Building up advanced practices around the globe – focusing on the needs of the person and his or her social networks.

Cover photo provided by Peter Yar & Basic Needs - Ghana
“Zahatu Saitah harvesting tomatoes from her dry season vegetable garden”

WORLD ASSOCIATION FOR PSYCHOSOCIAL REHABILITATION
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WAPR Board and Committees
The title of the recent world congress in Madrid was “Recovery, Citizenship, Human Rights; Reviewing Consensus”. We were invited to critical dialogues, discussions and actions in order to develop understandings and new insights of barriers and facilitators and to find ways of strengthening some of the core issues in psychosocial rehabilitation. Let us continue these dialogues and actions in order to support people’s recovery, to support family members and professionals in their efforts and facilitate recovery-nurturing environments. A core issue in all this is to incorporate people’s human rights. Previous WAPR President Afzal Javed and professor Michaela Amering, member of WAPRs editorial committee and Task Force on Ethics and Human Rights, wrote a paper about mental health and human rights in the Indian Journal of Psychiatry in 2016. They emphasised working in partnership with persons with a lived experience and their families and friends as a strategy of attending human rights. The authors referred to reports confirming the severity of human rights violations among this group almost in all cultures and countries though there are variations in frequency, intensity or severity. There is a need to further strengthen programs addressing abuse and violations of rights in our field. In future issues of the WAPR Bulletin we welcome papers and brief reports on efforts and examples of how human rights are protected in psychosocial rehabilitation throughout the world. In this issue of the Bulletin we are proud to present a recent research project on family and network practices. Open Dialogue involves a consistent family and social network approach to care, in which the primary treatment is carried out through meetings involving the person together with his or her family members and extended social network. A Greek clinical research team has explored an Open Dialogue pilot project in a Day center in Athens. They see these practices as a tool of health democracy within mental health reform in Greece. From Greece we are moving then to East Asia where Tae-Yeon Hwang explains the recent changes of mental health policies and services, specifically mentioning Korea, Hong Kong, Japan and Taiwan. The shift more and more to community-based care is comprehensively documented and a “new way of thinking about community mental health in the region” is strongly evident. Another important article that we are glad to be hosting in this issue is Ricardo Guinea’s work on “institutional supervision” and the relevant 4 year experience in Madrid over psychosocial rehabilitation teams. Qualitative methodology facilitates the emergence of themes that portray the importance of clinical institutional supervision associated with dealing with clinical difficulties and “crises”, group dynamics, negotiations on setting the “most correct” course of action and “understanding the great concepts at stake”. An interesting part of the presented work is the joining of institutional analysis, Recovery model and Human Rights-based approach. In the next article, we are hosting a more “experiential
narrative” from an internship that took place in Bergen supported and organized by WAPR Norway. Michalis Lavdas explains his experience as a young professional with an interest in mental health and refugee care how living for two weeks in Bergen gave him the chance to witness how the Bergen Municipality has been working (a) in the integration of refugees and migrants and (b) in providing recovery-oriented mental health services to the whole population through different levels. If put in a few words, the internship practice that is the 2nd year in place for WAPR Norway is a great way to understand advanced practices in mental health and contextualize them when you get back home.

In the following section concerning Advanced Practices we are proud to present the experience of the Basic Needs Ghana developed in two separate pieces; (a) Contributing to improving maternal mental health in Ghana and (b) On the path to Self-reliance; the story success of the Gambibgo Yinsognmah Self-Help Group. In the first case Basic Needs-Ghana is collaborating with the Regional Alliances for Mental Health and Development to increase advocacy for maternal, child health and survival. It is a crucial element that Community Volunteers are playing a central role in the project while non-experts are also trained and supported as part of the mobilization of the community towards this very important issue. In similar principles, Basic Needs-Ghana also promotes self-help through supporting mental health self-help groups made up of mental health and epilepsy service users and their primary carers. This very important experience highlights that the path to self-reliance requires a group perspective and a comprehensive psychosocial approach involving both financial as well as psychosocial empowerment.

Esther Ogundipe then presents recent evidence on service user involvement in research focusing on recovery amongst people with co-occurring mental health and substance use problems. Findings are based on “the accounts of people with lived experience and/or people working with them” and major concepts are researched revolving around major factors that contribute to recovery and successful treatment.

Our current issue hosts a lot of interesting News from WAPR branches all over the globe. As it is introduced “V.K Radhakrishnan, India WAPR vice-president, informs us of the extremely hard challenges WAPR has to face and of the way of working in the community. WAPR showed to be on the forefront in the aids to the areas destroyed by the floods in Kerala, as well to participate to joyful traditional celebrations in favor of children and their wellbeing”. In the Eastern Mediterranean Region report we are glad to be hosting news on psychiatric rehabilitation status in Arab countries as Medhat Elsababhy signs off. Here you can find information on trainings, conferences and workshops that were delivered by WAPR members in the area while networking fervent preparations of the 14th WAPR World Congress in Abu Dhabi 2021 are taking place. More news around conferences follow and the section of WAPR news ends with many interesting pieces provided by Afzal Javed and the WAPR Pakistan branch. Relations with Clubhouse Europe are being developed as well as new initiatives in the field psychosocial rehabilitation are actively supported. Training activities are also noted and welcomed in the WAPR news section.

This issue’s title summarizes best what we have been introducing in this editorial; building up advanced practices around the globe – focusing on the needs of the person and his/her social network! We deeply appreciate everyone’s contribution and we are avidly expecting continual interest in disseminating advanced practices to better promote mental health in our own respective context.

We hope you enjoy this issue and have a good read during summertime.

Michalis Lavdas & Marit Borg
We are nearing our Second Board Meeting on 12th December 2019 in Bangalore, India. I request as many board members to try and attend this meeting along with a two day international conference of WAPR. Organizers will shortly send the invitation to speakers, mostly by members and few other experts. In this bulletin I would like to present the issue of the intolerance and let us all discuss what WAPR can contribute towards improving the life of people to become happy and healthy.

Tolerance is the ability to have an objective, fair and permissive attitude towards people whose nationality, race, religion, practices and opinions differ from one’s own. It may involve rejecting people who are perceived as different. They may include members of different ethnic groups, political parties or sexual orientation. Discrimination may occur when they are treated less favourably because they are from different groups or categories. Ethnic intolerance in societies can be viewed as conflicts between majority and minority ethnic groups. This can be understood as the result of structural factors involving population arrangements and the distribution of power, especially as these are seen in ethnic enclaves. Studies show that majority group members living in enclaves dominated by a minority group are, through a combination of resentment and restraint on their power, more intolerant than in any other situation. Minority group members living in enclaves and experiencing both power and anxiety in their minority status are more intolerant than when living dispersed among majority populations. Such conflicting psychological and sociological factors largely contribute to ethnic intolerance between majority and minority groups. Research studies also show that people adopting concrete mind-sets emerging from conservative societies are less tolerant than liberals. However, there is not enough evidence to show that political orientation has a reliable effect on tolerance. But conservative economic policies that focus on economic growth but fail to consider economic inequality lead to intolerant social and political values, an attribute widely considered harmful for the health of democracy.

Some of the forms of intolerance and discrimination are xenophobia, racism, anti-Semitism, etc. Xenophobia can be defined as a morbid fear of foreigners or foreign countries that may even lead to irrational aversion. It is a prejudice related to the false notion that people from other countries are of threat to the society. Racism can
be viewed as discriminatory or abusive behaviour towards people due to their “perceived” inferiority. The impact of racist ideologies has contributed to slavery, colonialism and annihilations of people. It was the basis on which Nazi ideologies took control to exterminate Jews as they were considered inferior. Anti-Semitism is the hostility towards Jews as a religious group, accompanied by social, economic and political discrimination. Intolerance based on religion is another threat seen almost in every society that contributes to discrimination. Discrimination also occurs on the basis of gender, gender identity and sexual orientation. Women seen as inferior, commonly seen in sexist ideologies have given birth to feminism. LGBTQ population has been greatly affected by intolerance by various societies in terms of rights, hate speeches, hate crime, etc. that significantly affect their mental health. Homophobia is defined as an aversion and irrational fear of LGBTQ population based on prejudice. LGBTQ people are subjected to various forms of violence such as verbal attacks and even murder. In some countries it is still seen as an offence and are denied their basic rights.

Efforts have been taken by various groups of people to combat intolerance and discrimination. The European Court of Human Rights has taken up a huge responsibility in sanctioning homophobia. The Council of Europe has set up a unit on LGBT issues in order to handle work in LGBT matters. The “International Convention on the Elimination of All forms of Racial Discrimination” by United Nations that is monitored by CERD (Committee on the Elimination of Racial Discrimination) acts as an individual complaints’ mechanism that commits to the elimination of racial discrimination. Although significant efforts are taken up by larger bodies to combat intolerance and discrimination, they also need to be handled at more fundamental levels. Educational programs need to be conducted to raise awareness about intolerance and how they contribute to destruction in society. Efforts should be taken on the lines of appreciating diversity and promoting tolerance. Education about tolerance must begin right from the school setting by promoting intercultural learning and embracing diversity.

Psychosocial interventions including workshops and programs are necessary to increase tolerance among people with rigid notions about other groups. This can be accomplished by first identifying groups that have potential intolerance and then creating awareness in an insightful manner. Some psychological factors contributing to intolerance include lack of flexibility, insecurities, rigid notions and narrow mindedness. Interventions can thereby focus on increasing flexible thinking and open mindedness that would impact people at an individual level. Such interventions would contribute to behaviours that are more dialectical, accommodating and welcoming. They would also ensure diversity, peace and well-being among all groups of people.

References


The Open Dialogue pilot project in a Day center in Athens: a tool of health democracy within mental health reform in Greece.

