WAPR BULLETIN Nº 36

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“Beyond the Tradition, Create New Paradigm of Care”

12th World Congress of WAPR in Seoul 2015

Date_ November 2–5, 2015
Venue_ Grand Hilton Seoul, Korea
Homepage_ www.wapr2015.org
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I am pleased that WAPR has remained very active and vibrant for doing a number of activities in many countries. We have been involved in organizing meetings, conferences & different academic and clinical events that have been organized by our board members, national branches and especially the Regional Vice Presidents. All these efforts have played an active role in strengthening the mission & philosophy of WAPR in their respective countries as well as all over the globe.

**Links with other professional organizations**

During the last few years, WAPR has worked extensively for improving our links with other professional organizations. Our Board members needs special thanks for their contacts & links with many professional organizations & NGOs that has in deed strengthened our links and established further collaborations especially with the following organizations:

- World Psychiatric Association (WPA)
- World Association for Social Psychiatry (WASP)
- World Federation for Mental Health (WFMH)
- World Federation of Occupational Therapists (WFOT)
- International Centre for Clubhouse Development ICCD.
- European Federation of Associations of Families of People with Mental Illness (EUFAMI).
- International Society for Psychological treatments for Schizophrenias & other psychoses (ISPS).
- Pacific Rim College of Psychiatrists (PRCP).
- International Association for Women's Mental Health.
- European Psychiatric Association (EPA).
- Faculty of Rehabilitation & Social psychiatry Royal College of Psychiatrists UK.
- Asian Federation of Psychiatric Association (AFPA).
- SAARC Psychiatric Federation (SPF).
- World Health Organisation (WHO).

We have been having joint meetings, sessions and academic programmes in collaboration with all these organisations and have signed joint declarations with some of these organisations as well. We are pleased that such efforts are continuing with future plans for joint collaborative work in areas of mutual interest.

KL declaration “Psychosocial Rehabilitation in Asian countries” that was passed at Malaysian meeting (May 2014) is an important document advocating needs for implementing PSR in Asian countries and we are pleased that we are sharing this document with other professional groups including Royal Australian & New Zealand College of Psychiatrists for future collaboration and implementation in the Asian Pacific Region.

**Opening of new WAPR Branches**

This term has seen a growing interest for many friends in different countries for opening of new branches. Our regional vice presidents (Solomon Rataemane & Alberto Fergusson) are also exploring the possibility of having new branches in African & American region as well. A visit of WAPR officers to some Latin and South America (through courtesy
of Manantial Foundation, Spain) has indeed opened new avenues and we hope to have regional meetings in this continent in 2015.

**WAPR Meetings & Training sessions on PSR**

It is indeed a great opportunity to organize a number of training programmes during 2014 in almost all regions.

Many WAPR branches have continued organizing annual meetings and also collaborating with many other professional associations in organizing different academic, educational & professional activities during this year.

- WPA Regional Conference Slovenia 2014.
- WAPR Greece Branch meeting Athens, April 2014.
- WAPR Training Programme at AFPA’s regional conference Malaysia, May 2014.
- WAPR Latin America Project, May 2014 (with support from Manantial Foundation Spain).
- Manantial Foundation Spain Training at UK, June 2014.
- WPA World Congress Madrid, September 2014.
- WAPR UK meeting, Preston, UK, September 2014.
- PSR Meeting Canada, September 2014.
- WAPR Taiwan 2-4 November 2014.
- WAPR Pakistan & Easter Mediterranean Regional ongoing training (psycho education) in Fountain House, Lahore, Pakistan WAPR European Regional Training Programme, Hungary, January 2015.
- WAPR supported meeting, Abu Dhabi, January 2015.
- WAPR Eastern Mediterranean Regional Training programme / meeting, Lahore, Pakistan, February 2015 www.pprcpakistan.com
- WAPR Training workshop at Asian Federation of Psychiatric Associations (AFPA) World Congress, Fukuoka, Japan, March 2015.
- WAPR supported meeting, Colombo, Sri Lanka, March 2015.

**WAPR Bulletin & WAPR website** continues receiving a well-deserved appreciation from our membership. Thanks to the editorial team for their hard work. It is indeed a matter of great proud & privilege that Spanish version of our Bulletin has been added to the list of achievements in this area.

WAPR Bulletin has started a new section of invited articles on specific topics that will generate a discussion forum. This is a brilliant idea as debates on currently important topics will generate more ideas for the development of our services and approaches towards improving our strategies.

**Wapr Standing committees & WAPR Task Forces** are updating their work and reviewing their remit within the functioning of WAPR. The Task Forces on Users & Carers involvement in Treatment and Rehabilitation & Human Rights for persons experiencing mental illness had significant contributions towards WAPR work.

Similarly our operational committees on Constitution, Nominations for the next election and Congress committees are busy in preparing their recommendations for our discussions at the next general assembly.

**2015 proposed meetings**

Year 2015 is going to be another busy year and following meetings have already been confirmed.

- WAPR European Regional Meeting Italy, May 2015 http://www.wapr-italia.it/
- WAPR South Asian Regional Training programme Bangkok, Thailand, August 2015.
- WAPR Co-sponsored meeting of WFMH, Cairo, Egypt, September 2015.
- WAPR World Congress, Seoul, Korea, November 2015 www.wapr2015.org

Prof Solly Rataemane, Regional Vice President African Region, and Prof Alberto Fergusson, Regional Vice President American Region are also planning training programmes in their regions during 2015.

I once again thank all the Board members, national secretaries & membership of WAPR for their continuous support and hard work for WAPR.

Let us hope 2015 brings more prominence to WAPR work and we continue with our efforts for bringing a change and improving services for our patients and their families. This of course needs your continuous commitment and support.
During the last two decades, the Korean Association for Psychosocial Rehabilitation (KAPR) (founded 1995) has played a key role in Korea in promoting professional development in the field of psychosocial rehabilitation. As a nonprofit association KAPR has invested time and resources at every level by promoting legislation, policies, and programs for people with mental illness. KAPR advocates for patients and others such as their family members who have suffered from social prejudice. KAPR leads Korea in the development and dissemination of best practices in the field of mental health rehabilitation for the medical community as well as in the community at large. These efforts have yielded significant progress in how Korean society views mental illness.

As host of the 2015 WAPR World Congress, KAPR cordially requests your participation November 2, 2015 through November 5, 2015. Convening its first world congress in East Asia, the 2015 WAPR Congress will convene in Seoul Korea, heralded as one of the most attractive and dynamic cities to visit both in Asia and the world. The main theme of the Seoul WAPR World Congress will be “Beyond the Tradition, Creating a New Paradigm of Care”.

In 2015 the WAPR World Congress under the theme of “Beyond the Tradition, Creating a New Paradigm of Care”, anticipates that our experts will share their knowledge and experience in dealing with mental health problems from different perspectives. We trust that by discussing and exchanging our knowledge and experience we can create a new paradigm in the realm of mental health and consequently a fresh perspective to embrace people with mental health disorders. The initial Board Members of KAPR
symposiums will focus on introducing current mental health rehabilitation practices and programs followed by symposiums focused on exchanging our creative insights and perspectives.

Through more than 40 symposiums as well oral and poster presentations from around the globe, the 2015 WAPR World Congress offers a variety of rich and diverse viewpoints. Highlights of the World Congress include hearing from and dialoguing with world renowned speakers such as Afzal Javed (United Kingdom), Harry Minas (Australia), Helen Herrman (Australia), Kim T. Mueser (USA), Marianne Farkas (USA), Mohan Issac (Australia), Naotaka Shinfuku (Japan), Ricardo Guinea (Spain), Susie Kim (Korea), Thyloth Murali (India), Yu Xin (China), and Xiangdong Wang (WHO WPRO). Notably, WAPR president Dr Afzal Zaved, will invite consumers of mental health services and their family members to participate in the presidential symposium.


Travel award applications to the 2015 WAPR World Congress are available now. Awards support partial expense for airline tickets. Applicants must send an abstract for oral and poster presentation, be under 40 years of age, currently working in the field of mental health, and be from upper-middle-income and low-income economies classified by the World Bank. Deadline for application is May 20, 2015.

The WAPR World Congress is sponsoring several field trips in Seoul. These site visits will allow participants to understand the mental health field in Korea. There will be 5 different courses available. The first course circulates to both public mental health delivery system agencies located in Seoul as well psychosocial rehabilitation centers in the private sector. The second course provides a view of a general hospital psychiatric ward which pursues architectural and environmental design components to create an integral healing environment. There are also several community mental health centers in this tour. In the third course, visitors will discover a community based mental health center which utilizes a club house model with a home-like environment. The fourth course, located in the north western area of Seoul showcases a psychosocial rehabilitation facility and a residential facility. In a creative vein the fifth course highlights artwork in an art museum created by mental health patients.

Various social events will also be held throughout the WAPR World Congress providing venues for networking. The inaugural Welcome banquet includes traditional Korean entertainment and a performance by the famous Korean singer Taewoo Kim (photo with Dr Tae-Yeon Hwang, organizer of the Congress ), who is a honorary ambassador of Seoul Congress. Participants will enjoy a Gala banquet with a traditional Korean as well as a Western opera. An art exhibition showcasing art works done by mental health patients will be on site.

We look forward to your active participation in 2015 World Congress of WAPR and to welcoming you to the beautiful city of Seoul, Korea in November.

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Key Issues in the Development of Recovery Globally.

Larry Davidson, Ph.D., Yale University.

As “recovery” becomes a global phenomenon, a number of issues have emerged which will need to be addressed for practices to be transformed, and newly developed, to promote it. Briefly stated, these issues include recognizing the foundation of the recovery movement in a civil rights and social justice perspective; allowing for and cultivating cultural differences with respect to such core values as autonomy, self-determination, and the nature of “a good life”; and redesigning the scope, function, and role of what has historically been viewed as “clinical care.” I will take up each of these issues in turn.

