practice for mental health and psychosocial support in challenging humanitarian and development contexts”.

Source and Link to further information: <https://mhps.net/>

ARTICLES

Promoting Choice- a Cornerstone of Recovery Promoting Practice *(Revised Reprint)*

Marianne Farkas, Center for Psychiatric Rehabilitation, Boston University, Co- Principal Investigator, Rehabilitation Research and Training Center



Marianne Farkas

The field has been in intense discussions about recovery over the past decade or two--, what it is and is not, whether it is a model or a personal journey or a set of outcomes etc. Whatever the

focus of the debate, however, no debate raises more issues among providers than the notion of “choice”.

Why is choice so important to the experience of recovery?

The US federal agency in charge of mental health (SAMHSA) defines recovery as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential”¹. Other definitions emphasize the development of new meaning and purpose², the core idea of which underlies mental health policy in most of the Anglophone world³ and others⁴. These definitions all see the individual as the central actor in the process of recovery. It is the individual who “improves their health and wellness”. It is the individual who develops a new sense of meaning in life. At its heart, the recovery movement asserts that “people are not passive sites where biological and social forces meet—but [actors] who interpret their experiences”⁵ The process of recovery is, in part, the recapturing of a sense of agency—or in other words, moving from a passive recipient of life to an active agent of one’s future. Making self-determined choices and decisions about one’s life,

one’s goals and the means to reach those goals lie at the heart of becoming empowered to be a full actor in one’s own life.

There is some evidence showing that offering choice and shared decision making is more effective than traditional authoritarian approaches to treatment⁶, that service users prefer shared decision making and that unmet needs decrease with clinicians offer shared decision making⁷. The issue of providing choice as a cornerstone of recovery-oriented services, however, is also a question of rights and full citizenship, rather than only about evidence⁸. Putting the individual receiving services, at the center of care and giving that person autonomy has long been seen as a basic underlying premise for the provision of modern general healthcare^{9,10}.

Why is the idea of “choice” so difficult?

Most providers of services hoping to promote recovery are not, by nature, trying to infantilize or control adults with serious behavioral health conditions. Many providers who deliver services to individuals with serious mental illnesses or behavioral health conditions, deliver these services primarily when individuals are at their worst. They are in crisis, their symptoms have taken control over their lives and the risks for “allowing” self - determination seem to be very high—loss of jobs, home, relationships, finances, physical health and at times, even life itself. Choice then seems to fly in the face of common sense and the basic caring that brought providers into the field in the first place. Does a humane person simply stand back while another is hearing voices or is frequently drunk and allow that person to choose their own path?

In addition, providers often see people, who, when not in crisis, appear to be doing very little with their lives. They may be spending their time watching TV, smoking cigarettes and sitting on a sofa, with seemingly little motivation to make change, or to work on anything close to some future oriented goal. Providing the chance to make choices in these circumstances seems to be supporting the inertia

and the lack of motivation that is so plainly a barrier to the person's ability to succeed. Lastly, providers may have had experiences in which offered someone choices and received what seemed to be totally unrealistic or inappropriate responses. For example, in reply to the question "what kind of work would you like to do" responses like doctor, astronaut, rock star etc. may seem totally out of the question, given where the individual is at and the skills s/he possesses-

Choice from a recovery perspective

These three examples of common issues with choice (ie. choosing when a person is very ill; choice for "unmotivated people"; unrealistic choices) are addressed from a recovery perspective, not by pretending they do not exist, but by shifting the paradigm with which these interactions are understood and applying a set of skills to facilitate choice.

Choosing when a person is very ill

Both people with mental illnesses and addictions tend to have exacerbations and remissions. Most individuals with these conditions are not ill or in crisis 24 hours a day, 7 days a week. Providers can help people make proactive choices about the ways in which they want to have crises dealt with, the kinds of medications that they feel work for them, the interventions and people perceived as helpful, when they are not in the midst of suffering an episode. Types of Advanced Directives¹¹, elements from Wellness Action Recovery Planning (WRAP)¹² and other similar crisis planning tools provide methodologies to help people create plans for their care before they experience symptom exacerbations or crises. When taking the value of choice seriously, providers look for ways to engage the person when he or she is well, or functioning better, in selecting beneficial and personally desirable ways of intervening when the person cannot speak for him/herself, rather than operating from the assumption that control in the midst of a crisis is the only option possible.

Choice for "unmotivated people"

A recovery oriented provider does not ac-

cept the notion of "unmotivated people" but rather sees motivation as a function of the fit between the environment and the person. In other words, most behaviors can be analyzed as rationale responses to the environment once all factors are understood. For example, providers often think of clients who do very little as unmotivated. Many people with or without disabilities, have difficulty making important changes in their lives. Few people can tolerate frequent change, choosing, consciously or unconsciously to consolidate any change they make and then live with the results for quite some time, being "unmotivated" to try another change quickly. Information collected about different recovery journeys taken by individuals with serious mental illnesses, show that for many, there are fairly lengthy periods when nothing much appears to be happening. Rather than viewing such periods as evidence of a lack of motivation, some¹³ have described this as a phase in which people seem to be in a maintenance mode sometimes for years, when, as often occurs in other biological processes, the organism appears to be storing up energy for the next big change.

Other reasons that people go through periods of what appears to be aimlessness, is related to the lack of hope about the future. Hope has been called the "essential ingredient of rehabilitation"^{14,15}, as well as the critical element in promoting recovery¹⁶. If it seems that there are not likely to be any good jobs or decent housing or friends /partners to share it with, people in general, feel unmotivated to strike out on a new path. If a person's experience has been that change usually ends up being for the worse rather than for the better, regardless of the amount of effort put in, then that individual may well feel unmotivated. Engaging a person in choosing the elements of a meaningful life—i.e. developing a long term vision of what such a life would look like, requires that the person believes that change is possible, will be positive and will be manageable¹⁷. Arranging opportunities for the person to experience different options, experience tasks and responsibilities that the person can do well, meet peers who have made similar changes and can provide support, often creates the spark that helps individuals begin to believe in a future. That belief can inspire a desire

to begin to take an active role in creating a vision for a meaningful life-- choosing the elements (e.g. home, work, education, social etc.) and eventually choosing other recovery goals within that overall vision. Services such as Clubhouses and Peer Support¹⁸ are especially well designed to provide such opportunities to inspire hopefulness which can then make choosing seem feasible and worthwhile to the individual.

Unrealistic choices

No one is born knowing how to choose. For most of us, the process of trying things out, finding out what we like and do not like, what is important to us or is negotiable is the work of adolescence through young adulthood and beyond. Many of us had after school or summer jobs, for example, that helped us learn about the world of work, learn about our work preferences and learn about what we do poorly or well that others are willing to pay us to do. Individuals with serious mental illnesses or behavioral health conditions often experience their first episodes exactly during the period when this kind of self-knowledge is being formed—i.e. during adolescence. As a result, many spend their formative years learning about mental health and substance abuse services rather than about work, home or school options. Consequently, helping someone choose requires engaging, exploring and arranging for an array of opportunities for the person to actually experience and then helping the person to process or debrief those experiences so that the individual can identify whether they liked working with their hands more than with data, for example, or they liked being in a school that was highly structured more than one that had little structure, as well as simply understanding what is important for anyone to know about certain kinds of settings. Volunteer positions, visits, summer courses, workshops, internships, job shadowing, mentors are all methods that help individuals gain the experience they may be lacking in a domain of interest. Provider skills include how to identify what opportunities might be helpful to arrange for a person to learn about themselves or the domain in question; how to help the person understand what they experienced or saw

relative to their own values and standards; and how to help the person use decision making tools that focus on comparing one option against another in terms of the person's *own standards*¹⁹. Tools such as Shared Decision Making^{20,21} are particularly useful for those kinds of decisions which make sense to decide together with a professional. For example, decisions about medication regimens require both expertise in medications and personal expertise in the experience of using the medications. Some decisions are less often ones we normally share. For example, deciding where we work or live tend to be decisions we make privately. For those kinds of decisions, I believe that self-determined decision making is more normative and usual.

Choosing is the essence of what it means to be a citizen of a democracy. It implies living with both the freedom as well as the responsibility that comes with the choices we make. No one can claim or reclaim a meaningful life without the right to make choices along the way. Providers who believe in promoting recovery therefore must develop the knowledge and skill needed to help support informed choice as an integral part of their practice.

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Is there a future for recovery?

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“Recovery refers to the lived or real life experience of people as they accept and overcome the challenge of the disability ... they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability”
(Deegan, 1988).

It has now been thirty years since Patricia Deegan (1988) published her seminal article entitled “Recovery: The lived experience of rehabilitation”—in which she first defined the concept of “recovery” in relation to serious mental illnesses as above: as “recovering a new sense of self and of purpose within and beyond the limits” of what she proposed to call “psychiatric disability.” This article coincided with the substantial lobbying efforts of the mental health consumer/survivor movement, as advocates secured inclusion of serious mental illnesses in the provisions of the Americans with Disabilities Act (ADA), which was finally passed in 1990. Within the context of this legislation, serious mental illnesses became redefined as “psychiatric disabilities” for the purpose of securing the same rights to community inclusion, and the same expectations for the provision of accommodations, that were afforded to persons with physical disabilities. Deegan makes this analogy explicit in a second article published a few years later entitled “The Independent Living Movement and people with psychiatric disabilities: Taking back control over our own lives” (1992).