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A. Einstein: ‘The significant problems we face cannot be solved at the same level of thinking we were at, when we created them’

Mental Health Reform and Open Dialogue

Attempts towards a mental health reform in Greece have faced quite a few challenges since the 1980s, some of which still constitute primary obstacles today. The violation of human rights of mentally ill individuals, the increasing number of involuntary hospital admissions, the lack of involvement of service users and their families in the former’s individualized care plan aiming towards improving their quality of life, the lack of equality in shared decision-making and in the continuity of psychiatric care as well as the absence of institutional supervision and assessment, are only some of the issues that render the mental health reform fruitless and ineffective against the complexity of individual psychopathology and social anguish. Within this context, the biomedical model in the field of mental health remains dominant despite its epistemological indigence in considering that pathologies (psychiatric, medical and social) are inter-connected; human suffering transcends the individual and registers in the social, cultural and economic context. Finally, there is a severe segregation of mental health and well-being from the notion of human rights, as is evident in the high rates of involuntary admissions and mechanical restraint in psychiatric clinics in Greece (Stylianidis, 2019a; Chondros & Stylianidis, 2016). In that respect, the answers that the dominant psychiatric paradigm has to offer seem incomplete and ineffective and the immense disarray amongst mental health needs, services and policies often results in top-down rather than bottom-up institutional mental health policies, stale coding and classification of symptoms, differential diagnoses and near-abusive (polypharmacy) medication interventions. A new type of narrative is thus urgently required, a new type of social mediation amongst mental health services that will enable an in-depth understanding of service users complex needs and the relationship between mental illness, marginalization and social exclusion, stigma, social and economic hardship and discrimination (Stylianidis, 2019). This new narrative must be able to contain tensions, to integrate different approaches, to compose individualized care plans, to liaise with different services and professionals and ultimately to produce a new know-how that is not only evidence-based but also value-based. Taking these into account, we hereby maintain that the application of the Open Dialogue approach (Seikkula & Olson, 2003) in Greece as an alternative paradigm that holds the democratization of health at the heart of its mission can promote good practices by safeguarding the ethical and humanistic practice of psychiatric care. The Open Dialogue approach is an innovative approach to psychiatric care (particularly psychosis) that integrates principles of psychotherapy, family therapy and social network. It constitutes a democratic movement in mental health care that introduces the notion of the service user’s network (family, friends, relatives and mental health professionals) as an integral part of his/her
psychiatric care and psychosocial rehabilitation. The Open Dialogue approach outlines five key points: immediate crisis intervention, planning of timely therapeutic interventions aimed towards the individualized needs of service users and their families, emphasis on a reflective therapeutic stance, continuity in psychiatric care and assessment of therapeutic progress and finally evaluation of the outcome of interventions. This novel approach emphasizes the need for early intervention and provision of psychiatric and psychotherapeutic care for service users within their natural support systems and for an open, active and uncensored participation of the wider network including all members of the therapeutic team at both an inpatient and outpatient level. The Open Dialogue approach essentially highlights the need for a mental health reform, the democratization of knowledge and the understanding of the socio-economic factors that are implicated in human distress. Most importantly, it moves towards an understanding of mental illness and psychosis in particular on the basis of social co-construction whilst utilizing the notions of polyphony and dialogue as underpinning the development of a dialogical self. In that context, psychosis is viewed as a violent rupture to the person's biography and personal narrative; the notion of the patient's social network is considered as providing a safety net that can contain psychotic disorganization, relapse, crisis and acting out through the provision of meaning (Stylianidis, 2019b; Isari &Polyzou, 2015). In practice, the Open Dialogue approach is based on open meetings that are usually (but not exclusively) held in the patient's house, where the service user in crisis, his/her family as well as all professionals involved in the patient's care participate; it is the service user him/herself that decides who participates in these meetings. All thoughts that concern the continuity of the service user's psychiatric care are expressed openly and freely, in the presence of all participants, whilst there are no separate, 'private' meetings held by and for the professionals. The meeting itself is used as the context for the therapists’ reflection (Andersen, 1987; Brownlee, Vis &McKenna, 2009) in ways that promote the inclusion and empowerment of users and the co-construction of meaning. The service user’s family is viewed as an ally, whilst emphasis is placed upon individual narratives, attentive clinical listening and an in-depth understanding of the experiences of all participants involved. This ‘system’ is being reconstructed with every new narrative, whilst the dialogue itself (and not each individual service user, relative or professional separately) creates and reconstructs reality. This dialogical approach (Seikkula, 2011) creates a new language that facilitates the construction of meaning and the mentalisation of service user distress within the immediate context in which it emerges. The Open Dialogue approach regards the notion the ‘dialogue’ as the creation of a common co-constructed narrative for subjective experiences that remain undifferentiated within psychotic psychopathology. Such a communication-oriented approach to psychosis safeguards the containment of uncertainty, whilst the therapeutic team's reflective function introduces the elements of time and space in psychotic delirium by acknowledging the order of events, inner conflict and associations of the service user, by de-constructing and re-constructing the psychotic crisis thus providing a corrective emotional experience during such a polyphonic intervention. The network's reflective function (service user, family and professionals) provides containment, regulation and mentalisation of the psychotic symptom and a reconstruction of the service-user's psychotic narrative (Martindale, 2015; Lorenzini, Campbell & Fonagy, 2018). The Open Dialogue paradigm is consistent with WAPR's mission and principles of psychosocial rehabilitation and recovery that values service user and family member experiences as important knowledge bases. It actually promotes service-user autonomy, social inclusion and the active involvement of service users, their families and their wider social network (Gordon et al, 2016). Open Dialogue is an approach that is in line with WAPR core values of promoting psychosocial rehabilitation and recovery, in a process that facilitates opportunities for individuals impaired by a mental disorder to reach their optimal level of functioning.
in the community and it aims both at improving individuals’ competencies as well as introducing changes at an institutional and organizational level in order to improve their quality of life (WAPR, 2019).

The Open Dialogue approach and its role in the prevention of relapse and promotion of mental health has been systematically applied in Scandinavian countries, Northern Europe, Australia and the US with culturally specific modifications in order to adapt to different mental health services, whilst it does not seem to have been methodically explored in Greece. Within Northern Europe and the UK, the integration of mental health services and the implementation of practices such as the individualized care plan and Assertive Community Treatment have been associated with a reduction in involuntary hospitalizations (Bindman et al, 2002; Webber & Huxley, 2004; Wierdsma, 2007; Wierdsma & Mulder, 2009). In terms of its effectiveness, Open Dialogue is reported as being effective in young people during serious, acute psychotic relapses when compared to treatment as usual (TAU), particularly with regard to social functionality, return to employment or education, reduction of days spent in hospital and the individual’s overall psychosocial rehabilitation (Seikkula & Olson, 2003; Seikkula et al, 2006; Seikkula, Alakare & Aaltonen, 2011). In one study, it was reported that at a two-year follow up after the first psychotic episode, inservice user treatment was reduced to 19 days, use of neuroleptic medication was continued in only 35% of cases whilst in 82% of cases there was minimal persevering psychotic symptomatology. Within this study it was reported that only 23% of participants were receiving disability benefits following Open Dialogue treatment (Seikkula & Olson, 2003). Nevertheless, and despite the positive reported outcomes, Open Dialogue has not been explored systematically through RCTs, whilst there are significant methodological limitations such as the reliability and validity of selected samples and methods of analysis that render the generalisability of the conclusions with regard to its efficacy questionable.

The Open Dialogue Action Research Pilot Project

Within this context and in accordance to WARP’s guidelines regarding the organization of training opportunities for health professionals and the introduction of strategies for psychosocial rehabilitation within specialist and primary health care services, the Association for Regional Development and Mental Health (EPAPSY), in collaboration with Panteion University and the National and Kapodistrian University of Athens is attempting the novel and systematic introduction of the Open Dialogue approach along with a close and thorough research and exploration of both its assimilation within the therapeutic team as well as its application to the clinical work with service users suffering from psychosis and residing within the community. Along with EPAPSY’s commitment to the dissemination of experiences and best practices in the field of mental health and psychosocial rehabilitation in the community, the following action-research protocol has been designed and implemented since September 2018, in order to investigate the introduction and integration of Open Dialogue within the clinical practice of the multidisciplinary team with EPAPSY’s “Franco Basaglia” Day Centre for Psychosocial Rehabilitation. EPAPSY’s “Franco Basaglia” Day Centre for Psychosocial Rehabilitation is a community mental health unit for adults suffering from serious mental health disorders and their families; the multidisciplinary team (13 therapists in total, offering psychosocial rehabilitation services in the 5th psychiatric sector of Attica) consists of psychiatrists, psychologists, social workers, occupational therapists and psychiatric nurses whilst available services include a group-based psychosocial rehabilitation program for people suffering from psychosis and bipolar disorder, an Assertive Community Treatment (ACT) service for service users with severe and enduring psychiatric disorders, a psychotherapy service, social club, psychiatric care and depot clinic as well as couple and family psychotherapy and multifamily therapy. The main objectives of the Day Centre is the prevention of relapse and hospitalization of service users, the promotion of rights and employment opportunities of people
suffering from mental health difficulties and widely the de-stigmatization of mental illness, whilst there is systematic liaison with adjacent psychiatric clinics, local government and mental health services to ensure continuity of care.

The present research is attempting a pilot implementation of the Open Dialogue paradigm within the Day Centre, since the philosophical and ideological underpinnings of both seem to be complementary, particularly with regard to the provision of an alternative model of psychiatric care in the community on the basis of social psychiatry and psychosocial rehabilitation. Furthermore, it constitutes a valuable training opportunity for all mental health professionals working within the Day Centre to widen their clinical, dialogical and reflective skills as well as to incorporate qualitative research methods in the field of community mental health. The participant group (N=38) consists of all mental health professionals working within the Day Centre as well as service users and their families receiving psychosocial rehabilitation services, particularly those within the ACT and Multifamily therapy services primarily due to the network-based nature of these interventions and because they are more closely aiming at individuals with greater risk for relapse and involuntary hospitalization.

**Methodology of implementation**

The multidisciplinary team of the Day Centre was initially informed about the nature and aims of the research and initial thoughts, concerns and questions were explored with regard to the implementation of Open Dialogue. Similarly, service users were informed about the new paradigm and informed consent with regard to its gradual implementation was obtained. The therapeutic team’s resistance, concerns, different narratives and uncertainty with regard to the new paradigm were explored and contained by the researchers (some of which are also members of the multidisciplinary therapeutic team thus maintaining a challenging dual role requiring the practice of researcher reflexivity) in a process that mirrors the polyphony encountered within the Open Dialogue approach. During the first part of the study, three therapeutic groups (multifamily therapy group, advocacy and mental health rights psycho-educational group and the service-user self-organization group) from the Day Centre’s psychosocial rehabilitation program were selected for participant observation (Emerson, Fretz & Shaw, 2011; Isari & Pourkos, 2015) during which the practices of the therapeutic team were recorded on the basis of their convergence to the Open Dialogue approach. At the same time, three of the therapeutic team’s weekly supervision groups (namely ACT, the group-based psychosocial rehabilitation program and the newly established Open Dialogue discussion group) were subjected to participant observation by external researchers, in order to explore the ways in which the therapeutic team talks about service users and ways of working with them. The latter of these professional groups, the Open Dialogue discussion group is a newly established forum created by the professionals themselves that aims at the exposure, self-education and self-reflection of the therapeutic team on Open Dialogue practices, prior to receiving any formal training on the approach. This forum allows professionals to read material on the Open Dialogue approach, to discuss concerns with regard to the new paradigm, ways of implementing it with service users in crisis, ideological and clinical practice issues, the understanding of the notions of self-reflection and dialogical practice and other conflicts that may emerge as a result of the introduction of the new paradigm through structured training, seems particularly important as a review of the literature indicates resistance in the therapeutic team as the primary obstacle to the successful implementation of the Open Dialogue paradigm (Sondergaard, 2009). Indeed, it is reported in numerous studies that therapist theoretical orientation, issues of power, control and therapist identity and authority within multidisciplinary teams often prevent professionals from different mental health backgrounds from effectively incorporating reflective and dialogical ways of working in their clinical practice. According
to the literature, the full understanding and implementation of Open Dialogue, not as a mere collection of techniques but essentially as a relational and dialogical way of talking about service users when they are not present, of being with others as well as of tolerating and containing uncertainty, is often obstructed through a depreciation of the approach as introducing “nothing new” to treatment as usual (Sondergaard, 2009; Holmesland, Seikkula & Hopfenbeck, 2014). Subsequent parts of the research project predict the introduction of formal, structured training on the Open Dialogue approach and the clinical application and evaluation of the intervention on specific cases within the community. Indeed, there are a couple of service users currently in the care of the ACT team that have been identified as appropriate and some preliminary interventions based on Open Dialogue principles have been implemented; although the similarity between ACT interventions and Open Dialogue practices is easily noted, in terms of observable parameters (i.e. visits taking place at the service user’s own home with the participation of family members) it is important not to equate Open Dialogue with ACT practices thus undermining its philosophical, essentially relational and dialogical underpinnings.