Practically since its arrival on the policy scene in the late 1980s, there has been a tendency in the field to separate the notion of “recovery” from its historical and political roots in the mental health consumer/survivor movement (Davidson, 2006). To do so, however, is to paint a highly individualistic picture of a “personal journey” that leaves recovery unmoored from its social, political, economic, and cultural context (Topor et al., 2009). While such a picture may make sense in highly individualistic cultures, such as that of mainstream America, even within this context an individualistic picture of recovery runs the risk of two very unfortunate consequences. First, persons with serious mental illnesses who continue to experience significant difficulties can be blamed for not trying hard enough to recover. Second, and in a related vein, viewing recovery as an individual journey may lessen the sense of responsibility a society or a system demonstrates towards persons with serious mental illnesses (Rowe & Davidson, in press). As a result, this view of recovery can be used as a justification for cutting funding and/or services and supports, as people are expected to recover and therefore should not need as much support from others or from society at large, as has been documented already in the case of California (Braslow, 2013).

But before recovery came to be defined as a “deeply personal, unique process” (Anthony, 1993), it had arisen out of a civil rights movement led and fought by persons who had been institutionalized, most often against their will, for what they had been told was a serious mental illness. They were fighting as much against the laws and mental health policies and practices of the day as much as they were fighting for anything, and what they were fighting for, at the time, was their basic freedom and dignity as members of democratic societies. Like persons of color, women, and gays and lesbians, they wanted to be treated just like everyone else—which actually
meant just like white, heterosexual men. Those advocates who accepted the existence of mental illnesses (because, of course, many did not) then turned to their peers in the physical disabilities/independent living movement to argue that they should be afforded all of the rights and responsibilities that other members of society have who do not have disabilities (who Fred Frese III has called “chronically normal people”). It was within this context that Pat Deegan (1988) first defined recovery as “the lived or real life experience of people as they accept and overcome the challenge of the disability … [as] they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability.”

In order to avoid the misinterpretations and misapplication described above, it is crucially important that these experiences be examined, studied, and understood within their every day life context, and this context is one that is shaped in very important ways by history, culture, and political economy. The first step in any civil rights movement is to end the discrimination that already exists, and is sanctioned, against persons of a particular group. In this case, it would be to end discrimination against persons with serious mental illnesses in whatever myriad forms it may take. Until that happens, personal journeys will continue to be limited, undermined, and confined by these forms of discrimination. Until that happens, societies around the world are morally obligated to identify and rectify the forms this particular type of discrimination has taken on within their midst, whether that be being chained to posts along the roadside in some communities, being confined to squalid institutions in other parts, being unwanted in the neighborhood some places, or being denied jobs or housing many places around the world.

But as soon as one starts to take the social context of recovery into account, differences in worldviews between cultures come into clearer focus and pose another challenge to the recovery vision. In Western social democracies, the kind of “good life” to which most persons aspire, with or without disabilities, is one of self-determination and autonomy. As a result, one way in which the recovery vision is being operationalized in mental health systems in these countries is through the individual tailoring of services and supports to enable persons with serious mental illnesses to pursue their own hopes and dreams. This reform has been described as a shift to “person-centered care,” in which persons with mental illnesses are supported in making their own decisions, both about their own care and about their lives in general. While some might question how realistic this is for anyone even in social democracies, we have certainly learned over the last several years that this approach makes little sense in countries and cultures that do not valorize individualism as much as the U.S. And even within the U.S., many subgroups have refused to accept this “lone ranger” ideal, preferring to preserve their own more family-centered and collectivist values. As a result, we are learning that recovery may look different in the Hispanic, Native American, and African American communities than it does in the largely White suburbs.

I was first made aware of this by my good friend Roberto Mezzina, M.D., currently the chief of psychiatry for the city of Trieste, Italy. After I explained the premises of person-centered care planning to Dr. Mezzina, he responded with: “But Larry, in Italy nobody makes their own decisions. It’s a combination of the Momma, the Doctor, and the Priest.” As recovery becomes a global phenomenon, we must be prepared to allow it to be shaped by and to reflect the reigning cultural values of the person’s community. In Hong Kong, for example, person-centered care is giving way to family-centered care (Davidson & Tse, 2004). As another example, the American “evidence-based” practice of Individual Placement and Support (supported employment) is not nearly as popular a way to increase employment among persons with mental illnesses in Europe as is the social cooperative/affirmative business model developed in Trieste in the 1970s by Basaglia and his colleagues (Leff & Warner, 2006). As in most cases in mental health, cultural humility is called for in bringing the recovery vision into new and different cultures, and is most likely best developed “from the ground up” by local champions and advocates (Drake & Whitley, 2014).

This last consideration brings us face to face with the question of the nature of clinical care in relation to recovery. Recovery in many English-speaking countries is in the process of moving from being an afterthought or an add-on to existing services to a reason to reform all of mental health care, including clinical practice. But what, exactly, recovery-oriented clinical care will look like in the end is far from certain. Initial steps have been taken in this direction by Geoff Shepard, Julie Repper, Rachel Perkins, Glen Roberts, and their colleagues in the IMROC (Implementing Recovery through Organizational Change) initiative funded by the National Health Service in the UK. One example of this important work
is the reframing of professionals having to manage “risk” (which is typically the number 1 concern among clinicians when it comes to the notion of recovery) into the notion of the co-production of safety planning, in which the person is included as a key player in determining how best to keep everyone involved safe, including him or herself (Boardman & Roberts, 2013; Perkins & Repper, in press). But to be consistent with recovery, many others aspects of clinical practice will similarly need to be reconceptualized as based on a collaborative relationship involving the person with mental illness (and perhaps his or her loved ones, community elders, or other natural supports) having active and substantial roles to play.

Reframing clinical care as a collaborative practice from the bottom up (as opposed to being only one component, as in cognitive behavioral approaches) will require rethinking the scope of practice, the guiding purpose of care, and the role of the practitioner. Thus far, the best approximation of what this might look like in practice is the promising approach of “Open Dialogue” developed by Jaakko Seikkula and his colleagues in Finland (e.g., 2006). This program involves the social network of the person experiencing distress, is explicitly collaborative and transparent in its approach, and does not focus on cure or containment as its primary goal. How well this approach may work in cultures outside of Scandinavia is not known, but the initial outcomes achieved offer hope that introducing collaboration even into the clinical care component of mental health will prove to be both more effective and more efficient in the long run.

References
People who experience mental health problems are frequently marginalised in society. This social exclusion can be compounded by the ways in which mental health services are delivered, for example where services are delivered as specialist residential accommodation. However, very few studies have explored the experience of living in a specialist mental health rehabilitation service from the perspectives of the people who have used such services.

This report presents an account of a study, undertaken by the first author in fulfilment of her Master’s degree in Occupational Therapy, at Brunel University, London. The study was part of a larger study carried out in rehabilitation services (see Notley et al, 2012). The researcher explored the experiences and perceptions of three people who used residential mental health rehabilitation service from the perspectives of the people who have used such services.

This report presents an account of a study, undertaken by the first author in fulfilment of her Master’s degree in Occupational Therapy, at Brunel University, London. The study was part of a larger study carried out in rehabilitation services (see Notley et al, 2012). The researcher explored the experiences and perceptions of three people who used residential mental health rehabilitation service from the perspectives of the people who have used such services.

Social inclusion is... being involved in the community and feeling safe.

Exploring the experience of social inclusion for people with mental illness.

Anna Croucher, South London and Maudsley NHS Trust; Alison Anne Blank, University of Worcester, UK; Wendy Bryant, University of Essex, UK; Jenny Notley, Central and North West London NHS Trust & Hannah Pell, Central and North West London NHS Trust.

Three participants, one female and two males, took part in the study. All were between 30 to 50 years of age, had experienced severe mental illnesses and been resident in a 15 bedded rehabilitation unit. The unit provided interventions for daily living and personal skill development, as well space and time after an acute mental health episode. Stays ranged from six to twelve months.

Information about the study was provided to residents via their mental health community team; a follow up call by an occupational therapist from the service enquired if they wished to volunteer. Information about the study was provided prior to written consent being obtained. Participants were informed that involvement would not affect their treatment and they could withdraw at any point.

A phenomenological approach was chosen for the study because such methods are appropriate for exploring lived experience and turn on an understanding of peoples’ perceptions of the world in which they live and the meaning that this holds for them (Langdrige, 2007). The methodology values participants’ unique understanding and lived experiences rather than trying generalising findings (Willig 2008). Such an approach to research is suited to exploring the idiosyncratic nature of mental illness and social inclusion.

Four themes emerged - the importance of the self, the relationship with others, the world of mental health and the world outside, and engaging in occupations. Rehabilitation services were found to provide a valued space and time for recovery from mental illness, and engagement in occupations offered support for the transition into the community.
Participants were reimbursed for their time and travel. Ethical approval was granted by Brunel University Ethics committee and the Local Research Ethics Committee.

Data gathering and analysis
Semi structured interviews, incorporating photo elicitation (Harper, 2002), were used to gather participants narratives. An interview schedule allowed the interviewer the freedom to explore participants’ thoughts whilst ensuring certain areas were explored. The interview location was chosen by the participants; each interview was digitally recorded and transcribed.

The iterative approach to data analysis in IPA is described in detail elsewhere (Smith et al, 2008) so will not be reprised here. Suffice it to say that the stages of data analysis involve firstly reading and rereading, immersing the researcher in the transcripts. Ideas for themes are recorded, and clustered into overarching, super ordinate and smaller, subordinate themes. Attention is given to the convergences and divergences in the perceptions of the participants. Close attention is paid to the participants’ words, which are used to illustrate the themes identified.

Findings
Four themes emerged from the analytic work, carried out by the first author. These were - the importance of the self, the relationship with others, the world of mental health and world outside, and engaging in occupations. These will be presented and illustrated with excerpts from the participants’ narratives.

