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### WAPR Bulletin.
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Welcome to the new term of WAPR. The very successful World Congress in Seoul, (South Korea), and all the meetings and procedures, including the General Assembly, marked the turning point to a new Board, and a new term.

Afzal Javed, the outgoing President, presented on behalf the outgoing board an impressive report of activity in the last term, and showed how WAPR is a growing and becoming a more influential organisation. I think I summarise the general felling expressing my personal appreciation for the hard work of the outgoing team, which set a milestone for the beginning of the new term.

Now it is the time for a new effort that will reach its zenith in the next congress, to be celebrated in Madrid, Spain, 5-7 July, 2018.

WAPR will keep on being a global NGO, committed with all the people in the world that suffers from mental illness. That means an overwhelming task, which we have to try to afford with our limited resources.

In order to make the task more affordable, in my proposal of a general policy to the board in the first Board Meeting –Nov. 2015, Seoul-, I suggested to work in three main key ideas: accessibility to care, quality of care and fighting stigma.

Accessibility.

Data and experience show consistently that a great many of the mentally ill do not have access to care. This is a fact for LAMICs and also for developed countries. Globally speaking, independent agencies as WHO, with which we have a working alliance, state that many patients do nor receive the minimum aid or support they need to overcome their mental condition. “In low-and middle-income countries, between 76% and 85% of people with mental disorders receive no treatment for their disorder. In high-income countries, between 35% and 50% of people with mental disorders are in the same situation”. (1)

Increase accessibility to care is clearly a mayor task for the next years that should be shared by all parties involved in Psychosocial Rehabilitation: governments and health systems, policymakers, professionals, and the community in general. We, as WAPR, encourage our national branches to be work close with the national policymakers in order to increase awareness on this problem, and whenever possible, to engage in policies that can improve the level of resources.

Quality.

Quality is also a big challenge. There is public evidence, again disseminated by global agencies, that note that it is common that the available resources for mental health are not well used. “Levels of public expenditures on mental health are very low in low and middle-income countries (less than US$ 2 per capita). A large proportion of these funds go to inpatient care, especially mental hospitals; (2)

This means that it is likely that the only available attention, when received, will be delivered within the mental hospital, and the needed continuity of care after the attention in the hospital will be absent. This unfortunate situation leads to the well known “revolting door” phenomena, in which many patients are admitted
once and again due to the lack of an appropriate follow up in the community, where the resources are scarce.

Human Rights have been proposed to be a tool to monitor the quality of attention. It is a well known fact that psychiatry is a field where some practices are often in conflict with civil and human rights, and that “...paradoxically some of the worst HHRR invasions have happened in psychiatric facilities”. (3) In order to tackle this problem, a number of strategies should be considered: the corpus of laws on mental health should be revised and adapted to the current prescription of UN on this field, in particular, the UN Convention on the Rights of Persons with Disabilities (2006). There is a toolkit prepared by WHO that can also be useful for this purpose. (4)

Respect to HHRRs should be a basic concern in any approach to quality in Psychosocial Rehabilitation, but quality goes beyond this basic considerations. Currently, the “Recovery perspective” is providing a model of understanding how the process of recovery does happen, and which are the factors that can help or hinder in the process. We now know that the recovery process is a very unique and personal process, that challenges the approach to care in the traditional paternalistic role from the medical staff. Quality of attention in the Recovery Perspective requires a good level of working alliance with the user as well as his or hers involvement in the decision making process, the full consideration of the mentally ill user as a citizen in equal rights with all the rest, some organisational commitment on the values of community approach to treatment, and a steady support lasting all time necessary.

It should be noted that the recovery approach to mental illness may represent a deep revision of past consensus on many features of the process. The importance of the community approach versus the institutional strategy, a new way to consider the share of responsibility in the treatment, from a paternalistic approach to a partnership style model, the shift from treatment and symptom control to support in everyday living, changes in the philosophy risk assessment, etc. Many authors characterise this change as a true paradigm shift and probably so it is.

**Stigma**

The third proposed target for our activities is stigma. Stigma is a well known disadvantage for the mentally, who in addition to their own problems have to deal with a number of false assumptions from the community. Despite research and experience show consistently that the main risk associated to some mental condition is an increased risk of receiving an unfair treat due to a number of prejudices and stereotypes, stigma remains a problem in different domains. In social relationships, it represents an increased risk for unemployment, loneliness and social isolation. In terms of self-image and self-esteem, it represents a subjective disaster, including the feelings of shame, blame, hopelessness, and many times, the reluctance to seek for the necessary help or support.

Many actions have been taken to tackle this problem: the dissemination of good information, the dissemination of living experiences of successful recovery individuals from mental illness, including a number of celebrities; public actions as protests and demonstrations; the increased number of correct presentations of people with mental illness in the media, films and artistic representations, the incorporation of expert users in the training of staff, conferences, assessment of services and political meetings.

**Our Agenda.**

In this panorama, WAPR, after 30 years since its creation in 1996, has become a significant global NGO, with many representatives and branches disseminated in all the 6 continents. The latest issues of this Bulletin show an impressive amount on meetings and conferences, where our fundamentals are elaborated and transmitted.

In this term, we face a very interesting challenge. Among the usual commitments, in Seoul we have finalised the preparations for the WAPR Collaborating Centres for Research and Training
(WAPR-CCRT). Now we have a consensual document with the criteria for appliance and a procedure of admission so hopefully we will have in this term a number of collaborative centres (More details the organisational section in this issue.

Another novelty is that we have now a new standing Editorial Committee, chaired by Marit Borg (Norway).

As usual, we have a busy agenda of meetings. Some of them have already taken place in Torino (Italy), El Cairo (Egypt), Abu Dhaby (UAE), Johor Baru (Malaysia), and some will take place in the next months: in Chennai (Tayland), Colombo (Srilanka), Cape Town (South Africa), Bogota (Colombia), Lima (Peru), Quito (Ecuador).

Moreover the already mentioned Special Taskforce for WAPR-CCRT, we expect to have a number of active Committees: (Human Rights – Michaela Amering, Austria-, Training and Good Practices –Marianne Farkas, USA- , Forensic Issues – Gabriele Rocca, Italy-, Recovery from situation of Special Trauma – Alberto Ferguson, Colombia and Khalid Mufti, Pakistan-, Physical Health in Psychiatric Hospitals – Gabriele Roca, Italy- and Early Attention – Ricardo Guinea, Spain. A true panel of specialists that will surely provide good insights and proposals in their respective fields, that will also provide good material for discussion in the next World Congress, to be held in Madrid, Spain, in the Spring of 2018.

Finances will require some consideration in this term. We will have to be aware that the current way of funding our activities will not be sustainable in the next terms, and new ways for fund-rising need to be explored. So, along with Thylot Murali, the President Elect and Carmen Ferrer, our Treasure, I have launched the idea of creating a Fund Rising Committee to explore new ways of funding our activities.