As I will argue in the following, some progress has since been made in operationalizing, and actualizing, this vision of a disability rights framework in relation to serious mental illnesses (e.g., Amering & Schmolke, 2009; Davidson, 2016). There are concrete and substantial ways in which the adop-

tion of such a disability framework has changed mental health policy and practice, as well as the expectations of persons with mental illnesses and their loved ones. Some progress has been made. As the title for this article suggests, however, I also will argue in the following that this same vision may be getting lost in the process, and is vulnerable to being abandoned prematurely due to two related issues. First is the matter of how the concept of “recovery” is understood by policy makers, and second is the way in which the implications of this concept are interpreted and institutionalized by mental health practitioners. After reviewing some of the progress that has been made, I will then take each of these issues in turn.

Concrete Progress

As a result of the de-institutionalization and community support movements that pre-date the recovery movement, persons with serious mental illness are, for the most part, no longer kept locked in institutions for prolonged periods of time. In some, more wealthy countries, systems of community-based care have been created to offer treatment, rehabilitation, and supports in the person’s local community. Perhaps most importantly, young people are no longer being told to abandon all hope on first diagnosis of a serious mental illness and are instead encouraged to learn how to manage their condition should it become prolonged. Families similarly are no longer counseled to abandon their loved one to the care of a hospital, or to view his or her brain as irrevocably “broken” (Andreasen, 1982), but to hold out hope for improvement and to seek education and support for themselves. The terms “recovery” and “recovery-oriented practice” have made their way into numerous government policy statements, mandating a “transformation” of services and systems of care (Le Boutillier, Leamy, Bird, Davidson, Williams, & Slade, 2011). As part of these community-based systems, some new supports are being developed to promote broader community inclusion beyond housing (e.g., supported employment, supported education). The recovery community has begun to develop self-help tools (e.g., Wellness Recovery Action Planning) and innovative programs (e.g., Recovery Colleges) to put people in

the driver's seat of their care and recovery, and more and more people are being trained and hired to provide peer support, which instills hope and offers tangible role models of what recovery looks like on a day-to-day basis. Finally, psychiatry is beginning to follow the rest of medicine in adopting collaborative relationships and shared decision-making within the context of a model of "patient-centered care."

Areas of Vulnerability

With all of this evidence of concrete progress in implementing a recovery-oriented vision in mental health systems and care, why worry so much about the future? Because it seems that this initial progress is in danger of being both undermined and overshadowed by unanticipated turns in the road of mental health policy and practice. For example, while—as we have seen above—Deegan first defined "recovery" in relation to a persisting "psychiatric disability," subsequent definitions of this concept have increasingly de-emphasized the presence of the disability (or illness) in favor of emphasizing the variety of ways in which people choose to find meaning and purpose in their lives. This shift has become evident in the use of such definitions of recovery as being a "unique" or "deeply personal" journey (e.g., Anthony, 1993); definitions in which any mention of mental illness may be missing entirely. This shift may have culminated in 2010, when the U.S. Substance Abuse and Mental Health Services Administration arrived, through a consensus development process, at a definition of recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

In attempting to avoid the on-going controversy regarding the existence and nature of serious mental illnesses as illnesses, recovery thus came to re-defined vaguely as "a process of change" that could be equally relevant to anyone, whether or not they live with a psychiatric disability. In fact, some advocates have gone so far as to suggest that "everyone is recovering from something." While this may initially have been intended to destigmatize, or normalize, mental illnesses—as in "persons with mental illnesses are no different from anyone else"—it unfortunately has had the unintended con-

sequence of minimizing the impact of mental illness on the person's life, taking attention away from the needs that person may have for mental health care and supports in actualizing his or her right to community inclusion (as ensconced, e.g., in the ADA). This kind of "watering down" of the disability rights framework underpinning the recovery concept has led some policy makers to justify cutting funding for mental health care, as they have come increasingly to view recovery, defined as a "personal journey," as the person's own responsibility. If everyone is recovering from something, and each person's recovery is a unique and self-directed process aimed toward achieving one's full potential, society as a whole is no longer obliged to pay for mental health services and supports that were previously needed by people with illnesses or disabilities (Braslow, 2013).

This is but one criticism of what the concept of recovery is becoming and the ways in which it is being (mis)used in both policy and practice. These concerns have led some in the same mental health consumer/survivor movement that gave birth to recovery in the first place to want to throw the concept "in the bin" (e.g., *Recovery in the Bin*, 2018). In addition to the misuse of recovery by neoliberal governments "as an excuse to discharge prematurely or deny people access to mental health services" in the ways described above, the group that has come together to throw recovery "in the bin" argues that the original concept of recovery has been co-opted by conventional mental health practitioners as a way of packaging old wine in new bottles. I was made aware of this possibility early on in my career when attempting to articulate how recovery-oriented practice might look different from traditional care. At the end of one full day of training on this topic, a senior administrator said something to the effect of: "That all sounds fine, but what if the client won't cooperate with his own recovery?" Since then, both recovery proponents (e.g., Slade, Amering, Farkas, Hamilton, O'Hagan, Panther, Perkins, Shepherd, Tse, & Whitley, 2014) and detractors (e.g., *Recovery in the Bin*) have pointed out various abuses of the concept, from renaming day hospitals "recovery centers" without changing much else to recasting involuntarily administered medication as "assisted outpatient

treatment,” reframing coercive measures in positive terms (e.g., “she needs the structure to initiate her recovery”). A final example of this kind of co-optation is to describe the function of peer support as “a low cost way to get people to take their medications.”

Separate from, yet related to, this degeneration of the recovery concept is the relative, albeit implicit, neglect of the social and cultural determinants of mental health. Framing recovery as a “personal journey” or an individual responsibility diverts attention away from all of the other conditions and resources needed for recovery to occur. It doesn’t necessarily have to—one could conceivably talk about both individual and societal responsibilities. But according to its critics from the political left (e.g., Harper & Speed, 2014; Morrow, 2013), this notion of recovery is being used by neoliberal governments to overlook the social conditions in which people live and, as a result, “blame” them for not recovering as an excuse for preserving the inequitable status quo. As we find in the manifesto on the Recovery in the Bin website (2018):

“We believe the growing development of this form of the ‘Recovery Model’ is a symptom of neoliberalism, and capitalism is the crisis! Many of us will never be able to ‘recover’ living under these intolerable social and economic conditions, due to the effects of social and economic circumstances such as poor housing, poverty, stigma, racism, sexism, unreasonable work expectations, and countless other barriers.”

Salvaging Recovery’s Future

Salvaging a viable future for the concept of recovery would therefore seem to entail acknowledging, or bringing explicitly to the fore, the crucial role of the social, cultural, political and economic determinants of mental health as a counterbalance to the focus on the individual nature of the journey. It also will require re-emphasizing the importance of the disability rights framework for ensuring that people are provided the services and supports they need to live self-determined and full lives in the presence of an ongoing disability. Disability is defined as the result of a person-environment interaction, thus by definition acknowledging the role of social, cultural, and political/economic determinants of mental health and laying the foundation for the

use of environmental modifications. In addition, the disability rights and independent living movement have established legal justification for funding of long-term supports (in the face of long-term disability)—e.g., no one would presume to take away a disabled person’s wheelchair because he or she has failed to “learn” to walk—thus avoiding the neoliberal excuse of society not having responsibility for funding what is understood as an individual’s responsibility for his or her personal journey.

Moving in this direction requires grappling head on with the issue of mental illness as a disability, however. Even the most serious of mental illnesses have a broad heterogeneity in outcomes, though, with many people recovering fully and others having prolonged disabilities. For those who recover fully, use of the term disability is both unnecessary and incorrect. But those who recover fully are, by definition, not as much in need of long-term mental health care and community supports. These individuals may be considered to have recovered from a serious mental illness (Davidson & Roe, 2007) or achieved what Slade (2009) has suggested calling “clinical recovery.” These are not the people most in need of the alternative, “personal” form of recovery that Slade argues for; the same form of recovery first defined by Deegan in 1988 as “within and beyond the limits of the disability.” This form of recovery is paradoxically needed most by those people who do not recover, those people with prolonged disabilities. If this form of recovery is to survive into the future, it should be focused primarily on precisely those people who do not recover in the conventional, clinical sense of the term.

What does focusing on the needs of this population entail? First, and perhaps most importantly, it means distinguishing between recovery as “fitting in” to societal norms and expectations and recovery as being “let in” as one is (Davidson, Stayner, Nickou, Stryon, Rowe, & Chinman, 2001), i.e., as disabled. If it does not require full (clinical) recovery, fitting in may require hiding one’s disability; what persons in recovery have described as “passing for normal” (Flanagan & Davidson, 2009). But persons with other forms of disability are not required to “pass for normal.” Rather, environmental

accommodations and other community-based supports are provided for them to be able to function as well as possible in their self-chosen pursuits and relationships. Persons with visual impairments can learn Braille and have dogs 'see' for them, those with hearing impairments can learn sign language or how to read lips, and those with mobility impairments can use wheelchairs and have had curbs cut into sidewalks and handrails installed in bathrooms. We will not fulfill the true promise of the Americans with Disabilities Act, and the recovery movement itself, until we figure out what psychiatric equivalents to these strategies look like and how they operate. Notwithstanding such advances as supported education and supported employment, this remains a challenge for the future (Rowe & Davidson, 2016).

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Italian Mental Health Reform: some thoughts 40 years later .

Gabriele Rocca, WAPR President Elect



The origins
The law which promoted the psychiatric reform – known in Italy as the “180” – was enacted in 1978 at the end of a political season that managed to turn into law radical instances inspired by the respect of human rights and the need for social justice.

