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“Beyond the Tradition, Create New Paradigm of Care”

제12회 세계정신사회재활협회 학술대회
12th World Congress of WAPR in Seoul 2015

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www.wapr2015.org
I am pleased that WAPR has remained very active during 2014 and has been involved in a number of activities organized with the help of our board members, national branches and especially the Regional Vice Presidents have played an active role in strengthening the mission & philosophy of WAPR in their respective countries.

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 pride & privilege that Spanish version of our Bulletin has been added to the list of achievements in this area.

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.

Our Board members continue with their contacts & links with other professional organizations & NGOs and have strengthened our links 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
- World Health Organisation (WHO)
- 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)
We have signed joint declarations with some of these organisations and are pleased with the future plans for collaborative work in areas of mutual interest.

Opening of new WAPR Branches:

Our regional vice presidents (Solly & Alberto) 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 these continents in 2015.

WAPR Meetings & Training sessions on PSR

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

- WAPR UK meeting, Preston, UK April 2013
- WPA Regional Conference Slovenia 2014
- WAPR Greece Branch meeting Athens, April 2014
- WAPR Training Programme at AFPA’s regional conference Malaysia, May 2014
- Norwegian WAPR conference, Bergen, May 2014
- Manantial Foundation Spain Training at UK, June 2014
- Nordic WAPR meeting in Copenhagen, Denmark, August 2014
- WPA World Congress Madrid, September 2014
- WAPR UK meeting, Preston, UK, September 2014
- PSR Meeting Canada, September 2014
- Ongoing Local training (psycho education) in Fountain House, Lahore, Pakistan

WAPR has also been represented in many regional and international conferences during this year.

- Paraguayan Society of Psychiatry Meeting, Asunción, Paraguay, January 2013
- Planning meeting WAPR Indonesia, Bali, Indonesia, February 2013
- Congress on Schizophrenia Research, Bali, Indonesia, February 2013.

- WPA Section meeting on undergraduate teaching in Psychiatry, Coventry, UK, March, 2013
- WAPR UK meeting, Preston, UK April 2013
- WFPMH International conference “Crisis and Disasters: Psychosocial consequences Athens, Greece & signing of joint declaration, March 2013
- International conference “Crises and Disasters: Psychosocial consequences” Athens, Greece, March 2013
- WPA Regional Conference Bucharest, Romania, April 2013
- WAPR Training Programme Ethiopia, Oct 2013

Future proposed meetings:

- WAPR Taiwan 2-4 November 2014
- WAPR Training Programme, Hungary, January 2015
- WAPR India Conference, Bangalore, Feb 2015
- WAPR European Regional Meeting Italy, summer 2015

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

Afzal Javed
President WAPR
Dear Readers;

This edition of the WAPR Bulletin is a tribute to you people around the world engaged in improving the wellbeing, living conditions and services for fellow human beings struggling with mental distress. We are presenting reports from ongoing and new branches in our organization revealing inspiring and impressive activities.

The values and principles of recovery and psychosocial rehabilitation are highlighted and discussed in many communities and countries. In the last WAPR Bulletin Helen Glover highlighted a critical issue: “In our recovery oriented era there remains a strong fixation of changing the person as oppose to rethinking and transforming the service environments that create opportunities for people to realise their potential”.

Peter Lehman raises another important issue in the present Bulletin - many service users’ experiences of disturbing effects of psychiatric drugs. His point of departure is “the Valladolid Statement 2010” where WAPR calls on policymakers, professionals, users, caregivers, and other stakeholders, as well as NGOs, to continue efforts to

“Design and implement community based recovery oriented mental health and rehabilitation services, based on the principles of quality, accessibility, equity, users and carers’ participation, shared decisions, choice and self-determination, maximum use of natural supports and settings, and professional relationship built on trust and support...” (“Valladolid Statement”, 2010, p. 9).

Peter Lehman argues that if the problematic effects of psychiatric drugs are ignored the concept of recovery as a unilateral concept cannot be taken seriously. It would rather become an empty notion. This is an important discussion to keep alive in all parts of mental health services. Many people with lived experience have described psychiatric drugs as barriers to recovery due to all the side-effects. On the other side many get help from medication and see this treatment as an essential part of their recovery processes. Stratford and colleagues (2013) write in their paper about recovery, medication and shared decision-making:

“Recovery is not 'anti' medication; however, a recovery-oriented position does require the adoption of an enabling and empowering approach to the use of medication. The cornerstone of this is shared decision-making that respects the person's own lived experience and choice as well as the practitioner's professional expertise”.

This issue certainly needs some more discussion and we would like further comments and responses in this regard.

Some suggested links on this regard can be found in:

- Beaton, T <www.ncbi.nlm.nih.gov/pubmed?term=Beaton%20T%5BAuthor%5D&cauthor=true&cauthor_uid=23996671>

The Editorial Committee.
Two contradictory sides of recovery and psychosocial rehabilitation.

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Dr. Phil. h.c. Education in social pedagogy. Living in Berlin. Author and editor since 1986. In 2011, awarded with the Order of Merit of the Federal Republic of Germany by the President of Germany. mail@peter-lehmann.de, More at www.peter-lehmann.de/inter

“Doctors learn how to administer drugs. They do not learn to how to withdraw drugs. In a time when long-term medication has become the rule for many diseases (blood pressure, high cholesterol, diabetes), not only in psychiatry, this is a deficit, and maintenance treatment is often questionable. It is essential to understand that – from good or less good reasons – many drug consumers have had enough and quit further drug-taking” (Finzen, 2014).

The psychiatrist Asmus Finzen writes this in the abstract of his contribution to the symposium Coming off psychiatric drugs: Why, when and how, which will be held in November 2014 in Bremen (Germany) as a pre-event to the annual conference of the German Society for Social Psychiatry, together with the author of this paper. Both presenters mention the reasons why many are fed up with psychiatric drugs:

“The medical risks of psychiatric drugs (deficit syndrome, metabolic syndrome, tardive dyskinesia, increased cell death and increased mortality rates, especially if combinations are administered) increase steadily over the course of taking the drugs. Receptor changes, withdrawal-, rebound- and supersensitivity-symptoms to all kind of psychiatric drugs, and the customary cascades of combinations, require significant caution in withdrawal. To look nonchalantly the other way is usual, but is not a solution” (Finzen & Lehmann, 2014).

A decade before Finzen, Pirkko Lahti, 2001-2003 President of the World Federation for Mental Health, has already asked:

“Do we not leave our patients alone with their sorrows and problems, when they – for whatever reasons – decide by themselves to come off their psychotropic drugs? Where can they find support, understanding and good examples, if they turn away from us disappointed (or we from them)” (Lahti, 2004, p. 14).

Finzen now criticizes his colleagues, who abandon their patients when they ask for support in withdrawal:
"Treating doctors too often react to this stubbornly. Some threaten to break off the doctor-patient relationship. But this is not in accordance with the ethical principles of their profession. When a patient wants to reduce or withdraw from drugs that he or she has have taken long-term, the treating doctor has to support them kindly, even if they have a different opinion. It is the patient who decides. It is also the patient who carries the risks of taking the drugs. The doctor can support the person by conducting a phased withdrawal and by helping to minimize unnecessary risks" (Finzen, 2014).

No question, some individuals have the experience that they cannot exist in their current life situation without psychiatric drugs. But what if their conditions or opinions change and they decide to quit?

For mainstream psychiatrists, dealing with withdrawal problems and with recovery from drugs is not something they address. Similarly, many patients and ex-patients who took up the cause of recovery and psychosocial rehabilitation also avoid this issue. Why?

Two Sides of Recovery

Recovery is a relatively new concept used by those critical of psychiatry as well as by mainstream psychiatry itself, and turns against the therapeutic pessimism of past decades. "Recovery" can mean, among others things, rediscovery, healing, improvement, salvation, or the regaining of independence. A positive connotation of hope is common to all uses of this term, but it has many different implications, especially in combination with the administration or use of psychiatric drugs. For some, recovery means recovering from a mental illness, a reduction of symptoms, or a cure. Others use it to signify an abatement of unwanted effects of psychiatric drugs after their discontinuation, or the regaining of freedom after leaving the mental health system, or “being rescued from the swamp of psychiatry” (see Stastny & Lehmann, 2007a, p. 41).

In 1937, Abraham Low of the Psychiatric Institute of the University of Illinois Medical School in Chicago, founded the non-profit organisation Recovery, Inc., for people with various psychiatric problems, “a cornucopia of self-help methods and techniques that parallel those used in cognitive therapy” (“The Legacy”, 2005, p. 1). The aim of the program was to learn to cope with distressing trivialities of everyday life and – with the learned techniques and in conjunction with professional help – to gain expertise in coping with bigger challenges of live. The concept of Recovery, Inc., should be understood as an addition to professional care, not as its replacement: “The issue of medications is never discussed – that’s the physician’s domain” (ibid.).

After many decades of being ignored in the field of mainstream psychiatry, the term recovery was revived at the beginning of the 1990s. Until then, people with serious psychiatric diagnoses like schizophrenia were considered inherently as chronically vulnerable and, in principle, incurable. They could only hope for suppression or alleviation of symptoms. However, activists of the self-help movement, who were able to live an independent and healthy life after withdrawal of psychiatric drugs or after recovery from the brain-damaging effects of electro- or insulin-shock, challenged the concept of incurability. Lectures by users and survivors of psychiatry (also called [ex-] patients, consumers, clients) at conferences and universities, as well as user/survivor-produced books, magazines, publishing houses and websites could not be ignored any longer.