1. The importance of the self: ‘You have got to love yourself first; if you don’t love yourself first it is going to be difficult to love someone else’

All participants spoke of the need to develop self-understanding and self-respect, of challenging their own negative thoughts, and building their self-esteem and confidence.

“So people are worth treatment, they are worth being successful … and that was missing because of my illness and [having] no self esteem, no confidence, when you start to get it back you get in this state of mind [you think] ‘well do I deserve this’. George

Participants spoke about accepting themselves and their illnesses and motivating themselves to keep well, despite concerns about the risk of relapse.

“It has been so many years of negative thinking… there will be blips but I have started to ignore the blips, there will be problems” Gordon.

Participants were aware that [name of rehabilitation unit] aimed to encourage independence, and that this was closely linked to self esteem and confidence:

“One day when you go home you will be able to do some things for yourself, there won’t be other people helping you, you will be doing yourself …a favour if you are helping [yourself] in the rehabilitation” Fatima.

However participants differed in their opinion of how to achieve more independence:

“The independent thing I don’t agree with much now to be honest, you are just left on your own. Independence is good, if you can deal with it” (Gordon).

2. Relationships with others: “ I had my mum… to fight for me and with decision making when I wasn’t really too clear in my mind.”

The participants all spoke about relationships with other people – family, friends, other residents, and staff - and how these impacted and were impacted by their mental health problems and desire to transition to the community.

“You are not only one person. I am a mother to three kids…it is not only a person who has taken it [mental illness], [it is] the family, you know, like the children (Fatima).

Participants acknowledged the value of supportive and encouraging staff to help them move on.

“The OT [Occupational Therapist] is … a lot more friendly… and more of a human face and it aids… kind of recovery, you know, it is kindness and understanding with me in these situations that helps” (Gordon).
Participants valued the opportunity to interact with other residents although all participants described experiencing isolation.

“It is just a sense of doing something for other people so... and they all appreciate it so that is the reward,” (George)

“Because you are on your own you are on your own so... and then you can go darker into those sort of places and if you have no one to tell or talk to” (Gordon).

There was for one two participants a comfort in being alone, for self-protection, an acceptance that being on your own was a consequence of having mental health issues.

“Because at one point I was quite prepared just to... you know not have any friends and be a loner... there is that pull towards being sociable but there was also a pull with me in being like a hermit or... not allowing anyone in, it is braver to let people in because you... get all the social feelings back again” (George).

“When you are giving some effort things come back to you, ...but if you don’t give effort, right, if I don’t go to the corner shop and walk and buy a newspaper and pint of milk the shop keepers aren’t going to know me” (Fatima).

3. The world of mental health and the world outside: “The telephone is the lifeline to the outside world”.

The participants’ accounts depicted mental health services in general and the rehabilitation unit in particular as being separate from the rest of the world, even to the extent of having a separate currency (cigarettes).

“There is a whole thing around mental health where cigarettes are a currency of the day” (Gordon).

Shared understanding and camaraderie between members of the ‘world of mental health’ existed and there was a value in being with other people who were in the same position, with all participants giving accounts of times where they tried to nurture and support other residents.

“[Being] together is nestling strength [sic] in the other person, you know... if they are withdrawn, if they see the other patient doing good they will try to join in” (Fatima).
It was acknowledged that [name of rehabilitation unit] could be used as stepping-stone into the community, though the world outside mental health services could be seen as threatening.

“You know, it is often the case that a schizophrenic doesn’t feel safe.” (George).

Participants also recognised the difficulty in giving up the support and safety of the service, with moving on described as very challenging.

“[in the rehabilitation unit] you are protected by the staff, you are getting a lot of support, but when you are going as an individual in the community you...are challenged...at a higher level because being a mental health person is not easy, right?” (Fatima).

In the ‘outside world’ participants struggled but managed to establish a degree of belonging within their community, helped by engaging in day-to-day tasks.

“Social inclusion is like doing my voluntary work as well and being out in the community, going to have coffee and being confident enough just to go into town, have a cup of coffee with friends...being involved in the community, feeling safe.”

“it makes me feel important, that role, I lost it when I started getting this mental illness,...[it] comes back...if you stimulate with the community, and your friends come back to you” (Fatima).

The participants all described experiences of stigma and a lack of understanding from ‘the outside world’, and their accounts revealed perceptions of tension between the safety of the rehabilitation unit and the risks that might be encountered in the community.

“I do deserve to be a part of the community, you know, I can give a positive image of schizophrenia or bipolar” (George).

4. Engaging in Occupations: “When I go for a walk in the park locally, you know, just seeing the light coming down in between the trees [it is] that kind of appreciation” (Fatima).

Participants spoke of the value of occupations. Engaging in meaningful occupations provided a sense of achievement, identity and opportunities to increase social contact; experiences common when regularly partaking in activities. The participants also recognised the value of having balance and time out to ‘be’ whilst ‘doing’ activities to ‘distract your mind and have a focus on something else because otherwise you end up focusing on your illness’ (Gordon).

“...it just gave me the confidence in myself, like cooking, cleaning, doing my laundry and really mundane things that I was neglecting [before] and then the grander things ...so I started off small with the small things and moved on to the bigger and better things (George).

Discussion

The four themes revealed that for these participants multiple factors contributed to feeling able to make the transition to community living. The findings support literature where this transition is described as a step-wise process which is complex and unique to each individual (Prince and Gerber 2005). Mental health services play a part but are not the sole factor in what may be understood as the recovery process (Stickley and Shaw 2006).

The participants spoke of a ‘redefinition of a sense of self’ (Mezzina et al 2006:68). This process involved gaining a sense of social status and personal identity which is key to citizenship. Hope for the future has been identified as being crucial in recovery from mental illness (Shepherd et al 2008) and the participants’ accounts were threaded through with hopeful statements.

The social support received from the rehabilitation unit was experienced as valuable to participants in creating a sense of belonging and social inclusion. It
provided individuals with a sense of connectedness (Ware et al 2007) and opportunity to ‘give back’, such as sharing food, providing advice or comforting other people, reinforcing the findings of Davidson et al (2001) who emphasised the value of reciprocal friendships.

The struggle to readjust and find a place within the community is commonly reported by people with mental illnesses (Pinfold 2000). The aim of the residential rehabilitation service seemed clear to the participants; they knew it aimed to increase their independence, however differed in their responses to the idea of independence.

The feelings of isolation described by the participants are shared by many people who experience mental illness (Granerud and Severinsson 2006), often triggered by fear of discrimination from the community, and a sense of social exclusion (Ertugrul and Ulug 2004). The participants described facing stigma and a lack of understanding which is a common experience for people using mental health services (Prince and Prince 2002).

The participants described the subculture of the rehabilitation unit, being separate from the wider community. It has been found that people feared discharge from mental health services, as then they would be alienated from two communities; the world of mental health and the wider community, belonging in neither one (Bryant et al 2004).

The three participants described situations where they felt socially included, though this fluctuated. Pinfold (2000) suggested that people with mental illnesses often establish a safe middle ground between full participation and social isolation. This has also been referred to as a positive withdrawal (Sells 2004) - being involved in the community, through daily activities, however still choosing to be on the periphery of society, with a recognised benefit of being with other people with mental illnesses. More recently Sutton et al (2012) have described a continuum of engagement whereby people vary their level involvement in occupations according to their mental state, and that this facilitates recovery.

The value of occupations for structure, routine and normalisation described by the participants echoed findings from Craik and Pieris (2006), and Fieldhouse (2003). Engaging in occupations supported and smoothed the transition to social inclusion. Mastery of everyday tasks, such as cooking and cleaning, acted as stepping-stones to larger achievements (Borg and Davidson 2008). The opportunities for participation in community activities have been found to potentially enhance a sense of belonging and citizenship for people who use mental health services (Repper and Perkins 2003).

Summary
Addressing the marginalisation of people with mental health problems is on the public, professional and political agenda worldwide (Harrison and Sellers 2008). Despite this there is still minimal exploration of the lived experience of social exclusion. The research presented in this paper explored the experiences of three people who were planning to transition from a residential rehabilitation service to community living.

Residential rehabilitation services can play a key role in support a person’s journey towards social inclusion, providing the space and time to develop the self, utilise social support and master occupations, and preparing individuals in the transition from mental health service to ‘the real world’.

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Article

Clubhouse Model Promotes Recovery, Social Inclusion and Benefits for Service Users, Families and Funding Agencies.

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Abstract

The article celebrates the new era of collaboration between WAPR and Clubhouse International as well as Clubhouse Europe, started in October 2014 when the Parties signed a Memorandum of Understanding for promoting the innovative Psychosocial Rehabilitation (PSR) models and other methods related to the mental health (MH) policy reforms. Parties agree that we need more speed for strengthening the community based MH policy services, and to promote the use of evidence-based PSR – innovations, the Clubhouse model included.

The article at hand firstly describes the international context of MH policy reforms and the direction towards community-based services. Secondly, the article offers a description about the best practice Clubhouses, and what are the in-house and external crossectorial activities for the benefit of members of a Clubhouse. Thirdly, worldwide dissemination and the special strengths of the Clubhouse model are described. Fourthly, the evaluation research findings are presented, and finally, the conclusions for the basis of future co-operations are made.

Key words: WAPR, Clubhouse International, Clubhouse Europe, Community-Based services, Mental Health Policy Reforms, Clubhouse model, psychosocial rehabilitation.

Introduction

According to the ITHACA Project Group (2010) and the Mental Health Atlas of the World Health Organization (WHO 2011) the traditional psychiatric hospitals are still prevailing in many parts of the world, despite evidence that demonstrates the harm caused by hospitalisation, and the tangible benefits of living in community settings. With the advances of treatment and rehabilitation options, as well as recognition of the value of social support, nearly all
people with mental health problems can lead everyday life in community settings and contribute to society. In many countries, the ideology that segregation is in the interests of the individual and of society continues to shape mental health and social policies.