That period was characterized by a large anti-institutional movement that found a common ground with the first attempts of change within psychiatric hospitals. The complaint against violence towards patients, criticism of the doctors’ power, the affirmation of freedom as a fundamental right of patients, these are some of the theoretical nodes of a reform which started inside the world of psychiatry, but quickly turned towards other disciplines and institutions. Strong links, both in terms of content and method, emerged between mental hospitals and other areas of society, to a point that the field of psychiatry became emblematic of a debate that also involved other institutions such as the family, the university, the prison, the judiciary. Furthermore, the struggle within psychiatric hospitals allowed an innovative synthesis between theory and practice because the theoretical reflection proceeded at the same pace of the anti-institutional activity (Foot, 2014).

During the seventies the psychiatric movement progressively acquired the awareness that the process of closing/shutting down large institutions required, at the same time, a new general health care based on decentralization and a network of community services. This fostered the connection with the political and trade union movement that had been fighting for health reform for years, with the aim of outlining a new organization of public medicine

(Babini, 2009).

The same year – 1978 – saw the approval the law establishing the National Health Service (Law 833) that guaranteed the right to health for all citizens and defined a welfare state in which the new psychiatric organization could find its operating space. It is not by chance that a close interrelation between the two laws has been highlighted in terms of principles and organizational models, coming to affirm that there would have been no law 180 without the parallel transformation of general health care and that there would have been no Law 833 – as it was elaborated – without the law 180 and the anti-institutional psychiatric movement (Palumbo, 2018). In the parliament the discussion was brief and the law was approved during a dramatic phase of the political life of our country: four days earlier the President of the Christian-Democratic Party, Aldo Moro, was murdered by the terrorists. Francesco Maisto (2018), a judge who has always been committed to defending the rights of the weakest citizens, recently observed that the approval of the law 180 was an act of high reformist rationality that was opposed to the terrorists’ judgment: illegal, unjust, unfair.

As it is known, after the end of the second world war, most European countries, although in different ways, underwent a phase of deinstitutionalization. In Italy, Franco Basaglia played the role of protagonist. Already in the sixties he had been the leader of a very important experience of deinstitutionalization in the Psychiatric Hospital of Gorizia, a town in the northeast of Italy, on the border with Slovenia which at the time was part of Yugoslavia and the hospital was divided by the border. Gorizia was far from the University where Basaglia had studied and worked up to that moment; Gorizia was also far from the most important scientific and cultural centres. Gorizia was on the outskirts of everything. Nevertheless in this Psychiatric Hospital Basaglia was leading an extraordinary process of transformation: in the first phase the Hospital was reorganized according to the model of the therapeutic community as proposed by Maxwell Jones in Scotland. In the second phase Basaglia and his group claimed the necessity to put an end to psychiatric institutions at large. This turning point radically differentiated the Gorizia experience from similar

plans of deinstitutionalization in other countries and still characterize the Italian psychiatry in a peculiar way.

The therapeutic community itself – as a way of reforming mental hospitals – was rejected as an instrument that still encouraged a paternalistic approach inside the institutions, with unacceptable contradictions related. A new model of care was developed and the aim was the disappearance of large institutions by the progressive realization of community mental health services. It was affirmed not so much the possibility but the necessity of a psychiatry without psychiatric hospitals.

Gorizia Mental Hospital Staff Meeting – 1967
From the left to the right: Basaglia, Casagrande, Slavich, Jervis, Pirella, Comba, Fruttini, Schittar
(Foot, 2014)

Other projects of closing down psychiatric hospitals started, but actually they were hospitals of a few towns (Arezzo, Ferrara, Nocera, Parma, Perugia, Trieste). These were very significant experiences which created a new cultural identity among young psychiatrists and psychologists, but which didn't change the organization of psychiatric care. And therefore, when the law was approved, psychiatric care, in Italy, was based on Mental Hospitals with very limited activities inspired by the community mental health model.

The Law

Despite the decisive role played by Basaglia and his group, the law was the result of a mediation between political and cultural positions that were different and on certain topics conflictual. And several technicians, politicians and significant figures of the cultural world contributed to drafting it. The law is composed by a few and clear articles and establishes that it's forbidden to admit new patients into Psychiatric Hospitals and to build new Psychiatric Hospitals; mental health care has to be managed by new community-based services; inside General Hospitals new Psychiatric Units, which will not exceed 15 beds, have to be created to treat acute psychiatric disorders. Furthermore a new procedure was introduced to carry out compulsory admission following these criteria: the patient needs an urgent

therapeutic intervention; the patient rejects the intervention; it's not possible to treat the patient in the community. These criteria attribute the responsibility of the decision to the doctors, while the judicial authority has only a function to control after the admission has taken place.

As a consequence of the law admissions into Psychiatric Hospitals stopped immediately and during the following weeks and months the carrying out of new Psychiatric Units in General Hospitals started.

Looking back at 180, Mezzina (2018) highlights the different aspects in which the law affected culture and society not only in Italy:

- “- As a new set of norms respecting human rights (the normative character);
- As the climax of a crisis of psychiatric hospital as an institution and the rising of community-based mental healthcare (the policy character);
- As a promise of a true paradigm shift in psychiatry, a new way of thinking about people with psychiatric issues, that is a model for all countries, with all its cultural shifts and implications (the seminal character);
- As an expression of a social and, to some extent, political movement for expanding civil and social rights of vulnerable groups (the citizenship character)”.

In fact, Law 180 led to a radical change in psychiatric care and in the patient's legal status. According to the previous law, people were admitted to the mental hospital because judged “dangerous for themselves and for others” and for the same reason they were deprived of their civil rights. On the opposite, with the new law patients were recognized as citizens with their full rights, who need psychiatric care. Their power to decide about the care has increased and the conditions to establish a relationship of mutual trust with the carers were created. Thanks to this new freedom of care there is now the possibility of a responsible consensus that determines negotiating limits to various decisions, also in the case of compulsory admissions. In this context, initiatives and proposals of the users' movement have been developed to achieve an active role in the planning of mental health services and in the elaboration of treatment plans. We can clearly see the evolution of the care relationships still taking place today, mov-

ing from a paternalistic model to a contractual one, focusing on the responsibility of the patients on their own lives (Ferrannini, Peloso, 2012).

The end of psychiatric hospitals

When the new law stopped the admissions, 78,000 people were inside Mental Hospitals. Over 20 years, patients were discharged, overcoming the distrust of those who did not believe that this could happen. In 1999 the era of the large psychiatric institutions that existed for almost two centuries ended. About the outcomes of this process it could be interesting to present the Antonini Mental Hospital experience – in Milan metropolitan area – in which I was personally involved.

Antonini was one of the three Psychiatric Hospitals in the province of Milan, the oldest and largest. In 1996, at the beginning of the closure plan, in the Hospital there were still 337 inpatients, judged not dischargeable. They were people with a long history of illness and their clinical symptoms and social disability were assessed (BPRS and DAS). During the following years they were discharged and 163 of them were resettled in the community entering a range of community-based residences that provided different levels of care. Follow-up of patients who moved to the community, carried out three to four years after discharge, showed significant stability both on the clinical and on the social side. There were no adverse events such as suicides or accidental deaths and annual admission rate to General Hospital Psychiatric Units was low if compared with those of similar studies. This experience aroused interest and distrust at the same time due to the high number of patients placed in non-hospital residences after many years of institutionalization. We ourselves, who had wanted and implemented the project, faced the various phases of discharge and the activation of residential facilities and houses with deep concern. But the result of the plan confirm that institutionalized patients can live in the community providing that the residential team is integrated with the community mental service and the other health structures. (Barbato, D'Avanzo, Rocca et al., 2004).

Today

Now a network of mental health services is widespread in every region and it is capable to re-

spond to people's mental health needs. These services – and I would like to underline it – are universal, cover all the citizens, receive public financing, are integrated with the other structures of the National Health Service. It's a radical community psychiatric system, which is founded on the principles of the deinstitutionalization.

The organization is based in the Department of Mental Health (DMH). The Department is the set of facilities and services that is responsible for prevention, treatment and rehabilitation of mental disorders in a catchment area. The entire national territory is divided into different areas; in total, in Italy there are 163. The DMH has the task of organizing the care, managing the budget and having relationships with social services and social companies. Regarding the relationships with other services of the same area, we can find different levels of integration. Almost 50% of the Departments include other services like those for drug abuse, child and adolescent psychiatry and clinical psychology.

The Mental Health Services for Adults, that interests us here, consists of the following services: General Hospital Psychiatric Units (GHPU), Community Mental Health Centres (CMHC), Non Hospital Residential Facilities (RF), Day Centres (DC). Thanks to these structures various types of interventions can be provided: rehabilitative programmes of short or long duration as well as in-patient treatments for acute crises for almost 780.000 patients. A significant indicator of the functioning of the system is the suicide rate (ISTAT 2017): in 2014, compared to the European rate (11.25/100,000 pop.), Italian one is 6.8/100,000 – in decrease since 1994 (8.1/100,000 pop.).

This organizational model, even if with some differences, is implemented in all the country. The following data are part of a Report of Ministry of Health (2018) and describe the network of services for the year 2016.

GHPU. There are 4,831 beds in General Hospitals with a rate of 9.5 per 100,000 population. The average length of stay in 2016 was 12.7 days. A critical indicator: almost 90% of Units are functioning with the door permanently closed. Recently an association began its activity to promote open door and the complete end of coercion.