Recovery from the Illness.

In their understanding of recovery, many psychiatric workers have been influenced by William Anthony, director of the Center for Psychiatric Rehabilitation at Boston University, who is “considered the father of the Recovery Movement” (FEMHC, 2012, p. 6). Anthony himself was influenced by Judi Chamberlin, a founder and key leader of the American self-help movement, who had worked at his center. Anthony summarized the descriptions of recovery in the US literature. There:

“Recovery is described as a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (Anthony, 1993, p. 13).

The World Association for Psychosocial Rehabilitation (WAPR) shares this view; they note
“... that research has revealed that recovery in severe mental illnesses, considered as a creative and many faceted path people take in their everyday lives in order to overcome the problems and obstacles associated with the illnesses, and achieve an active, fulfilling and meaningful life, is real and possible...” (“Valladolid Statement”, 2010, p. 9).

Psychiatrist Michaela Amering and Margit Schmolke also put “mental illness,” from which people should recover, into the center of their understanding of recovery. In their book Recovery: The end of incurability they consider “Recovery as development from the limitations of a patient role up to a self-defined and meaningful life (...) for people who have to overcome serious psychiatric illnesses” (Amering & Schmolke, 2012, p. 17).

In articles about recovery, Anthony, Amering & Schmolke, and many other authors like to invoke Patricia Deegan, a US user of psychiatry, who considers the acceptance of disablement as basis of recovery:

“Recovery often involves a transformation of the self wherein one both accepts one’s limitation and discovers a new world of possibility. This is the paradox of recovery, i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. (...) People with psychiatric disabilities are waiting just like that sea rose waited. We are waiting for our environments to change so that the person within us can emerge and grow. (...) It is our job to form a community of hope which surrounds people with psychiatric disabilities” (Deegan, 1996).

Apart from the fact that of course all humans – and not only those with psychiatric diagnoses – are well-advised to know the own limitations (which should not exclude attempts of “transgression” and risk-taking), this raises questions about the recovery process from users and survivors of psychiatry:

- who do not accept the limitations and ascriptions of disability and weakness any more, which are set by outside agencies or temporarily integrated into the self-perception;

whose madness primarily consists of a troublesome and uncomfortable way of living and perceiving life or in a temporarily extraordinary state of mind with boundary-expanding potentials and who therefore have been made into psychiatric patients;

who have been damaged by psychiatric drugs and/or electroshocks and who want to protect themselves from further electroshocks or find their way back to health and well-being by coming off psychiatric drugs; or

who are searching for non-medical ways to cope with mental problems or to recover from them.

Recovery from Psychiatric Treatment

Peter Watkins, a psychiatric nurse in Australia who identified with the movement critical of psychiatry (Laing, Foucault, Breggin, Thomas, Romme, Mosher, Bracken etc.), published a holistic concept of recovery. After four decades of professional experience, he recognized the advantage of abstaining from predetermined approaches and trusting in the capability of humans to assign their problems a meaning and to make decisions which make their life more bearable. He based his elaboration of these ideas on anthologies with stories of recovery and on long-term studies, which use a strict set of criteria for the definition of recovery: continuing wellness in spite of – and often also because of – the rebelling mind, no “relapses” within two years, and not taking neuroleptics (Watkins, 2009, p. 17).

With his concept of recovery, Watkins is in line with the British National Institute for Mental Health, which defined the rebuilding of control over one’s own life as the most important criterion for recovery:

“Recovery is not just about what services do to or for people. Rather, recovery is what people experience themselves as they become empowered to manage their lives in a manner that allows them to achieve a fulfilling, meaningful life and a contributing positive sense of belonging in their communities” (NIMHE, 2005, p. 2 – original emphasis).

User- and Survivor-oriented Concepts of Recovery
Users and survivors of psychiatry who accept psychiatric drugs- and those who refuse them-complain, as a general rule, about the fact that the right to make one’s own decisions is taken away from them in states of crises. So for all of them, it is important to have alternatives beyond psychiatry, as well as humane treatment within the current system; to have tools to determine possible processes of crises and recovery by themselves (Stastny & Lehmann, 2007b). Advance directives (Ziegler, 2007) belong in this category, as do recovery plans (Copeland, 2010) and recovery plans including advance directives (Perkins & Rinaldi, 2007). Mike Slade of the Institute of Psychiatry at King’s College London makes a similar point in his book Personal Recovery and Mental Illness; his recovery concept involves a shift away from traditional psychiatric ideology, such as attempts to manage risk and avoiding relapse with psychotropics, towards new priorities: supporting people in working towards their self-defined goals and taking responsibility for their own life:

“Supporting personal recovery requires a change in values. The new values involve services being driven by the priorities and aspirations of the individual, rather than giving primacy to clinical preoccupations and imperatives. This will involve mental health professionals listening to and acting on what the individuals themselves say” (Slade, 2009, p. 3 – original emphasis).

Psychiatric Drugs in the Focus of the Recovery Discussion

In contrast to most psychiatric workers, many users and survivors of psychiatry challenge psychiatric drugs when they discuss recovery or quality of life. Of course, other issues are important, too, like self-stigmatisation, discrimination, withholding appropriate support, dependence on the mental health system on major pharmaceutical companies, and reducing the human being to a psychiatric diagnosis or a function of genes. But one fact is often overlooked: that recovery under the influence of psychiatric drugs is rather unlikely.

The experiences of the Berlin Runaway-house, a house for people seeking shelter from degrading psychiatric forced treatment, as reported by Kerstin Kempker in Coming off Psychiatric Drugs, show what people can do “without.” Community, support, experienced staff (if possible with their own experience of withdrawal) and responsible doctors can help to support ambivalent users and survivors of psychiatry in need of support.

“There’s a lot of tea-drinking, various herbal teas, and sometimes coffee. The punching bag in the basement is used, even more than the wide fields that stretch from the end of the street to the next village. If you can’t sleep at night, you stay up and talk with us or those staying here or with yourself, take a bath, listen to music, read, cook something for yourself. The staff and/or the occupants love to take long evening walks. (...) Because most people living here for more than two weeks are not taking psychiatric drugs (60%) and/or withdraw completely or gradually while here (40%), there is a lot of experience that gets shared concerning how one can ‘do without,’ and all that one can do again ‘without’ the drugs” (Kempker, 2004, pp. 270-271).

Problems beyond Psychiatric Drugs

Even if psychiatric drugs – with their risks or unpleasant effects for mind and body – are a burden for psychiatric patients, simply stopping them, whether slowly or abruptly, often is not a sufficient way to cope with one’s mental problems. Going mad is a signal showing the necessity of a change, says Maths Jesperson, a regional secretary of the Swedish National Organization of Users and Survivors of Psychiatry:

“Madness is no illness to be cured. My madness came to call up a new life for me” (Jesperson, 2004, p. 76).

Indeed, those who learn to take feelings seriously, to follow their own intuition and to take notice of and react to warning signals of a developing crisis, are more likely to escape the danger of having psychiatric drugs prescribed a second time. When users and survivors of psychiatry understand the connection between violence or abuse and their difficulties, when they understand mad and troubling symptoms and react in alternative ways to crises, it is easier for them to break emotional attachment to life problems and deal with them. The quest for understanding that begins at the end of an acute phase of madness or depression takes on preventative qualities, as Regina Bellion, a German survivor of psychiatry, explains:

“Whoever gets to the bottom of his or her psychotic experiences afterwards obviously
does not run into the next psychotic phase all too soon” (Bellion, 2004, p. 284).

Some co-authors of Coming off Psychiatric Drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers (Lehmann, 2004), who gave accounts of how they came off psychiatric drugs without once again ending up in the doctor’s office, regard it as a fundamental condition to notice their own (co-) responsibility for their lives, their problem-burdened past and their responsibility for their future. In the same anthology, professional helpers note their humane presence and their availability in the critical moments of coming off as a prerequisite for effective support. But the users and survivors of psychiatry have to do their share in overcoming the problems that can appear when coming off, too.

The problems which led to administration of psychiatric drugs may return when people stop taking them for different reasons, so it is important to understand the reasons for one’s mental problems. Experiences within the self-help movement of users and survivors of psychiatry show that the belief that it was the “evil others” (neighbours, husband, wife, parents, family doctor, psychiatrist, police, psychosocial services etc.) or the “mental illness” (metabolic disturbance, genetic disposition, etc.) that led to the administration of the psychiatric drugs in the first place can prevent or make it more difficult for people to take full responsibility for their own lives, since the habit of looking for someone or something to blame is hard to break. Mental crises – like physical crises – offer a chance for change; in fact, they demand it. This calls for dealing with one’s own history, whether in dialog with oneself, in a self-help group, with friends, relatives, or therapists, as long as they are free of the baggage of psychiatric beliefs and power play.

Psychiatric Drugs or Recovery?