The United Nations’ (UN) Convention on the Rights of Persons with Disabilities (CRPD, UN 2006) includes people with mental disorders, and promotes the right to live and receive services in the community (see Article 19 CRPD). All countries which ratify the CRPD are under an obligation to take steps to implement this Article, and all the other Articles of the Convention. Since 2008 when CRPD came into force, all International Mental Health (MH) Policy recommendations are built on the principles defined in the Convention. Prior to the CRPD, a number of UN instruments were adopted focusing specifically on people with mental health problems, complementing the other UN resolutions on human rights. However, recent findings indicate that the universal human rights documents are not very well known by MH professionals and policy-makers (Hänninen 2012: 29).

The principles and goals of mentioned human rights documents have steered the development of the Clubhouse psychosocial rehabilitation model, originally Fountain House approach that is the main topic of this article. The community-based Clubhouse support and recovery model for people with mental disorders contributes also to the implementation of the MH policy recommendations, namely:
- World Health Organization’s (WHO) Pyramid Framework for Optimal Mix of MH services (WHO 2007 & 2009);
- Community-based rehabilitation (CBR) guidelines launched jointly by WHO, ILO and UNESCO that includes also a chapter for community-based MH policy (WHO 2010); and

According to Caldas de Almeida and Killaspy (2011, 16) the prevailing strict biomedical model will be replaced by a more holistic approach which understands mental disorders as result of the complex interactions of biological, psychological and social factors. Clubhouse model concentrates in these psychological, social inclusion and human rights needs of the members in all Clubhouses.
What is a Clubhouse?

Referring to survey of Patientview (2013) mental health services are helping service users and caregivers mostly by medication and traditional psychiatric treatments, and support least the needs important for recovery and social inclusion. Similar results are published e.g. in USA, UK and Finland. The unmet needs concern education possibilities, vocational training, employment possibilities and support to find jobs, independent housing, and help for managing many forms of discrimination and stigma perceived in the local communities.

The Clubhouse model is completely focused on supporting the realisation of the unmet psychosocial needs of members to pave the ways towards recovery, empowerment and social inclusion. This means participation in the community as he or she chooses, and share the social, economic and political rights on equal basis with others. Clubhouses do not offer any kind of clinical services.

The operational principles of Clubhouse model are defined in the International Standards for Clubhouse Programs, first time launched in 1989 and after that reviewed in biannual International Clubhouse Seminars. Present version came into force in 2012. Standards are a tool for quality assurance of the daily Clubhouse activities, and they are used as assessment criteria in the quality accreditation processes.

The word ‘Clubhouse’ derives from the work and vision of Fountain House, the very first Clubhouse founded in New York in 1948. Fountain House has served as the model for all subsequent Clubhouses that have been set up around the world. Fountain House was formed when former patients of a New York psychiatric hospital began to meet informally as a kind of ‘club’. Communities around the world that have modeled themselves after Fountain House have embraced the term ‘Clubhouse’ because it clearly communicates the message of membership and belonging. This message of inclusion is at the very heart of the Clubhouse way of working for recovery, and demonstrates the fact that people with mental health problems can and does lead normal, productive lives. Clubhouses provide members with opportunities to build long-term relationships. Clubhouses offer people who have mental health problems hope and opportunities to achieve their full human potential (Clubhouse International 2014):

- A Clubhouse day in which the talents and abilities of members are recognized and encouraged;
- Opportunities to obtain paid employment in mainstream businesses and industries;
- Assistance in accessing community-based educational resources;
- Assistance in accessing medical, psychological, substance abuse, wellness, and other community support resources;
- Assistance in securing and sustaining safe, decent and affordable housing;
- Support for accessing to crisis intervention services when needed;
- Participation in consensus-based decision making regarding all important matters relating to the running of the Clubhouse; and
- Evening/weekend/holiday social and recreational events.

The personal stories of members and their families and an increasing body of research provide evidence that Clubhouses provide a holistic, inspiring and cost-effective solution for people living with a mental disorder.

Clubhouse is most importantly a community of people who are working together to achieve a common goal. During the course of their participation in a Clubhouse, members gain access to opportunities to rejoin the worlds of friendships, family, employment and education, and to the services and support they may individually need to continue their recovery.

Membership in a Clubhouse is open to anyone who has a history of any mental disorder. This idea of membership is fundamental to the Clubhouse concept: being a member means that an individual has both shared ownership and shared responsibility for the success of the organization. To be a member of a Clubhouse means to belong, to fit in somewhere, and to have a place where one is always welcome. Membership is voluntary with no time limits.
In-house and external activities

The daily work of the Clubhouse community is organized and carried out in a way that continually reinforces the message of belonging. This is not difficult, because in fact the work of the Clubhouse does require the participation of the members. The design of a Clubhouse engages members in every aspect of its operation, and there is always much more work to be done than can be accomplished by the few employed staff. The skills, talents, and creative ideas and efforts of each member are needed and encouraged each day.

Participation is voluntary, but each member is always invited to participate in work which includes e.g. clerical duties, reception, food service, transportation management, editing newsletters, upkeep of database of addresses of members and stakeholders, outreach, maintenance, statistics and research, managing the employment and education programs, financial services and much more. Daily works are organized in units that are different from a Clubhouse to another - like in normal workplaces. Members participate as they feel ready for side-by-side working and learning, and according to their individual decisions.

The Clubhouse integrates several personal support methods for the benefits of its members (e.g. supported education, supported employment, job coach and job seeker methods, health and fitness promotion, use of learning tutors and mentors etc). To realize members’ social inclusion goals Clubhouses have both in-house activities e.g. works to keep Clubhouse running, learning support (ICT, PC, internet and social media skills etc.) and language courses; and external activities that are organised in collaboration with local educational institutes (supported education), with local companies or public agencies, i.e. with employers (supported employment by a job coach, same as in the IPS model) leading either to part-time fixed-term job-contracts in form of transitional work experiments, or longer contracts in form of supported employment, or even in form of independent employment if a member and employer share the idea that it is a sustainable decision. Clubhouses follow the CBR guidelines on crossectorial collaboration.

Clubhouse also builds up advocacy relationships to support a member’s needs e.g. for better housing with housing agencies; to ensure that a member get all social security benefits she/he is entitled to; and all kind of support she/he or her/his nearest ones need in relations to social welfare services, banks, law issues or debt settlement agency, or health services etc. Clubhouse as members’ support community coordinates its members’ in-house, external and advocacy activities, and possible other health and social service needs.

Worldwide use of and support to Clubhouses

The Clubhouse model was originally a user-led initiative during 1940s when the first Fountain House was opened in Manhattan in New York in 1948. The model was developed slowly until 1970s when its dissemination started in North America. First Clubhouse in Europe was opened in 1980 in Stockholm, Sweden, followed by first Clubhouse in Munich, Germany, in Amsterdam, Netherlands and in Copenhagen, Denmark, and later in Finland when the first Clubhouse was opened in 1995. By the end of the 1980s the Clubhouse model was disseminated into Australia, South-Korea, Japan, Hong Kong and in Europe (Propst 2003: 31).

At the end of 2014 the worldwide use of the Clubhouse model was following: Around 330 Clubhouses are operating in 35 countries, 190 in North America, 80 in 20 European countries, in Asia 40, in Australia and New Zealand 11, in Africa 2 and in South America 2 Clubhouses. The number of Clubhouses is increasing, but during economic recession some Clubhouses do not get funding and are closed. Finland is the leading country in Europe with a net of 25 Clubhouses (1 CH per 210 000 inhabitants); the model is a part of Finnish MH services’ development program.

For the international development support Clubhouse International (formerly ICCD since 1994), and its affiliation the Clubhouse Europe (formerly EPCD since 2007) were established. Both were renamed in 2013. These non-profit organisations support Clubhouses in different countries by training courses, by defining
international standards as guidelines of good Clubhouse practices, quality assurance by the accreditation support, and with international scientific research program and online database of research findings.

In addition, World Association for Psychosocial Rehabilitation (WAPR), Clubhouse International and Clubhouse Europe negotiated a Memorandum of Understanding to strengthen mutual collaboration and support. It was signed in October 2014 in Stirling Scotland and approved by Boards of all three parties. This cooperation opens new possibilities to promote the wider use of the Clubhouse model together with other innovative psychosocial rehabilitation methods as means to a new community-based MH policy.

Special strengths of the Clubhouse model
During last 30-35 years development Clubhouse model has grown to an evidence-based psychosocial rehabilitation method that is used worldwide as a means to deinstitutionalisation reforms. The special strengths are built upon:

International Standards for Clubhouse Programs are defining the principles of a Clubhouse and steering the operational activities in Clubhouses;

Clubhouse Training Program, developed and maintained by Clubhouse International helps in organizing the daily program for Clubhouses and “keep them on track”; Worldwide 10 international Training Bases are in operation, of them 2 in Europe (London & Helsinki);

Quality Assurance Program that is based on the Clubhouse Standards leads to Accreditation process in different phases: (1) self-study of the Clubhouse concerned, (2) outside team of 2-3 assessors evaluate all activities in the Clubhouse and compare their findings with the self-study report, (3) team of assessors give their report to Clubhouse International for defining the level of accreditation award – either for 1 year or for 3 years;

International Research Program for (1) collecting annual statistical reports of all Clubhouses, (2) to provide Clubhouse International with statistical analysis every year, (3) organise and support scientific studies on different aspects of the Clubhouse model, and (4) maintain the online database of all study findings and publish the study results in the scientific Journals for disseminating the information worldwide.

International Collaboration between Clubhouses that benchmark each other and learn from other Clubhouses; Clubhouse Coalitions work in all countries where several Clubhouses are in operation, and special Clubhouse Conferences are organised in different parts of world, e.g. biannual European Clubhouse Conferences, and finally Worldwide International Seminars organised also biannually.

Collaboration with WAPR opens new possibilities to disseminate, for mutual benefits, the knowledge on the evidence-based PSR models - Clubhouse model included - in different thematic conferences in the MH policy field.