CMHC. The CMHCs are 1,303 (2.6/100,000

pop.) widespread throughout the national territory. RF. 1,844 Residential Facilities (3.6/100,000 pop.) are available with 26,117 beds, equal to a rate of 52/100.000 pop. The average length of stay in 2016 was 673,9 days.

DC. Day Centres are 827 with 13,949 places.

Some critical points

The implementation of reform.

The Italian Mental Health System, organized on the departmental model, is widespread throughout the country and guarantees the treatment of persons with mental health problems in community-based services. Nevertheless, the structural and service use data show significant differences between the various regions (Ministero della Salute, 2018) suggesting a relevant variability in service provision. Various standards such as compulsory admissions, length of stay in residential facilities, allocation of resources etc. point out the way in which the reform is implemented in every area. They also offer important elements of debate to proceed, in all the country, with a consistent consolidation of community-based services to avoid any form of re-institutionalization.

Fortunately, the regional division does not mean strict administrative separation and consequently a balanced national transformation process is possible.

Families and service users associations.

During the first years after the law's approval, psychiatric services and family associations could not find areas of fruitful collaboration. In the process of deinstitutionalization, divergent and sometimes conflicting opinions emerged, delaying the identification of goals to be followed together. Specifically, interventions for the involvement and support of family members lacked, highlighting a technical delay.

An association named National Union of the Associations for Mental Health (UNASAM - Unione Nazionale delle Associazioni per la Salute Mentale) progressively defined a dialectical proposal that allowed identifying important points of convergence. But above all, family associations have become essential interlocutors at an institutional and political

level, where they are listened to and respected.

Our friend Ernesto Muggia, who left us one year ago, member of WAPR and EUFAMI Board for many years, was a founder of this association. He led UNASAM for a long period and under him the association promoted a psychiatric care without institutions and without coercion, respectful of the rights of users, able to promote innovative projects. UNASAM and Ernesto were also very interested in the consumer's movement. In Italy there is no similar user's movement to that, for instance, in the US. Italian associations carry out integrated programs with mental health services in a non-conflictual perspective. Among the others I would like to mention the project concerning expert users in peer support that involves some services in Lombardy (Kauffman et al., 2017). These are not very frequent projects and WAPR wants to promote similar initiatives that today represent an interesting field of intervention.

Compulsory Admissions

Involuntary hospitalization generate a problematic situation for all the participants. For the patient, who is deprived of his freedom and who must be treated in a condition of constraint and seclusion. For the society, which increasingly requires security and control of various forms of behaviour, by delegating this function to mental health services. For the psychiatrist, who on the basis of a clinical evaluation decides to respond in an unilateral way to the need identified in the patient. For the judicial authority, required to play a role of guarantee and control over the various phases of the entire hospitalization. Because of this clinical, legal and social complexity, compulsory admissions define the way in which a service addresses the issue of freedom and human rights. The constant effort to minimize coercion is a crucial aspect of mental health care over the world considering that "some of the worst human rights violations and discrimination experienced by people with mental disabilities, intellectual disabilities and substance abuse problems are in health-care settings" (WHO, 2012).

In 2016 there were 7,963 compulsory admissions with a rate of 16 per 100,000 pop. with a great variability among the various regions.

The number of compulsory admissions critically decreased since 1978 – when they were 20,294

– and the rate is much lower than those observed in other European countries (Salize, Dresing, Peitz, 2002).

Moreover, the Italian data contradict the hypothesis that the reduction of beds provokes an increase in compulsory hospitalizations (Barbui, Papola, Saraceno, 2018).

Residential Facilities.

It is very difficult to collect reliable data about residential facilities because there are several types of structures with several goals and there isn't an international consensus regarding a classification (McPherson, Krotofil, Killaspy, 2018). Only recently the Ministry of Health proposed definitions to be used nationwide.

From 2000 up to today there has been a progressive increase in the number of beds, from 17.138 in 2000 to 26.117 in 2016. For two years the increase in the number of beds has stopped but only for administrative decisions to limit costs.

Each of these residential facilities does not have more than 20 beds and in three quarters of them the staff works with rounds over 24 hours. To a complete European comparison it's useful to considering all the amount of beds in mental health systems. We can see that in Italy, RFs plus GHPUs beds reach the rate of 61.4 beds per 100,000 pop. In Europe, where Mental Hospitals are still widely present, the rate of psychiatric beds reaches 88.9 per 100,000 pop. (WHO, 2017).

It's unclear if the current number of residential facilities is adequate for the needs of the new psychiatric network. But the percentage of discharge from Italian residential facilities is low. A recent study – which confirms previously collected national data (de Girolamo et al., 2002; Picardi et al., 2014) – shows that in an index period 25.8% of patients were discharged, but only 13.6 to home and 2.2 to Supported Housing; instead 8.2 to other RFs, and 1.5 to prison (de Girolamo et al., 2014).

It seems that even if these structures have rehabilitative aims, it's hard for patients to live again outside them. The complexity of the situation probably requires a deepening of the actual rehabilitative function of the residential structures and the role that they have in determining the lives of the patients.

Deinstitutionalisation

Italian Mental Health Care was built, as shown, keeping in mind the goal of deinstitutionalisation. As Fioritti, (2018) clearly highlighted, “the deinstitutionalisation paradigm means to Italy much more than the closure of psychiatric hospitals. It is a social and political construct designed to reformulate relations between individuals and the society, balancing power relationships in favour of the vulnerable subject. It implies an attitude of constant awareness of the iatrogenic, destructive and dehumanizing effects of heavy institutional interventions and a continuous effort to minimise them”. In the last years Italian society is changing. The awareness of freedom as a fundamental value has decreased. In the community a common sense of solidarity is being lost and a request for more security is increasing. Due to the long economic crisis, some population groups are living in great hardship. At the same time mental health services are operating with fewer resources than in the past (Starace, 2016) and are facing with new needs as migrants, adolescents, vulnerable people that are asking a relevant attention and the respect of their rights. This critic situation could undermine the inspiring principles of the reform and could lead to a transformation in a regressive way of the social role of mental health services. To avoid this risk it is necessary to redefine their objectives, the way to obtain them, with which resources. In other words, in the face of the new scenario, the mental health system will have to rethink its identity and its mission. This cannot only concern technicians, but requires the involvement of politicians, large sectors of society and representatives of users and family members.

The history of the last 40 years shows us the way forward.

Conclusions

The Italian experience suggests that it is possible to realize an effective mental health care without psychiatric hospitals giving great attention to the risks of re-institutionalization. In the world psychiatric hospitals still absorb large part of resources: their global rate of beds in the world is 11.3/100,000 pop., but in Europe it is up to 34.2 (WHO, 2017). It is not just an economic question: the existence of

mental hospitals affects mental health care in the community in a negative way. Psychiatric hospitals always constitute a concrete choice of intervention, they influence the culture of the staff, are deeply in contrast with the community based services and constantly violate human rights.

For these reasons we can affirm that only without psychiatric hospitals a high level of community mental health care can be implemented and patient's rights can be actually respected.

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Revising the consensus in Psychosocial Rehabilitation (PSR) – After the XII World WAPR Congress.

Ricardo Guinea, Past President of WAPR



FEARP received the responsibility of organizing the XIII World Congress of the World Association for Psychosocial Rehabilitation (WAPR) in Spain. The Organizing Committee of the Congress planned its task in collaborative partnerships, in alliance with the Spanish Association of Neuropsychiatry. It received sponsorship from national and international scientific organizations - significantly, the World Psychiatric Association, WPA -, from family organizations and other actors in this field. In the financial aspect, it was sponsored by WAPR, FEARP, AEN, Manantial Foundation, Murcia - European Social Fund, the The Madrid Agency for Family and Social Affairs, and other more modest but not less valuable financial sponsorships. We managed to



make a reasonably independent Congress viable - and in particular, although that was not necessarily a specific Congress objective, completely independent of the pharmaceutical industry.

To assess in its proper perspective the meaning of a World Congress in Spain, it is interesting to take into consideration the path traveled, the current state of affairs in our country, and future challenges.

The assignment represented in the first place

a gesture of confidence and recognition from WAPR to Spain, to FEARP, to our professionals in Spain. It was a similar gesture of confidence related to the task developed in favor of the implementation and development of the Psychosocial Rehabilitation model in Spain for two decades now. This involves countless scientific and training activities, several national and European conferences, the development of publications and other tasks, such as the promotion and support of associative movements of carers and users, and campaigns and activities to combat stigma.

It is interesting to remember that in the last 20 years in Spain we have achieved a huge evolution. Spain raised the reform of its psychiatric system from the General Health Act of 1986, with years of delay compared to other European countries. A model of attention specifically based on the philosophy of psychosocial rehabilitation began to be considered in the beginning of this century, with the pioneering impulse organizations such as ARAPDIS in Catalonia, AMRP in Madrid, then FEARP from the national associative world, and a growing number of people, social and scientific leaders and public and private organizations.

The practical advances that have taken place since then have been numerous. To highlight only two aspects. The PSR as a philosophy of attention has been progressively taken into consideration by public organizations and administrations. Although varied throughout the country various models of attention and management have been implemented. And two: quite quickly, the new practices have evolved since then and have been updated to a point where we would say that the delay in Spain with respect to other countries has been reduced in a good way.