All people, but especially people who decide to try to recover with psychiatric drugs, should know that the life expectancy of psychiatric patients is reduced by – on average – two to three decades (Ösby et al., 2000; Colton & Manderscheid, 2006; Manderscheid, 2006; 2009; Aderhold, 2007; Weinmann et al., 2009; Chang et al., 2011; Lehmann, 2012; Janssen Pharmaceuticals, 2012) and that for three decades, the mortality rate has continued to grow (Saha et al., 2007, p. 1126). “Average number of years prematurely that people with serious mental illness die,” warns the Foundation for Excellence in Mental Health Care, a charity based in Oregon, USA, on their homepage (FEMHC, 2014). “People with serious mental illness” is another term for people receiving psychiatric drugs – substances with a considerable amount of adverse effects.

While you can discuss endlessly the role of psychiatric drugs in the early deaths of psychiatric patients, if psychiatric workers, nurses included, are seriously interested in recovery processes, they should inform their patients and their relatives about the possible unwanted effects especially of neuroleptics, the most risky group of psychiatric drugs. In general, these are administered without informed consent, especially without information about unwanted effects which could be identified as early warning symptoms for developing chronic and lethal diseases (i.e., neuroleptic malignant syndrome, diabetes, metabolic syndrome, myocardial infarction, apoplectic stroke, agranulocytosis, asphyxia, tardive dyskinesia, etc.). Without being able to identify these warning symptoms, patients, their relatives, friends and supporters cannot react appropriately if these effects arise, when rapid response would be life-saving (Lehmann, 2013).

Users of psychiatry and psychiatric workers should seek information and think carefully about the risks and possibilities of coming off psychiatric drugs, especially when the drugs have been administered long-term. And if the decision is to withdraw from drugs, they should come off slowly, step-by-step, when required (Lehmann, 2004). Too-rapid withdrawal of neuroleptics can cause chronic damage. If, at withdrawal, psychotic symptoms appear, this could point to developing (organic-based) supersensitivity psychoses, which might get chronic by further administration of neuroleptics and make each recovery process impossible, so it would be important to use non-neuroleptic methods to alleviate withdrawal symptoms.

Of course, antidepressants can also trigger chronic problems. One of them is the danger of dependence. In the early 1970s, doctors expressed the suspicion that antidepressants lead to depression becoming chronic (Irle, 1974, pp. 124-125). Meanwhile, the study of a team led by Paul Andrews (2011) in the Department of Psychology, Neuroscience & Behaviour at the McMaster University in Hamilton, Ontario (Canada), showed that synthetic antidepressants interfere with the
brain’s natural self-regulation of serotonin and other neurotransmitters, and the brain can overcorrect once medication is suspended. Therefore, new depression would be triggered (see “Patients”, 2011).

Neuroleptics and antidepressants should be a focus of the recovery discussion, not only because of their risks, but because they can also inhibit self-healing tendencies. It is important that all stakeholders become aware of the tremendous lack of resources in the health field when people decide to withdraw from psychiatric drugs. This lack of resources results in preventing recovery and can lead to patients becoming chronically physically ill and psychiatrically disabled. Chronic illness and disability hinder people with mental health problems to reach the status they deserve as citizens with full rights. Chronic illness and disability prevent rehabilitation, too.

**Addressing Contradictions**

WAPR calls on policymakers, professionals, users, caregivers, and other stakeholders, as well as NGOs, to continue efforts to

“Design and implement community based recovery oriented mental health and rehabilitation services, based on the principles of quality, accessibility, equity, users and carers’ participation, shared decisions, choice and self-determination, maximum use of natural supports and settings, and professional relationship built on trust and support...” (“Valladolid Statement”, 2010, p. 9).

If the disturbing effects of psychiatric drugs, which might prevent recovery, are ignored, the concept of recovery as a unilateral concept cannot be taken seriously; it would become an empty notion. Existing contradictions, which need to be part of the recovery discussion, lie throughout the entire psychiatric field: obvious as well as hidden damages caused by psychiatric drugs, particularly neuroleptics, and brain damage caused by electroshock, as well as other factors, which obstruct recovery and rehabilitation processes. Concepts of recovery which try to exclude these factors should be regarded as typical psychiatric labelling fraud. In a fair discussion, at least the different approaches of recovery – taking psychiatric drugs or recovery by coming off psychiatric drugs – should be described openly. People could then make their own informed decisions about how to proceed.

Holding a fair discussion could be a step to establish the diagnosis “dependence on neuroleptics” and “dependence on antidepressants,” which would enable doctors who really want to support their patients in withdrawal to get their costs reimbursed by insurance companies. Also, doctors could learn better how to support patients in withdrawal from psychiatric drugs. The experience-based wisdom of ex-patients who withdrew successfully on their own and could now be good teachers in education, workshops and conferences, should not be underestimated.

**Note:** Thanks to Darby Penney and Peter Stastny for support in translation matters. Copyright by Peter Lehmann 2014, all rights reserved. Sources see [www.peter-lehmann.de/document/wapr](http://www.peter-lehmann.de/document/wapr)
Psychosocial Rehabilitation and Severe Mental Illness: Experiences of the Community Mental Health Services (CMHS) in AlAin Hospital, United Arab Emirates.

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Introduction

After the discovery of psychotropic medications and introduction of rehabilitation programs in mental health services, the field of psychiatry and mental health started to grow rapidly. The goals of treatment were shifted from stability of persons with mental health problems towards supporting the persons in community integration and recovery. The current service models is shifting from illness models towards a social functioning level, including two broad intervention areas:

1. Improving individual’s competencies.
2. Introducing environmental changes to improve individual’s quality of life.

The deinstitutionalization movement, which started in the 1950s -1960s, has changed the locus of treatment for most people with severe mental illness from the hospital to the community (Kim et al 1998). Some problems were associated with deinstitutionalization such as negative social effects, increased rates of defaulting treatment, illness relapses, forensic offences and homelessness as undesirable consequences. Community-based mental health services were developed to address these needs (Wei et al, 2005).

CMHS in AlAin Hospital

The Community Mental Health Service (CMHS) of Behavioral Sciences Institute in Al Ain hospital is a district wide, multi-disciplinary psychiatric outreach service, which was established in 1994. It aims to provide comprehensive mental health care for people with mental health problems in home settings, in order to minimize the need for readmissions and to optimize the person’s functioning and quality of life (QoL) within his/her home setting and the community at large. This is in
compliance with the overall mission of the institute which is to provide quality, cost-effective, multidisciplinary mental health services, training and research in partnership with our patients, their families and the relevant stakeholders in the community. The team covers the Al Ain area which is the second largest city in the Emirates of Abu Dhabi with a population of 568,221 (2010). The population covered by the service is mainly local citizens with few patients from other nationalities. The number of patients enrolled in the service and is rapidly increasing (Figure: 1) and the team is currently serving 180 patients.

The team adopts an integrated bio-psycho-social approach in assessment and support for the persons in need of mental health care. Our clients are mainly those who suffer from severe and persistent mental illness, which has major impact on life functioning. In addition to individuals who have persistent psychotic or mood disorders, the team is also serving a group of persons with cognitive deficits with diagnoses of mental retardation and dementia.

An assessment of mental health and physical problems, daily needs, level of social support and skills training is on the agenda in the first visit in

![Graph showing total number of patients enrolled in the CMHS]

### TOTAL NUMBER OF PATIENTS ENROLLED IN THE CMHS

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<th>Month</th>
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<th>Jan-09</th>
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<td>26</td>
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### Figure 2.

- Psychoeducation
- Challenging stigma
- Psychological support to patients and families
- Problem-solving and social skills training
- Behavioural modification and CBT if indicated

- Assessment; psychiatric and physical
- Monitoring; psychiatric symptoms, physical comorbidity
- Planned assessment and investigations
- Long-term pharmacologic management
- Integrating management and including other specialties when needed

- Creative work
- Craft work
- Reading
- Writing
- Exercise
- Daily schedule

- Social problems solving
- Advice regarding future plans of social and occupational functioning
- Interventions when family and social supports are lacking or ineffective
order to have an initial treatment and rehabilitation plan. In challenging situations with the person having prominent psychotic features, we usually delay the non-pharmacological interventions until the symptoms are becoming less severe to have better engagement. However, psycho-education and efforts towards challenging stigma and the ways of collaborating with the person in need, are usually discussed and performed in the first visit. Our approach to management is based on a collaborative approach in which all the team members work in partnerships with one another and with the person towards achieving the goals of treatment (Figure: 2).

We assessed the outcome of our CMHS service in terms of the need for hospitalization, and the patient’s satisfaction with the service. The total number of hospital admissions and the number of days that the patients spent in hospital were significantly reduced after being enrolled in CMHS. Patients had high satisfaction rates with the CMHS in terms of the information and advice they received from the team members, their relationships with CMHS workers, and their access to mental health services as well as with their drug treatment (Mufaddel et al, 2014).