Research Evidence
The concepts of recovery and empowerment mean that people are supported in helpful ways so they can start taking control over their lives and making their own decisions and choices. They can change their life situation in ways they want to and contribute to their living communities. The Clubhouse model offers a suitable framework for these empowering activities. Clubhouses are evidence-based psychosocial rehabilitation practices committed in the recovery-orientation and empowerment.

SAMHSA (USA Substance Abuse and Mental Health Services Administration) has approved the Clubhouse model as evidence based practice (http://www.nrepp.samhsa.gov/).

In Finland the Clubhouse model has been approved by STAKES and THL (National Institute for Health and Welfare) as a good practice based on several evaluation studies (in Finnish language only): (http://www.sosiaaliportti.fi/fi-Fl/hyvakayttanto/)

In addition, as summarized by researchers of the latest multi-method Clubhouse study in Finland that covered 18 Clubhouses (Hietala-Paalasmaa et al.
the Clubhouse membership does generate positive economic impacts that support the wider use of Clubhouse rehabilitation model. Alongside the economic efficiency, the study indicated that the key strengths of Clubhouse activities are the feeling of belonging and a sense of community they provide. The Clubhouse community is a place where members can feel themselves valuable and productive.

Available evidence substantiates the fact that Clubhouses provide communities around the world with a cost-effective solution for dealing with the devastating impact which mental health problems has on society, and for helping people who live with a mental disorder achieve their full potential in their communities. According to available research evidence, Clubhouses achieve the following tangible results for members and their communities (McKay 2011; Hietala-Paalasmaa et al, 2009; Nääppä & Rantanen 2009):

- Participation in Clubhouses’ activities promote members’ recovery;
- Participation in Clubhouse activities reduces hospital stays and costs significantly;
- Participation helps members obtain employment or jobs in local open labour market;
- Clubhouses are cost-effective, they have positive impacts both on users, their families and nearest ones, as well as on funding agencies and social security benefits system;
- Taking part in Clubhouse activities improves general wellbeing, and physical and mental health of members of a Clubhouse;
- Participation in Clubhouse activities improves quality of life;

However, Clubhouse activities are not satisfying the needs of all members, for them other choices are needed e.g. psychiatric day centres or day hospitals.

Conclusions
Economically, scientific results since 1980s based on a set of studies in different continents have proved that regular participation in Clubhouse activities decrease by 60 – 80 % the need and use of hospitalization that is the most expensive part of the MH service system. Also the need and use of outpatient health and other social services decreased by around 30-40 % as compared to the period before the start of participation in the Clubhouse activities.

Another economically important finding is that at least in developed countries the annual costs of 1½ - 2 psychiatric hospital beds are the same or higher than the annual costs of a new Clubhouse for 25-30 daily attendants with rented space, needed equipment and salaries of hired Director and 3-4 support staff members (Hänninen 2014). The opening of Clubhouses as evidence based successful and cost-effective psychosocial rehabilitation centres are investments with good value for money or excellent social return of investments for all parties in society.

If properly organised the Clubhouses as recovery and psychosocial support centres in the communities are providing benefits both to users - members of a Clubhouse - their families or nearest ones, funding agencies and to social security system, as well as to the health and social service agencies. In management science this is called a “win-win-win-situation”.

Following the thinking of Finnish professor Ville Lehtinen (2008: 4) Health is a characteristic shared by both individuals and society. Maintaining health requires a multisectorial, transdisciplinary approach. Health is generated by all policies, in all sectors of society. As we approach the information society, mental health will become more and more important - There is no health without mental health.

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http://www.iccd.org/mission.html
http://www.iccd.org/recent_research.html
http://www.clubhouse-europe.org
(Comprehensive information source about the European Clubhouses and International Cooperation)
(Facts about the reality of public mental health services in the world)
The Czech mental health care system has been struggling with its outdated structure and poorly functioning services. Mainly a preponderance of in-patient beds in big asylums, a lack of community based services and inadequate coordination among different service providers.

In such a fragmented system, the lack of common principles or a basic philosophy of care is obvious. The main goals of the two projects, which were delivered by the Centre for Mental Health Care Development in 2012 – 2014 were to support the orientation of recovery and the involvement of peer specialists into mental health teams and in the education of future professionals.

The projects involved 20 people with lived experience currently recovering from severe mental health conditions, who were trained and employed part time.

In the first project, ten people were trained and hired as peer specialists and became regular members of mental health teams in 10 regions. As part of their preparation for this role the peer specialists, they all went on study visits in the Netherlands. During these visits they established contact with and gained a greater understanding of their role from experienced peer specialists working in FACT teams. The project also supported the members of the professional care teams through the initial phases. This focused on their values and motivation to engage peer specialists within their teams. Throughout the project both groups of stakeholders were provided with ongoing support and coaching. That helped the teams to maximize the benefits of peer integration.

The outcomes of this project were very encouraging. Firstly, nine out of ten involved mental health teams decided to prolong the employment of peer specialists beyond the timeframe of the project. Secondly, it was found that the peer specialists were not more on sick leave compared to other workers and the time spent in direct contact with clients was the same. Finally their fellow workers recognised their positive contribution to the culture and values of the care teams.

In the second project, further ten people with lived experience attended a specially designed course which enabled them to teach pre-graduate students at universities. Subsequently they created four 6-hour courses on **Recovery**, **Stigma and discrimination**, **Self management** and **Peer programmes** in cooperation with experienced teachers and mental health specialists. Peer specialists from the UK and the Netherlands were involved in the development of the courses.
These courses were offered to students in social work and psychology programs at two participating universities in Prague. The students who attended the courses highly valued them for bringing new insights and a unique perspective to them. At both universities, the process of inclusion of these courses into the regular curricula has begun.

These two projects were successful. Both the practitioners in the mental health teams and students at universities reported positive and unique contributions made by the peer specialists. At the same time the peer specialists made a remarkable progress in their own recovery, improvement of their social status and an increase of self-confidence. We are convinced that the results of these projects bring a new hope for positive changes to the mental health care system in the Czech Republic.

Currently we further develop peer programmes in the Czech Republic. If you would like to get in contact, don’t hesitate and let us know. We are keen to cooperate internationally. cmhcd@cmhcd.cz
WAPR organised a special training programme on the topic of “Managing Trauma, violence and Stress among Children and Adolescents” during 9th International Conference on Psychosocial Rehabilitation held at Lahore, Pakistan from 26-28 February 2015.

The conference was organised by World Association for Psychosocial Rehabilitation Eastern Mediterranean Region and WAPR Pakistan Chapter, Pakistan Psychiatric Research Centre, Fountain House, Horizons - an NGO working in Peshawar and Psychiatry Department of Service Medical College, Lahore.

The meeting had the co-sponsorship from Pakistan Psychiatric Society (PPS), WPA Zones 15, WPA Sections on Child & Adolescent Psychiatry, SAARAC Psychiatric Federation (SPF), Asian Federation of Psychiatric Association (AFPA), World Federation for Mental Health (WFMH), World Association for Social Psychiatry (WASP) & South Asian Forum on Mental Health (SAF) Pakistan Chapter.
Being the first Training programme on Rehabilitation and treatment for Children and Adolescents suffering from Trauma, violence and related disorders, this was attended by more than 400 mental health professionals from all over the country. The programme provided a unique opportunity to the delegates for listening to national & international experts who spoke about topics related to the theme of the meeting.

Special workshops were held on “Understanding Post-Traumatic Stress: Theory and Treatment, Dealing with trauma / PTCD in Children and Adolescents, Trauma Spectrum Disorders in Children and Adolescents, Autism, Development aspects of Child Psychiatry, Developing services for the transitional period from Childhood to adolescence, Management of abnormal grief and Depression in Young People & Paediatric psychopharmacology in the new millennium, what to do, what not to do and what to do with great caution”.

The faculty included Dr Gordana Milavic (UK), Dr Shahid Munir Ahmad (UK), Dr Muhammad Ather (UK), Dr Sobia Khan (UK), Prof S Naqvi (USA), Prof Helen Herrman (Australia), Dr Muhammad Shafique Tahir (UAE), Prof Khalid Mufti, Dr Ali Ahsan Mufti & Mrs Romana (Pakistan), Dr. Ayesha Minhas (Pakistan), Dr Nazish Imran (Pakistan), Dr Irum Siddique (Pakistan), Dr Nadeem Ahmad (Pakistan) & Prof Naeem Siddiqui (Karachi).
This year within the activities of the Argentina Branch of the WAPR, we have made the V Psychoneurorehabilitation Conference: "From clinical to psychosocial rehabilitation practice”. Argentina. Celebration of the World Mental Health Day.

They were held in the Council Room of the School of Medicine, University of Buenos Aires (UBA) on October, 6th and 7th.

The event was organized by Fundación Humanas, Fundación Contener and co-organized by this university.

In this context we have met professionals and representatives of institutions dedicated to different issues and approaches in the field of mental health to exchange opinions, views and experiences that have served not only to academic upgrading, also they have provided input to the development of new activities.

This time we were accompanied by Dra. Ana Pitta, WAPR representative of Brazil, and have attended Dr. Roger Montenegro, Dr. Luis Ignacio Brusco and Lic. Gorbacz Leonardo, among others.

We thank all participants, attendees and the WAPR, for all their support to carry out successfully these days.

Dr. Luis Ignacio Brusco & Dr. Roger Montenegro.
WAPR Western Pacific.

Japan. Special WAPR Session.

at the 5th World Congress of Asian Psychiatry (WCAP2015)
Organised by Asian Federation of Psychiatric Associations (AFPA)
Asian Federation of Psychiatric Associations organised its 5th World Congress in Fukuoka, Japan from 3-6 March 2015.

WAPR being a co-sponsoring organisation for this congress, organised a special workshop session that was attended by a large number of participants. The theme of this joint AFPA-WAPR session was “Promoting Psychosocial Rehabilitation in Asia”

Prof Tae Yeon Hwang(Korea) & Prof Tadashi Takeshima(Japan) co-chaired the session and speakers included Prof Tadashi Takeshima(Japan), Prof Tae-Yeon Hwang(Korea), Dr Abdul Kadir Abu Bakar(Malaysia), Dr Si-Ting Hsu(Taiwan) and Prof Imran Ijaz Haider(Pakistan).