Initial research data

Preliminary data collected through participant observation of the three therapeutic groups for service users and the three supervision groups for professionals, were analyzed using thematic analysis (Braun & Clarke, 2006). Thematic analysis for the two different set of data was undertaken by two or more different researchers. Three superordinate themes emerged from data analysis of the professional groups, which included a total of eleven subthemes; Table 1 below outlines the master themes and corresponding subthemes from the professional groups. Similarly, three superordinate themes emerged from data analysis of the service users’ groups, which included a total of seven subthemes. Table 2 outlines the master themes and corresponding subthemes from the service user groups.

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<th>Superordinate themes</th>
<th>Subthemes</th>
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<td>Power/ Authority</td>
<td>- Academics vs. Practitioners</td>
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<td>- Inclusion vs. Exclusion</td>
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<td>Polarization/ Splitting</td>
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<td>- Systemic vs. Psychoanalytic approach</td>
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<td>Ambivalence</td>
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The first superordinate theme that emerged from participant observation reflected the professional perception that the Open Dialogue paradigm was imposed by EPAPSY’s management in collaboration with the Universities and that they had no choice but to agree with this decision. As a result, professionals within the multidisciplinary team seem to be split in two categories, namely the academics that are involved in the implementation of the research project and who are perceived as having secondary gains and favorable treatment by the management and the therapeutic team that are involved in the clinical application of Open Dialogue with service users, who experience themselves as ‘guinea pigs’, with no voice and as being the ones that have to face the practical difficulties of implementing the new approach. Similarly, there seem to be power struggles and emerging mistrust within the multidisciplinary team with regard to
who is involved or excluded both from the research as well as the team of therapists that will be involved in the clinical implementation of the Open Dialogue approach. Initially some members of the therapeutic team did not feel that the research on Open Dialogue was concerning them thus being absent from seminars or meetings, whilst handling new referrals in closed groups with the ‘atypical exclusion’ of the academics. Similarly, this polarization in the therapeutic team is also manifest in an idealized perception that the ‘academics’ seem to hold about the Open Dialogue approach and its application in the field and the reality of mental illness, the challenges of applying the new approach in the community and the emotional as well as practical burden faced.

Participant observation of supervision groups further revealed a polarity between mental health and illness, evident in the procedural manner of referral of service users, the psychiatric language used in the meetings and the loss of the service user's subjective sense of suffering. This exclusion of therapist empathy along with the use of humour, may communicate an emotional disengagement as a defense against the threat of ‘madness’ or identifying with the patients' healthy parts. The professionals in the multidisciplinary team seem to be split with regard to the methodology of applying the new approach, with some preferring a concrete, formal training and others favouring the use of therapist reflexivity, experiential and embodied 'learning' of the Open Dialogue model. Finally, the professional team seems to be polarized with regard to the either systemic or psychoanalytic origins of Open Dialogue with the team struggling with the expropriation of the model, thus missing out on the notions of polyphony, uncertainty and the dialogical approach.

The superordinate theme of ambivalence, as emerging from participant observation, seems to reveal a conflict between desire and resistance towards the introduction of the Open Dialogue paradigm within the multidisciplinary team. This was mostly evident through the systematic delay of professionals in attending staff meetings, the procrastination on theoretical thus non-threatening issues regarding the novel approach without reaching any conclusions and the avoidance of thinking about clinical application issues. The professional team's ambivalence was also evident through the rejection of offers for practical help as well as an attempt to equate Open Dialogue with the usual practices within the Day Centre; the multidisciplinary team's ambivalence is also evident in the hurried selection of the clinical case for the pilot application of Open Dialogue, which is one of the most difficult cases and may communicate the team's unconscious attempt to sabotage the model. Finally, it seems that the identity of professionals may be threatened as a result of the introduction of the Open Dialogue paradigm on three levels, as employees within the Day Centre, as therapists embracing a particular theoretical orientation and as social subjects. There seems to be a lot of anxiety with regard to the position of professionals within the organization, with fears of being dismissed or losing their job but also with regard to fearing that they will lose their identity as professionals of a given theoretical model. Since Open Dialogue is not linked to any particular theoretical approach, the therapeutic team often feel as sacrificing their formal training and renegotiating their professional identity. The introduction of the service user's family and social network and the model's questioning of the notion of expertise may also challenge professional identity in this context. Finally, professional identity may be challenged with regard to the team's positioning against rather than on the side of service users. Therapists’ detachment, dispassion and use of humour when referring to service users may allow them to separate themselves from the suffering of psychosis and to preserve their sense of self as mentally healthy individuals.

These dynamics seem to be reflected in the themes emerging from the thematic analysis from data collected through participant observation of groups for service users and their families.

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<td><strong>Superordinate themes</strong></td>
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The first superordinate theme of power/authority seems to refer to the notion of involuntary admission to a psychiatric clinic following a Public Prosecutor’s Order. This is mostly verbalized by the service users’ families, who seem to feel that there is no other option unless the service user adheres fully to treatment, as prescribed by the psychiatrist and the therapeutic team. In this case, the professionals either find themselves identifying with the families and considering compulsory treatment as inevitable or identifying with the service user and defending his/her right to choose their treatment. At the same time, the theme of power extends to the notions of a paternalistic protective stance towards service users versus emphasizing their personal responsibility and autonomy. It seems that there is an alternation of the notion of service user responsibility that is either verbalized by the family or the professionals, who in turn often find themselves serving as rescuers or as agents of empowerment. The families often display a paternalistic ambivalence towards their relative; one hand they are encouraging the independence of the service user whilst worrying about the loss of their carer role should the service user gain his/her autonomy. With respect to the notions of power and authority, it appears that members of the therapeutic team that facilitate the observed groups adopt quite a didactic style in the form of teacher-student interaction, with the groups themselves resembling a school classroom.

Ambivalence emerges as a superordinate theme in the narratives of service users and their families, with idealization vs. devaluation and loss of identity constituting the main subthemes. The families seem to be idealizing mental health professionals and the Open Dialogue approach on one hand, considering it as the magical solution to all problems whilst at the same time being sceptical towards such an empowering model and seeking the mental health professionals’ expertise and guidance. Indeed, service user families report experiencing Open Dialogue interventions as confusing, frustrating and often as feeling forced to participate. It seems that service user families may often experience the loss of the role of the expert as perplexing and worrying, in addition to the loss of their role as carers as somewhat threatening. The theme of ambivalence as being mirrored both by professionals as well as carers underpins the systemic (in addition to the intrapsychic) parameters of mental illness. The final superordinate theme again refers to the notion of splitting across premises such as mental illness vs. mental health, exclusive use of medication vs. complete absence of medication as well as the polarity of an active group facilitator vs. a passive service user. Such defenses are usually unconsciously employed in order to contain the unspeakable distress of psychosis, as a means of simplifying and containing contradictions.

Discussion

To sum up, these findings describe the process of assimilating the paradigm of Open Dialogue within the context of a well-established multidisciplinary mental health team, up to this point in time, although there is some evidence that these differences are temporary and transient. The findings seem consistent with existing literature regarding the resistance of mental health professional teams in assimilating Open Dialogue as part of their professional practice (Sondergraard, 2009; Seikkula, 2011; Holmesland, Seikkula & Hopfenbeck, 2014). These dynamic processes within the multidisciplinary team may indeed reflect the nature of working with psychosis itself, with the professionals occasionally identifying and acting out aspects of it. Thankfully, institutional psychoanalytic supervision is invaluable in managing such processes and dynamics within the multidisciplinary team and safeguarding the orderly operation of the
service; it seems that the reported discrepancies and conflicts within the multidisciplinary team are indeed beginning to be integrated, bridged through the making of meaning. In conclusion and taking on board the present findings as well as existing literature, it seems that Open Dialogue requires a complete change of culture, both organizational and professional in order for it to be effectively applied.

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MH NEWS

Regional Meeting of EU Branches in Athens, 5-6 of November 2019

The Greek Branch of W APR is organizing a regional European Meeting the 5th and 6th of November 2019. There will be plenary sessions and workshops on themes concerning advanced practices in human-rights based approaches in mental health, psychosocial rehabilitation and community integration. What services for what needs and what should be considered helpful from which perspective? How dialogic practices can be integrated in everyday practice? How can we contextualize the role of Peer Support Worker in different local examples? What is already there in the community and how should integration take place?

We invite everyone interested in these themes to join us in Athens in November. We are also grateful for suggestions of themes and contributors in the workshops.

More information will be published soon.

For any contact relevant to the event contact Michalis Lavdas in ml@epapsy.gr
Mental Health Policy for People with Chronic Mentally Illness in East Asia

by Tae-Yeon Hwang (National Center for Mental Health in Korea and Past President of KAPR)

Introduction
Mental disorders are associated with significant long-term disability and decreased physical and psychosocial functioning. While most countries in this region have mental health legislation, policies and plan, the standards and quality of mental health services provision vary widely between and within countries. Stigma associated with psychiatric conditions and lack of community acceptance remains a major barrier for recovery from mental illness throughout the region. But recently mental health services for the mentally ill people are rapidly changing from hospital based care to community based that community rehabilitation facilities provide better and earlier care for the people with mental illness, help preserve the human rights of mental illness sufferers, and limit the stigma of mental health treatment.

In this paper, I will introduce recent changes of mental health policies and services in East Asia including Korea, Hong Kong, Japan, and Taiwan.

Korea
Since Mental Health Act establishment in 1995, Korean government has started to focus on deinstitutionalization and community mental health services to provide for psychosocial rehabilitation of the people with chronic mental illness, who are staying long in mental hospital. From that time, central and regional government invest mental health funds to establish community facilities that now we can see 348 community rehabilitation
centers, 251 community mental health centers, and 50 addiction management centers as shown on Figure below. These facilities are contributing recovery, social reintegration and quality of life of mentally ill people after discharge from the hospital.