**Psychosocial Rehabilitation**

Despite the fact that most of our patients are suffering from severe forms of mental illness we aim to support and improve the persons’ quality of life and functioning in terms of reducing stigma, improving social functioning and skills training. Once the person is referred to the service a comprehensive assessment is done by all team members including current psychopathology and response to previous treatment, assessment of physical problems and physical disability, psychological assessment, social assessment, and assessment for involvement in occupational therapy activities. We believe that pharmacotherapy and response to treatment and assessment and management of physical status should be the first step of intervention, as stability in this respect will aid further plans directed towards achieving better functional and social functioning. The psychologist provides psychoeducation for families and tries all efforts to challenge stigma and to include person in ordinary family activities. Some persons and their families need supportive psychotherapy due to distress resulting from problematic life situations and long-standing symptoms and frequent relapses and admissions. Such a kind of support is needed in order to maintain hope for the future and continue to be engaged in rehabilitation services and activities. The social worker has regular follow-up and communication with the team so they can help families in solving social and family problems. Social intervention is frequently needed for some persons who need better support from the families and for families not showing engagement in the
rehabilitation plans. Following initial home assessment which is usually done by all the psychiatrist, nurses and psychologist, there will be a team meeting to discuss the treatment planning, collaboration strategies and future interventions. The occupational therapy (OT) activities efforts are directed towards helping patients discover their own strengths and skills. The rehabilitation plan is discussed with the psychiatrist, psychologist and nursing staff and progress on activities is discussed periodically. All team members help in follow-up of the activities given during the visits. The number of persons participating in OT activities is 66. A total of 25 persons preferred to participate in creative works which include drawing, coloring glass painting etc... The team provides items used for the selected activities for the persons in rehabilitation. There are 5 involved in craft works and 15 are doing simple exercises that do not require complicated settings. The later activities are planned to be more tailored by providing leaflets to facilitate memorizing the activities given. Some patients prefer to have reading (11) and writing (6) activities, including reading newspapers, magazines and the books provided by the CMHS. Books are carefully selected according to person’s preference and their abilities and educational status. They were also encouraged to write summaries of what they read or from their own imagination and creativity. For those who have severe levels of functioning and who showed no interest to be involved in certain activities daily activities are scheduled and discussed with them. Daily activities scheduling is suggested by adding day to day activities and exercise in a time based manner with follow-up for progress by team members.

**Characteristics of Staff**

We aim to have more work on psychosocial rehabilitation over time and to transmit this message to our trainee who joins the service particularly residents. Special desirable characteristics are needed for those who are willing to work in CMHS services which are discussed and encouraged. Desirable staff characteristics are to be humble, having gentle firmness, open minded, non-intrusive, practical and problem-solving oriented, flexible, optimistic and supportive, humorous, and thinking contextually. Undesirable characteristics are not helpful in working in CMHS such as consistent distortion of information, the rescue fantasy, pessimistic outlook, being suspicious and blaming others, over controlling and needing to do for others. (Ruzanna and Marhani, 1994).
References


CMHS team: Dr. Amir Mufaddel, Dr. Badr Salih, Sister Nora Croza, Mr. Paul Norton, Sister Daisy Abraham, Mr. Joshua Peter (occupational therapist), Dr. Yahya AlTakriti, Mr. Habib Belhaj, and Mr. Nasser AlHekmani (CMHS psychologist).
Dear Dr. Afzal Javed,

I take this opportunity to write on behalf of the National Council for Mental Health ‘Sahanaya’, after the Inauguration of Sri Lanka Chapter (WAPR) which gave us a very good start, in recognizing ourselves to the world.

I am happy to inform you that the NCMH was able to commemorate World Mental Health Day on 10th October 2014, which was a great success. The Management was able to introduce our new documentary to the world, which I am pleased to share with you through our website www.ncmh.lk.

This indeed give us a chance to link with other groups and also promoting us to many other professional partners working in the field of mental health.

Pleased see enclosed a few pictures that were taken on world mental health day.

Hope you will be able find a few minutes of your busy schedule to log into the website.

Thank you

Best Regards

MRS. Soniya Sshumacher
Secretary. National Counsil for Mental Health.
SRI LANKA
Having a launch of WAPR chapter in Malaysia is indeed a significant development in Asian region for WAPR. Malaysian friends have been trying to have a formal presence of WAPR in their country for many years and Malaysian Psychiatric Association (MPA) always wanted collaboration and links with WAPR. It was however the current leadership of MPA (Dr Kadir and Prof Prof Nor Zuraida Zainal with their other committee members) who agreed to include one full day scientific deliberations in the programme of their annual conference (22-24 May 2014) and decided to develop formal links between MPA & WAPR.

This conference was also joined by Asian Federation of Psychiatric Associations (AFPA) as their regional meeting. The collaboration with AFPA certainly increased the participation of delegates to this important regional meeting from a number of Asian countries including Malaysia, Thailand, Indonesia, Vietnam, Cambodia, Philippines, Taiwan, Japan, Australia, Fiji, India, Pakistan, Bangladesh, Singapore & Sri Lanka).

WAPR deliberations in the scientific programme of this conference (that was also attended by delegates from many Asia countries) included a full day workshop on the theme of “Developing Psychosocial Rehabilitation in Asia countries”. The workshop was facilitated by Dr Afzal Javed & Prof Pichet Udomratn and following speakers presented on different areas of needs and opportunities for PSR:

- Prof Mohan Isaac (India / Australia)
  Needs and opportunities for PSR in Asian region
- Prof T Murali (India)
  Developing Models of PSR service provision
- Dr Abdul Kadir Abu Bakar (Malaysia)
  Service delivery "what works and does not work - the Malaysian perspective"
- Dr Yongyud Wongpiromsarn & Suchada sakornsatin (Thailand)
  PSR for urban and Rural Models
- Prof. M. Thirunavukarasu (India)
  Developing teaching & training modules in PSR
- Dr Maria Tomasic (Australia)
  Psychosocial Rehabilitation for special groups
- Prof Nalaka Mendis (Sri Lanka)
  Involvement of patients, carers & families in PSR programmes
Final session was chaired by Prof Lourdes Ladrido-Ignacio (Philippines).

At the end of the session, a set of recommendations / guidelines was approved as WAPR KL Declaration. It is hoped that this document will help in setting priorities for developing psychosocial Rehabilitation services in different countries.

The session ended with a formal opening of WAPR-MPA Chapter and it was agreed that while this chapter promotes PSR philosophy of WAPR, will also help and support other regional counties in areas of training, research and manpower development.

WAPR would like to thank Dr Abdul Kadir Abu Bakar, Prof Nor Zuraida Zainal, Prof Marhani Midin and their team for extending a memorable hospitality to all WAPR officers and Board members during their stay in Malaysia.

Afzal Javed
President WAPR

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.
Dear Editor of the WAPR Bulletin;

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. 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.

Dra. Ana Pitta (WAPR Brazil) is located in the middle of the photograph, on her right Dr. Roger Montenegro, on her left Dr Luis Ignacio Brusco, accompanied by other members of the Argentine Branch. (Deanery, School of Medicine-UBA)

Kind regards,

Dr. Luis Ignacio Brusco and Dr. Roger Montenegro.
WAPR organised a mini Board and Officers meeting during the WPA world congress held at Madrid on 15th September 2014. In a joint session with WPA Section on Psychiatric Rehabilitation, discussions took place about the WAPR Seoul Congress and Dr Jonggook Lee presented the arrangements and a progress report from the local organising committee. The participants of the meeting were pleased with the progress and hoped that this will be a very successful meeting.

WAPR also supported few scientific sessions at this congress on the topics of rehabilitation, recovery and resettlement of mentally ill back to the community.

A reception was also organised by WAPR and was attended by a large number of mental health professionals from many countries. This was a good opportunity to pass on information about WAPR. This also generated a lot of interest among non WAPR members who attended this reception about joining WAPR and starting WAPR branches in different countries.
The Hellenic Branch of the World Association for Psychiatric Rehabilitation (WAPR), under the pressure of the pernicious economic crisis striking the country, undertook the initiative of organizing a scientific event on “Psychiatric Rehabilitation amid the Recession” in Athens on the 10th of May 2014. The event was jointly implemented by the University Mental Health Research Institute and the First Department of Psychiatry of the University of Athens, in close collaboration with Families’ Association for Mental Health (SOPSI); while it was open not only to mental health professionals but to people with severe mental illness and their relatives.

The title of the event was “Psychiatric Rehabilitation in Greece during the financial crisis: Psychosis: Psychotherapeutic Interventions for the Patient and the Family” and it entailed both lectures and a workshop.

The main speech was given by Dr Afzal Javed, President of WAPR, on the importance of involving patients, carers and their families in the treatment programmes for severe mental illness. Dr Javed elaborated on the benefits, evidence base and potential obstacles of such an approach by presenting effective practices from the international literature. Professor Michael Madianos, former President of WAPR (2006-2009) described the impact of the recession on social and health outcomes; while Dimitris Ploumpidis, Associate Professor of Psychiatry and President of the Greek Psychiatric Association, concentrated on its adverse effects on psychiatric rehabilitation.

The emphasis of the event was given on “Psychotherapeutic Interventions for Patients with Severe Mental Illness and their Family Members”. Therefore two roundtables following the key lectures were focused on the implementation of germeane programmes in Athens area. Marina Economou; Assistant Professor of Psychiatry, President of the Hellenic Branch of WAPR and of the Scientific Committee of Families’ Association for Mental Health, highlighted the importance of family psychoeducation as a means of addressing cost-effectively the challenges posed by psychosis.

The event culminated in a workshop with the title “Psychoeducation in practice for Families with a member suffering from Psychosis: what I should know, what I can do”, involving both mental health professionals and relatives. The workshop; led by Marina Economou and Alexandra Palli, PhD psychologist, provided tangible advice on dealing with psychosis in everyday life and triggered a fruitful discussion.

The event’s concluding remark was that the family, which remains a very strong institution in Greece during the economic downturn, needs specialized support and psychosocial interventions in order to circumvent the obstacles posed by the severe mental illness.