So, we have a exciting number of challenges to achieve in the next term. I’m sure that with the enthusiastic support of the new Board we will be able to continue our activities for the sake of the all the mentally ill in the world.

Ricardo Guinea. WAPR President. Madrid, April, 2018.

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We are well into the New Year 2016 and a lot of activities are flourishing in our organisation. The World Association for Psychosocial Rehabilitation (WAPR) is celebrating 30 years anniversary this year. WAPR was established in 1986 in France. The growth of WAPR during the years has reflected the increasing importance of preventing psychosocial problems and promoting recovery-orientation of services, community inclusion and citizenship. Human rights work, anti-stigma programs, community mental health development and empowerment have been prioritized agendas and activities. Today, WAPR is recognized as a non-governmental organisation with consultative status with the WHO, the United Nations (UN) Economic and Social Council, and the International Labour Office. Moreover, it also maintains relations with the European Commission and the African Rehabilitation Institute.

WAPR has also a leading role in promoting psychiatric reforms and improvements in collaboration with local leaders in different regions, as Latin America, Africa or or the Balkans area.

We are happy to share this year’s first edition of the **WAPR Bulletin** with you. We are also proud to present our new editorial committee representing comprehensive experiences within psychosocial rehabilitation and recovery from various parts of the world.

**Barbara Davanzo** is a researcher and leads the laboratory of Epidemiology and Social Psychiatry at the IRCCS Istituto di Ricerche Farmacologiche Mario Negri, in Milan, Italy. She is the national secretary of the Italian WAPR Branch.

**Michaela Amering** is a Professor of Psychiatry at the Medical University of Vienna. She has engagement in international organisations such as WPA, EPA, WASP and WAPR, where she co-chairs a Task Force on Ethics and Human Rights.

**Peter Yaro** has a degree in Sociology and two masters degrees, one in Adult Education and an International Master in Mental Health Policy and Services. He is working with BasicNeeds (www.basicneeds.org / www.basicneedsghana.org) in Ghana.

**Pedro G. Delgado** is professor in psychiatry and works at the Instituto de Psiquiatria Universidade Federal do Rio de Janeiro, Brazil. and WAPR Regional VicePresident for the Americas.

Three of us from the previous editorial committee continues.

**Tae Yeon Hwang**, professor in psychiatry and the director of WHO Collaborating Center for Psychosocial Rehabilitation and community mental health as well as the director general of Yongin Mental Hospital. He is also special delegate for liaison with Un and its agencies.

**Ricardo Guinea** is the current WAPR Executive President, Chair of the WAPR-WHO Committee for Action Advocates and has been advisor in many actions in Spain and at international level.

**Marit Borg**, professor in mental health care at the Centre for Mental Health and Substance Abuse, University College of Southeast Norway, and editor of the WAPR Bulletin. She is also active in the Norwegian Branch.
Mental Health: pending task in Central America.

Mental Health and Psychosocial Rehabilitation challenges in Centre America.
Some reflections after the Central America and the Caribbean Congress, Managua May 20, 2015.

Dr. Luis E. Aleman Neyra

In April 29-May; 2015, it was held in Managua, Nicaragua, the XXIX ACCAP Congress (Central American and Caribbean Association of Psychiatry), with delegations from countries of ACCAP, and the recent integration of Caribbean countries as Dominican Republic and Puerto Rico.

This event was organized by the Nicaraguan Association of Psychiatry, with the presence of the President of WPA Dr. Dinesh Bhugra (UK), Dr. Pedro Ruiz, former President WPA and Dr Edgar Belfort (Venezuela), Secretary of Education of the WPA. ACCAP is a trade organization with an important role in scientific development in the region, and inherited a tradition of psychiatric associations and work of the psychiatric field; with 26 consecutive annual sessions, since the first one in Managua in 1988, with the rise of the Sandinista Revolution and the advances in mental health in the country, a group of psychiatrists with the outstanding participation of the last Dr. Mario Flores Ortiz and Dr. Roberto Aguilar Briceno, who took the task of revitalizing the partnership in psychiatry within Central America and Panama (APCAP), which was subsequently renamed as ACAP, given Panama is inherent in the region, and now ACCAP with the integration of the Caribbean.

I emphasize the role of the Associations of Psychiatry and conferences, because within these scientific meetings important declarations have emerged and have been the scene of momentous debates about the role that we psychiatrists should have in the social development of our nations. In them, the development of psychiatry and humanization of care for the mentally ill person has been advocated, with topics such as peace and society, disasters, crisis, globalization, quality of life, integration, deleting stigma, humanism, work together and together; all these topics have the name prefix HEALTH MENTAL as a clear commitment to developing the capacities and potentialities of human beings, not focused on their pathologies or biologic approaches; and the slogan adopted in Nicaragua that “mental health is a pending task” calls for reflection on the current state of the reform of psychiatric services in this region, mainly in Nicaragua.

I use the term “people with psychosocial disabilities”, (PCDPs), to refer to those people with severe mental illness or disorder, including those whose condition is associated with intellectual deficits and neuro psychiatric problems that lead to serious situation of disability, ie, facing significant barriers that prevent their social inclusion; this term is promoted by the international organization CBM (Christian Blind Mission).

It was my responsibility in this conference to organize and coordinate the International Symposium "Experiences of Community Psychiatry and Psychosocial Rehabilitation", with the active
and relevant participation of the lecturers Dr. Guillem Homet (Spain), Marcia Basaco (Cuba), Georgina Fumero (Costa Rica), William Mayorga (Nicaragua), Gabriela Lopez (Spain), Rosalba Guardian, Roberto Soza and myself Luis Alemán (Nicaragua), sponsored by the World Association for Psychosocial Rehabilitation (WARP). This symposium had the purpose of reflecting on the everyday reality of Mental Health and Psychosocial Rehabilitation in our region, on the theoretical frameworks that guide these processes, on the different implementation models, and to disseminate various experiences in practice than illustrate the effort made in middle- and low-income countries to implement the Utopia of the psychiatric reform. This effort made during the event and in previous days it gives rise to this writing.

The relevant issues to be discussed are: the global framework of principles in which Psychiatric reform is developed in the region, an analysis of the status of Mental Health issues Human Rights, the organization of services, coverage, accessibility, public administration, etc., and experiences and practices developed mainly in Nicaragua.

Global Framework of Principles for the psychiatric reform in our region.
In the Ottawa Charter for Health Promotion (WHO, 1986), different strategies are indicated, based on five areas of action that would contribute to achieving “health for all” in 2000, to be said, the establishment of healthy public policies; creation of environments that support health; strengthen community action for health; develop personal skills, and reorienting health services. The principles of the Ottawa Charter partly led to reflect on the reform of care services for people with psychosocial disabilities in the Americas.