**Annual Increase of Community Centers in Korea**

Besides rehabilitation of mentally ill people, there are many other mental health issues in the community. To address the mental health problems associated with high suicide rate, human rights violation, recovery for the people with mental illness, the government submitted the “Mental Health Promotion and Welfare Act” to the National Assembly, which was reviewed and passed at the plenary session of the National Assembly in May 2016. The main change in this revision is the narrower scope of defining mental illness as “a case in which independent living in daily life is difficult.” This change was made to decrease the discrimination and biases towards the mentally ill, strengthen the requirements for involuntary admission to improve human rights of the mentally ill, expand the welfare service provided to the mentally ill, and form the basis of mental health services provided to all citizens.

Also in accordance with the Comprehensive National Plan for Mental Health in 2016, the government targets to integrate people with severe mental illness into the community by expanding psychiatric emergency services, developing a half-way house model between institutions and community centers, and early detection of psychosis among high-risk groups.

**Taiwan**

Since 1985, Taiwanese government designated 7 core public mental hospitals according to its geographic catchment area to develop and coordinate community services and network. The main tasks of this core hospital was training of mental health professionals, consultation of regional mental health facilities, and operating program for suicide prevention, substance abuse prevention and treatment, treatment of domestic violence and sexual offenders, disaster mental health service and promoting school mental health. Typically Taiwanese community mental health services were originated from this hospital-based service development by government.

Now in Taiwan, people with mental illness are primarily treated in the acute ward. Some of them who need extended hospitalization, they can move to the rehabilitation ward. For patients who are suitable to be discharged to the community, they can receive a series of community mental health services including day care, vocational rehabilitation, and home care support. In addition, the social welfare policy implemented by the Bureau of National Health Insurance would support low-income and needy patients in terms of accommodation, half-way house and other social residential facilities, so as to improve their living and recovery in the community.

**Japan**

In 2005, the new “Act on Support for Persons with Disabilities” was established which has five main aims: to streamline three disabilities (i.e. physical, intellectual, and mental) to provide the same types of services; to put greater emphasis on user-oriented services; to enhance support for employment; to clarify the benefit supply process; to secure financial resources. This reform process has had a large impact on community mental health. However many community and hospital service providers are struggling to cope with this major change. Future directions to expand the current capacity of community mental health in Japan are: development of more community services especially housing support, vocational rehabilitation and outreach services; dissemination of good quality care management and building close networks in the Integrated Community Care System for People with Mental Disorders.
the community; quality improvement such as staff training, consumer and carer involvement and outcome measurement. Below figure shows this integration in the community.

**Hong Kong**
Mental health care is largely provided in the public sector through the Hospital Authority, a statutory body established in 1991 to manage all the public hospitals and institutions in Hong Kong. Through its network of 74 general out-patient clinics and seven hospital clusters, people with mental illness can seek help at the primary level and if necessary be referred to specialist clinics. Hong Kong supports the recommended mixture of mental health service components by WHO, and the Government’s direction is to strengthening both community care and primary care in mental health. Hong Kong has to strike an appropriate balance between hospital versus community care. Local experience has demonstrated that with limited resources in an overcrowded city, a hybrid mode of community care could be developed together with adequate inpatient beds in purpose-built facilities, where patients are cared for with dignity, respect and adequate space.

NGO activities are very strong that New Life Psychiatric Rehabilitation Association, which was established in 1965 are serving 18,000 mentally ill people and their families. Specializing in the community mental health services, it is operating 22 social enterprises (Figure below) and providing vocational rehabilitation services for its members.

**Conclusion**
Although there is wide diversity in the models of community mental health care found in East Asia, there are universal principles of community care that can be generally adopted from international guideline by WHO. Following this guideline, four countries in East Asia are developing diverse community mental health system to supporting recovery of people with severe and chronic mental illness. Most recently there is evidence of new ways of thinking about community mental health in this region. The exchange of information about this regional practices and solution to challenges is helpful in building appropriate community-based mental health care in the future.
Supervision of Psychosocial Rehabilitation Teams. An experience of 4 years.

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ABSTRACT:
We present an experience of systematic institutional supervision, developed between 2012 and 2015 in 12 community teams of the Community of Madrid that were providing psychosocial rehabilitation services for people with severe mental illness. The experience included about 150 work sessions, with a duration of two hours.

INTRODUCTION:
Professional and institutional supervision is a practice known and used in the international institutional panel, in the fields of medical, psychological, psychotherapeutic and teaching practice.
Clinical institutional supervision is a mode of supervision addressed to clinical teams. According to Senediak (1), it aims to “maintain the standards of patient care and ethics, and to encourage independent reflective thinking”. It is expected that it “will enable clinicians to develop problem-solving skills, to maintain a process of lifelong learning, and self-care skills.”
Reviewing several definitions of supervision, such as Falender and Shafranske’s, (2) or Cornish, Klonoff and Baker’s (3), we can consider as their fundamental components:
a. Supervision contains a hierarchical transmission element (based on the greater experience of the supervisor).
b. It must provide security and support.
c. It is a systematic process (not a punctual intervention).
d. It is not an evaluation, but it includes an evaluation component.
e. It establishes the primacy of ensuring the welfare and safety of the end customer.
f. It contains a supervisor-supervised alliance component.
g. Encourages the development (professional, intellectual) of the supervised.
h. Sometimes it is considered as part of the process of entering the profession.

IMPORTANCE OF THE SUBJECT.
According Falender and Shafranske, (2) or Cornish, Klonoff and Baker (3), we can justify its interest as:
a. part of professional training and qualification,
b. improving professional satisfaction,
c. improving clinical outcomes and
d. as a protective factor of professional burnout.

DESCRIPTION OF THE EXPERIENCE:
An experience of supervision in diverse services of Psychosocial Rehabilitation of people with serious psychic disorders in the Community of Madrid is summarized. This work refers to approximately 150 supervisory sessions, of two hours duration (in total about 300 hours of work) developed in 12 different services between 2012 and 2015.
The teams under supervision can be described attending several characteristics: by their specific function, by number of professionals, by their level of experience (years of experience as a team) and by their dominant theoretical orientation.
- Regarding their specific function, they included general psychosocial rehabilitation services (CRPSs), services supporting users in job seeking (CRLs), residential services (mini-residences), services provided by community social care teams (EASCs), and personal supervision of directors of the centers (not described here).
- The teams were composed by a variable number of professionals (psychologists, occupational therapists, educators, workshop teachers, etc.). The Community
Social Care teams - which intervene by visiting users in their own environment - were small (four or five professionals). Other institutional devices - such as residential ones that require three shifts of attention - were much larger, up to 20 professionals.

- Regarding the level of experience, more or less half of the services included professionals with a relatively short path in Psychosocial Rehabilitation (less than 4 years). Others, however, were teams with extensive travel (most professionals with experience in the field exceeding 10 years).

- Regarding the type of theoretical framework preferred by the professionals, several of the teams worked according to a dominant conceptual framework (sometimes in some version of the broad psychodynamic framework, sometimes in versions of a cognitive-conceptual model).

**METHODOLOGY:**

- The supervision sessions were programmed by the technical direction of the agencies responsible for the services; they were offered to the teams (usually directed by a psychologist and composed of professionals in number between 4 and 20 professionals (psychologists, occupational therapists, educators ...). The agendas for the sessions were coordinated by the director of each center in contact with the supervisor. The supervisor was chosen for each service from a panel of supervisors proposed by the agency.

- The supervision sessions (three or four a year) were two hours long.

- The supervisor encouraged teams to freely raise the topics connected with the institutional professional practice that seemed more relevant or timely.

- Sometimes the team asked the supervisor for reference texts, which the supervisor chose and contributed to be read by teams prior to the supervision sessions. The reference texts were classical texts of institutional analysis (such as those of Bion or Pichon Riviere), specific texts on the model of Recovery in Psychosocial Rehabilitation, or texts related to the perspective of Human Rights in psychiatric practice.

- The supervisor proposed to keep the discussions in the conceptual framework and using the technical language in which each professional felt more comfortable (which was generally the one in which he had been trained).

- The supervisor, according to the “participant observation” model, took notes after each session, detailing the aspects treated in the form of thematic references, and the way in which they were treated.

- After 4 years, the same supervisor, starting from approximately 140 files registered with text notes, made an analysis of the thematic references, grouped them into categories that emerged from their thematic analysis, counted the references by their frequency of appearance, and reflected his observations on the debates developed. (In another variant, the collection of information was attempted from summaries prepared voluntarily by one of the workers participating in the session, but the system did not function adequately due to the limited number of summaries obtained and the paucity of its contents).

**RESULTS OBTAINED:**

Broadly speaking, the evaluations on the activity (carried out independently by the agency managing the services by means of a questionnaire distributed to the participants) showed that the experience was quite unanimously positively valued by the participants.

181 individual topics were registered in the summaries of the sessions. From all them it was possible to extract a general idea about the frequency of appearance of the different topics in the discussions, and about the time used in the discussion of each topic with respect to the general framework.

Subsequently, a thematic analysis was carried out and the references to the specific aspects of the practice were grouped into four main thematic areas, which are detailed:

- **a. Difficulties related to the professional relationship - user** (93 ref.);
- **b. Difficulties identified in the functioning of the team as a group,** (41 ref.);
- **c. Technical doubts to identify and agree on the most correct activities in the team** (38 ref.);
- **d. Elaborations on how to understand the great concepts at stake in RPS** (9 ref.).

Next, we summarize in some detail the result of the analysis of the collected data.
a) Thematic area related to the professional – user relationship.

With 93 references this is the group of topics that attracted more discussion and consumed more time. Within this group, the work focused on aspects of the reaction such as:

- “Difficulties or dissensions when defining consensus on how to frame the professional relationship with the user” within the institutional environment (19 ref.);
- “Feeling of lack of authenticity of the working alliance with the patient”, or of “working with nominal expectations, but without real expectations”, or “the relationship with the user became a routine” (16 ref.),
- Analysis of the achievement or not of an adequate “working alliance” with the user in the light of the recovery perspective (9 ref.), Or of the perception by the team of whether or not there was “motivation to change” in the user (9 ref.).
- Difficulties perceived by professionals in the relationship with the user in the form of feelings of “frustration” (10 ref.) Or “anger” (7 ref.),
- Difficulties in handling user behaviors that frequently exhibited “relational problems” or “poor acceptance of the regulatory framework” in the service (12), or that were perceived as “provocative” (2 ref.), Or that “lied” to the team in relevant issues (2 ref.).
- Patients with “unrealistic expectations” (3 ref.), With “rentier” attitudes (3 ref.), or who “do not wish to collaborate in activities” (1 ref.), Or users who were perceived as fundamentally “demanding care” (1 ref.).

b) Thematic area on “internal relations” -within the team- and “external relation” -between the team and other teams of the care network” (41 ref.).