During this time, FEARP has been a leading scientific society and a pioneer in spreading PSR philosophy and values in Spain. Proposals such as the creation of specific rehabilitation services, the improvement of residential facilities, the creation of real training and employment opportunities for users, the creation of opportunities for participation through art, sports or political action, the creation of opportunities for participation of people with personal experiences through the promotion of user organizations. The varied initiatives have been proposed, widely accepted and with results of extraordinary richness and creativity. FEARP has also been a pioneer in some innovative actions of great symbolic

importance. In 2005, at our first national congress, people with lived experiences of mental illness were invited for the first time in Spain to present their perspectives at a scientific meeting, an initiative that has been widely followed.

In the field of theory, the introduction in Spain of the recovery perspective for scientific discussion has been another significant contribution of FEARP. This perspective, which has been included in almost all clinical guidelines and European and national program-documents in the last 15 years, has brought to the table new visions - or perhaps not so new - about the process of experiencing mental illness and experiencing recovery. In a historically discouraging field such as coping in everyday life with mental illness, the recovery perspective has brought a more hopeful outlook to the people affected and their families. More recently, in the political line of the UN and the WHO, the dissemination of the Human Rights perspectives and living conditions has introduced new debates and revealed problems that have been there for many years, in expectation of exploring new solutions.

To finish the perspective in Spain prior to the Congress, it will not be wrong to note that our journey of the last 20 years, time that coincides with a very recognizable generation of professionals, includes the creation of many services and organizations. In the past in Spain, in order to get



information about how to implement services, our only option was to refer to studies, work, and experiences from other countries in our environment - the case of Italy, the Anglo-Saxon world, Brazil, or the Scandinavian countries. In contrast, today, after 20 years of experiences, you can start talking about “the Spanish experience”. The practices that have been implemented in our cultural environment are

already a capital of empirical study, on which academic researchers are developing their work. For all these reasons, the organization of a world congress, which has put our practices in view of professionals from all over the world, can be considered as a national success and reason for pride.

I would like to mention some important lines that aimed the composition of the program.

One of them has been the policies of intervention. On this subject, we have had presentations on the 40-year experience of the Italian psychiatric reform, on policies in the world (Thyloth Murali for India, Tae-Yeon Hwang for Asia, José M. Caldas de Almeida for Europe). We have had an important presentation on the Peruvian reform with the participation of Yuri Kutipe (Director of Health services mental of Peru) and Debora Kestel (representing PAHO). An important presentation taking into account that WAPR, and Spanish professionals have played an important role in its beginnings and in its ongoing development of the reform. The experience of Madrid (Abelardo Rodríguez and other professionals) was presented to the international audience along with that of Trieste (Roberto Mezzina). We have had presentations by internationally recognized speakers on psychological aspects of rehabilitation (with Paul Lysaker), on experiences of early intervention (Andrew Thompson), on the notion of recovery (Marianne Farkas, Larry Davidson and others). Also, in an innovative way, attention was paid to the gender perspective in mental health (interesting projection topic, with Helen Herrman, President of WPA).

The congress had as one of its explicit objectives to review the consensus, so we have sponsored the presentation of diverse views on controversial issues. For example, we wanted to echo the discussions about optimal pharmacological strategies in the psychiatric treatment of schizophrenia, with Afzal Javed and Joanna Moncrieff presenting different visions in an academically documented manner. We have echoed the current academic debates that occur in the international arena around the notion of schizophrenia, the discussions about its reliability and its validity (John Read). On human rights we have Tina Minkowitz, (lawyer and collaborator at the United Nations), and Natalie Drew (from WHO).

I would like to emphasize that the proposal of the Congress to review the consensus was not based on the a priori defense of one or another

ideological vision; much less it housed a dogmatic pretension. Every informed professional in the field of mental health -and the PSR- is up to date with the discussions and diverse approaches that polarize the current debate. This has to do with the extraordinary epistemological complexity that surrounds everything related to the mental. And more in such a complex area as the PSR, where science and values, social and health meet in a complex interaction.

To mention an example, the perspective of recovery is usually presented as a paradigmatic change. Indeed, the notion of recovery emerges in the transition from the manicomial model to the community model. It implies, wherever it is implemented, a great revision of the notion of mental illness, of the role of the sick person, and of the role of society and services. It is understood in the transition from a model based on custody to a model based on the rescue of the person's values and in supporting their possibilities for participation and social inclusion. It represents the transi-



tion from a model focused on disease control to a model focused on the reduction of disability and social disadvantage, which incorporates the experience of people who have been able to recover as a new source of evidence. The study and debate on the

possibilities and practical implications of this model is under development, and more time will be needed to understand its true impact, its real implications in the design of services.

The debates on the awareness and implementation of the Human Rights perspective are another hot topic of discussion. A historical and geographical review shows to what extent psychiatric practices around the world have collided with basic rights - it is easy to find concrete examples. Both from the perspective of the invasion of personal rights - personal freedom, legal capacity - as well as social rights - equity in access to quality treatments and opportunities for training and participation. The issue today is more acute as there is greater sensitivity than ever in regard to individual rights. International documents such as the International Convention on the Rights of Persons with Disabilities, ratified by most countries, are global indicators of this new sensitivity. A new sensibility that emphasizes qualitative values - freedom, dignity, equity, non-discrimination - whose value is hardly questionable. But its implementation and its implications in the multiple environments of real practice - the emergency room, situations in which the mental condition hinder the exercise of personal rights - are under study and discussion. The congress has echoed this discussion, which needs to be continued. Discussion that, to be fruitful, must be produced in broad terms, and counting on all social actors, and in real world situations if we do not want to risk limiting ourselves to producing a split between the world we want to have and the world we can have. It is necessary to continue working to perfect the formulas that allow reconciling individual rights with the collective ones in subjects that concern security, and in reconciling the right to legal capacity with protection in situations in which it is difficult to exercise it, only to mention two aspects.

In this global scenario of paradigmatic change, it would have been a naive pretension that the congress would try to establish the new consensus in such a complex field, where different approaches can legitimately take place. Admitting the complexity of a discussion in a scenario of great and accelerated change is a good starting point to lead it. In recent years, and in Congress, we have been able to confirm that debates can be very passionate. This is very understandable considering that what is at stake affects the rules of professional ethics, the tradition of services and established practices,

health, dignity, sometimes freedom of people, or the coexistence in families. The debate takes place in new conditions since other actors have been incorporated -families, users-. It is a debate than concerns



values -in which everyone is legitimately called to participate- but also science -which is subject to strict rules and it requires specialization for its correct understanding-. A broad discussion of this kind is not simple. The framework of the “trialogue” has been proposed for years, a conversation framework that incorporates professionals, users and relatives; but for complex reasons to analyze, there was not a meeting of this type in our congress. What seems clear to me is that a discussion that does not include all actors and all sensibilities runs the risk of deriving in simplified or purely rhetorical positions, and to be irrelevant in terms of operating real and lasting transformations in the real world.

From this perspective, I would dare to venture some personal expectations for the future of the PSR. In general terms, on the side of the new consensus, psychosocial rehabilitation, once presented as a practice awaiting a theory, has already shown in practice its possibilities and its power to improve the lives of many people. This alone is already a great result. We notice a reality now for many people with disabilities, who in the past would have drastically reduced their life expectancy, can now work and participate in the community. Life with and beyond the illness can be dignified and not necessarily miserable.

Regarding the pending tasks, we still do not have a definitive vision on several of the aspects under discussion. For example, there is a growing sense that the validity of the “schizophrenia” construct

needs revision, but at the same time that the present alternatives have not been able to replace it in a solvent way at the moment - (About this, see the last issue of the World Psychiatry). The discussion on the role of drugs had a prominent place in the Congress, and it was clear that there is still discussion about what an optimal pharmacological treatment can be, especially in the long term.

Face to the future, another interesting aspect - in Spain - will come from the evolution of user’s participation. We already know that in the world there are many consolidated experiences of users’ participation. There are models of services designed and directed by users (for example, the case of the Club House model, with increasing implantation whose best known antecedent is Fountain House in the USA). In the international scene, the cases of outstanding contributions such as Judi Chamberlin or Pat Deegan are often quoted – but the list could be numerous. They are people who add to their personal experience of mental distress and recovery, their academic training as professionals or as researchers.

In our country, the experience of user participation has recently begun; time will tell how it will be consolidated. The professionals close to the recovery perspective consider that the information from the people with lived experiences is valuable to improve the understandings of what is relevant in the recovery processes, and for years we have enabled the means to present it on each occasion. We favor the idea that the service user / patient needs to be seen as a person in his/her context, that participation and self-determination should be prioritized, and hope needs to be transmitted. But it must also be remembered that recovery is defined as a highly personal process that implies a non-delegable personal responsibility of the user. And that the achievement of a collaborative relationship between users and services, which is described as a favoring factor, is only achieved if every party - professionals and users - reconcile their beliefs , goals and skills and disposition for it.

It should be borne in mind that to the extent that user movements legitimately participate as political actors in the social debate, they also acquire a political responsibility. Responsibility that, as in any other group of political representation, can be and is used in different ways. In that sense, I would dare to venture that it will be the mutual recognition of each actor in his responsibility that it will be possible to

move forward.

The future of the PSR will continue to need the participation of many. It needs visionaries to maintain the values and the transforming spirit of our discipline, it needs scientists to continue searching for the answers to the pending issues, the work of managers and policymakers, etc.

The XIII World Congress showed in my opinion that progress has been made, but that further progress is needed to make opportunities accessible to people, to better understand the complex mechanisms of getting ill and recovering, to advance in the consensus that makes viable coexistence and the respect of individual rights.



MH
NEWS

The Lancet Commission on global mental health and sustainable development.