The psychiatric reform in America takes the principles highlighted in the Declaration of Caracas (1990) and then in Brasilia (2015) where the role of Protection of Human Rights of persons with psychosocial disabilities is relevant (PCDPs), and it is proposed: to create alternative services to the Psychiatric Hospital to ensure a comprehensive, multidisciplinary and close care to populations, promotion and prevention of Mental Health, establishing strong links with primary care services where PCDPs should receive the attention, participation of users and relatives caregivers in mental health actions in consultation with various stakeholders in order to improve the mental health condition of populations, and finally calls countries to have legislation, plans, programs and strategies that benefit this important sector of the population. Such principles in our daily life are scarce and invisible.

So also we find recommendations to different countries of OPS area to: strengthen plans, programs and policies in mental health; improve
funding of mental health programs, diversification of services in relation to psychiatric hospitals; restructure psychiatric hospitals; foster hospitalization in general hospitals; increase training for workers in primary health care; develop specialized resources; support user organizations; enhance systems of information and advocate in protection of human rights. These recommendations were driven by PAHO since 2009 and have had little impact in the region due to its implementation has been extremely heterogeneous.

Although there is a PAHO regional strategy (2010-2019) for Mental Health, which greatly strengthens the efforts of the last 30 years, in most countries in our region this strategy is little known and widespread, it has not been included in the nationals plans of the region. The strategy promotes, within its lines of action, the need to formulate and implement plans, programs, policies and national mental health laws; the promotion of mental health and prevention of mental disorders primarily in children; providing services in primary care; strengthening resources and human resources to provide services, evaluate them and use the acquired information.

The strategy recommends 10 key points: national mental health plan; national legislation; financing; national coordination mechanism; Specific activities for the promotion and prevention; service organization; interventions focused on priority problems; training; evaluate and systematize information. (1).

This framework of mentioned principles, forms a suitable platform to advance effectively in the reform of psychiatric care and improve care for people mentally ill, but not all countries have attempted to develop them and, up to date, results have not been the expected.

Dr. Guillem Homet (Region of Maresme, Spain), in his presentation entitled "Promotion of Mental Health and Prevention of Mental Disorder, a utopia in countries low- and middle-income" related to one of the lines of action of the regional mental health strategy, stressed that mental health is determined by multiple factors, biological, psychological, social and environmental, that interact in complex ways (Mrazek and Haggerty, 1994). Described that promotion of mental health is a process that tends to enable the individuals and communities to take control over their lives and improve their mental health, strengthening individual capacities and coping skills, self-esteem and family and community support, and change broad environmental factors that influence mental health, i.e., increasing control over determinants of mental health. It is aimed to general population, risk population and people with mental illness throughout his life.

Meanwhile, the prevention of mental disorder is focused on reducing risk factors and in strengthening protective factors associated with mental health determinants, with the aim of reducing risk, incidence, prevalence and recurrence of a mental disorder, the duration of the disease, decreasing the severity and impact of the disease on individuals, families and society. It is addressed to general population and specific population groups, but their goal is a specific mental disorder.

The difference between promotion and prevention is that the first aims to promote health increasing positive mental psychological well-being, competence and resilience and creating appropriate living and environmental conditions. The second aims to reduce symptoms and ultimately mental disorders. Evidence shows that the approach to mental health must be comprehensive, articulating different actions and avoiding competition among them, and that recovery is the common goal (BC Health Authorities, 2009). (13).

Dra. Georgina Fumero, who participated on behalf of the World Association World Association for Psychosocial Rehabilitation (WARP) presented the model of psychosocial rehabilitation and processes map from primary care, hospital, healthcare resources psychosocial rehabilitation from the clinical experience models developed in Spain, Denmark, Belgium, England and Holland, and tested intervention models that showed scientific evidence of the validity of psychosocial rehabilitation principles.

The major burden of mental illness in the world.

Mental disorders are highly prevalent and contribute to morbidity and mortality premature. Dr. Homet in his speech pointed out that mental health problems are present in all countries, regions, societies, cultures, men and women. Mental disorders may affect more than 25% of the population (1 in 4) anytime at some moments of life, and affect 10% of the adult population and up 15% in children (WHO 2001).

This means that 450 million people a year are affected by mental disorders, from which 160 million are diagnosed with depression, 25 million
with schizophrenia, 90 substance dependence and a million suicides per year (63,000 correspond to the Americas). The treatment gap in low- and middle-income is higher than 75%, aggravated by stigma, social exclusion and violation of human rights (PAHO, 2009).

Approximately 20% of patients attended in primary health care have one or more mental disorders, and there is a correlation between mental disorder and development of certain physical diseases (WHO 2009).

By the year 1990, mental illnesses accounted for 11% of DALYs considering all illnesses and 28% of all years lived with disability; it is estimated that by 2015 the burden of mental illness will be 13% and in 2020, 15% between all chronic diseases reaching 30%. Most of this increase will be in low- and middle income countries, with a consequent greater impact (WHO 2001).

The situation of mental health in the region, marked by the deterioration of Human Rights of people with psychosocial disabilities.

An example on the situation of Human Rights and Persons with Psychosocial Disabilities in our region is the fact that the Inter-American Commission on Human Rights (IACHR) issued precautionary measures for Federico Mora Psychiatric Hospital in Guatemala City since 2012, and last December (2014) the High UN Commissioner for Human Rights in the country called again to guarantee and protect the human rights of patients after new allegations of abuse, and urged to investigate, punish and initiate administrative proceedings against those responsible for Human Rights violations in the psychiatric facility, the latter in response to an investigation by the BBC entitled "Rape and torture; hell in the worst American Psychiatric Hospital", which highlights the inhumane conditions, in which patients seem to be in a concentration camp rather than in a mental institution. (11)

The National Psychiatric Hospital "Dr. Jose Molina Martinez" in El Salvador, is presented by the digital newspaper “Counterpoint” as "a day in hell", beside its custodial characteristics assumed by all staff and that operates as closed to the public; the entrances to the different rooms are behind closed doors, even during the day, regular use of chains and padlocks, public baths for patients, where users remain naked on the floor, beds without mattresses, many in condition for discharge but without support from their families and without institutional capacity to relocate in their homes (8).

The situation of psychiatric hospitals in the rest of Central America is similar to which has been...
known in Guatemala and El Salvador; to the violation of Human Rights, institutions it can be added that are institutions with poor accessibility and affordability for most of the population, especially for those living in the Caribbean coast because they have been built in big cities; their occupancy rate is under 90%, in recent years facilities for people with addictions, attention to child and youth ages and geriatric people have been implemented; communication difficulties with their families are frequent.