Thanks again to Michael Madianos & Marina Economou and Stelios Stylianidis for their leadership and hard work for WAPR.
ATHENS DECLARATION on
“LIVING WITH SCHIZOPHRENIA”

Schizophrenia is a serious illness, starts early in life, affects 26 million people worldwide and more than half of the persons with this condition do not receive appropriate treatment. If neglected it can have serious consequences for the persons who suffer from it, for the people who care for these persons and for society as a whole.

In view of the above, the following facts should be considered:

Prevention of schizophrenia (in its primary, secondary and tertiary degree), treatment (with biological, psychosocial and other methods) and health promotion are both possible and cost/effective.
Recovery from schizophrenia is possible and rehabilitation of chronic institutionalized patients in the community can be achieved by most people.

We want to draw the attention of the global, regional and local authorities and organizations and the society as a whole to the above facts and urge them to:

Take into account the degree of suffering associated with schizophrenia for the patients and their families
Note that during periods of stress, like disasters, wars and financial crises vulnerable people are at risk of developing mental illness and people already suffering from it can experience relapse and exacerbation of their symptoms
Consider the existing evidence that curtailing the funds of mental health services can have detrimental effects on persons predisposed for schizophrenia or persons who are already suffering from it.
Call for support and advocacy of the persons who suffer from this painful and potentially self-destructive condition. People with schizophrenia receive less attention for their health, discontinuation of smoking strategies are less vigorous in their case, they rarely undergo angioplasty after a heart attack and they are not protected from developing a substance abuse disorder as if they are children of a lesser God.
Note that schizophrenia may be one of the most serious disorders in psychiatric nosology but with due person-centered care recovery is possible and the persons who suffer from it may lead a normal, fulfilling and productive life.

Given in Athens on 10th October 2014
(World Mental Health Day 2014)
On the days 8th and 9th of March, led by Peter Hughes and Sophie Thomson, Consultant Psychiatrists, and with the support of the Royal College of Psychiatry, around 50 psychiatrists, psychologists, general practitioners and other mental health professionals working mainly in UK but with origins and relationships with India, Pakistan, Lebanon, Ghana, Nigeria, Brazil, Lithuania, etc., discussed through a participative methodology – role-playing, case studies, etc., the main contents of mhGAP.

Particular emphasis was placed by the leaders of the course on the new mhGAP module about Conditions Specifically Related to Stress, which contains assessment and management advice related to acute stress, post-traumatic stress and grief in non-specialized health settings.

The leaders of the Course, who have been working with this teaching methodology along the last years in Somalia, Uganda, Kashmir, Syria, etc., stressed the interest of the mhGAP Guide, that can be used as a powerful tool to start working in developing countries, to reduce the GAP between what is needed and available involving mental health questions. The guide represents a first step to make possible for the family care practitioners and other non specialised professional categories related to mental health to work with a limited training and with very strict times and having for the first time the possibility of, even in a limited way, addressing unmet needs.

Along the Course, Peter Hughes, as Member of the Board of the Volunteering and International Psychiatry Special Interest Group (VIPSIG) launched at the College of Psychiatry on 22 June 2011, informed us about the activities of the Group. VIPSIG aims to promote and support mental health globally, focusing on the low and middle income countries as defined by the World
The Group reports to the College Council and to the College’s International Advisory Committee regarding volunteer activities, and has been the driving force of teaching activities concerning mhGAP during the last years.

The possibilities opened by the mhGAP are remarkable, it supposes a standardized and manageable approach, and looking at it from the approach and objectives of WAPR, it is a step forward, particularly in the assessment and the possibilities of approaching psychosis not only with a psychopharmacologic but also with psychosocial interventions.

The General Principles of Care of the guide give an idea of the importance given not only to treatment but to assessing and facing the environmental difficulties of people with psychiatric conditions:
1. Communication with people seeking care and their carers.
2. Assessment.
3. Treatment and Monitoring.
4. Mobilizing and providing social support.
5. Protection of human rights.
6. Attention to well-being.

On my point of view, the risks of this kind of training have to do with the complexity of our profession. Trying to reduce the mental health and psychosocial interventions to simple categories can conduce to the medicalization of the population, as long as drugs are the only really simple thing concerning the management of mental illness and possibly the best understood message.

Relating to this question the leaders of the group emphasized the fact that mhGAP training does bias in training towards psychosocial interventions to have a broad based treatment covering pharmacology as part of a package, and also the importance of the methodology of the courses, avoiding intensive and fast approaches and opening possibilities to more prolonged trainings, and stressed the value of the supervision to avoid an excessive reductionism of the proposed model.

Dra. Carmen Ferrer.
WAPR Board Member.
The Danish Society for Psychosocial Rehabilitation and the Norwegian WAPR branch organised a Nordic conference in August this year. The objective was to strengthen the Nordic collaboration and networking in the area of psychosocial rehabilitation and recovery-oriented research and practice development. The participants were people with lived experience of mental distress, family members, practitioners and researchers. The conference was organised in a combination of plenary sessions and workshops.

Themes in focus were:
- status and challenges in mental health services in our countries
- what do recovery-oriented practices mean and involve?
- employment, supported education, meaningful activities
- hearing voices networks
- user-run services
- crisis support and asserted outreach work
- recovery oriented practises
- family and network programs and Open Dialogue

About 60 colleagues participated, shared and informed one another about what seems to work and where the major challenges are. The value of involving citizens with lived experience of mental distress and/or substance abuse in service development, management groups, training and research was highlighted.

The leader of the Norwegian branch Audun Pedersen presented WAPR - as a world association with many-faceted activities and a central agent of change in many counties. We also informed about upcoming conferences and hope to see Nordic colleagues in both Hungary, Italy and South Korea next year.
On 16th May 2014 a conference entitled “From close-up nobody is normal” was held in Tirana. It was organized by the Albanian Ministry of Health and the Italian NGO “Psychologists for the peoples in the world” which had just concluded the three-year training project “Albania tomorrow”.

The participants were nurses, psychiatrists and psychologists of the Albanian mental health services and especially of the two Community Centers involved in the project.

WAPR gave an important contribution with three speakers: Germana Agnetti, Member at large; Angelo Barbato, Past President and the Vice President Gabriele Rocca.

The Conference was a time for reflection and debate on the significant phase that the mental health system is undergoing in Albania, which is characterized by the transition from psychiatric care based upon large institutions to a community centered one.

The first session was opened by Milva Ekonomi, Vice Minister of Health and by Diana Chuli, President of FIDA (Independent Forum of Albanian Women) who presented the recent history and the current situation of mental health in Albania. Until a few years ago all the economic resources were used in psychiatric hospitals and there were no services apart from them. Stigma associated with mental health problems was very strong in all areas and this affected both families and the person involved. In 2005 an Action Plan was approved and a WHO office was opened to promote programs of deinstitutionalization in all five region where there is a mental hospital. The next decisive step was the new law in 2012. It provides legal protection for patients, the establishment of services for children and adolescents, the possibility to care for people at home and the procedures for both voluntary and compulsory admissions and for treatment. A process of change has started in different fields: cultural, instrumental and social, with the involvement of new professionals such as psychologists and sociologists.

The project “Albania Tomorrow”, launched in 2011, tried to make use of the most innovative aspects of this context and to introduce and facilitate the most central principles of psychosocial rehabilitation. Paolo Castelletti, psychologist and the NGO president, highlighted the efforts of building new networks in the community with the involvement of service users.

A significant part of the project was the training courses for the professionals at the mental health
centers in two different towns: Berat and Scutari. Thanks to this and already during the first year, some rehabilitation projects involving more than 30 patients was initiated. At the same time the two working groups dealt with the important issue of employment and established contacts with local companies. In fact the focus of the activity gradually shifted from inside to outside, from the service to the society, with an increasing participation of general practitioners and family members.

The members of the staff who participated in the course also had an internship in Italy, visiting the mental health services and discussing with their colleagues. They were introduced by Germana Agnetti, Supervisor Psychiatrist of the project, who also presented the most significant results:

- Establishing and consolidation of the rehabilitation programs within services that are the first structures of the community mental health system. It means collaboration with an increasing number of patients who receive support and rehabilitation services in the community
- Starting up a Day care Centre;
- A great commitment in the employment field with the initiation of placements and of two social companies;
- The involvement of general practitioners through two training courses focusing on the issues of early intervention and community mental health services.
- The establishment of two families associations which have a strong relationship with the services and participate in rehabilitation projects. They represent the change that has occurred in the last years in such a way that at the end of the project the services are able to continue in their transformation.

Angelo Barbato describes the closure project of the Milan psychiatric hospital during the four years from 1995 to 1999 that involved 337 patients. In offering this experience he focused on some key points of the deinstitutionalization such as the assessment procedures of the person involved, care planning and defining level of care, staff training, creation of a network of residential facilities with different levels of care, the need for a close relationship between the new residential facilities and the community mental health services. This evolution - he clarified - has its own economic compatibility because the new community services aren’t more expensive than psychiatric hospitals. He also recommended the founding principles of high-level psychiatric care which were also highlighted by Ledia Lazeri, WHO Psychiatrist: accountability, continuity, social inclusion, accessibility, human rights and epidemiological information. She linked these topics with the content of the European Mental Health Action Plan introduced in 2013 by the WHO Regional office for Europe which presents strategies to reduce stigma and improve access and quality of services.