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In accordance with the Sustainable Development Goals, a Lancet Commission puts forward research, evidence and implications for policy making towards global mental health. As it is presented in *The Lancet*: “A decade on from the 2007 Lancet Series on global mental health, which sought to transform the way policy makers thought about global health, a Lancet Commission aims to seize the opportunity offered by the Sustainable Development Goals to consider future directions for global mental health. The Commission proposes that the global mental agenda should be expanded from a focus on reducing the treatment gap to improving the mental health of whole populations and reducing the global burden of mental disorders by addressing gaps in prevention and quality of care. The Commission outlines a blueprint for action to promote mental wellbeing, prevent mental health problems, and enable recovery from mental disorders”.

Source and Link to further information: <https://www.thelancet.com/commissions/global-mental-health>

RECENT EVIDENCE ON SERVICE USER INVOLVEMENT IN RESEARCH. *by Esther Ogundipe*

Introduction

There has been growing interest in the involvement of service users in research. These days more and more funding bodies demand explicitly evidence of collaborative research. In this issue, we have chosen three articles, which focus on people's experiences with doing collaborative research.

World Association for Psychosocial Rehabilitation
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Fall 2018 | www.wapr.no

Moltu, C., Stefansen, J., Svisdahl, M. & Veseth, M. (2012). Negotiating the co-researcher mandate – service users' experiences of doing collaborative research on mental health. *Disability & Rehabilitation*, 34(19), 1608 – 1616.

Background: This article explores co-researchers with experiential knowledge in collaborative research. The article also explores their experiences with attending a Norwegian training program in research methodology and design. The aim of the training program was to empower them as active participants in research projects.

Method: Co-researchers' experiences with participating in projects as well as in attending the training program were explored with the aid of focus groups interviews. The first focus group interview was held straight after the last gathering of the training program. Whereas the second focus group interview took place 3 months later. In total, there was 12 co-researchers (participants), nine women and three men. Preliminary analysis was taken back to co-researchers for discussion, auditing and reanalysis.

Results: Three major themes were identified: 1) Self-definition as co-researcher: the emergence of a stronger we through meetings peers. 2) Constructive differentiation: knowing the field of academic research without becoming engulfed. 3) Negotiations: balancing loyalty and influence. The themes reflect the important social processes involved in the participants' development of a consensual understanding: self-definition, constructive differentiation and negotiations.

Conclusion: In the discussion section, the authors put forwards hypotheses on how participatory research within the field of mental health can be organized, in a way that empowers co-researchers with experiential knowledge to be active and constructive participants.

Bryant, W., Parsonageb, J., Tibbsa, A., Andrews, C., Clarka, J. & Francoa, F. (2012). Meeting in the mist: Key considerations in a collaborative research partnership with people with mental health issues. *Work*, 43, 23-31

Background: This article examined an established collaborative research group experiences with conducting collaborative research. The aim of the study was to identify the barriers and facilitators to successful joint working, with a particular focus on user involvement and knowledge transfer.

Method: Eight members of the collaborative research group participated: five service users, one assistant, one occupational therapist and an academic. Structured individual reflections were recorded and shared for initial analysis. These were the types of questions asked: What has been positive about being a group member? Were there any problems or difficulties you found in being part of the group? What do you feel you have learned through being in the group? Afterwards, more data was obtained through a group discussion, in order to conduct a comparative analysis.

Results: Four themes emerged: 1) Meeting in the mist, which was a metaphor used to describe participants' journeys within a collaborative cycle. 2) Collaborative working as a cycle, which described, with the aid of a visual model, the collaborative cycle. 3) Creating space, which emphasized the importance of having sufficient time and space to create a shared vision of the future. 4) The warp factor, which focused on relativity theory to highlight the sense of innovation.

Conclusion: The authors claim that collaborative work can be based on knowledge transfer and ideas about user involvement, generating tangible benefits for all involved, including engaging in productive occupations.

Mjøsund, N. H., Eriksson, M., Espnes, G. A., Haaland-Øverby, M., Jensen, S. L., Norheim, I. Kjus, S. H. H., Portaasen, I.-L. & Vinje, H. F. (2016). **Service user involvement enhanced the research quality in a study using interpretative phenomenological analysis – the power of multiple perspectives.** *Journal of Advances Nursing* 73(1), 265-278.

Background: This article is based on a study, which aimed to examine how service user involvement can contribute to the development of interpretative phenomenological analysis methodology and in turn, enhance research quality.

Method: Data is based on experiences associated with a 4-year collaborative research project; from year 2012 to 2015. An advisory team, which consisted of five research advisors, collaborated with the research fellow through the entire research process.

The advisors either had a diagnosis or, were related to a person with a severe mental illness. The analytical discussion were audiotaped and transcribed. The transcripts were analysed using interpretative phenomenological analysis.

Results: Findings revealed the power of multiple perspectives. Multiple perspectives influenced the qualitative analysis, by providing more insightful interpretations of nuances, complexity, richness and ambiguity. Overall, these findings suggest that the outcome of service user involvement was increased breadth and depth in findings. The advisory team became the researcher's "helping hand".

Conclusion: The authors claim that service user involvement improved the research quality, because the interpretative element of interpretative phenomenological analysis was enhanced by the emergence of multiple perspectives.

Person-centred care: implications for training in psychiatry Royal College of Psychiatry. United Kingdom, September 2018

Putting the experience of the person as a whole, in the core of mental health practices while claiming to establish and run recovery-oriented services means that a change of culture and change of practices is in order. A substantial change can be achieved through training mental health professionals and specifically psychiatrists in person-centred care. The Royal College of Psychiatrists (RCP) has published a report on person-centred care with implications for training in mental health setting out to bridge the existing gap between "values and experience, principles and practice, intention and achievement". As we move to an anthropocentric care in mental health it has been often noted that psychiatry still remains "remote to individuals, ignoring their broader subjective and cultural experiences". The authors of the report stress that although there is a concrete foundation in a holistic approach to care in psychiatry, no explicit reference to person-centered practice is included in the psychiatrists' training curriculum. The report aims at outlining the rationale for embedding person-centred practice in postgraduate training and assessment while providing recommendations to enable the delivery of person-centred care through postgraduate psychiatric training and assessment. The report has been written by the Person-Centred Training and Curriculum (PCTC) Scoping Group consisting of members and non-members of the

College, including service users, consultants and trainees. Lived experience was in a dialogic relation to psychiatric education as well as clinical psychiatry reflecting the collaborative and co-productive ethos that was intended. The PCTC scoping group carefully revised current evidence in moving training in person-centred care from ideas to actions and worked closely with major stakeholders before reaching the following key findings and recommendations.

In brief, among the key findings was that there is an extensive literature that supports the benefits of person-centred approaches for clinicians, patients and service delivery. Additionally, the adoption of a person-centred approach is widely supported by a wide array of national (ie. Other medical Royal Colleges, Health professional bodies, NHS) and international stakeholders (ie. WHO, WPA). Also, certain gaps were identified in terms of availability of person-centred training across the country, "despite an overwhelming wish for its inclusion in psychiatric training on the part of both trainers and trainees". Lastly, it was argued that current RCPsych core curriculum signals the importance of "of respect towards people who use services but it makes no reference to 'co-production', 'values', 'personalisation', 'personal budgets', 'ethics', 'human rights', the community context of people's lives, 'self-care' or 'self-directed care'."

Recommendations can be categorized in five different fields that work in complementarity starting from the revision of the curriculum stating the importance of reflecting “person-centred” nature in the language of the curriculum as well as the need to include relational competences related to person-centred care in the curriculum (shared decision-making, self-directed support etc.) and competences related to broader aspects of person-centred care like ethics, human rights, community engagement and social inclusion. As for postgraduate psychiatric training it is stated that while making sure to deliver the core values for psychiatrists it should also be noted that the role of service users, carers and patient representatives is strengthened at planning and delivering courses. Additionally, the necessity to create guidelines and standards for course organisers for working inclusively was noted along with the promotion of involvement of trainees in Recovery Education Colleges. Joint training sessions with other medical professionals and other professional groups in mental health are also emphasized with a view to facilitating embedding person-centred care in training placements. The next field refers to assessment. Assessing and examining competences related to person centred care. This important field emphasizes the need for assessment in both summative as well as formative assessments and refers to the need for reviewing the current practices in the respective fields. Quality assurance is a major part of the recommendations consisting of two major notes; (a) the recommendation that Health Education England and its counterparts in the devolved nations to

ensure that benchmarks and quality assurance criteria for MRCPsych courses and other postgraduate psychiatric training include competences related to person-centred medicine and (b) the recommendation that RCPsych is the main body responsible for setting professional standards for psychiatric training and practice in the UK. As such, “it must develop mechanisms to assure and demonstrate that postgraduate training and assessments in psychiatry across the nation are able to consistently deliver core values and objectives outlined in the curriculum consistently”. The fifth field of recommendations refers to values and reinforcing the importance of the set of core values for psychiatrists. Three main recommendations are falling into this field starting with (1) the necessity that all RCPsych publications and documents should demonstrate consistency with the document Core Values for Psychiatrist, following with (2) the recommendation to incorporate relevant aspects of values-based skills training into the curriculum and finally (3) amending “the core curriculum to explicitly demonstrate its consistency with these core values, including the core value of person-centred practice”.