The teams elaborated mostly about:
- difficulties affecting good communication between professionals - such as “internal communication disagreements” (9 ref.) -, or “poor coordination with other services” (4 ref.).
- “perception of practical difficulties to implement technical guidelines received from Mental Health services or from the technical direction of the agency” (4 ref.).
- In the teams of the Mini Residences -which are more complex because they have three shifts and cover attention 24 hours / 7 days per week-, the issue of the perception of “incoherencies of action in the teams, by different views among professionals in the same shift, or between the different work shifts” (2 ref.).
- The professionals presented perceived difficulties when they were exposed to “violent events” or “bizarre behaviors” of the users; They expressed “feelings of overload” and the need for “spaces to talk about it”. On the way to consider how to act in such situations, different attitudes were made explicit: attitudes of the “omnipotent” type (“I can cope everything, nothing affects me”), “impotent” attitudes (“I cannot cope this situation, it surpasses me”), and more reflective attitudes that considered “the limit of what a person or team can cope” in the exposure to certain relational situations (6 ref.).

c) The team and technical issues.

With 38 references, we have a group of references grouped around the thematic area that we call “technical issues”. It is, for example, about:
- as “assessing negative attitudes or symptoms of users” (8 ref.), generally in a context of trying to understand “what users can or cannot do”, what they do not do “because they do not want to”, and what they do not do “because they cannot”.
- Another frequent issue is the “specific problems of working with people with a borderline personality disorder profile” (7 ref.), Which were perceived as very demanding for the teams and a challenge for the stability of teamwork and good coexistence of broader patient groups.
- Some services - the outreach community teams that usually visit users in their own home (4 ref.) And Mini-residences (2 ref.) - have raised the difficulty of “identifying their specific targets” and their “realistic possibilities and targets” with certain users. Sometimes the issue has been raised upside down and the subject of “the suitability of patients for some resources” has appeared (5 ref.).
- Some teams have considered “revising concepts and ways of working” in order to improve their skills to work with families (5 ref.) Or groups (2 ref.).
- On two occasions, the teams raised how to deal institutionally with the death or suicide of users (which had happened recently).
Other topics were related to the “work of users of other cultures” and the “handling of confidential information” in some situations.

d) Elaborations on “how to rightly understand the main concepts at stake in Psychosocial Rehabilitation”.
The work on this aspect aimed to complete or complement the training of professionals on theoretical aspects of rehabilitation that at the time when they were treated were novel (such as how to implement in everyday work the implications of the perspective of recovery, or of reconceptualizing the portfolio of respective rights and duties of patients and professionals from the perspective of Human Rights from the Convention of New York. This aspect was discussed from documents provided by the supervisor, read and discussed in their practical implications.

**DISCUSSION.**

In general terms, in an objective manner, the supervisory experience was positively valued by the teams (according to an evaluation questionnaire used by the agency that the professionals responded to).

Regarding other identifiable objective results, the evaluation tool used by the agency responsible for the teams broadly identified the satisfaction of the team with the experience, and the fulfillment of the “specific objectives” (general satisfaction, number of meetings, punctuality, participation, suitability of the bibliographic materials contributed, etc.).

However, since the evaluation tool was not designed to identify possible “qualitative” achievements of supervision, it is not possible to derive information from the questionnaire in this regard.

From a qualitative assessment, what follows should be considered a general description of the experience provided by the supervisor -and author of this summary-. Professionals who have been directly involved in experiences of institutional supervision will be able to recognize and evaluate the notes that follow based on their own experience. Teams with less time of experience (less than four years), spent a lot of time directly presenting difficulties that needed to be discussed, and explicitly requested technical guidelines from the supervisor. In this situation, the supervisor suggested working on specific clinical cases - asking the teams to present extensively information about their work with a specific user; based on these reports, the team’s experience was elaborated so that the technical directives that were requested for each specific case could progress “from the particular of each individual experience to a more general framework”.

Other teams -typically those with a longer time of experience- used more time to discuss divergences in teamwork that were perceived as obstacles to adopting consensual institutional strategies. Typically, as perceived in the discussions, prior to their treatment in the supervisory sessions, these discussions had already consumed a lot of discussion time in the teams - both in formal spaces and in private conversations; In spite of this, it was not possible to advance in their resolution and they also had created discomfort in the professionals.

In these cases, an attempt was made to work on the understanding and identification of the difficulties in achieving consensus views. From the content of the discussions, it became clear that most problems seemed to follow complex causes. Partly to divergences - more or less explicit - in the theoretical framework preferred by the various professionals. Partly due to tensions related by more or less explicit variants of informal group leadership phenomena - that is, leaderships different from the formal one of the director of the service. On three occasions difficulties especially related to emerging difficulties due to the particular performance of a particular professional were revealed.

On two specific occasions, supervisory work managed to objectively improve one of these “crises” of the teams, which had created great uneasiness (impression expressed explicitly by some team members and shared by the supervisor).

On other occasions, the difficulties identified (discomfort and divisions in the teams due to disagreements related to differences of opinion on how the team should act or respond on specific occasions) put on the table problems of operation in the teams that “had been there a long time”
(as described in the thematic section “b” of this summary), which had previously been discussed in the team, usually informally, without having been able to talk openly about them in the work spaces normally enabled for this purpose -such as regular team meetings-. On these occasions, the success may have been to enable the team to treat these problems explicitly; sometimes with a clear sense of “improvement”; other times without it being clear at the end of the experience to what extent those problems had been improved. On one occasion a team decided to change the supervisor because of disagreements about the theoretical perspective (the supervisor proposed an eclectic and integrative conceptualization, and some team members preferred a specifically psychodynamic elaboration).

LAST CONCLUSIONS:
Institutional supervision is a viable methodology, is generally appreciated by professionals, and has a useful dimension as part of the ongoing training of teams and the review of practices.

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Asking “What’s most important for you” should be a question that is addressed in recovery-oriented services; journal notes through my internship by WAPR Norway in Bergen.

Michalis Lavdas, Psychologist, EPAPSY NGO, Greece

Introduction

“Your program for the 2 weeks of internship is almost ready – with confirmation from all the places to visit. I think it will be interesting, but also some demanding, for you. Many addresses to find – persons to meet and subjects to discuss. But I am sure it will be fun for all of us!”

That’s what Audun Pedersen, leader of WAPR Norway, told me via an email in the months before my visit to Bergen, that I had long been expecting since we first met in the WAPR World Congress in Madrid in July 2018. What is mental health if not the ability and possibility “to have pleasure and fun” as Marit Borg and Bengt Karlsson are often saying, through networking and meeting with interesting people and exchanging good practices and experiences?

As a young professional in mental health, my experience has long been in the mental health reform and the community-based approaches in Greece. Through my work at EPAPSY NGO I came to meet partners from different parts of the world at the wide family of the World Association for Psychosocial Rehabilitation. Living in Greece during times of financial instability and increased forced migration, we have witnessed the country being an “entry point” for more than a million refugees in the past 3 years. Thus, the sense of community began widening and the needs of the community started to change including migrants and refugees as part of a whole in a “post-migration perspective” as Langhoff (2011) mentions. Working towards this end, we collaborated with UNHCR Greece to develop innovative responses to people facing extreme psychosocial difficulties in urban places in Attica and just recently in Thessaloniki. It was very fortunate to have been receiving much help from academic partners with clinical mental health experiences and particularly Prof. Marit Borg, Bengt Karlsson and Trude Klevan from the University of South-Eastern Norway. In our meeting for the WAPR World Congress in 2018, Marit introduced me to Audun Pedersen, leader of WAPR Norway who discussed the possibility from the WAPR Norway to host an internship program in Norway. This would give me the chance to experience refugee care and support and integration strategies in Bergen, as well as community mental health and recovery developments that have been organized in Norway. Having a keen interest in “Peer Support” I was already familiar with advanced practices and innovations that have been running in Bergen as a part of recovery-orientation of community mental health services. I was eager to apply and was happily accepted for a two week internship at Bergen which took place in March-April 2019. After some time has passed and all these rich experiences are settling down, I am writing this piece in the form of “journal notes” hoping it’s going to be both interesting to read as well as doing justice to all the people who contributed in this exciting experience.

Refugee Care and Integration in Bergen

The first thing I noticed as a newcomer was the big sign that read “Bergen?” and that question mark summarized my thoughts and questions of “what Bergen is about” and “what can I expect”. My mind went to the refugees that arrive in Bergen; full of questions and a system in place to facilitate their integration in the city. As it was explained to me in the first days of my internship, there are two ways to get to Bergen as a refugee; either through the reception centers or through United Nations High Commissioner for Refugees (UNHCR). After closing down the borders in many countries, very few refugees actually get to Norway these days with a result in reduction of services, personnel and units that used to offer refugee care. Close to 640 refugees are currently in the integration program that is run by the Municipality of Bergen with a span of 2 to 3 years for someone to qualify. Grethe Grung and her partners at the resettlement unit in the Introduction center for refugees, welcomed me and gave me an overview of the whole system and how it’s been based on building up the existing knowledge of refugees and also adjusting the program to the needs that each user faces. A very important aspect of the integration program is (a) language and (b) work placement. The idea of linking together language skills and work placement make it much easier for someone to integrate in the Norwegian society albeit it’s still too much to do and a lot of barriers that refugees face concerning “cultural differences” as they report. Such differences involve mainly
social life where not knowing the local “social codes” the refugees are feeling isolated and excluded from socializing with the locals which can result in several difficulties as time goes by. Main ideas that run through the system involve “connecting everything as fast as we can” so that newly arriving refugees have more chances to successfully integrate in the local society. “Learning by doing” was also a motto used by the professionals working in integration services understanding the complexity of the needs and the different starting points of refugees when they first enter the Norwegian society.

When you have the chance to discuss with the Center for Migration Health, you can understand how deeply rooted is the idea of “depathologization” and understanding refugees as people with “normal reactions to adverse conditions”. In the words of the personnel at the Center for Migration Health; “understanding the mixture of what refugees have been through with the future prospect facilitates the normalization of their reactions and show you ways of providing proper care to the population”. The above way of thinking can be of crucial importance when dealing with people who have been repeatedly asked since the moment they entered EU, for example in the Greek borders, to identify themselves “as vulnerable as possible” so that they have access to fundamental services and in many cases thus ensure survival for them and their families. Understanding mental health through the concept of social determinants, it has been well established and documented by WHO and other major organizations and relevant research that mental health can be protected or burdened by a wide range of factors specifically including adverse psychosocial conditions widely experienced in refugee populations. Understanding leads to trust and trust leads to therapeutic relationships which according to the colleagues working in the CeMH “happen when you are being listened to and when your needs are properly acknowledged”. An interesting moment for me as well, was the chance I was given to discuss with a refugee service user and Rolf Vårdal who is a physiotherapist working with refugees at the CeMH. During this meeting we discussed about the difficulties to integrate in the Norwegian society and how refugees themselves can often facilitate this process through helping others understand “how it works”. Solve Sætre who is responsible for building the internship for refugee integration along with Audun, expressed the main rationale in saying that “refugees are normal people facing an extraordinary situation”.