Dr Afzal Javed, President WAPR, thanked the participants and the AFPA Scientific committee for adding this important session to the Congress programme. He also hoped that WAPR congress at Korea will be another success meeting in this region and invited all participants to this WAPR event taking place in November 2015.

WAPR also had an officers meeting with different WAPR members & leaders from WAPR Branches representing various countries including Armenia, Australia, Bangladesh, Cambodia, Japan, Korea, Kenya, , Malaysia, Nepal, Pakistan, Sri Lanka, South Africa, Thailand, , Taiwan and UK.
The 5th Asia Pacific Regional Conference on Psychosocial Rehabilitation was held from 6th - 8th Feb 2015 at MS Ramaiah Medical College and Hospitals, Bengaluru, Karnataka, India. The conference was organized by the World Association for Psychosocial Rehabilitation (Indian Chapter) and Foundation. The Co Organisers were M S Ramaiah Medical College and Hospitals, Bengaluru and Medico Pastoral Association, Bengaluru. The conference was supported by the World Psychiatric Association, Asian Federation of Psychiatric Associations, SAARC Psychiatric Federation, Indian Psychiatric Society, Indian Association of Social Psychiatry, Indian Association of Clinical Psychologists, Indian Association of Professional Social Work and The Richmond Fellowship Society.

The Asia Pacific Regional Conference on Psychosocial Rehabilitation is a biennial event organized by World Association for Psychosocial Rehabilitation (WAPR) to update knowledge and disseminate information about psychosocial rehabilitation from around the world and specifically from the Asia Pacific region.

The conference was attended by delegates from around 16 countries across the world with representation from the WHO. The invited speakers were chosen for their contribution in in the field of psycho social rehabilitation.

This was the first international conference of this nature to be organized in a private medical college and a general hospital psychiatry department in India.

The conference of two and half days was approved and partly funded by Medical Council of India (MCI). For the conduct of this international conference the necessary ministries were informed and permission sought to facilitate the participation of international delegates and speakers. The Karnataka Medical Council granted five CME credit hours for the conference.

The first day of the conference started with the registration and followed by the inaugural function. The President of WAPR India Chapter, Dr. V K Radhakrishnan, presided over the function. Dr. B N Gangadhar, in charge director of National Institute of Mental Health and Neurosciences (NIMHANS) inaugurated the conference. This was done by watering the Tulas plant which is sacred in this part of the world and is considered auspicious.

In his inaugural address, Dr. Gangadhar spoke about the importance of psychosocial rehabilitation and the role of Yoga in facilitating the rehabilitation process. Dr. Ricardo Guineu, Dr. S Kumar, Dr. A S Hegde and Dr. Mohan K Isaac were the guests of honor. They emphasized the role of psychiatrists in reducing psychological morbidity through psychiatric rehabilitation.
During the inauguration, persons who had contributed to the growth of psychosocial rehabilitation in India and Karnataka were honored. Dr. Swaminath G read out the citations of the people who were honored.

Dr. R M Varma
Dr G N Narayana Reddy
Dr Joyce Siromoni
Mr Gopalakrishnan
Friends of NIMHANS (Ms Usha Srinivasan)
Mrs Dorian Chacko
Dr. A C Ashok, Principal and Dean of M S Ramaiah Medical College released the conference souvenir. The vote of thanks was given by Dr. Ravi Shankar Rao.

The inaugural program was followed by key note address by Dr. Mohan K Isaac, Professor of Psychiatry in University of Western Australia and Visiting Professor of Psychiatry in NIMHANS and President of Medico Pastoral Association. Dr. Isaac spoke about the current status of psycho social rehabilitation in the Asia Pacific Region and the steps that were required to improve it.

Report of Scientific deliberations of conference

There were 3 plenary sessions, 14 symposia and 14 invited lectures spread over two and half days.

The conference was attended by more than 350 Indian and foreign delegates representing 16 different countries including representation from WHO.

DAY ONE 06/02/2015

Plenary session

The first plenary was themed “Challenges in Asia Pacific region”. The topic was discussed by Dr. Murali Thyloth from India who spoke on ‘Psychosocial Rehabilitation in Asia Pacific region: challenges ahead’. Dr. Ricardo Guinea from Spain spoke on ‘Supervisions in Psychosocial Rehabilitation: training staff in Recovery model approaches’ and Dr. Zebulon Taintor from USA on the ‘Experiences from US in PSR and its challenges expected in Asia Pacific region’.

Symposia

Symposium 1

This symposium was themed as ‘Regional Collaborations’. Dr. Radha Murthy from India and Dr. Dharitri Ramaprasad spoke about the multimodal activity and recovery oriented approach. The session also emphasized on the collaborations required to make psychiatric rehabilitation work better.

Symposium 2

The theme of the symposium was ‘Work and the Madhouse - a historical appraisal ‘The speakers were Dr. Sanjeev Jain, Dr. Alok Sarin, Dr. Prathima Murthy, Dr. Sudipto Chatterji and Dr. Radhika P.

Symposium 3

This session was dedicated to discuss the contributions of the NGOs in the field of psychosocial rehabilitation. It was rightly termed ‘Contributions of NGOs’. Mr. Mukul Goswami, Mr. Santhosh Joseph and Mr. PA Johny who represented NGOs working actively in the field spoke of their experiences.

Symposium 4 Psychosocial Rehabilitation involves various factors. This session was titled ‘Psychosocial rehabilitation from different perspectives’. ‘Neurobiological Basis of Rehabilitation’ was discussed by Dr. Harischandra Gambheera from Sri Lanka, ‘Rehabilitation and Transcultural Psychiatry’ was discussed by Dr. Atsuko Ibata from Japan and ‘Challenges of establishing psychiatric rehabilitation services in Ethiopia’ was discussed by Dr. Markos Tesfiaye.

Invited Lectures

Invited Lecture 1

Dr. Mathew Varghese spoke on ‘Programs for Caregiver intervention and Support in Mental Disorders’ and Dr. Solomon Rataemane spoke on ‘Stigma and Mental Health’.

Invited Lecture 2

Dr. E S Krishnamurthy from Neurokrish, Tamilnadu talked about ‘An Interdisciplinary and Integrative approach to Neuropsychiatric Rehabilitation’ and Dr. Jagadisha Thirthahalli from NIMHANS spoke on ‘Research on rehabilitation: Past, Present and Future’.

Invited Lecture 3

‘Challenges in the care of homeless persons with mental illness: Chittadhama experience’ was discussed by Dr. Ravi Shankar Rao. Dr. Abdul Kadir Abu Bakar from Malaysia spoke on ‘Transforming the Mental Hospital: from inside out’.

Invited Lecture 4

Dr. Ravindra Galgali spoke on ‘Recovery and Rehabilitation: Challenges within and beyond the Medical Curriculum’ and G Swaminath spoke on ‘Challenges in provision of free psychiatric medications to Mental Health Camps in rural areas’.

Workshops

Workshop 1
The workshop “Therapeutic community methodology as a low cost long term, bio psychosocial treatment model for persons with chronic psychiatric diagnosis” was conducted by Mr. Anando Chatterji, Ms. Shama Parkhe, Mr. Rex Haigh, Mr. Jan Lees, Mr. Madhura Vittal and Ms. Maitreyi Kanjilal.

**Workshop 2**

Dr. Rajesh Mohan and Dr. Gopinath Ranjith from UK spoke on ‘Tackling physical health co morbidity in psychosis’

**Workshop 3**

This session was on ‘Neurosurgical interventions in Psychiatry’ by Dr. Ravigopal Varma, Head of Neurosurgery Dept., MS Ramaiah Medical College demonstrated neurosurgical interventions and their role in psychiatric rehabilitation.

**Workshop 4**

This workshop was titled ‘Training Mental Health Professionals on Parental Skills Management: an approach to Public Mental Health’. The speakers were Dr. Bino Thomas and Mr. Tony Sam George from Christ University, Bengaluru.

**DAY TWO 07/02/2015**

**Plenary session 2**

The second plenary themed ‘Evidenced Based Rehabilitation, are we ready for it?’ presented by Dr SK Chaturvedi emphasised the importance and significance of evidenced base rehabilitation. Dr VK Radhakrishnan, spoke on ‘Psychosocial rehabilitation : a mass movement’ and Dr. Wolfgang Krahl spoke on ‘Long term Rehabilitation for Substance Dependent Patients in a forensic unit in Germany’. This plenary session also discussed the research available and the need to follow newer approaches in rehabilitation.

**Plenary Session 3**

The third plenary focused on having a ‘Holistic approach in the current scenario’. Dr. Akiyama Tsuyoshi from Japan discussed about ‘Facilitating recovery and relapse prevention: re work program in Japan’, Dr. E Mohandas from India spoke on ‘Neural underpinnings of Psychosocial Rehabilitation’ and Dr. Taen Yeon Hwang from South Korea discussed the ‘Integration of Human Rights, Neural underpinnings in Rehabilitation and Recovery oriented approaches’.

**Symposia**

**Symposium 5**

The theme was ‘Rehabilitation in special populations’. Dr. Venkataramaiah spoke on need for ‘Reformation in PSR’. Dr. Andrew Mohan Raj discussed ‘Crisis into opportunity - post tsunami mental health intervention in Aceh’. Dr. Medhat El Sabbahy spoke on the ‘Challenges in establishing PSR in Gulf region’.

**Symposium 6**
‘Experiences from around the World’ was the theme of this symposium. Dr. Zebulon Tainter spoke on ‘Learning from the American experiences, especially failures’. Dr. Ida Koza from Hungary spoke on ‘Spirituality in Psychosocial Rehabilitation’ and Dr. David Ndetei from Kenya spoke on ‘Human resources in Mental Health in Africa with special reference to Kenya - challenges and opportunities’.