The full report can be found here: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr215.pdf?sfvrsn=7863b905_2

WHO Problem Management Plus (PM+); scaling up psychological help for communities exposed to adversity



PROBLEM MANAGEMENT PLUS (PM+)
Substantial psychological help for adults impacted by disaster, displacement,
or violence

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Reducing the treatment gap in mental health in LAMIC countries has been a WAPR goal over the years. WHO with a view to scaling up cost-effective care for mental health has launched a new intervention manual for adults impaired by distress in communities exposed to adversity; Problem Management Plus (PM+). This intervention has been backed up with research evidence with RCTs in Kenya and Pakistan and relevant publications (Dawson et al, 2015, Rahman et al 2016, Sijbrandij, 2015, 2016). More details can be found here: https://www.who.int/mental_health/emergencies/problem_management_plus/en/

WAPR NATIONAL BRANCHES REPORTS

As usual, we are presenting a few reports from WAPR National branches. These are not meant as formal reports, rather as some pieces of information aimed to get us more aware of the issues and problems of each country and how intense is the activity of their branches. They often show how important is in WAPR the interplay between social and political issues with psychosocial rehabilitation, recovery and empowerment activities and values.

Slovenia

In 2017 and 2018 ŠENT- the Slovenian association for mental health actively participated in several fields, where inadequate treatment of people with mental health problems was noticed:

We participated in the finalization and implementation of the Slovenian 2018-2028 mental health plan. The representatives cooperated in building an action plan which clearly defines the guidelines to work in the area of mental health and areas that have so far been inadequately addressed.

ŠENT participated through two representatives of users and relatives in the working group for changing the law on mental health.

In 2017 we participated in promoting the right to subsidized public transport ticket in the municipality of Ljubljana: Article 25 of the Municipal Decree states the right to free tickets for public transport for people with occupational handicap I. cat. according to the Employment Relationships Act. They do not realize, however, it is comparable to the 1st degree handicap, defined in the Pension and Disability Insurance Act, thus not recognizing their right for a subsidized ticket. The Equalization of Disabled Persons Act is also violated. ŠENT informed the ombudsman, who recognized our effort and will include our achievement in the Annual Report of the Office of the Ombudsman.

Taiwan Association for Psychosocial Rehabilitation (TAPR)

In modern society, people with psychosocial disability still encounter numerous hardships that severely affect the well-being and personal development of

them. As the relevant social issues have consistently become more complex than ever, the impacts of these hardships become more patent as well. For the effective alleviation, after time-and-energy consuming preparations, a group of dedicated physical and mental health professionals established TAPR on July 3rd 2010. Within these members, their expertise includes, but is not limited to, psychiatrists, social workers, lawyers, and scholars renowned for their mental health research. Among practitioners, they have abundant experiences working with women, people with psychosocial disability, and others who are socially and economically disadvantaged. Their efforts and activities have provided a new dimension to the analysis of the needs of people with psychosocial disability. Also, it has laid the firm foundations of services that TAPR is still growing and enriching today. In 2018, we engaged in the services presented below.

Service Programs

1) The peer-support team for independent living from North to South in Taiwan: From January to April this year, regular meetings were planned and implemented by a 7-psychosocial disabilities peer team to complete tasks which prominently improved their independent living capacities (e.g., interpersonal cooperation, evaluation of pros and cons in everyday life, organization ability). A main task of the team was designing and scheduling the outline of the 2018 Independent Living Workshop that lasted two days at the end of October. For the further reinforcement of independent living capacities, we advanced 2018 Independent Living Workshop contents in ways that the former two did not. The peer-support team is the advanced point TAPR explores in 2018. Participants with psychosocial disability were required to engage in the peer-support team and attended at least ten weekly discussing meetings from the early June to October. Their engagement strongly exposed themselves to the intensive practices of reflective thinking, mutual emotional and practical supports offering, as well as independent living skills enhancement through individual life goals settings and its action plan. Among professional practitioners who offer daily needs and assistance to these participators, TAPR also equipped them with not only the deeper independent living concepts but the

relevant practical applications leading to the purpose of building an environment that enables people with psychosocial disability to outline and realize their independent living plans by themselves.

Among all participants with psychosocial disability, they were divided into four groups based on their residential places. It is worth noting one of the groups consisted of people living in remote areas which can be reached by very limited social resources.

2) The 2018 Independent Living Workshop: Sustained from positive changes brought about by the peer-support team, the main purpose of the 2018 Independent Living Workshop was to assist people with psychosocial disability to enhance the cultivations of their independent living application abilities for daily life as well as self-confidence in realizing that task. The 2018 Independent Living Workshop was held as the two-day activity on 20th and 21th October. Under the criterion of participant selection set to meet the minimum attendance rule, namely attending 10 weekly meetings as the member of the self-motivated discussion within the team, over 35 people engaged in that workshop.

As the feedback from 2018 Independent Living Workshop participants demonstrated, Independent Living Workshop indeed benefited not only people with psychosocial disability but professional practitioners as well. For the former group, their knowledge base in various skills entailed by independent living was strengthened. For the latter group, Independent Living Workshop can become the platform that enables them to expand the positive impacts of independent living skill and knowledge promotion to more people with psychosocial disability in homecare-like agencies and other professional institutions.

3) Personal Counseling Services: How to manage and limit the impact of psychosocial disability and continue the daily needs maintenance becomes extremely tough. In this regard, TAPR plays an important role in empowering people with disabilities and working with them to ignite their resilience via offering personal counseling services. On average, we have offered 1-to-2 hours counseling for people in need every week in 2018.

4) Telephone Counseling Services: Due to the unique social context and cultural norms, a great proportion of people who are most in need are reluctant to search for help in a way that demands face to face. In this regard, pure calling becomes the

available way. Since the first day of the foundation of TAPR, we have been offering telephone counseling services everyday during working time. For emergency cases, we also provide the correspondent 24hr telephone counseling.

Advocacy

1) The Mental Health Act Revision Engagement to comply with the Convention on the Rights of Persons with Disabilities (CRPD): In Taiwan, the Mental Health Act was firstly amended in 2007 since it was acted in 1990. The main purpose of the enactment of the Mental Health Act is to improve the human rights of people with psychosocial disability and promote their accessibility to appropriate care and community services without limitations as well as decreasing compulsory treatments. However, there are still fundamental problems that beset governance and delivery system. To resolve the relevant flaws, TAPR has consistently cooperated with members (psychiatrists, social workers, lawyers, and scholars renowned for their mental health research) to offer insightful suggestions that public agencies rely on to make the Mental Health Act better comply with CRPD. Through the numerous meetings with the representatives of public agencies (e.g., the Ministry of Health and Welfare, Ministry of the Interior, Department of Social Welfare at Taipei City Government) and working allied with the other NGOs and legislators in the past year, the Mental Health Act will be possibly amended much more in compliance with CRPD in 2019.

2) WAPR Participation: People with psychosocial disability interact in the society. At the same time welfare system varies progressively. In order to discuss the cutting-edge social issues stemming from the consistently changing interaction patterns (such as independent living support program responding to article 19 of CRPD), we organized a session to talk about the community support programs to psychosocial disabilities in East Asia with Korea and Hon Kong in XIII WAPR Congress this July. That session presenting was also live on line (TV and internet) simultaneously. In addition to the more professional conversations with other outstanding experts in WAPR, we also reinforced by working with Taiwan legislators and Ambassador in Spain to initiate a great dinner for the discussion of the relevant issues.

Summary: Promoting the well-being of people with mental illness is a tough task. However, as an NGO,

it is far tougher for TAPR to stand out and stop our efforts here due to its difficulties which are still increasing at present. In 2018, we have continued our mission and added the new way to serve for the people who need. After 2018, we will still insist on improving the well-being of people with psychosocial disabilities, just like what we have strived for, always.

Norway

This year's national WAPR conference in May was centred around the themes of community and choice, with additional focus placed on social exclusion, discrimination and human rights for people suffering with mental health and drug issues. One key theme centred around street football and sports as socially inclusive initiatives in mental health and substance abuse. Alan Pringle, researcher at Nottingham University, commenced proceedings. Since 2013, Nottingham University has been working closely with Notts County football club, where they have evaluated some of the initiatives the football club has taken regarding marginalised groups in the city. He explained how the collaboration with the club has given hope and a sense of progress to young boys with mental health problems.

The Notts County project has evolved into something more than football. The club now offers physical activities in several sports to a range of people. They have taken preventative measures in relation to young people at risk of committing criminal acts and to those in child welfare. One of the findings of the research highlighted the importance of using professional trainers and non-healthcare workers. This leads to normalisation. Exercise succeeds in eliminating the hierarchy between those who are ill and those who are healthy.

In Bergen an organization called "Psykiatriliansen" (the Psychiatry Alliance) was presented by the initiator Per Nilssen and Claus Lundekvam, a former Premier League player.

This is a sports community which has been running for 12 years and is a collaboration between various providers in Bergen. All of the coaches are well-qualified and have acquired knowledge in the field of mental health. There are several different types of exercises and sports activities in the community to choose among. Demand for new activities is currently so high that they have had to temporarily put the brakes on. In addition, they offer a cafe once a

week, which is also well-attended.