These hospitals face as a critical situation the need to provide treatment to offenders in special wards, whose occupancy is often higher that 281% (118 inmates in 40 beds, El Salvador), attended by armed guards within the psychiatric wards, aggravated by the presence of gangs inside the institutions, with indiscriminate use of physical restriction without any use of protocols(9).

The prevalence of mental health problems in the region.

Mental health situation in our region is complex and has been affected historically by a series of social, political and environmental events. Our history is linked to traumatic events such as natural disasters and armed conflicts.; these events have deepened poverty which impacts on vulnerable populations as the children, the elderly and ethnic populations, in which the problem has increased psychosocial morbidity and mental disorders. (6).

In our region the prevalence of any mental illness ranges from 12.7% to 15%; the gap to attention is bigger in children and adolescents than in adults.

This bio-psycho-social context determines that interventions should be psychosocial and not only based care in prescribing psychotropics drugs; problems like suicide with an adjusted mortality of 7.4 per 100 000 inhabitants; alcohol abuse scores an average adult prevalence of 5.7 per year; abuse of illegal psychoactive substances, mainly marijuana and crack, that starts at an early age of 12 to 13 years of age, domestic violence indicators of prevalence between 14% and 52% in women 15-49 years; high rates of homicides and femicides, sexual abuse; child abuse; gangs are psychosocial issues that have the greatest impact on the mental health of our populations and contribute to the morbidity of mental disorders.

Depression is a common disorder, the average prevalence throughout life is 13.9%, most without access to treatment.

Suicide Nicaragua is estimated at a rate of 14.6 / 100,000 inhabitants, well above the averaged over the region; despite these references, forensic institutes in Nicaragua officially reported at 148 in 2012 and 501 in El Salvador in 2011; other frequent problems in the country are, anxiety disorders and substance abuse of illegal psychotropic among others. In Nicaragua there is a lack of official information about main statistics of mental disorders and psychosocial problems such as suicide. Alcoholism is a particular problem where measures for health promotion and prevention of diseases linked to alcohol consumption are non-existent, consumption is associated with homicides, drownings, traffic accidents and injuries in general; PAHO study points out that the annual consumption of per-capita pure alcohol is 7.5 liters in Guatemala, Costa Rica 5.8 and 5.2 in Nicaragua, (study performed in population over 15 years old).

In El Salvador, a study shows that 84.8% of the population suffers from nervousness and this unsecurity, more common in women and people living in urban areas (UTEC, 2011).

Lack of public investment for the development of research in the region mental health issues is common; the media addresses the issue of mental health in a sensationalist way, in red and stigmatizing news, which contributes to the low perception of the risk of mental illness and the consequent increase in risk behaviours. Only 0.18% of published papers were devoted to mental health in last years.

The lack of attention of states and policy makers to mental health in the region: "only one sick society abandon their sick "...

Nicaragua is one of the few countries in the region that does not have a plan, program or national mental health policy. In combination with this, there is no national benchmark to make minimal efforts at the central level of the ministry of health, does not have a national coordination, all which leads to the absence regional invitations to national leaders to address issues related to Mental
Health. In other countries in the region, although some have regarding policies, programs and plans, its implementation is very low.

In Central America attention is focused in the 9 psychiatric hospitals: El Salvador (2) Honduras (2), Guatemala (2), Costa Rica (2), Nicaragua (1). In all countries there is at least a psychiatric hospital, built in the region in the late eighteenth and early XIX centuries. When built, they were located far from the cities, but with the growth of populations and extension of the cities, now they are inside urban areas. Some of them have been relocated or rebuilt, located in areas of the Pacific coast. The initiatives taken for the decentralization and de-concentration have been discontinued, increasing gaps for mental health care to 100% in some areas of the countries of the region.

In El Salvador, a process of decentralization of the Mental Health has begun, with the creation of 7 units of psychological and psychiatric care in general hospitals.

Generally, about 1% or less of the budget of the Ministries of Health Nicaragua and Dominican are allocated to mental health programs. Other countries are between 1 and 2%; Costa Rica (2.9%), Honduras (1.6%), Guatemala (1.4%), El Salvador (1.1%). The biggest part of this budget is directed to psychiatric hospitals (over 90% in El Salvador, Guatemala, Honduras and Nicaragua), where stockouts of medicines are frequent; this situation is different in countries of Panama and Belize where 56% and 7% are assigned to community services.

Psychiatric beds per 10,000 inhabitants corresponding to 2.3 Costa Rica, El Salvador 0.1 (426 beds), 0.3 Guatemala (336 beds), 0.5 Honduras; Nicaragua has 168 beds psychiatric. The main diagnoses are disorders associated with alcohol and drug use, affective disorders and schizophrenia; psychiatric units in general hospitals are underdeveloped, also institutions engaged in psychosocial rehabilitation.

Mental health services located in primary care have not been strengthened or expanded in the last decade, El Salvador (49), Guatemala (32), Nicaragua (34); Only Belize, Costa Rica, El Salvador and Guatemala have protocols of attention for problems of mental health in primary care; although PAHO has promoted the program mhGAP and the use of primary care to reduce the care gap in the gateway to the health system, most workers do not have the tools necessary for a proper assessment, diagnosis and treatment of very frequent problems in the population. (5.7, 9, 10).

Human resources are insufficient to meet the demands of a dynamic society consisting mostly of women and youth. Regarding psychiatrists, there are 0.6 for 100.00 people in Guatemala, 0.8 in Honduras, 0.9 Nicaragua, 3.06 in Costa Rica and 1.4 in El Salvador; between 14.5% and 48% are located in psychiatric institutions (Guatemala 47.9%, El Salvador 16%, 10% Nicaragua, Honduras and Costa Rica 45.7% 19.2%).

In Nicaragua the formation of Psychiatrists has been discontinued in the last two years after 30 uninterrupted years of teaching without an explanation of the reasons that led to health authorities to make this decision.

The assessment of the AIMS-OPS (Assessment Instrument for Mental Health) concluded that: in the region an institutional system based care psychiatric hospitals prevails, centralized in the Pacific and in large cities; the size of the care gap is greater in rural areas and the Caribbean; the assessment emphasizes the need to develop the mhGAP program, plans and health policies mentally, invest in human resources training to develop skills in management mental health services and the need to link the mental health services with other sectors such as education, labor, judicial, police and social welfare sector, among others. (2. 3).

It is generally considered that the status of mental health in the past 15 years is characterized low level of implementation of plans, policies and programs; limited coverage, lack of training for workers, deficiencies in the integration and coordination in those decentralized services, insufficient integration in general health system. (4).

Examples that show the little relevance of psychiatric hospitals.