**Symposium 7**
This symposium was themed ‘Experiences of the Service Providers’. Dr. Nirmala Srinivasan, Ms. Lata Jacob and Mr. Shaji Philip were the speakers representing ACMI, Medico Pastoral Association and Advantage Elder Care home.

**Symposium 8**
This session focused on various ‘Concepts in Rehabilitation’. Dr. Padmavathi R spoke on ‘PSR for Schizophrenia as Outpatients: is this feasible and effective?” and Dr. Shashi Rai discussed ‘Substance use in Adolescence, their Treatment and Rehabilitation’.

**Symposium 9**
This symposium was themed ‘Taking a stand: on developing a code on Sexual Boundary Violations’. The speakers were Dr. Alok Sarin, Dr. Ajit Bhide and Dr. Sunita Simon Kurpad.

**Symposium 10**
Dr. T Siva Kumar, Dr. Sailaxmi Gandhi and Dr. Devvarta Kumar spoke on ‘Recent initiatives in Psychiatric Rehabilitation in a tertiary institution: NIMHANS experience’.

**Symposium 11**
This symposium was themed ‘Suicide and Psychosocial Rehabilitation’. Dr. Sathesh V spoke on psychosocial rehabilitation of attempted suicide, Dr. Hemendra Singh on ‘Suicide in psychiatrically ill patients’ and Dr. Preeti on ‘Suicide Prevention’.

**Symposium 12**
The theme of this symposium was ‘End of the road: what next?’ Dr. Anukanth Mittal spoke on ‘Ethics of terminally ill’. Dr. Sudhir Khandelwal spoke on ‘Long term care facilities for mentally ill: necessity vs. convenience ‘and Dr. Somnath Chatterji discussed ‘Rethinking Disability’.

**Invited Lectures**
**Invited Lecture 5**
Dr. Esko Hanninen spoke on ‘Mental Health Policy targets related to Psychosocial Rehabilitation and Social inclusion of people with mental disorders’. Dr. Kiran Rao spoke on ‘Models of Psychosocial Rehabilitation, the more the better or one too many?’ and Dr. Sridevi Kaldindi talked about ‘Influencing National Policy and setting standards: the work of the Rehabilitation and Social psychiatry faculty RCPsych, UK’.

Invited Lecture 6
Dr. H Chandrashekar discussed ‘Psychosocial services using Ambulatory methods’ and Dr. Thomas John spoke on ‘Empowering persons with Mental Disabilities, Issues and Challenges (Indian Scenario)’.

Invited Lecture 7
Dr. Pandu Sethiavan spoke on ‘Psychosocial Rehabilitation: the most important strategies in Indonesia Mental Health Policy’ and Dr. Harry Minas delivered his talk on ‘Human Resource development in PSR in Asia Pacific region’.

Invited Lecture 8
Dr. Vivek Benegal and Dr. TSS Rao spoke on ‘Rehabilitation in Substance use disorders’ and need to ‘Change mindsets and strategies and disability and psychosocial rehabilitation’ respectively.

DAY 3: 08/02/2015
Symposia
Symposium 13
‘Innovations from South India’ was the theme of this session. Dr. G Gopalakrishnan spoke on ‘Dawa and Dua: Gunaseelam experience’, Dr. C Ramasubramanian spoke on ‘Holistic Mental Health Care for the persons with Mental Disabilities attending religious faith healing center at Erawady, Tamil Nadu, South India’ and Dr. Rajesh Krishna Bhandary spoke on ‘Using Community Resources for Vocational and Social Rehabilitation of persons with chronic mental illness - Hombelaku experience.’

Symposium 14
This session discussed ‘Special Issues in PSR’. Dr. Shantha Kamath emphasized the role of ‘Residential centers for Chronic Mentally Ill - SCARF experience’, ‘Rehabilitation of Mentally Ill Women’ was discussed by Dr. Rajini Chatterji and Dr. Mahesh Gowda spoke about ‘Establishing PSR centers and its Challenges in Urban setup’.

Invited lectures:
Invited Lecture 9
The talk on use of ‘Memantine as an augmenting agent in treatment non responsive schizophrenia’ was given by Dr. John P John and Dr. G Venkatasubramanian spoke on ‘Reintegration in schizophrenia: clinical utility of Transcranial Direct Current Stimulation (tDCS)’.

Invited Lecture 10
Dr. Shivarama Varambally spoke on ‘Yoga based interventions in Severe Mental Disorders’ and Dr. Tae-
Yeon Hwang discussed ‘Cognitive Rehabilitation Program for patients with Schizophrenia’.

Invited Lecture 11
Dr. Kishore M spoke on need for ‘Training of Undergraduate and Post graduate students in PSR’ and Dr. Vijay Danivas highlighted the ‘Challenges in PSR for young professionals’.

Invited Lecture 12:
Dr. Indla RamSubba Reddy with number of videos in his presentation spoke on ‘Cinema and Stigma’.

Invited Lecture 13:
Dr. Kasi Sekar gave a talk on ‘Psychosocial support and Mental Health Services in Disaster Management’ and Dr. MV Ashok spoke on the ‘Differences in Palliative Care and Psychosocial Rehabilitation in Chronic Mental Illnesses.

Invited Lecture 14:
Dr. Mesali Jamal spoke on ‘Initiating Psychiatric Services’ and Dr. C Ramasubramaniam spoke on ‘Organizing Training Program for College Teachers on Psycho educational skills: our experience’.

E Posters and oral presentations:
Six sessions of scientific oral presentation on 7th and 8th of Feb emphasized on the research work done by young professionals and specifically by the post graduate students. There were total of 28 oral paper presentations of the original works which was evaluated by 2 judges.

72 e-posters in 3 sessions were presented. These sessions were well attended and each presenter was evaluated and best poster awards were given during the valedictory function.

Cash Awards were presented the following for E Posters of 4 first prizes and 3 second prizes:

1st prize:
Dr. Barjis Sulthana, Dr SMCSI Medical College Karakonam
Dr Priya Treesa Thomas , Dept of Psychiatry, NIMHANS
Dr Surabhi, M S Ramaiah Medical College, Bangalore.
Mr. Ashfaq, Dept of Psychiatric Rehabilitation services, NIMHANS

2nd prize:
Dr. Abhishek Pathak, Dept of Psychiatric Rehabilitation services, NIMHANS
Mr Praveen A, Dept of Psychiatry, KMC, Manipal
Dr Shivanand Hiremath, Dept of Psychiatry, Karnataka Institute of Medical Sciences, Hubli.

The conference was successful in providing a platform for the scientific deliberations which were of high quality and various aspects of rehabilitation were discussed with the experts in their respective areas. The scientific programs were highly appreciated for their content and for following the time schedule.

This platform also gave an excellent opportunity for the post graduates and young professionals to interact with the experts from other parts of the world and with speakers who shared their knowledge and experience. This went a long way in inspiring and kindling interest in psychosocial rehabilitation in mental health professionals and service providers.

The conference ended with the valedictory function. Dr. DV Guruprasad, Chief Executive, Gokula Education Foundation (GEF -M) was the Chief Guest. He was welcomed by Dr T Murali. Dr Tae- Yeon Hwang spoke about the conference and upcoming events by WAPR. Dr Mathew Varghese, Ms Lata Jacob and Ms Thilaka Baskaran were present on the dais. Dr Ravishankar Rao and Dr Virupaksha HS read the conference report. Various delegates from across the world shared their experience of the conference and appreciated how it had facilitated their learning. Dr. VK Radhakrishnan, President, WAPR IC declared the conference closed.

Dr. Ravi Shankar Rao
Organising Secretary
WAPR organized a training programme in Hungary on 28th January, 2015. WAPR Hungary Branch hosted this event in collaboration with Hungarian Psychiatric Association. This Training programme was attended by a large number of professionals (including patients and carers representatives) not only from Hungary and the Partium Christian University – Nagyvárad, but also from neighboring countries.

The session that was a part of WAPR European Regional Training Project, was opened by Dr Molnar Karoly President Hungarian Psychiatric Association, Dr Afzal Javed WAPR President and Dr Ida Kosza Regional Vice President WAPR.

Speakers included Dr Afzal Javed (UK) (Changing trends in concepts & practice of psychosocial rehabilitation), Prof Michaela Amering (Austria) (Human rights, stigma and stigma resistance, triadogue, carer and user involvement), Dr Ricardo Guinea (Spain) (Recovery oriented practice: analysing the professional relationship with the patient), Dr Shahid Quraishi (UK) (Role of Crisis Resolution & Home) & Prof Ida Kosza and Tibor P. Biro (Hungary) (Spirituality).

WAPR also had a special session on PSR in the main conference on 29th January, 2015 as well. Speakers for this session included Prof. Michaela Amering (Austria), Dr Ricardo Guinea (Spain), Andras Keleti (Hungary) and Varga-Tana Unige (Hungary).
WAPR supported 3rd Annual International Child Mental & Behavioral Health Conference.

There was a special WAPR session at this meeting where topics relating to Psychosocial Rehabilitation were discussed. Dr Medhat Elsabbahy, Deputy Regional Vice President was among the organisers of this conference and was very active for including the topic of PSR in this international conference.
HKAPR is a non-profit making professional organization with the intent to improve outcomes and quality of life for those with chronic mental disorders, and to promote awareness of psychosocial rehabilitation. The Association was established by Prof. Ki-Yan Mak back in 1998, and is now chaired by Dr. Wai-Song Yeung. There are now over 100 members in the Association including medical doctors, nurses and other mental health professionals.

HKAPR is dedicated to the improvement of overall management of mental disorders, and its main activities in recent years are highlighted below:

**2011**

Two scientific lectures featuring invited international speakers were organized focusing on relapse prevention, medication adherence, and the use of long acting injectables in schizophrenia.