The next theme was human rights, attended by the Head of Department at the Equality and Anti-discrimination Ombud. She referred in particular to the significance of the Convention on the Rights of Persons with Disabilities (CRPD). This was set up by the UN in 2008 and represents a paradigm shift in relation to the rights of those with disabilities. The convention challenges specific legislations regarding coercion, both in terms of its legality and in cases of a lack of support for voluntary assistance and decision-making. Norway committed itself to the CPRD in 2013, but it has yet to be incorporated into legal policy. Norway currently faces some serious human rights challenges pertaining to this convention. There are considerable differences in the use of coercion among the various health institutions. This can be explained by variations in treatment cultures, differing organisation and use of resources, as well as varying degrees of cooperation between different services. In practice, the use of coercion in Norway prevents services from being equal. It can lead to re-traumatisation and further health damage. Norway must fall into line with the CPRD by repealing current laws regarding coercion in its treatment of mental disorders. The focus must shift more towards autonomy and shared decision-making. The presentation highlighted the need for a change in our mindsets regarding the decision to use as well as the act of using coercion. Legislation will be a challenge. Norway is going through a paradigm shift. Will there be a new law with more emphasis on decision support?

Drug-free treatment is a new development in specialist services in Norway. A local project in Bergen was presented by a professional and a peer-support worker both engaged in it. They shared experiences concerning the right of the person to drug-free treatment through use of collaborative means, as well as evaluation methods used in this work. The therapist and patient collaborate to select the course of action, treatment and follow-up the patient wishes to undertake. The patient receives support in finding the best solution based on the best available knowledge of the pros and cons, and exploring their own opinions and values. This consultative collaboration allows the patient to take more responsibility and participate in their own treatment. The patient is also given the chance to know what treatment works and that which suits them best. There must be some scope for trial by error in order for the patient to

gain their own experience. The quality of treatment turns out to be better, the patient takes more responsibility and explores different treatments in collaboration with the therapist. The patient is longer a passive recipient of treatment.

A peer support worker concluded the day by sharing her experiences in finding her feet on the journey from outcast to community. She was a heavy drug user for almost 30 years and after several different types of treatment she finally managed to quit addiction. She explained that the turning point was an older man who was working as a volunteer at a training session. He was the never-say-never type and just wouldn't give up, called her and taking her out cycling and training. This motivated her in a manner that suited her best and now the training and bike-riding provides a new way of shaking off anxiety and unease.

Community and choice were represented through several perspectives during the conference and proved to be the common thread throughout the day.

Brazil

Political crisis seriously affects psychosocial rehabilitation services

Since April of 2016, Brazil is going through political changes, which directly affect the functioning of the public institutions and the democratic system, bringing consequences to the public health and mental health care. Since 1990, the country has begun to build a wide public and universal health system, the SUS (Single Health System), in which are included the mental health and psychosocial rehabilitation centers. The country has 2.400 Psychosocial Care Centers, distributed in all the regions, and in the most far away from urban centres, such as the interior of the Amazonia states and the Northeast, regions most in need.

The democratically elected president, Dilma Rouseff, deposed in August 2016, was substituted for a government which has immediately taken financing measures to reduce public health. A government proposal of freezing the social public expenditures (health, education, social providence, assistance, housing) over a 20-years period was approved. In 2018, in an election process marked by the inappropriate interference of the judiciary, an extreme-right candidate has been elected, who proposes a

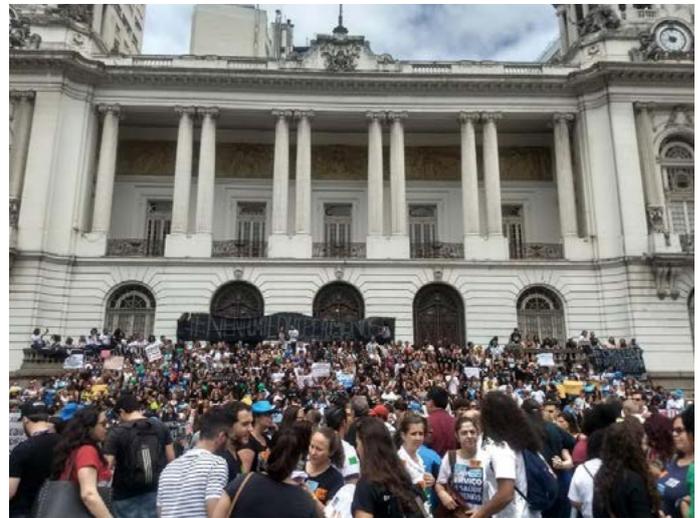


A manifestation in defense of the public health services (SUS).
September 2018

hard neoliberal adjustment for the social area. It has already been announced the reduction of the social costs and the closure of the activities among many health public centers.

In 2001, Brazil approved a mental health law which determined the substitution of the psychiatric hospitals with community services, in the perspective of deinstitutionalization and psychosocial rehabilitation in the community. The Brazilian experience of psychiatric reform is recognized by the World Health Organization as the most important in Latin America, beside the one carried out in Chile.

The WAPR Brazilian Branch strongly supports the mental health changing process, in which are in-



A manifestation in defense of the public services.
Rio, October 2018

involved thousands of professionals. The country is extremely unequal according to social indicators and, although it is the 8th world's economy (considering GDP), it is in 79th place on the HDI (Human Development Index). Thereby, the psychosocial rehabilitation activities, sustained by the public sector (federal government, 27 states and 1556 cities), are key measures to attend the mental health grievances and to alleviate the consequences of the poverty, violence

and inequalities.

Many initiatives try to increase the autonomy and the leadership of service users and their families, contributing for their well-being and their effective social inclusion. The program De volta para Casa (Going back home), for instance, socially supports the discharges from long hospitalization. Therapeutic residential facilities are designated for the housing of those who can't go back to their families of origin. There are among 600 initiatives of work and other income generating activities for the mental health service users operating at the moment, besides the many projects of art and culture, such as the carnival block "Tá Pirando, Pirado, Pirou", which counts on many users and professionals of the mental health services in Rio de Janeiro.

The WAPR Brazilian Branch is part of a national coalition of professional associations (as well as ABRASME - Brazilian Association of Mental Health), family and user groups, research groups in several universities, professional collectives in many services. All of them share a major concern with the future of the psychosocial rehabilitation centers, and are mobilized through debates and activities all around the country.

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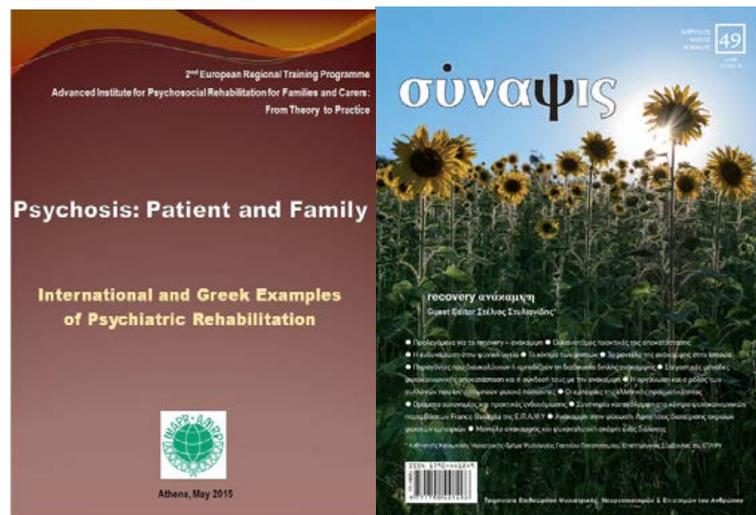
Greece

The Greek WAPR Branch has reported the following activities that have taken place over the last years:

- Organized in Athens the 2nd European Regional Training Programme Advanced Institute for Psychosocial Rehabilitation for Families and Carers: From Theory to Practice, May, 2015. The presentations were published as a monograph and added at the WAPR website
- Represented by two professionals at the National Congress of the Italian WARP branch in CESENA, 9-10 June 2017

Greek branch was one of the 40 different agencies from 15 countries participating.

- Participated in the XIII World Congress 2018 in Madrid with a number of presentations and attended the General Assembly Meeting
- Published a Special issue on the Greek psychiatric journal "Synapsis" (issue 49/2018) on Recovery in Greece with the participation of the WAPR President Ricardo Guinea. Edited by professor Stelios Stylianidis, ex vice president of WAPR.



Plans for 2019: Organizing a national Greek WAPR Branch congress with the collaboration of the Greek Federation of NGOs for mental health and psychosocial rehabilitation ARGO and experts from WAPR worldwide.

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- Participated in the ENTER Mental Health Network, EPAPSY and UNHCR meeting "Mental Health, Refugees & Migration" in Athens 24/5/2018. The



USEFUL LINKS

In this section we offer links important for our field. If you have suggestions for websites and links, please mail the Editor: marit.borg@hbv.no

Convention on the Rights of Persons with Disabilities:

<http://www.un.org/disabilities/default.asp?id=150>

Toolkit and information about policy and implementation of human rights and recovery perspective can be found in:

http://www.who.int/mental_health/policy/quality_rights/en/

Implementing Recovery through Organisational Change:

<http://www.imroc.org/>

Yale Program for Recovery and Community Health:

<http://www.yale.edu/PRCH/>

Movement for Global Mental Health

<http://www.globalmentalhealth.org/>

The Gulbenkian Global Mental Health Platform

<http://www.gulbenkianmhplatform.com/>

The Mental Health Innovation Network (MHIN)

<http://www.mhinnovation.net/>

Mental health publications can be downloaded from the links below or ordered from the WHO bookshop:

The WHO Mental Health Gap Action Programme (mhGAP):

http://www.who.int/mental_health/mhgap/en/

The WHO Mental health action plan 2013 – 2020:

http://www.who.int/mental_health/publications/action_plan/en/

WHO QualityRights Project:

https://www.who.int/mental_health/policy/quality_rights/en/

WHO MiNDBank (online databases of good practices worldwide):

<http://www.mindbank.info/>



WAPR 2018 - 2021

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