Gabriele Rocca introduced the theme of the gap in life expectancy of patients with mental disorders and proposed some operational indications inspired by the WHO QualityRights Tool Kit. Next he illustrated the International Classification of Functioning Disability and Health (ICF) as a new and crucial instrument for assessment and planning rehabilitation services with the person involved. Moving from this perspective he suggested that one of the main aspects of psychosocial rehabilitation is an increasing awareness, thanks to which it is possible to begin working on and experiencing a recovery process.

In conclusion I would like to highlight the climate of the conference. As I previously wrote Albania is in a phase of transition and the participants expressed their warm interest for psychosocial rehabilitation. There was a clear understanding that the introduction and strengthening of psychosocial rehabilitation models are significant instruments and facilitators of change. The WAPR organisation and ongoing activities was presented and we hope that WAPR becomes a meaningful partner of the Albanian mental health services.
A three member’s team from Manantial Foundation Spain visited UK on 2-3 June 2014. The team comprised of one Psychiatrist and two Clinical psychologists (Miguel Castejón, Santiago Gil and Silvia Parrabera). WAPR facilitated this trip at the request of Francisco Sardina Ventosa (WAPR Board member) and helped.

Manantial Foundation, a major service provider for mental health services in Madrid, for having this visit and meeting UK experts working in early intervention, recovery and other related services. Manantial Foundation is an important member organization of WAPR and being a non-profitable organization has been commissioned with a number of projects by the local authorities in Madrid. They are now working on a project developing service for the young persons with a first psychotic episode and setting up an early care unit providing psychosocial rehabilitation to the young persons. The main purpose of the visit was to meet experts from UK and get some knowledge about services in the UK. They also had a meeting with EI service leads in Birmingham and Warwickshire. The Team had a busy two days period at Birmingham and visited different service components of Birmingham & Solihull Mental Health Foundation Trust (BSMHFT).

They received briefings about the services designs and got an opportunity to learn about Birmingham model as well as had discussions about their own future projects. John Short, Chief Executive of BSMHFT greeted the team as well. Special thanks to Dr Pavan Mallikarjun and his team (Diane Ryles-Service Development Manager, Robert Michael-Team Manager, Chris Jackson-Lead Clinical Psychologist, Carl Smart CPN, Sarah Cross-Secretary, Natalie Glenfield-Fairbridge program & Colin Webster-Asst Care coordinator) for their time and deliberations explaining Birmingham Model to the visitors. Prof Mohan also needs appreciation for his kind role in making this visit a real success.

Visiting team also met Dr Andrew Thompson & Dr Afzal Javed from University of Warwick & Coventry & Warwickshire NHS Trust who briefed them about the local services and also advised about some ideas that maybe helpful in evaluating newly proposed Madrid service at a later stage. The team was equally impressed with the Warwickshire services and thanked for having an update about local services & also discussing current directions about setting up similar services.

Team members were impressed with these services and were inspired to take a number of ideas from the working of teams at both places. They were hopeful that they will be able to replicate some of the services (if not all) based on their current visit and discussions with EI experts from UK.
Preamble:

Social and psychological disabilities associated with long term mental illness and neuropsychiatric disorders cause a considerable amount of distress and burden on the individual, care givers, families and the society in the Asian region. People with such disabilities need to be given the benefit of the new developments in the field as spelled out in the UN convention on the rights of persons with disabilities in 2006 and the protection of persons with mental illness and the improvement of mental health care of 1991.

Article 1.1: Authorities responsible for the development of Mental Health need to take immediate steps to upgrade reform the existing PSR programmes and establish new programmes to respond to the needs of patients, care givers and families including minimizing stigma, eliminating discrimination and protecting rights.

Article 1.2: Academics, professionals and other stakeholders need to identify and formulate the concept, principles, components and activities of psychosocial programmes based on the culture, economic, social and health system in the countries within the context of universally accepted principles and norms.

Article 2.3: Political leadership needs to integrate PSR programs to all health, social welfare, economic, education, labour and other policies and ensure that such policies are given effect.

Article 2.4: Public agencies put in place the necessary structural, administrative, organizational and financial facilities to provide the, resources and institutional mechanisms necessary for the
development of PSR programmes. The lead public agency for mental health and rehabilitation activities should coordinate the planning, development and implementation of PSR programmes with the participation of all stakeholders.

**Article 2.5:** Community agencies, community workers and others working in the community need to take a leadership in raising awareness of disabilities, play an advocacy role develop community based PSR services and mobilize resources. Steps should be taken to empower patients, care givers and families by organizing patients, care givers and families self help groups to improve their quality of life.

**Article 2.6:** Those responsible for the development and implementation of training programmes needs to ensure the integration of PSR to all professional medical, health, mental health, social welfare and other similar training programmes with a special emphasis on developing desired attitudes and appropriate skills.

**Article 2.7:** Those responsible for providing services needs to ensure integration of PSR to mental health programmes and provide accessible services to meet the needs of all groups of disabled including special categories.

**Article 2.8:** Public agency responsible for PSR needs to ensure standards are maintained in PSR facilities (staff, facilities, resources and care approaches) by enforcing rules and regulations through an established organizational mechanism.

**Article 2.9:** Research planners, researchers and funding agencies need to undertake studies to develop models, activities, interventions, practices and evaluation programmes that are likely to be effective in PSR programmes

**Article 2.10:** All mental health professionals need to take steps to acquire necessary competencies to identify the psychosocial needs of their patients, care givers and families and give the necessary leadership to develop and provide PSR to meet the needs of their patients.
The 2nd Asian CNS summit at Seoul, Korea on 14-15, June 2014 was attended by President Dr. V.K. Radhakrishnan. The meeting was conducted at Cornad Hotel, Seoul. More than two hundred psychiatrists from different Asian countries participated in the programme. I had an occasion to be a discussant in the plenary session. During the discussion the rehabilitation initiatives of WAPR came in to picture.

Following the session separate meetings were conducted by different Asian groups.

**Meeting with Pakistan group**

Pakistan group under the leadership of Dr. Ajmal Kazmi, Director Institute of Behavioral Science, Karachi. Conducted a meeting in Cornad conference hall. The meeting was chaired by Dr. V.K. Radhakrishnan. In the presidential address he highlighted about the WAPR objectives and activities in India. The Pakistan chapter of the WAPR shown interest in combined training programmes and regional cooperation in policy making. Dr. Saderf Rasheed faculty in Fathima Jinnah Medical college opined the importance of formulating rehabilitation strategies suitable for this part of the world as we are sharing a lot of cultural characteristics. The meeting unanimously agreed for a more effective regional cooperation.

**Meeting with Myanmar Group**

The Myanmar group was very eager to know about the WAPR objectives and activities. During a meeting at tea session Dr. Soe Min General Secretary, Mental health Society Myanmar recalled his earlier discussion with Dr Afsal Javed regarding WAPR, Prof Dr. Win Aung Myint Professor of Mental Health University of Medicine Yangon, Myanmar agreed to take initiatives in forming a WAPR chapter in Myanmar.

**Meeting with Hong Kong Group**

The Hong Kong group under the leadership of Dr. Lee Wing-king discussed about the various rehabilitation activities of Hong Kong. They are not aware of the WAPR activities in the Asian region. President Dr. V.K. Radhakrishnan briefed about the objectives and activities of WAPR. Hong Kong has rehabilitation facilities in government sector. The patients were trained to work, socialization and community living skills. They are having large occupational therapy department with Kitchen office and recreation facilities. The day care centres are known as PRSC. Patient resource social centres which function from 9.30am to 5.30pm. Government is providing drugs in subsidized rates. After the initiatives of rehabilitation programmes there is a remarkable decrease in wandering mentally ill patients in last ten years. There are hostels for patients run by government, NGOs and few private hostels. They also expressed their interest to have training programmes in India and to start WAPR activities in their country.

Dr. V.K. Radhakrishnan
Dear President, dear Editors of the WAPR Bulletin,

The picture below as attached was taken during the recently concluded Regional Committee Meeting of the WHO/WPRO where a major agenda item was Mental Health. This agenda item was started with a "High Level Panel Discussion on Mental Health" chaired by Shekhar Saxena, WHO/HQ Head of the Dept of Mental Health.

The Regional Committee Meeting this year was chaired by the Philippine Sec of Health Dr Enrique Ona who stands third from right. WHO/WPRO officials who spearheaded the inclusion of mental health in the regional agenda for health were Dr Shen (Regional Director, WPRO, standing 2nd left and Dr Susan Mercado (WHO WPRO Director for Healthy Population, next to Dr Shen) and Dr Xiangdong Wang (WPRO Regional Adviser for MH).

The panel was composed of Dr Harry Whiteford and Dr Graham Thornicroft as paper presentors and I served as one of the panel of reactors with Drs Setoya the Representing the Pacific Islands and Dr Sigue from Japan.

It was a good meeting and the Ministers and secretaries of Health from the 36 member countries of the Western Pacific Region endorsed the resolution for a Regional Strategy of Action in Mental Health.

Thank you for sharing this bid of news from our Region to our colleagues around the world.
Announcements

WAPR Participation in Nepal Meeting.

WAPR is co-sponsoring 8th International Conference of SAARAC Psychiatric Federation’s meeting being held at Lumbini, Nepal 27-29 Nov 2014.