Although the psychiatric reform does not show significant progress in the region, there are isolated and uncoordinated effort of countries, institutions, organizations to boost care initiatives with innovative approaches based on new paradigms, including include the following experiences:
1. The experience of Cuba in Childhood Mental Health.

The development of this symposium allowed to know the experience of Cuba presented by Dr. Marcia Basaco, Member of the National Mental Health Group Cuba, in terms of progress and challenges of the Child and Adolescent Mental Health in Cuba; this population has been prioritized by considering children the most precious resource of societies.

Care system is based on the principles of the Cuban health system as being universal, free, accessible, socialist, regionalized and comprehensive and based on conventions, constitution, codes and laws.

Human resources in Cuba (for 100.000 inhabitants) include general psychiatrists (10.27), child psychiatrists (17.6), psychologists (1.97), nursing (29.50) and social workers (3.0).

The most relevant aspect of this development were achieved through the development of a Mental National Policy for integration of Mental Health into the general health system; training of specialists in child psychiatry in order to achieve coverage national; creation of child psychiatry services in pediatric hospitals; creation of a national group of Psychiatry; creation of Community Mental Health Centers; analysis of the mental health situation in order to create national plans; allocation of specialized resources in the first level of health care; development of research; training staff for mental health management in Social Psychiatry and Community Mental Health; development of operational guidelines for care staff primary; developing links between the health system and other systems (education, judicial) and development of plans and programs of psychosocial rehabilitation. (14).

2. The experience of the Caribbean Coast of Nicaragua: Bluefields CAPS.

Dr. Guillem Homet (Spain) presented the experience of the Psychosocial Care Center (CAPS) of Bluefields, which begun in 2003 supported by the local government and in cooperation with the Spanish (Region of Maresme, Barcelona Provincial Council and mayors Catalan Group).

An initial analysis found low community awareness of mental health issues, weak network of care for adults and children exist, lack of psychiatric drugs, attention uncoordinated, no existence of mental health teams, absence of psychosocial approach, little community support, high rate of suicides, violence, substance use, and no training mental health.

From this analysis a strategy was established, through the definition of targets at individual, groups, institutions and communities level. Relevant actions have been the establishment of the catching area of CAPS, creation of multidisciplinary teams, definition of training systems, programs, and schedules, and participation of citizens and institutions.

The defined programs would priorise to attention of the mentally ill, rehabilitation psychosocial, family violence, addictions, public awareness, training, engage problems of remote communities and visualization of CAPS. Important identified components are the promotion of mental health through the media -local radio and TV-, health workers, self-help groups, fighting stigma, and preventive actions addressed to addictions and domestic violence.

Noteworthy is the psychosocial rehabilitation day center, includomg a chronicity programme (with home visits, rebinding, family and social integration), fighting discrimination, labor activity, and cooperation with the Court of Adolescence, the Women Commissioner and the Family Ministry. The strengths achieved are community approach, networking, increased CAPS recognition, expanding demand, intersector and interagency links, multidisciplinary team enlargement, and the appropriation of the project by national institutions. (15).

3. Experience of Strengthening Mental Health Network of Esteli.

A project was promoted by the Ministry of Health of Esteli, a Spanish Community Task Force, and Manantial Foundation (Spain). A facilitator was
placed in the Local Health System, in linkage with
the mental health teams and participating in
meetings of health programming.

It started in 2012 with the development of a
diagnosis of the health situation, with the further
creation of an action plan that defined the main
lines of action. The target population of the project
are people with severe mental disorders, defined as
a group having severe difficulties in functionality,
integration and dignity.

There has been a process of delimitation of
shares with a progressive deepening in its approach
and adjustment of protocols from the experience.
The theoretical framework of the project is
governed by psychosocial rehabilitation principles,
with a focus on Human Rights.

The main actions are the identification and
registering of people with Mental Illness, training
formal and informal staff (health brigadiers) on
issues mental health, human rights, depression,
adiction, psychosis, epilepsy, disasters, violence,
suicide; elaboration of material support and
training, networking, people sensitization, and
search of a more specific support from the General
Hospital, targeted to the increase of opportunities of
attention for the mentally ill, and creation of an
electroencephalography department to provide
support in diagnosis and treatment of epilepsy.

Positives outcomes have been found in working
with mentally ill people and their families, home
interventions, interdisciplinary approaches, inter-
institutional coordination, and incorporation of
changes in paradigms, attitudes and commitments.

4.- The experience of Community Mental
Health Project in Esteli and Juigalpa, in
Nicaragua.

These projects are boosted by the Ministry of
Health, the organization ASOPIECAD (association
of integrated projects in the community Astrid
Deleman) and Christian Blind Mission (CBM). They began in Esteli (2009) and Juigalpa,
Chontales (2012).

They are based on the human rights approach,
where the legal framework for protection to people
with psychosocial disabilities is emphasized
(Convention on the Rights of Persons with
Disabilities, Constitution, codes, laws), in the
promotion of mental health and prevention of
Mental Health because it promotes mental health in
all members of the community, allows promotion
and prevention, provides care, facilitates the
participation of people with psychosocial disabilities
and their families and its purpose is the inclusion of
the mentally ill.

CMH promotes its projects in three lines:
inclusion of mental health in projects of community-
based rehabilitation; integration of primary care
services and specific projects of community mental
health.

The main actions are the training of community
mental health agents, community leaders, home
visits, training health workers on issues of mhGAP,
teachers and members of institutions are linked to
community self-help groups for mental health work,
personal growth groups with students and
campaigns in the community.

Major needs have been identified: providing
attention geographically accessible, medicines,
nondiscrimination and elimination of barriers, family
education, training health workers and education
and greater social and employment opportunities for
people with mental condition.

A significant experience in these projects has
been the systematization of training using the
mhGAP, it has been proven its assimilation and
implementation by Mental Health workers. (17).

5.- A Experience involving users: the
Association “Cuenta Conmigo” (“Count on me”) in Matagalpa.

The association was created in 2005, with the
twinning support of “Mano Vuelta” Committee and
Tilburg Committee, with the aim of supporting
people with psychotic disorder and their families.

It develops a Human Rights approach to count
on its board of directors with representatives of
users, relatives and technicians; frequent psychiatric
diagnoses in users of the Association are
schizophrenia, depression, delusions, bipolar
affective disorder.

The main activities include home visits to users
and their families, follow-up workshops,
assemblies, awareness of the population using the
media and marches, informative workshops to users
and their families, technical computer courses,
occupational workshops, activities recreational and
interagency coordination.

The achievements are the legal status of the
association, agency collaboration network,
institutional recognition, community awareness and initiation of projects for employment. (18).