Many interesting questions are being raised around the issue of refugees and forced migration in Bergen while the Department of Psychology in the University of Bergen has been working on building evidence (Markova & Sandal, 2016; Guribye, Sandal & Oppedal, 2011) about how refugee communities understand mental health, what are their coping strategies and how services should be developed to cater for those needs. Meeting and discussing with the research group under Prof. Gro Mjeldheim Sandal in the University of Bergen stimulated ideas for research and good practice developments. Expanding the area of research on how refugees are coping with a large number of stressors in the country of reception is essential. This will help us to build more “human centered policies” and widen our understanding of mental health and mental ill health to a direction that has to involve more and more the users themselves in multilevel approach (planning, research, implementation, evaluation).

Involvement is an essential ingredient in any “recovery-oriented” systems or services and since the Norwegian scientific society has often provided ample evidence that leads us to a more recovery-oriented way (Pedersen, 2004; Ness, Borg & Davidson, 2014; Hummelvoll, Karlsson & Borg, 2015), involvement is promoted and often supported by the municipalities in different ways. Such an example is Queer World in Bergen which is part of a larger network based in several Norwegian cities. Visiting Queer World and understanding the need for LGBTQI+ (Lesbian Gay Bisexual Trangender Queer Intersex +) inclusion I had the chance to have an inspiring discussion with Nader and Osama
who have been promoting human rights for all in the refugee communities and in Bergen. As they emphatically stress “during integration we help LGBT refugees accept themselves, facilitate the coming-out process and empower them in their difficult journey to deal with their identity, the members of their respective communities and the society in general”. Although Norway is a largely progressive country, it was noted that “leaving the big city centres you can find yourself dealing with homophobia and social exclusion”. That’s why Queer World often lobbies so that LGBT refugees can be moved to bigger cities in Norway. Meanwhile “helping the people touch the pain of discrimination and exclusion” means that you need to work more widely educating and raising awareness among refugee communities as well. An interesting discussion and presentation followed where Nader and Osama showed me how you can approach the issues of sexual orientation and gender identity not in a “westernized way” but through the culture of the members of refugee communities. It even involves delving deeper in the local culture in The Middle- East for example where much of homophobic behaviors derive from colonialism. Another aspect of the activities that Queer World promotes is social gatherings in the community where people from different roads of life can meet and have the chance to socialize while feeling safe. Tsion offered me another interesting meeting. She is working with women of different cultural backgrounds at Papillon Bergen. This is an organization founded by women of a multicultural background. The aim of Papillon is to empower young women and girls through different actions while collaborating with the municipality, schools, migrant organizations, social welfare and others. The idea is to offer a “meeting place” where everyone feels security, belonging and freedom of expression. Another complex issue that I had the chance to learn more about was the issue of Unaccompanied Minors (UAM) in Bergen. Currently there are different ways to provide care to UAMs and it was very interesting to visit a home where 4 UAMs were staying along with the staff. It would take too long in the context of this brief report to explain the full depth of this issue in Bergen. The fact is that integration means to know the language, have activities, go to school and understanding the society and how it works. The homely atmosphere that many people can finally enjoy in Bergen unfortunately is not the case for many UAMs that have to travel through dangerous journeys and do not always make it to a “final destination” of their choice. It was relieving to see that the needs of the minors were prioritized and how they were facilitated to integrate to local society, yet the image of many Greek islands where UAMs are wandering around helpless and often hopeless often resulting in in teenage refugees selling sex or experiencing drug dependencies is still something I cannot easily forget. Part of my visit to Bergen made me think how vital would be to link people in need with quality services that promote human rights. My internship at Bergen showed me that there are ways but not always accessible and not always feasible to other contexts. Leaving the homely house that the UAMs were living I saw a basketball court were children and adolescents of different cultural background were playing. “Sports is a common language” I thought and wondered over the need to communicate and the need to co-construct a language that we can all understand each other.

Stepped Care Model in services; examples from community mental health practice

A “stepped care” model is widely used in Bergen and by assumption to the Norwegian system which starts from lower intensity interventions scaling up gradually to more systematic interventions with an ultimate goal to provide as much help as needed in each level. This notion is in line with recovery principles where you in partnership with the person provide necessary support and help so that you can facilitate autonomy and independency as much as possible.

Norwegian mental health care has two levels of support and treatment with municipalities having a major role in providing prevention and promotion of mental health as well as being a “gatekeeper” in the system evaluating when referral to a specialist health service is necessary. Roughly 2000 adults with severe mental illness live in Bergen and 80% of those are living in their own arrangements following care services at their own community according to data stated by the Bergen Municipality healthcare services. This is a way to respect human rights for people with severe mental health issues since it is a fundamental right to be able to “choose among different housing options” and to be able to live with as much support as needed at your own arrangements. The chance to visit the District Mental Health Center (DPC) in Bjørsvin gave me an in-depth view of how the secondary level of support and treatment works between the community
An enthusiastic student in law helped me understand better how he wanted to change profession and get on with studying law and how supported education empowered him in achieving his goals.

“All people are welcome, always” is the motto of Psykiatrialliansen. This is a sports-club which provides access to a wide range of sports activities while being inclusive and understanding of mental health and substance abuse. Linking up sports with mental health can be greatly beneficial and much more when the trainers are taking it seriously to actually train other people in an “all-welcoming” environment. It was great to know that Psykiatrialliansen is supported by Claus Lundekvam a well known Premier League football player who battled with addiction and mental health issues and was able to actually promote recovery in its purest sense. Lasse was my guide for that day and I had the opportunity to join the group for 10 minutes of “innebandy” (floor hockey) wearing the same colors and sharing the excitement of teamwork! As some organization coaches briefed me later on, it was very interesting to learn how people are recruited to join free activities in a safe place, while providing paid work to people who can take up such positions in time.
Supporting the most vulnerable or even “invisible” populations in Bergen

Any important work that takes place within the community means that people with little or no access to information and services should be prioritized in receiving support. Interestingly, there are different kinds of organizations that have been set up in Bergen with the scope of building on the social resilience and providing access to healthcare, socializing opportunities, important information and other relevant sources of resilience. Robin Hood Huset (The Robin Hood House) has been an example of an organization which is very active in the above. As it is stated in their mission “Robin Hood Huset is a drug and alcohol free, religiously neutral environment for those who have financial difficulties or who wish to expand their network. […] The house is a place for social interaction, self-help and socio political interest work”. It was really interesting to discuss the EU politics and how they affect and interact with the Norwegian society, the barriers that migrants face within a system often remaining “invisible” to a large part of society, the financial hardships and how they affect the people in Bergen especially coming from a migration origin, the difficulties to integrate and move through the labour market and in Norway and other issues that are of crucial importance when we consider for example the UN’s Sustainable Development Goals for universal coverage. Talking with legal advisors, helpers and volunteer in the Robin Hood Huset was really inspiring to keep working in the field of human rights for vulnerable populations. In a similar sense, the meeting with Theresa working in the organization providing healthcare services to undocumented migrants was equally important in understanding social exclusion and how it’s being dealt with in an urban context. Undocumented migrants only have access to emergency health care. As Melberg, Onarheim, Spjelknaes, & Miljeteig (2018) state “migrants with no legal right to remain are only entitled to receive ‘immediate medical assistance if intervention cannot wait without risk of imminent death, permanent severe disability, serious injury or acute pain’”.

“Philoxenia” in Bergen

One word that could summarize my experience in Bergen could be “philoxenia” which in Greek means “to show love and care to strangers”. In the ancient Greek context that used to be a “divine ethical rule” that all should follow. Although so far from the Greek context, WAPR Norway and all the colleagues that met me in different services took so good care of me and happily exchanged ideas and good practices. Starting from my actual home in Bergen with Kari Melberg who was a wonderful host and made me feel “like home” I had the chance to witness Norwegian culture and understand how things work from the inside. I had also the chance to share a meal together, another aspect of “philoxenia”, with Audun, Tor, Ingeboeorg and Lill Susann from the WAPR Norway Board, as well as share so many beautiful “office lunches” with many hard working colleagues in different settings.

Epilogue

Bringing my own experience to the experience in Bergen was a much fruitful and stimulating “exercise” that lets me keep my creativity alive. The sense of urgency, the always pressing need, the lack of cohesive infrastructure and connected services, the outcome-related financing of services and other factors that are widely present in Greece, especially in the refugee field, can sometimes burden you. Building bridges, exchanging experiences and experiencing solidarity can make you feel “whole” again and “back on track” to the values of humanistic sciences and to “rediscover” what motivated you to work in this field in the first place. Being “recovery-oriented” is not dictated and does not just concern a type of service for the users. As Audun mentioned in our last meeting; the services and the system have to facilitate the process of finding “what is important for you”. After a lot of thought I understand that the question weighs much more than the answer; it brings our services into question, it brings ourselves
to constantly evaluate where we are. I left with a larger potential to both tolerate uncertainty and keep asking myself and the services I work for; “what is important for each one of us and how should we negotiate about what should be done from all different levels”.

References


Contribute to improving maternal mental health in Ghana
Basic Needs Ghana

The WHO indicates that globally about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression. In developing countries this is even higher, that 15.6% during pregnancy and 19.8% after childbirth. Virtually all pregnant women or new mothers are at risk of experiencing some form of mental health challenges. Pregnancy related mental illness is considered a major public health challenge. Other risks to pregnant women include poverty, migration, extreme stress, exposure to violence (domestic, sexual, and gender-based), emergency and conflict situations, natural disasters and low social support. Affected mothers cannot function properly. In severe cases mothers may even commit suicide, homicide or even infanticide. Prolonged or severe mental illness hampers the mother-infant attachment, breastfeeding and infant care. Very young infants are highly sensitive to the environment and the quality of care and as such their growth and development may be affected negatively.

The UK aid funded Maternal Mental Health project implemented by BasicNeeds-Ghana and three other local Non-Governmental Organisations is currently implemented in five Regions of Ghana, covering a total of seventy-four districts. The project, ‘Enhancing Maternal Mental Health of pregnant women and mothers and their children to realise maternal and child health in Ghana’, seeks to realise improved maternal and child health outcomes for poor, vulnerable girls and women in Ghana and their children.

Project participants benefited from tailor-made trainings on a range of topics aimed at enhancing their knowledge and competence to live meaningful lives. 96 Project officers, selected midwives and community-based Self-Help Groups were trained on psychoeducation, wellbeing and counselling to serve as Trainer of Trainers. Participants appreciated the possible causes of post-natal depression/anxiety and the normalisation of distress as well as the implications on individuals, families and society, when maternal mental health issues are not addressed.

The training programme specifically exposed participants to the definitions, sign/symptoms, prevalence and psychological models to help the trainees understand the causes and maintenance factors of Maternal Mental Health issues. The biopsychosocial model served as a helpful tool that encouraged normalisation and understanding of MMH distress, as it linked biological, psychological and sociological factors. The model useful in letting people appreciate that depression and anxiety are not the fault of the individuals experiencing it and therefore reduces self-blame, social stigma and criticism.