Psychiatrists’ Association of Nepal, host organisation, has chosen this venue because of its high significance in Peace which matches with the theme of the conference “Global Peace: To Nurture a Healthy Mind”.

This will be a major landmark meeting bringing together mental health professionals from the SAARC region with presence of esteemed members of World Association for Psychosocial Rehabilitation from the Asian region.

WAPR will organise a workshop on Psycho-social Rehabilitation at this meeting.

For details please contact Dr. Sandip Subedi Organizing Secretary sandipsubedi@hotmail.com

WAPR 5th Asia Pacific Regional Conference on PSR.

to be held at Bengaluru from 6th to 8th February 2015. www.waprapc2015.org
In this section we offer links important for our field. If you have suggestions for websites and links, please mail the editor:

marit.borg@hbv.no

Convention on the Rights of Persons with Disabilities:

www.un.org/disabilities/default.asp?id=150

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


The WHO Mental Health Gap Action Programme (mhGAP):

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

The WHO Mental health action plan 2013 – 2020:

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

Implementing Recovery through Organisational Change:

www.imroc.org/

Yale Program for Recovery and Community Health:

www.yale.edu/PRCH/
This is a summary and memorandum about the WAPR Project to develop our WAPR activities in Latin America.

In the context of the WAPR efforts in disseminating our philosophy and principles globally, Latin America is a key area. Previously, WAPR presidents (Benedetto Saraceno, Angelo Baratto, and others) have leaded some initiatives there, and a number of relevant WAPR officers have been developing activities in the Region (Roger Montenegro and Ignacio Brusco in Argentina, Ana Pitta and Pedro Gabriel Delgado in Brazil; Rosalba Bueno in Mexico, Alberto Fergusson in Colombia).

Considering that Ricardo Guinea, the next President (and current President Elect) is a latin and Spanish speaking person, it was detected the opportunity for a strategic effort to enhance the interest of Psychosocial Rehabilitation in Latin America, specially in countries where WAPR had no previous presence. In the course of this effort, a number of contacts have been made that offer promising possibilities of future new achievements.

The Project was well received by the latin members of the WAPR Board, and has been developed by Francisco Sardina, WAPR Board Member Representing Families, Alberto Fergusson, WAPR Regional Vice-president for Americas, and Ricardo Guinea, WAPR President Elect, with the invaluable sponsorship of Fundacion Manantial, a Spanish organisation and organisational member of WAPR.
WORLD ASSOCIATION FOR PSYCHOSOCIAL REHABILITATION
ASSOCIATION MONDIALE POUR LA RÉADAPTATION PSYCHOSOCIALE-ASOCIACIÓN MUNDIAL PARA LA REHABILITACIÓN Psicosocial

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2012-2015

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September 08, 2013

Dear colleagues in the Latin American Region:

WAPR (www.wapr.info) is a global NGO that disseminates a corpus of ideas that globally is well-known as “psychosocial rehabilitation” of the mentally ill. We have representation in more that 33 countries all over the world. WAPR has organised 11 world congresses (last in Milano, Italy; Athens Greece; New York, USA; Bangalore, India). WAPR was created only in 1986 and is experiencing a quick growth. Currently WAPR is a NGO in official consultative status in WHO and has work relationships with UN, and many professional organisations (as WPA, WLMH, etc.)

Our President Elect, Ricardo Guinea (Spain), that will take executive office in our congress in Seoul (Korea) in 2015, is very interested in making special efforts as to disseminate our philosophy of attention in America in his period of office. This idea, that is already taking place already in other regions (Asia, Africa) is fully supported by WAPR Executive Committee and Board.

In order to prepare that efforts, some previous and informal contacts have taken place, with the assistance of some senior colleagues that have previous relations in America in different circumstances (e.g. Francisco Torres and the academic “Marist Network”, or Victor Aparicio, former WHO officer in the region). This has allowed us to prepare a list of key contacts in 14 countries. This is why we are approaching you.

We kindly ask your advise about how to use wisely our limited efforts in contributing to the improvement of the situation of the mentally ill different countries of the region, through academic or professional meetings, training, supporting the development civil organisations of carers or users, helping in creating new professional organisations that can be linked in WAPR, etc., as we are already doing in other regions. We will appreciate your advise and collaboration in further and more personal contacts that will be conducted by Ricardo Guinea (our President Elect) and Alberto Fergusson (our regional Vice President).

Thanking you

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WAPR Project Latin America.

The Preparation.
The activities had been prepared since 2013. In early 2013, a meeting took place in Madrid (Spain), between WAPR officers (Ricardo Guinea, Francisco Sardina, Carmen Ferrer) and some senior advisers experienced in international collaboration in Latin America, including Dr. Victor Aparicio (Spain), former PAHO member, Dr. Manuel Gomez-Beneito (Spain), advisor of Spanish Ministry of Health, Dr. Manuel Desviat (Spain), former director of 9th mental health District in Madrid, and Dr. Francisco Torres, for University of Granada.

A plan was agreed including:
• A period of preparation, with contacts with as many representatives and stakeholders in Latin America as possible, in order to prepare the visit of a WAPR Delegation.
• In this period, the special committee for developing WAPR activities in Latin America was created, to include Francisco Torres and Miguel A. Casteleno). It was decided that the plan could include a 15 days visit of the WAPR delegation to four countries.
• The countries were selected for this visit considering those that offered better perspectives to develop a good high level working agenda, including contacts with local policymakers, members of the academy and civil society, including users and family member organisations.

The countries selected for the visit were Mexico, Peru, Brazil and Uruguay.

Coordination with WAPR
In October 2013 it was create an “ad hoc committee” for the development of WAPR activities in America, chaired by Afzal Javed, CoChair Ricardo Guinea, with Francisco Sardina, Alberto Fergusson, Carmen Ferrer, Francisco Torres and all american Boardmembers. It was agreed a plan on the flowing bases.
• We will go in official WAPR trip to America (under Foundation Manantial’s sponsorship). We will choose as countries to visit those that have shown interest in WAPR and where we still do not have a structure. The aim will be to make new contacts and establish new branches. This strategy will allow us to strengthen and contact some small groups that are very interested in WAPR and need our support.
• We acknowledge the great work made previously in Chile. We think they are organising their group. We express our support and interest in that group, and agree to advise our colleagues in Chile to keep on building their organisation and when they are ready, to gather WAPR and consider organise a international conference, possibly in 2015. That conference will be offered to be held under the WAPR framework, if our colleagues agree.
• We advise our colleagues there in Argentina and Brazil to consider organising a Regional WAPR meeting in 2016.
• We acknowledge the network “Red Maristan” as an academic partner in the region. We agreed with Francisco Torres to make a memorandum of interest between WAPR and “Red Maristan”, in order to have common understanding for future collaboration.
Mexico.

Xochimilco University, Mexico DC.; D. Francisco Sardina, Prof. Lidia Fernandez, Dr. Alberto Fergusson, Prof. Anel Garcia, Dr Ricardo Guinea.

Mexico DF; May, 2nd.

WAPR activities in Mexico were dealt in Mexico DF, in coordination with Dr Anel Garcia, the Chair of the Mexican Branch, in collaboration with Xochimilco University, (Dep, of Education and Extension), and Drs. Anel Garcia, Lidia Fernández, María Eugenia Ruiz Velasco, Aura Sylvia Valdés Vega, former Mexican WAPR Readers and representatives.

Activity in Xochimilco University. Mexico DC. (May 2nd). The one day meeting included presentation of Dr Alberto Fergusson (The perspective of Psychosocial Rehabilitation in the history an culture of Latin America), Francisco Sardina (The experience of “Fundación Manantial”) and Dr. Ricardo Guinea (Psychosocial Rehabilitation, the Core Concepts).

A number of professional presented their perspective and experience in different aspects of PSR: Sara Makowski the “Radio Abierta” project; Patricia Robles the “Antares” project, Rosa Diaz presented “Instituto Nacional de Psiquiatría “ and Ángel Hernández the “Casa de Medio Camino”. Representatives of Colectivo Chuhcan, a users movement with advocacy activities in the field of Human Rights from Mexico DC were also invited.

On may 3rd, Ricardo Guinea called for special meeting under the presidency of Dr. Anel Garcia, Chair of the WAPR Mexican Branch, and Ricardo Guinea, WAPR President Elect. The meeting was honoured by the presence of Rosalba Bueno and Aura Sylvia Valdés Vega, who were pioneers of Psychosocial Rehab. in Mexico.

In the meeting, a conversation about the state of the art and new possibilities of the Mexican Branch was dealt and a number of new en enthusiastic member joined the branch.

The Mexican Branch renewed its board, and as a final act, the following statement was proclaimed.

D. Francisco Sardina; Prof. Anel Garcia, Dr. Ricardo Guinea, Dr. Alberto Fergusson, Mexico DC.
MEXICO DECLARATION

We, the members of the Mexican Chapter of WAPR, together with the special delegation of WAPR for Latin America (Ricardo Guinea, Alberto Fergusson, Francisco Sardina), participants of the Conference "Psychosocial Rehabilitation and new strategies of care for people with mental illness", adherents and sympathizers:

Reaffirm our adherence to the fundamental principles of WAPR expressed in the Consensus Declaration WAPR-WHO.
Renew our commitment to strengthen actions to improve the social, institutional, and health conditions of people with mental illness, their families and support networks.