As a closure of the symposium a video meeting with different stakeholders committed in community mental health and psychosocial rehabilitation was organised, with participation (form Spain) of Dr. Ricardo Guinea, President Elect of the WARP (Spain) and Dr Alberto Fergusson (Colombia), Vice President of the WARP for the Americas. The video-meeting encouraged the commitment of participants to participate in a network of professionals to promote psychosocial rehabilitation, exchange experiences and information, and reflected as relevant issue the need for training health professionals in Psychosocial Rehabilitation.

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History and summary of the project

The performing arts company Geometrance began its work in 2009, after receiving the Premio Innova de Fundación Manantial, with the aim of developing a scenic space and their training, outside of the psychosocial rehabilitation centres in Madrid. It involves the general public working with a group of people who are already stigmatized: those with mental health problems. It is composed of 2 test groups: A group of “actors” and a group of “musicians”. The cast members are part of an artistic group, composed of 12 people. Some are suffering from a mental illness and some are not. (There have been drop outs, additions and reinstatements throughout the process). We “present” to each other, in spaces created for music and theatre.

The methodology in the group of musicians (the group that I am in charge of) has been mainly compiled as a group by incorporating the concepts and tools of group tasks, musical therapy, psychoanalysis and Gestalt groups. The theatre group meets every week for two hours and is run by an actor and choreographer, whilst the group of musicians meets for 2 hours every week in a different space and is run by a musical therapist and psychologist as a group training session. There are meetings between the professionals and with the project director, who is the person that manages issues of communication and liaisons. Prior to the début performances, they take part in intensive rehearsals that last for 4 hours, depending on the amount of preparation needed for the work in question.

The creation of the artistic material is a collective product developed beforehand, in an exploratory and educational group space over a period of a few months, through the format of "workshops". The company members are jointly responsible for the company’s texts, staging and music, in collaboration with the directors.

In the first year, the actors were creating scenes on their own that were called "esquizotrances", which resulted in the creation of a contemporary work of theatre, structured almost like a jigsaw and which they wanted to call "monologomatron." This work shows how people are perceived through their deliriousness: a subjective state, explained in words. The actors presented themselves to each other as representatives of their imaginary worlds and the musicians performed live music. As a final result, the music tried to “accompany” the different scenes in the work.

Although they did not present themselves as having rehabilitative aims and by avoiding talking about the process in “clinical” terms, it
has been almost impossible to ignore these thoughts about the work that have been growing over the past few years. These thoughts will be expanded upon in the next section.

Reflections regarding “creativity and mental health” in the work of the Geometrance company.

Creativity and roles within the group
To begin with, one of the first ideas that I proposed in the development of my work as the musical director of Geometrance, was that the stage plays out the phenomenon of individual and group creativity in terms of the allocation of roles. I am talking about the stage as an intermediate zone (between the mad and the sane) or a playing field which encourages the group to blossom through the allocation and taking on of roles. I think that the “user”, which in our group takes on the role of an actor and/or musician, was at the time a spokesperson or designated sufferer, named by their main group or by another group. They have had to fully engage with the world for subsequent groups that have lived in different times and in roles that have left them “stereotyped”. We would say that it has formed a CROS (including my own CROS), a conceptual and referential operating scheme, which is an outline of their place in the world (in other words, a world view). The diagnosis (or whichever way they have been labelled as being sick) has assumed that the concept and role of the illness surpasses or appropriates a person’s previous roles and significant training, thus being able to gain a comprehensive hold of almost all the areas of the person with mental health problems’ life. I believe in the importance of retraining, which assumes an openness to change and learning. This is in itself, an exercise of creativity through the creation of changing characters in developing situations, both on the theatrical stage and on the pedestal of life.

Talking about creativity in mental health, for me, should be linked with attempting to move away from stereotyping. Stereotypes are understood to impose a certain sense of rigidity to learning and roles, and they block the ability to respond in a creative way to new situations. In other words, a “non-stereotypical” method avoids rigidity and encourages a repertoire of unique responses to different events. Here we have a rough idea of what “creativity” means.

Creativity, Context, and Rewriting
One of the changes that I have noticed in myself when it comes to working with the groups has been that of having to understand mental illness as a phenomenon that is rooted in its context. There is no chronological order when the stories are moving. You can revisit the mental illness and thus play with roles in the “intermediate zone” of the group’s creativity, this zone being the stage. In the reconstruction and deconstruction of narratives and established roles, this is the dimension of the process unblocking of the structures (In psychiatric and psychological language through “cultural colonization”, but that stops the focus upon capabilities). Thus, this opens up the possibility of subjectivism and the understanding of the dimension of time within the context of mental health, where sometimes it appears that time, training and processes have been frozen in some place in the past.

The group is more than a mere combination of its different parts and the notion of creativity develops within a group context. It is where the participants can create their stories, music and narratives.

The role of the musical director, is on one hand, that of being a “good mother figure” that ensures that the conditions of the group’s setting are maintained, or watches over to ensure that consistency is maintained. They bestow a rhythm, allowing rhythm to the
learning process which allows the formation of relationships, with group members getting to know another person (team mate). They also create a learning process in which others can be mediators, companions, or can take on changing roles according to how we go about a task or divert off from it. The sessions have a stable format and are open to new elements. The director calls the absentees if they are worried about the material of the sessions. Furthermore, I believe that part of my work aims at promoting self-responsibility through the exercising of adult roles encouraging participants to pursue the aim of the group. In this sense, this exercise means that I take up a kind of “fatherly role”.

I am in the process of understanding that the group members are subjects whom are continuously making choices and decisions. We are beings in this world. Without the judgements looks of others, nor without the admiring look of someone else, who is a therapeutic ally, we would not be where we are today. Another principle that I work on, is that of demonstrating confidence in potential and capabilities. A supporting upon the people whom we are working is needed. Capabilities do not mean technical knowledge regarding music specifically, but the ability to demonstrate subjectivity. Each group member brings different “capabilities” to the construction of a group artistic piece. In this second approach to the phenomenon of creativity, I think that it is important to talk about the process regarding the musical group. We have to bear in mind the individuality of each member. Hence, there is some difficulty in finding rules and options for maximising the group's creativity in a way that is suitable for all participants in a uniform way.

**Creativity in the musical group**

I believe that music, and the musical instrument, is an intermediary object that encourages relief from anxieties and demonstrates the subjective world of the people
we work with. This vehicle of expression is non-verbal, and it is through this that the large majority of communication is made (people with psychosis understand this). This vehicle of expression is music.