To promote the awareness of community psychiatry, the Hong Kong Expert Meeting was conducted to explore case management model for schizophrenia. As a follow-up, the first Mental Health Case Manager Workshop termed “Who am I?” was then established to introduce the concept of multidisciplinary team approach in public psychiatric service in Hong Kong, by defining the role of case managers (CM) and implementing the Personalized Care Program (PCP) that emphasizes “Care and Need”. The workshop attracted over 200 participants, and the success of the workshop planted the seed for providing enhanced community support and care for patients and their carers using a personalized case management approach.

**2012**

A schizophrenia clinical expert program, facilitated by Prof. David Castle (Australia), was conducted with a focus on compliance issues and comprehensive model of care. Fifteen mental health practitioners attended the event addressing the gaps in schizophrenia management in Hong Kong.

Building on the positive impact of the “Who am I?” workshop, the second Case Manager Workshop was organized to review the role of CM and the latest advances and innovations in community psychiatry. Both local and overseas (Australia) speakers delivered talks on a range of topics relevant to case management practice, including compliance, mental health law and recovery. There was also experience sharing among local CM.
A Clinical Expert Meeting consisting of local psychiatrists and CM was held with an aim to develop Hong Kong’s first consensus statement on adherence issues in schizophrenia. The manuscript on the consensus statements has been recently published in the Asian Journal of Psychiatry, and a subsequent survey on the statements was conducted in 2014.

The theme of 2013 Case Manager Workshop was “Hope & Recovery”, which focused on optimizing patient recovery and providing updates on novel models in community mental health care. To help patients achieve effective disease control, HKAPR introduced the first mobile phone application in mental health care (known as “Mental Wellness Everyday”) during November 2013 (Chinese version), with features such as medication alerts, clinical appointment reminders, and motivational goal setting, etc. This Android/iphone app is also adopted by patients from other Asian countries, and is expected to be used by many more with the English version now being launched.

For the past few years, HKAPR organized various events to help create an information network among mental health professionals and provide support in local psychosocial rehabilitation. In particular, the Case Manager Workshop has now become a signature and anticipated event for local CM to gain knowledge and share their experience in community care. HKAPR will continue its sustained effort in mental health care support, and imminent actions include the development of a local schizophrenia adherence scale to assess patients’ compliance to therapy.
WAPR participated in the 8th International conference SAARC Psychiatric Federation (SPF) that was organised in the historic city of Lumbini (birthplace of Lord Buddha) in Nepal from 27-29 November 2014. Nearly 300 delegates, from the SAARC countries and from the rest of the world representing about 14 countries, participated in the conference.

WAPR was represented by Dr Afzal Javed (President) and Prof Nasar Sayed Khan & Dr Alok Sarin (Board members). WAPR also organised a special session that was chaired by Dr Afzal Javed & Prof Mohan Isaac (Australia). Dr Nasar Syed Khan spoke about resilience and how this can be linked to psychosocial wellbeing especially during disasters and traumatic situations. Discussions about formulating police and mental health programme were initiated by Dr Alok Sarin who was involved in reviewing some of the mental health plans in India.

He emphasised the ways that PSR should be included in such polices while resources for mental health services continue to face reductions.

Dr Afzal Javed who is advisor to this organisation was also a plenary speaker and gave his talk on Ethics in psychiatry and current directions in the field of Psychosocial Rehabilitation.

The conference programme also included Haroon Rashid Memorial session and was one of the salient features of the scientific programme. The session was dedicated to the memory of late Prof Haroon Rashid Chaudhry who was among the founder of SAARAC Psychiatric Federation that was started in Lahore in 2005 and also a WAPR Board member. Prof S M Sultan and Prof Mowadat Rana were the speakers at this session and both of them paid a great tribute to Late Prof Haroon Rashid Chaudhry especially his services for uplifting PSR services in Pakistan through Fountain House.
WAPR Western Pacific.

4th WAPR Asia Pacific Conference on Psycho Social Rehabilitation
Taichun, Taiwan. 2-4 November 2014.

WAPR Taiwan organised a very successful conference at on 2-3 November 2014. The meeting was held in collaboration with Taiwan Society of psychiatrists and was well attended by mental health professionals. Eva Teng, Secretary General, Taiwan Association for Psychosocial Rehabilitation and her Board needs special thanks for initiating this collaboration for bringing the subject of PSR as a main theme in the conference of local psychiatrists and other allied professionals.

The scientific programme included plenary talks by Dr Afzal Javed, Prof Harry Minas, Prof N Shinfuku and Prof Michaela Amering who spoke about different aspects of recovery and rehabilitation. The second day of the conference included presentations about policy and issues of human rights and Rights of Persons with Disabilities. These sessions were chaired by Dr Happy Kuy-lok Tan, Director Mental & Oral Health and Dr Wen Cheng Wu, Deputy Executive Director Ministry of Health & Welfare Taiwan. The deliberations of these sessions generated a lot of discussions and emphasised the needs for involving patients and families in the future planning for services for mentally ill and other persons with disabilities.

Dr Happy Kuy-lok Tan, Director Mental & Oral Health invited WAPR delegates to a meeting in her office in Taipei where medical superintendents and other high officials from the Health department were also present. This session included discussions about promotion of mental health and the proposed mental health programmes and initiatives at Taiwan by the Ministry. The Director thanked WAPR delegation and hoped that this collaboration will continue and her Ministry will make full use of WAPR in planning further changes in mental health services in Taiwan.

WAPR would like to acknowledge and thanks WAPR Taiwan for orgnaising this meeting and look forward for this branch playing an important role in the promotion of PSR in East Asian countries.

PSR/RPS being a national organisation and committed to the cause of psychosocial rehabilitation is a representative organisation that has been working in Canada for many years. PSR/ RPS Canada is a leader in transforming the mental health sector through education, research and knowledge exchange. We are committed to the promotion of social inclusion, recovery and well-being of all individuals and communities. PSR’s Vision reinforces and makes PSR a leader in transforming the mental health sector to be a society where people achieve full social inclusion. PSR/RPS Canada has recently released the PSR Standards and Definitions for Recovery Orientated Services.

The current work of the Canadian Board is to work with its members and the Mental Health Commission of Canada to advance the PSR national education plan and a Recovery Project. The competency document for Practitioners of Recovery-Orientated Practices provides the basis for establishing the skills required for people who work in a recovery-orientated system. The development of a national PSR registry is also underway.

The conference was attended by a number of delegates not only from all over Canada but also from many other countries. Four plenary speakers, over sixty workshops and a number of Institutes provided great learning opportunities for the approximately 170 participants. Dr Afzal Javed President WAPR and Dr Mart Borg Deputy Secretary General WAPR attended this conference on a special invitation. Thanks to Vicky Huehn, a board member of WAPR, for initiating this invitation. On September 21st the Board of PSR/ RPS Canada had a meeting and met with Marit Borg and also had further meetings with Afzal Jared on September 23rd.

PSR/RPS Canadian Board members are eager to work with WAPR to ensure that psychosocial rehabilitation is advanced throughout the world. WAPR would like to congratulate PSR Canada and its Board for their impressive work in areas of psychosocial rehabilitation and hope there will be more collaboration between these two organisations.
Clubhouse International & Clubhouse Europe organised their meeting at Sterling on 13-14 September 2014. WAPR was invited to participate in the meeting and also to explore further collaboration among these two organisations. Dr Afzal Javed President WAPR gave a plenary talk and also had formal session about discussions on the future joint collaboration. Clubhouse International showed a keen desire for strengthening links with WAPR and a MoU was agreed by both organisations at this occasion.
WAPR IN SPAIN.
III Meeting ACRP.
March, 18-20th., Las Palmas, Cannary Islands, Spain.

WAPR was represented by Ricardo Guinea in the III Meeting of the Cannary Association of Psychosocial Rehabilitation, (AACR) “Subjectivity in Psychosocial Rehabilitation”, in Las Palmas de Gran Canaria, Spain, March, 18-20th. The meeting explored and discussed some subjective aspects of Psychosocial rehabilitation with different stakeholders from the professional, carers’ and users’ perspective.

Different papers and presentations related to the central topic were presented, including topics as “Supervision of Teams”, psychotherapy in PSR, and Human Rights.

ACRP is member of FEARP, the spanish branch of WAPR.
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


Mental health publications can be downloaded from the links below or ordered from the WHO bookshop: http://www.who.int/mental_health/resources/publications/en/index.html

The WHO Mental Health Gap Action Programme (mhGAP): http://www.who.int/mental_health/mhgap/en/


Implementing Recovery through Organisational Change: http://www.imroc.org/

Yale Program for Recovery and Community Health: http://www.yale.edu/PRCH/
### EXECUTIVE COMMITTEE

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## WAPR COMMITTEES

### Congress committee
Co-Chair: Ricardo Guinea (President Elect)
Members:
- T Murali (Secretary General)
- Shahid Quraishi (Finance Secretary)
- Angelo Barbato (Chair of organizing committee of previous Congress)
- Tae-Yeon Hwang (Chair of organizing committee of next conference)
- Harry Minas (Regional Vice President from the region where next Congress is taking place)

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- Ida Kosza
- Anne Grethe Klunderud

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- Oliver Wilson

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Anne Grethe Klunderud
Michaela Amering

**Task Force on Ethics & Human Rights for persons experiencing mental illness**
Chair: Mathew Varghese
Henrik Wahlberg
Marianne Farkas

**Task Force on Curriculum & Training—particularly focusing on recovery**
Chair: Michael Sadre-Chirazi-Stark

**Task Force on Rehabilitation programmes for Adolescents & Young Children**
Chair: Arshad Hussain
Pedro Gabriel Godinho Delgado

**Task force on Preparing guidelines for PSR Services in low Income countries**
Chair: V.K. Radhakrishnan & Alok Sarin

**Task Force on Asia-Pacific Projects Development and Dissemination**
Chair: Harry Minas

**Task Force preparing a statement on Societal Connectedness, Social Capital, Identity and Moder Terrorism.**
Chair: Marianne Farkas

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