Community Volunteers (CVs) play a central role in mobilising individuals as well as other identifiable...
social organisations in the community. They are young, energetic, enthusiastic and respected individuals who have a passion to serve their communities. Community volunteers are usually nominated by community leaders and therefore have the approval and support of the community for their activities. They are people with a sound knowledge of their communities and the residents. For them to support activities of the Maternal Mental Health Project in their communities, community volunteers and Self-Help Group leaders were trained on identifying common mental disorders in pregnancy and referring women for screening in the project areas. This has ensured that pregnant women regularly visit health care facilities not only for routine ante-natal check-ups, but they are also encouraged to seek mental health services and psychological counselling. This will make it possible to stem any mental ill-health in good time.

BasicNeeds-Ghana is collaborating with the Regional Alliances for Mental Health and Development to increase advocacy for maternal, child health and survival. The Alliance for Mental Health and Development consist of government and non-governmental organisations as well as key individuals to broaden the advocacy for mental health. Members of the Alliance observed that maternal mental health had been left out in their advocacy engagements and awareness creation activities and therefore agreed to integrate maternal mental health into the on-going advocacy work. They are currently using the platforms available to them to draw attention to the maternal mental health in their programmes.

The Maternal Mental Health project combines realisation of improved health and incomes as a priority. Economic empowerment initiatives have therefore been embedded in the project to enable poor and vulnerable pregnant women and girls as well as mothers with babies below two years earn an income. Poor pregnant women and girls most in need of support for economic liberation are either supported to enrol in vocational training / apprenticeship or assisted with micro finance to undertake income generation ventures. Consequently, a train-the-trainers training on livelihoods skills has been delivered to beneficiaries of livelihoods under the Maternal Mental Health Project.

Mental health is highly under-prioritised in Ghana and this has a bearing on maternal mental health outcomes. The Maternal Mental Health project serves seeks to support pregnant women and mothers by ensuring early recognition of mental disorders in this group, providing care to mothers with mental disorders an refer appropriately in order to improve the quality of lives of mothers with mental disorders and their families as well.

A Self-Help Group is an organisation of individuals sharing a common concern. They meet regularly to provide and receive emotional support and exchange information. Mental Health Self-Help Groups (SHGs) are peer support groups made up of mental health and epilepsy service users and their primary carers. Basic Needs-Ghana (BNGh), as part of implementing its Mental Health and Development Model, facilitated the formation of SHGs in eight (8) of the ten (10) Regions in Ghana. Currently, BasicNeeds-Ghana is working with 307 SHGs across Ghana with a total membership of 21,564. The Yinsongmah SHG in Gambibgo in the Upper East Region is one of many SHGs established and supported by BNGh. Yinsongmah was formed in May 2015 and has become one of the vibrant groups BNGh is working with.

The group consist of 4 males and 23 females. 8 of the members are care givers. Members meet monthly to review their activities and discuss issues about their wellbeing. They also receive their medication from the Mental Health Officer, Sophia Nsoh at the Gambibgo Health Centre. Sophia does not only provide mental health education and medication to the group; she also supports the group in other activities including writing meeting minutes and keeping records. They also support one another in their economic activities, remind one another about the renewal of NHIS cards, emphasise adherence to their treatment as well as reminding one another of Specialist Psychiatrist’s outreach clinics organised by BNGh.

The Yinsongmah SHG also contributes to the development of their community in various ways. They mobilise themselves periodically and invite Mental Health Officers and volunteers who work closely with them in their communities to provide them with mental health outreach services, give health talks and health information they may require. With support from the UK aid through BNGh under the project, “Promoting an inclusive and Empowered Civil Society to Advance Socio-Economic and Political Development in Ghana” members of this SHG have been supported with resources consisting of cash grants or equipment to undertake various economic ventures. Some of the economic activities members of the group undertake include petty trading, beekeeping and rearing small ruminants. Others engage in tailoring and dressmaking as a means of secure livelihoods. Out of the 27 beneficiaries who were supported, 5 engaged in farming and animal rearing, 6 in petty trading and 21 in basket weaving. Eight (8) of the group members were also supported with sewing machines to enrol into dress making apprenticeship. Two of them have since passed out and have become master artisans. Members of the Yinsongmah SHG group have benefited from trainings on group facilitation, leadership, conflict management and human rights. They have also been trained on managing small businesses and resource mobilization. Equipped with this range of information and knowledge, members agreed to use the proceeds of their livelihood support to further strengthen the group and economically empower themselves by establishing their own savings and loan scheme. The group has been able to print membership and savings cards for members.
They also paid for the construction of a metal savings box with contributions from group members. The metal savings box is secured with three (3) padlocks and keys to these padlocks kept by three (3) different group members. The box is opened by the treasurer, together with the two group members keeping keys of the other locks on their meeting days. The treasurer then counts and updates members on the amount of money in the box.

The group meets fortnightly to make contributions into their savings. Members who need loans are granted during meeting days at a minimal interest of 5%, payable within three (3) months. Loans due for repayment are paid during meetings and the amount realised together with the interest is granted as loans to other group members who require loans.

This group is on the path to self-reliance. They are free from paying high interests charged by financial institutions. Members of their community now accord them the needed respect and dignity because of economic empowerment. Akolpoka Adugbire, a member of the group testified during a group meeting, “but for this initiative, I wouldn't have known where I would have gotten money to purchase my medicines every month. I can now purchase my medicines and also have some resources to engage in basket weaving, I now earn more profit now than before I became a member of this group”. This innovation is contributing to improving the bond and peer support among members. It has enhanced their self-confidence and they now speak publicly about their conditions and campaign against stigmatization and discrimination of their members.
Introduction

In this issue, we have chosen three articles, which focuses on recovery amongst people with co-occurring mental health and substance use problems. All three articles present findings on how to support recovery. The findings are based on the accounts of people with lived experience and/or people working with them.

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Aim and background: Although, recovery in co-occurring mental health and substance use problems usually involves relationships with professional helpers, little is known about how these are experienced by service users. In this article Brekke et al. (2017) explores and describes behaviour and attributes of professional helpers that support recovery, as experienced by persons with co-occurring mental health and substance use problems.

Methods: The study is a part of a bigger collaborative research project that investigates the recovery orientation of community mental health and addiction services in a local authority area in Eastern Norway. Underpinning the study is an understanding of recovery as a personal and social process. The data for this paper derived from eight in-depth individual interviews with persons with co-occurring mental health and substance use problems.

Results: The authors presents four categories of recovery-supporting behavior and attributes of professionals helpers. The ability to build trust cuts across all of them: Building trust through: a) hopefulness and loving concern, b) commitment, c) direct honesty and expectation and d) action and courage.

Discussion: In the discussion, the authors discuss the importance for services to allow for flexibility, continuity and training, so that professional helpers can establish trust, which they argue is vital when trying to reach out to this group.
substance use problems. The authors wanted to found out how clients describe the importance of treatment factors for the recovery process, and how these descriptions relate to professional descriptions of these factors.

**Methods:** Both in-patient and outpatient units in psychiatric care and addiction treatment in Sweden were contacted for recruitment of participants. Eleven units participated, and semi-structured interviews with 40 clients and 15 professionals were conducted. The data collection lasted eight months and occurred during the years 2016 and 2017.

**Results and conclusion:** All but one client described treatment as important for their recovery process. Clients and professionals mentioned three common treatment factors. These were medication, treatment methods and the professionals. To conclude, the authors highlights the importance of creating safe milieus, confident and secure professionals.


**Aim and Background:** Brekke et al. (2018) explores and describes staff experiences with dilemmas in recovery-oriented practice to support people with co-occurring mental health and substance use problems. More knowledge on this topic is seen as important, because staffs’ perceptions of recovery-oriented services may be a key component of implementing recovery principles in day-to-day practice.

**Methods:** Data collection were carried out in Norway and over the course of two years. The findings are based on three focus group interviews with practitioners. The first interview lasted 90 minutes. While the second and third lasted 60 minutes.

**Results:** The thematic analysis revealed three themes /dilemmas: 1) Balancing mastery and helplessness, 2) balancing directiveness and non-judgmental attitude and 3) balancing total abstinence and the acceptance of substance use.

**Discussion and conclusion:** In the discussion, the several dilemmas practitioners face relating to recovery-oriented practice to support people with co-occurring mental health and substance use problems are discussed. The authors point out the need for further definition of recovery-oriented practice from different stakeholders’ perspective. They also call for innovation approaches to practice development, and research that address the inherent dilemmas in recovery-oriented practice aimed at people with co-occurring problems.

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.
Dr. V.K Radhakrishnan, India WAPR vice-president, informs us of the extremely hard challenges WAPR has to face and of the way of working in the community. WAPR showed to be on the forefront in the aids to the areas destroyed by the floods in Kerala, as well to participate to joyful traditional celebrations in favor of children and their wellbeing.

VIDYARAMBAM FUNCTION FOR TRIBAL CHILDREN AT WAYANADU
WAPR with Ajaya Smrithi Charitable Trust conducted Vidyarambam function for tribal children at Poovanchi Colony Wayanadu on 19th October 2018. Vidyarambam is a traditional custom followed in Kerala for the beginning of the education for the children by writing the first Malayalam alphabet in rice kept in brass plates. Dr. V.K Radhakrishnan inaugurated the function. Dr. Rajesh Menon, Mr. N. Radhakrishnan, Mrs. Geetha, Mrs. Sareena, local MLA, Local Panchayathu President spoke during the inaugural meeting. Following that, Vidyarambam function was conducted. The lamp was lighted children wrote in the rice in brass plate which according to the tradition. More than sixty children attended the function. After Vidyarambam, the study materials were also distributed. High school students were given a steel table and a plastic chair. One hundred and twenty pieces were distributed.

KERALA NATURAL DISASTER
The devastating floods in August 2018 was the worst in last hundred years. More than four hundred people lost their life. There are more than 79 dams in Kerala, most of them were over flowed due to the heavy rain fall. In addition to the above normal rain fall between June and August and the extremely heavy rainfall between August 15 and August 17. The wide spread destruction caused by the flood was unimaginable: in 48 hours time thousands of people lost everything they could save during their life time. The farmers lost their cultivation, the merchants lost their products stored in their showrooms. Thousands of vehicles was immersed in water for more than a week. At S.N. Medical College campus people were trapped in 4th floor for four days and rescued by Indian Navy.

The Government of India and Kerala Government immediately converted the schools and colleges in to relief camps for the people who lost their houses. Navy, Air Force, Police and public swing in to action which reduces the casualties. U N Disaster management team also visited the state. The Prime Minister of India spend two days in Kerala supervised the situations. Lakhs of people were affected by various physical and psychological problems.