The instruments were organized by the director. He talked to the group about the work and had the task of creating music that accompanied texts, with a team of musicians who were both experienced and inexperienced in musical training. He also bought the small percussion instruments. We started to work in the Centro Hispano-Africano, then we moved to a neighbourhood association centre, a rehearsal room in Lavapiés and then we went to the UVA de Hortaleza, all located in Madrid. In the Centro Africano, where we started, we were reliant on the possibility of recording in a well equipped studio. My first approach was to organize the sessions using elements that offered a certain “structure” that established a musical basis (solfa, melody, rhythm...). I realise that this approach did not achieve any results, and the participants and I became frustrated. They were not following what I had asked them to do, and I was unsettled. I tried to suppress this type of anxiety. Then, after sharing all of this with a colleague, they suggested that I tried free improvisation. I came from a background of studying improvisation through music therapy, but I had never led a group improvisation session outside of a music therapy session. During that time, we did some recording and there were some interesting parts to the recordings, but the majority of the material was unrecognizable. It lacked something that would make substantial musical production. The difficulty was putting together a joint musical language in a shared code. At this time, it annoyed me that the participants were not working nor preparing or planning anything between the sessions. I thought that they were becoming too comfortable. The participants appeared to be “hindered”, due to their lack of technical capabilities. Others were battling the anxiety of undertaking a task within an unknown context. I started to compose and then assign the musical tasks to each musician (musical or rhythmic parts), allowing for creativity and composition. At that time, I got some recording software. We then tried different melodic or rhythmic parts and recorded them into a structure. During the process, musicians had to overcome moments of frustration about “not knowing what to do”. Generally, the music was capable of accompanying a theatrical work, with a brief time frame for each theme (1 to 5 minutes) and with the phrases repeated in a loop. It was not helpful to teach music in an abstract way, nor by free improvisation. In the performances, I had to record the participants in their stage roles. They were battling with stage fright and I knew that it was something that was bound to happen. I had to reassure the participants and calm their anxieties. Overall, it has been less difficult to memorize musical phrases than I had expected.

Creativity and subjectivity

I believe that I have tried to get closer to an idea of creativity from a group point of view. I think that considering the idea of creativity from an individual point of view acknowledges subjective elements that express something of an individual’s behaviour in their own personal world.

The idea of redeeming subjectivity can be explained by using the following terms: from a more general level, the company offers the possibility of recovering personal subjectivity through art, dealing with it through demonstrating capabilities and recognising the power that can be found in every viewpoint, and which can be represented and communicated to the audience. It is trying to create a “bridge” (a play area, for identities and roles) where ways of transmitting all the states of the personal emotive and sensory universe can be found. This can be achieved through working with the
consciousness and exploring the unconsciousness of every person through artistic language, in order to channel this towards an aesthetic form that may emerge on a personal or group level. This “bridge” tries to facilitate understanding so that the artists understand from the dimensions of stability and self responsibility, that a group project can help the population to see the communicative abilities of the actors, and also the understanding that they can eventually make a quality product that can be presented to others in the conventional realms of the stage, such as in theatres or other artistic spaces.

On this point, I stop to highlight that from my artistic point of view, my perspective is that there are musicians that display a great level of creativity, but struggle to pinpoint musical ideas in repeated or recognisable phrases to others. Other musicians are more strict and need an accompanying director or more concrete tasks to do within the group. On this point, there is a steady progress in my work against intervention (assisting with things another person is unclear of how to do and thus needs helps with) and more towards being there as an attendant (i.e., moving ahead, going along with, or moving behind participants). In all cases, I emphasise the idea that the musical director can assist with the process.

Some ideas about the professionals in the groups

The group director exerts maternal and also paternal functions to set out the rules and the setting. The group creativity in this exercise plays with the dimension of neurosis-psychosis, understood in terms of the structured-unstructured. The psychotic becoming neurotic is one of the problems that I have been confronted with. My starting point was free musical improvisation, and from there the musical content in the collective creative piece did not appear to be clear for a hypothetical spectator. The task for me seemed more or less clear regarding giving the team certain musical and group competencies (team work, playing music to one another, following the rhythm, remembering melodies, maintaining a stage
This gave them a stage for the public, which could have been acting as a continuum between intervention and training. The idea of bonding in this process has been one that I was able to stick to quite well. I prefer the risks of the affected, over those of the disaffected from a distance. As Diego Vico says, the groups are made out of love, and the dimension at stake is that of the affected. Although we call it transfer and counter-transfer, this helps us move things along. The danger of intervention, even if it is educational, is that of making the agreed shapeless structure neurotic or making it too rigid according to conventional standards, and thus there is a risk of making the final result a grey product, and unrecognisable in its originality and difference. The danger of a lack of structure would be the loss of the dimension that we listen to, thus losing the ability to imagine it and in turn revealing our subjectivity in a narcissistic and omnipotent way.

There are those that need more help, and there are those that have more time for composition because they tolerate anxiety better from the outset. There are no scores; we try to use a shared language that allows better communicability.

There are no objectives of rehabilitation in this project, but there are indeed objectives regarding social matters. The people who we work with have responsibilities and capabilities. The reinforcement and rescue of “sane” identities acts as a vehicle for training, and we believe in the potential of the people. We believe in the importance of subjectivism and we think that context should allow for retraining, and should be important regarding the ideas of bonding and compositions.

**Some final ideas**

The music group’s task was intended to be that of making or producing music for the theatre or an artistic product that could be showcased in traditional auditoriums.

It was not meant to use language related to rehabilitation, medicine or clinical areas. We included in this approach the idea of “social inclusion”, bearing in mind the notion of exclusion in the social space of those who have been diagnosed with a mental illness. In the same way, and in the background, some ideas...
concerning "learning" or "lack of learning" as agents of change, try to keep the group focused on the task at hand.

The musical training or aptitude of the members was varied from the outset, there were people without any musical training whatsoever, and there were those who had sufficient or insufficient technical experience regarding playing an instrument, but possessed technical skills that could be "represented" in public.

The issue of giving shape to the production's lack of structure, being as delirious as it is non-delusional, on the whole approached the idea of communicability between the alleged and the general public (previous structure), and led to thinking within the ideas of permanency and structure (these are understood to be elements that allow subjectivism or provide support). Consequently, this relates to the idea of compositions, which are understood to be the constant elements that allow the display of the whole process (including training and meetings).

Another idea that was in the background of the company’s work was that of the regulatory function of the community space. The meeting places (the Centro Hispano Africano, kiosks, streets, the metro, buses, bars, neighbourhood association centres, radio, the houses of the musicians) can be bridges extended into other contexts (or other “intermediary spaces”). These informal settings (bar, street, etc.) are no longer seen to be "no go" places and now generally offer moments of non-threatening and genuine exchanges. My position is that of trying to maintain a sense of proximity between the people and the musical director, who are not very different. In this sense, my professional position is also changing, since I am making changes in the group. It changes my way of behaving in the work space.

**Final words and synthesis**

I thank the organisation for these meetings and the opportunity that they have given us to be able to present our work.

I have learned how to write and to attempt to organise random ideas. I have found it somewhat difficult to directly deal with the theme of creativity, but I am thankful for and value the exercise greatly.