Call on professionals, users and carers in Mexico, individually or through their organizations, to join forces with the Mexican Chapter to develop proposals and take action to improve the social and institutional framework for users, relatives and professionals.


Meeting of the Mexican Branch, and proclamation of the Mexico Declaration.
Lima, May, 4th-6th.

The visit to Peru was prepared with the assistance of Dr. Francisco Torres, and Dra. Maria Edith Baca, (member of PAHO). The result was a very complete agenda including visits to main Psychiatric Hospitals in the Lima, contacts with the Mental Health Department of the Ministry of Health in Peru, and Dr Yuri Cutipé, the Director of the Ministerial Department of Mental Health.

The activities began with visits to different hospitals in Lima: Hermilio Valdizán Hospital and Instituto Nacional de Salud Mental Honorio Delgado - Hideyo Noguchi.

In the visit, a very productive open talk with the professionals of the different services was maintained. The delegation expressed their appreciation for the effort of the local organisers.

Dr. Yuri Cutipe kindly offered an informal conversation to exchange information about

the current situation in Peru and the recent possibilities of improvement of in budget and priority of Psychosocial Rehabilitation the country.

Meeting with colleagues in Honorio Delgado - Hideyo Noguchi Hospital, Lima, Peru.
On May 6th, Meeting in HOSPITAL VICTOR LARCO HERRERA with professionals from different hospitals of Lima (Hospital Hermilio Valdizán, Instituto Nacional de Salud Mental “Honorio Delgado – Hideyo Noguchi” and Hospital Víctor Larco Herrera; representatives from psychosocial rehabilitation services and representatives of Carers and Family Members Associations, Francisco Sardina, Alberto Fergusson and Ricardo Guinea offered presentation about the state of the art of Psychosocial Rehabilitation globally and the possibilities of innovation and actualization in Peru, followed by a very good discussion about the current situation in Peru and the possibilities of implementing reforms:

ON may 7th, a conference was held in the Hall of the Ministry of Health, under the presidency of Dr Yuri Cutipé, Director of the Mental Health Department of the Ministry.

In the evening, a meeting in the Medical College with relevant stakeholders of the medical community of Lima took place, and again a very fruitful exchange took place.

A meeting was held to explore the possibilities of creating a WAPR branch in Peru. Dr Cutipé was committed to explore the situation and to report if it was possible.
Meeting with colleagues in Larco Herrera Hospital, in Lima, Peru.

After the plenary Session in the Health Ministry in Lima, Peru; Dr Yuri Cutipé, D F Sardina, A Fergusson, R Guinea and Dr. Manuel Escalante.

Dr Ricardo Guinea and D Francisco Sardina, Instituto Nacional de Salud Mental “Honorio Delgado - Hideyo Noguchi”.
Brazil.

Rio de Janeiro; May, 8th-9th.

The meeting in Brazil was a very good opportunity for a reencounter with the colleagues of the Brazilian branch, under the Leadership of Pedro Godinho Delgado and Ana Pitta. There was a two days meeting with delegates form different parts of Brazil and participation of carers and service users, and more than 70 participants. On May 9th, there was the meeting “Seminário Internacional de Reabilitação Psicossocial, Experiências brasileiras”, in Centro de Estudos do Instituto de Psiquiatria da UFRJ- Campus da Praia Vermelha, Casa da Ciência da UFRJ.

The WAPR delegation was kindly invited to visit a CAPS (Centre for Psycho Social Attention).

The opening conference about Reabilitação Psicossocial no Brasil was made by Ana Pitta, President do Capítulo Brasil da WAPR, followed by a round table about “Atenção psicossocial, autonomia, restabelecimento (recovery)”, under the coordination of Octávio Serpa (IPUB – UFRJ), Eduardo Vasconcellos (Escola de Serviço Social – UFRJ) and Pedro Gabriel Delgado (WAPR e UFRJ). Other topics were “Saúde mental e “medicina tradicional”: relato de observação transcultural em Moçambique e Guiné Bissau (by Nei Marinho – Rio de Janeiro, RJ (ASMELP); “Residências terapêuticas em São Paulo – 20 anos de experiência” (Mirsa Delosi – São Paulo, SP, Coordenação: Domingos Sávio do Nascimento Alves – Rio de Janeiro, RJ), “Meditação Mindfulness – a experiência do IPUB, (Ireneide Castro de Oliveira, IPUB/UFRJ), Saúde Mental e Economia Solidária: A experiência d’O Bar Bibitantã (Ana Luiza Aranha – Escola de Enfermagem – USP e Rede de Saúde Mental e Economia Solidária de São Paulo, an Neli de Almeida (Projeto Efeito de Papel e IFET – Campus Realengo). The second day started with the round table “Pacientes
The team of the CAPsi for children.

The team of the CAPsi for children.

Pedro Gabriel Delgado, Ricardo Guinea, Ana Pitta and members of the WAPR Brazilian Branch.

Brazil.

Madri, Espanha - Representante dos familiares junto à WAPR, followed by a round table with Ana Pitta – Presidente do Capítulo Brasil da WAPR, Maria Tavares Cavalcanti – Diretora do IPUB/UFRJ, Pedro Gabriel Delgado – Vice-Presidente Regional WAPR. The next activity was a conversation with carers and family members, with participation of the Group “Familiares Parceiros do Cuidado – Rio de Janeiro”. There was the presentation of the film “Familiares Parceiros do Cuidado”, before the final discussion.

This was also an opportunity to for a meeting of the Brazilian Branch, the renewal of the board with incorporation of new members. The programme included plenty of experiences and perspectives.
Montevideo; May, 12th-14th.

The agenda in Montevideo, Uruguay was prepared with the assistance of Miguel Angel Castejon (Fundacion Manantial, Spain) and Denisse Dogmanas, Gabriela Novoa, Claudia Ceroni, Horacio Porciuncula, and a number of colleagues from Uruguay, and received the official support of ASSE (Administracion de los Servicios Sanitarios del Estado, de Uruguay).

The agenda included a number of friendly informal meetings between the WAPR Delegation and colleagues from Uruguay, and a very stimulating official Agenda in the Hall of the Ministry of Public Health in Montevideo.

On May 12th there was an opening ceremony, with the conference “Current trends in Psychosocial Rehabilitation” by Dr. Ariel Montalbán, Responsible of the Mental Health Programme in Uruguay, followed by presentation by Dr. Ricardo Guinea, Dr. Alberto Fergusson, and D. Francisco Sardina, and open discussion.

In this session, Ofelia Stajano de Caldeyro received a Lifetime Achievement Award for her untiring efforts as the leader of the family movement in Uruguay.

In the afternoon there was a meeting with representatives of Carers and family member organisations.

The next day there was a meeting with an only point in the agenda: the creation of the Uruguay WAPR Branch. Dr. Ariel Montalbal was committed to

Ministry of Public Health, Ofelia Stajano de Caldeyro receives a Lifetime Achievement Award for her untiring efforts as the leader of the family movement in Uruguay.
Uruguay

conduct the procedure towards the creation of the new Branch.

The agenda ended with a visit to the “Centro Nacional de Rehabilitación Psíquica: Centro Martínez Visca”.

Centro de Rehabilitacion Martinez Visca.

Meeting with representatives of carers and family members.

D. Francisco Sardina, Dr. Ariel Montalbán, Dr. Ricardo Guinea, in the preparatory meeting for the creation of the WAPR Uruguayan Branch.

With a group of users in Centro Martínez Visca.

Thanks to D. Francisco Sardina, President of the Board of Fundacion Manantial, thanks to all the Board of Trustees of the Foundation and to Miguel Angel Castejon, Director de Recursos, for their invaluable collaboration and sponsorship to make this project possible.

No conflict of interest was derived from this sponsorship.
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**MORE INFO IN [WWW.WAPR.INFO](http://WWW.WAPR.INFO)**
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Members:
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- 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)

#### Nomination committee
Co-Chair: Ricardo Guinea (President Elect)
Members:
- T Murali (Secretary General)
- Lourdes Ladrido-Ignacio (Immediate past president)
- Alberto Ferguson
- Ida Kosza
- Anne Grethe Klunderud

#### Membership committee
Co-Chair: Germana Agnetti
Members
- Ricardo Guinea (President Elect)
- T Murali (Secretary General)
- Shahid Quraishi (Finance Secretary)

#### Publication committee
Co-Chair: Marit Borg (Deputy Secretary General)
Members
- Ricardo Guinea
- T Murali
- Tae-Yeon Hwang

#### Constitution committee
Co-Chair: Solomon Rataemane
Members
- Pichet Udomratn
- Zeb Taintor
- Antonio Maone
- Pedro Gabriel Godinho Delgado

#### Ethics & Review committee
Co-Chair: Lourdes Ladrido-Ignacio
Members
- Ricardo Guinea
- T Murali
- Gabriele Rocca
- Alberto Ferguson
- Oliver Wilson

### WAPR TASK FORCES
- **Task Force on Users & Carers involvement in Treatment and Rehabilitation Planning**
  
  Chair: Helen Herman
  Anne Grethe Klunderud

- **Task Force on Ethics & Human Rights for persons experiencing mental illness**

  Michaela Amering

- **Task Force on Curriculum & Training—particularly focusing on recovery**

  Chair: Mathew Varghese
  Henrik Wahlberg
  Marianne Farkas

- **Task Force on issues relating to Professionals’ Burnt Out**

  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)