The WAPR Indian Chapter were actively participated in the relief programs. Members conducted medical camps in different places and distributed food, medicines and clothes. As a WAPR project we immediately prepared modules to manage PTSD following the disaster. We conducted specific training programs for the consequences of natural disasters targeted to social workers, nurses and voluntary organizations. They were able to identify cases who needs expert management. The patient were managed by WAPR members under the leader ship of Dr. V.K Radhakrishnan and others.

WAPR President Dr. T. Murali visited Ernakulam District and conducted training camps for professionals. WAPR Board member Mr. Santhosh Joseph actively involved rescue operations at
Pala. The public and local person appreciated the WAPR initiatives. I take this opportunity to thank our national and international board members who offered whole hearted support for the WAPR initiatives.

**PROGRAMME AT CHAVAKADU INDIA**
Raja Charitable Trust Chavakadu is a model centre for psychosocial rehabilitation. The Raja group is running various business in different states of India. They have more than seventy thousand employees in their factories. Out of that more than two thousand employees are recovered mentally ill people. They have employed with full salary and other perk. Considering the herculean task taken up by the organization WAPR Indian Chapter decided to honor Mr. Abdul Salam for the selfless services.

As he is reluctant to attend any public function to receive any honors. WAPR Indian Chapter entrusted Dr. V.K Radhakrishnan to honor him at his place. So it was decided to honor him during the annual function of the Raja Charitable Trust at Chavakadu on 19th February 2019. Dr. Pfizer, Dr. Damodharan, Mr. A. Abdul Haseeb, Mr. M. Sivadasan Press club president, Dr. V.K Radhakrishnan and Mr. Abdul Salam spoke during the occasion.

**Dr. V.K Radhakrishnan**  
Vice President WAPR,  
Director, C N K Hospital,  
Changanacherry, Kerala, India

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**WAPR Eastern Mediterranean Region Report**

*Psychiatric Rehabilitation Status in the Arab Countries*

*By Medhat Elsabbahy*

In the last 3 years the WAPR Eastern Mediterranean Region has been very productive with many training opportunities, opening new branches, organizing workshops, organizing conferences and establishing new psychiatric rehabilitation units as well as recognizing 3 WAPR CCRTs. Being the Regional Vice President of the EMR I worked with colleagues in Egypt, UAE and KSA to establish branches for the WAPR and we managed to do that with the support of Prof. Dr. Afzal Javed and Dr. Ricardo Guinea. Moreover, I worked with colleagues to recognize Psychiatric Rehabilitation Unit in Sheikh Khalifa Medical City and Ain Shams University Psychiatry Institute as WAPR Collaborating Centers for research and training (CCRT).

We managed to train more than 50 staff members to help them to open similar psychiatric rehabilitation units in Al Amal hospital Dubai, and Ras Alkhaima hospital as well as training colleagues in Rashed hospital Dubai to open community psychiatric outreach program. This training was arranged by me in collaboration with WAPR, Arab Federation of Psychiatrists and the Ministry of Health of UAE.

I worked in collaboration with the WAPR President Dr. Ricardo Guinea to conduct training to colleagues in Dubai and Ras AlKhaima (RAK) late 2016. Also we supported the annual regional conference of integrated psychiatry for 4 successive years 2016-2019. Also we shared in many conferences in Cairo, Abu Dhabi, India, and Thailand together with the President Prof. Murali Thyloth, Secretary General Prof. Solomon Rataemane, WPA president Prof. Afzal Javed as well as Dr. Ricardo Guinea.

The 1st International Congress of the World Association of Psychosocial Rehabilitation (WAPR) – Abu Dhabi that was held on 21-23 September.
2017 at Abu Dhabi National Exhibition Centre, UAE offered a supper opportunity for many professionals in the region and beyond the region to attend expert updates and share the best practices and experiences on many aspects of Psychosocial Rehabilitation relevant updates, quality treatments, updated policies, recovery oriented services, research, human rights in mental health, legislation, accessibility to job and accommodation for patients, accessibility to psychoeducation for families and many more.

The WAPR Congress was a mayor event in the region with more than 500 participants from 10 countries, 3 tracks with outstanding state of the art sessions, 57 proffered scientific lectures and 10 workshops on thought provoking keynote lectures and a variety of topics. Prominent national and international speakers and leading experts in the field of psychiatric rehabilitation and mental health provided comprehensive, up-to-date research-based answers to the most frequent questions that arise on psychosocial rehabilitation in order to encourage the highest standards of clinical practice and to increase knowledge and skills about mental disorders. This unique event signifies the importance of improving the quality of life and promoting recovery in those people affected by serious mental illness and their families in both the medical and social communities. The CME program received the highest attendance to date and the delegates’ feedback was extremely positive.

Workshops were attended by more than 200 attendees, and we managed to cooperate with Psychiatric Rehabilitation Association and Academy (PRA) to present the CPRP Exam Preparation And Primer with 2 full day training course By Prof. Anne Sullivan as well as presenting other workshops as: Introduction to Psychiatric Rehabilitation ; If You are New, We Welcome You and The Beginning of the Journey Achieving the Promise: Psychiatric Rehabilitation by Prof. Veronica Carey

Another workshop by Prof. Marianne Farkas titled Working with individuals with serious mental illnesses: Treatment? Rehabilitation? Recovery? What’s the difference?

From 2018 July when we got the honor to host the 14th WAPR world congress in Abu Dhabi 2021, we started to arrange the needed logistics with Prof. Murali Thylloth the President of WAPR. We had many WAPR supported conferences where we shared with lectures and workshops.

COMMUNITY BASED MENTAL HEALTH SERVICES IN BERGEN presented by Audun Pedersen, Senior Advisor of Mental Health, City of Bergen Norway.

Care-giver’s Group meeting, in Schizophrenia & Bipolar Mood Disorder presented by Dr. Ismail Shihabuddeen TM, PhD, India Mental Health RELIEF SERVICES FOR CHILDREN AFFECTED BY THE ARMY PUBLIC SCHOOL MASSACRE IN PESHAWAR, PAKISTAN. Presented by Prof. Khalid Mufti, Pakistan.

Word Association Psychosocial Rehabilitation (WAPR) UK Branch - Annual meeting on 13th April 2019 with collaboration of LCFT, BPPA & WPA; Invitation as invited speaker, I presented Strategies for establishing psychiatric Rehabilitation services in Developing Countries.

Moreover, WAPR supported the WAPR Egypt branch in organizing the 6th Annual Regional Conference of Integrated Psychiatry, Preventive Psychiatry 13 April 2019 in Cairo, where we shared with two video conference presentations by Dr. Ricardo Guinea and Medhat Elsabbab.

Also WAPR supported the first RAK International Psychiatry conference, and we presented two lectures Prof. Murali Thyloth; Scope of psychosocial rehabilitation in a changing world. I presented Neuroplasticity implications in psychiatric rehabilitation.
Asian Federation of Psychiatric Association (AFPA) World Congress Sydney, Feb 2019

Asian Federation of Psychiatric Association had its world congress in February 2019 at Sydney. A large number of participants attended it from Asian countries along with a number of WAPR members. The scientific programme included special emphasis on recovery and psychosocial rehabilitation.

Clubhouse Europe appoints past President WAPR as its Advisor

The Board of Clubhouse Europe is very pleased and honoured to invite Dr Afzal Javed to become a permanent advisor for the Board as well as to become a member of the Advocacy Group. Advocacy is currently the main activity of Clubhouse Europe along with promotion of the vision that ending social and economic isolation for people with mental illness by growing the number and quality of Clubhouse rehabilitation programs worldwide is possible and feasible.

Clubhouses model powerfully demonstrate that people with mental illness can and do lead productive & happy lives provided they be offered support and empowerment in areas of functioning & social living.

WAPR signed a MoU with Club House Europe in 2014 for joint working and future collaboration in different areas of psychosocial rehabilitation.

The overall goals of collaboration based on this MoU included:

- Improving the general social inclusion, educational and labour market integration and participation in the local communities of people with mental disorders worldwide;
- Increasing opportunities of mental health service users to participate as members in the empowering Clubhouse communities as defined above; and
- Strengthening and expanding the network of high quality Clubhouses worldwide, as well as, other evidence-based best practice methods of the psychosocial rehabilitation.
- Disseminate information about the Clubhouse rehabilitation model at Congresses and through News Channels.
FOUNTAIN HOUSE LAHORE PAKISTAN
OPENS NEW RESIDENTIAL FACILITY FOR FEMALES WITH INTELECTUAL DISABILITIES
(WAPR Pakistan branch is based at Fountain House, Lahore & actively engaged with this rehabilitation facility)

Fountain House, Lahore provides a facility for rehabilitation and treatment of mentally ill with a vision to improve their living and functioning as independent citizens. This institution was established around 50 years ago & provides state of the art mental health treatment and rehabilitation facilities, on outdoor as well as on Indoor basis, to the patients suffering with psychiatric illness from across Pakistan.

Ayesha Siddiq Compassion Homes is the latest addition towards achieving Fountain house's aims for serving the humanity through its services. These Compassion Homes are for adult females having intellectual disabilities especially when their caregivers / guardians have been passed away or not able to take care of them due to which these females face maltreatment & stigma from the society. It is a unique model of service where we provide complete care to the Adult Females with Intellectual Disabilities, Mild Autism and other related intellectual disabilities. These homes are long-term stay facility for these adult females where we provide the state-of-the-art treatment and rehabilitation facilities under secure and controlled environment with the complete female staff.

Out of the 10 proposed homes with capacity of 25 Female Adults in each home, two homes are initially completed & opened at Fountain House Farooqabads's Agro-Based land on the refreshing atmospheric location of Farooqabad near Sheikhupura, Punjab. These two homes are constructed through the contribution of the philanthropists of the society & were formally inaugurated by the Speaker of National Assembly of Pakistan in April 2019.

Currently available facilities are as following:

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<tr>
<th>Medical / Clinical Care Facility</th>
<th>Healthy &amp; Hygienic Environment</th>
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<tbody>
<tr>
<td>Physio &amp; Psycho Therapies Facility</td>
<td>Complete Security</td>
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<tr>
<td>Vocational Training Facility</td>
<td>Mosque / Prayer Area</td>
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<tr>
<td>Speech Therapy Facility</td>
<td>Indoor / Outdoor Sports</td>
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<tr>
<td>Nursing Care Facility</td>
<td>Recreational Activities</td>
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<tr>
<td>Boarding &amp; Lodging Facility</td>
<td>Special Needs Activity Plan</td>
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</tbody>
</table>

Research and Leadership Skills Course for Early Career Mental Health Specialists and Students, Ukraine

At a course on Research & leadership skills, talks were given about conducting research in psychosocial rehabilitation. This was a meeting organized by Ukraine Psychiatric association and attended by a number of young psychiatrists from many European countries.
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:  

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

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:  

WHO MiNDBank (online databases of good practices worldwide):  
http://www.mindbank.info/
<table>
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<tr>
<th>POSITION</th>
<th>Nominees 2018-21</th>
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