I did not want to quote the authors directly, but in a creative sense, I bounce off ideas that were not originally mine and it would be ungrateful not to acknowledge them. There is Pichon-Rivière and sometimes Winnicott appears, and I am sure that there are more authors. I preferred to create an account that is halfway between theory and practice, by recalling my first-hand experience.

To finish, I am adding a brief synopsis of the new work:

*The Outsider Pub, the “Guilson” bar, is the place where the participants can go to relax. Society is left on the outside; they are just spending time with one another and themselves and they gather here to talk. They draw upon images of others to try to explain the madness.*

All illnesses cause pain and they play with whatever it is that causes them the most pain. They use theatre. They seek laughter outside of this dimension and trying to overcome these limitations. The periphery is the bar and the mind’s echoes come together in one place in the “Outsider Pub”.

The company Geometrance created this work to be able to provide ample reflection on madness as a real way of life. We feel, as humans of the contemporary era, that we push each other and sometimes go way over the limit, whether we are ill or not. We want people who are perfectly sane to see us as human beings too and to be able to identify with our illnesses.

We want to defend ourselves from stigmas, fears and snubs from others. We are helping ourselves. We are doing this together, by putting humour into pain and alienation. We are searching for the healing power of the human smile and expression. Thus through humour, we are looking for the effective amount of immunity in order to fight against isolation.

Marcelo Orueta.

The music of Geometrance for “the voice bar” is a collective creation, inspired by many existing dialogues and discourses and by the poetry created by the group members. Composed of a mixture of styles, this music tries to display and accompany a “real feeling” of the themes reflected in the work. Away from virtuosity, it tries to embody in its resonance, the feelings that accompany madness, in a message that is clearly understood by those who listen to it.

Enrique Meza.

You can visit our website: [http://icasillas.wix.com/caegeometrance](http://icasillas.wix.com/caegeometrance) (in Spanish)
Working with traditional healers in Kenya to reduce mental health treatment gap.

PAST, PRESENT AND FUTURE: FROM IDEOLOGICAL STAND TO ACCEPTANCE OF FACTS

David M. Ndetei.

Introduction

In Kenya, traditional medicine is popular in communities (both rural and urban) which have little or no access to modern medicine and in particular mental health services. Traditional health practitioners are normally part of the communities where they live. Over 20,000 traditional health practitioners are registered in Kenya, yet this is considered a gross underestimation of the total number. We can classify traditional health practitioners into the following broad categories based on their diagnostic methods and treatment approaches:

Herbalists – Use a set of signs and symptoms to make a diagnosis of the physical and psychological disorder and treat using either herbs or psychotherapy or a combination of both.

Witch doctors (for lack of a better English word) - Use divination to establish the cause of illness and apply the cause-effect relationship to suggest management. They may also use herbs for treatment.

Effectiveness of Traditional Approaches in the Treatment of Mental Illnesses

There are various specializations from each of these categories. Mental illness is treated by most categories of traditional practitioners each applying various methods specific to their trade. The effectiveness of traditional approaches to treatment and management of mental illness have been documented such as the success of a traditional form of psychotherapy documented by Rappaport and Dent in 1979 and the story of Chief Adenoka of Abeokuta going to the UK to treat a psychotic Nigerian there with Rauwolfia herbs with great success in 1929, long before we heard about Delay and Deniker invention of chlorpromazine in the early 1950s.

Studies in Kenya

We have conducted various studies on the effectiveness of traditional practitioner’s collecting both quantitative and qualitative data in collaboration with the following:

Basic Needs Kenya in Nairobi and other urban areas.

The Ministry of Culture and Social Services through joint funding.

A task-shifting project funded by the IDRC and working with local administration who knew each practitioner by name and where they practice.

A GCC star grant to one of our researchers in collaboration with the Traditional Practitioners Association of Kenya.

Our findings

The only suspected physical harm caused by traditional practitioners is when they tie their
patient’s hands who are likely to cause harm to themselves and/or others before being referred to hospital. Sometimes the patient tries to untie themselves or escape and so may inflict some injuries on him/herself. This is done as a form of prevention of self harm and not a form of treatment. In particular, we did not find beatings or inordinate abuse of human rights out of proportion to the usual involuntary sedation of patients in hospitals or clinics, locked high wall isolation rooms found all over the world or restraining by relatives or police of violent patients as they escort them to hospital.

Can Traditional Practitioners Effectively Refer Cases of Mental Illness?

Results from the study “Dialogue to empower traditional and faith healers to deliver evidence-based psychosocial interventions to reduce treatment gap in Kenya (DIALOGUE)” funded by the GCC star grant program

A total of 47 persons were referred by traditional healers participating in this study.
23 persons were referred as negative for depression
24 persons were referred as positive for depression

Of the 23 referred as negative, 21 were confirmed to be negative for depression by a mental health specialist at the health centre (psychiatric nurse) i.e. a 91.3% accuracy.

Of the 24 referred as positive for depression, 8 were confirmed by the mental health specialist i.e. a 33.3% accuracy.

Results from a study on Task-Shifting in Mental Health in Kenya (funded by IDRC)

Traditional healers referred 16% of the total referrals by lay health workers. The average accuracy for positive identification of mental illness for traditional healers following confirmation by clinicians at the health centre was 36%.

Conclusion and the way forward

In countries where traditional practitioners are accepted such as Kenya, the best way forward is to together find ways to:

Regulate them just as much as we regulate doctors.

Get the two systems (formal and informal health systems) to work together to complement each other through constructive DIALOGUE to maximize on good practices and minimize bad practices.

Enhance human rights aspects of their practices just like we continually do with doctors and other professions.

Enhance best practices supported by evidence such as the NICE guidelines for practitioners in the UK.

There is also need to conduct more research especially RCTs using traditional healers, to find ways of maximizing their effectiveness.

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The closure of the forensic psychiatric hospitals: a new deal for the Italian Psychiatry.

Massimo Casacchia¹, Rita Roncone²

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Member of the Italian Board of the World Association for Psychosocial Rehabilitation

The Law 180 did not involve the 6 Italian forensic psychiatric hospitals (Ospedali Psichiatrici Giudiziari [OPGs]), that hosted those acquitted on grounds of mental infirmity and judged to be socially dangerous for a term commensurate with the crime committed and extendible without any upper time limit. In fact, placement in OPGs and treatment of offenders with mental illness have been the only area of mental health care not affected at all by the Law 180.

The need to re-align these 2 different systems of care of persons affected by mental disorders was repeatedly emphasized and in the last years progressive steps were conducted in order to close these psychiatric forensic hospitals.

Five of them (Reggio Emilia, Montelupo Fiorentino, Naples, Aversa, and Barcellona Pozzo di Gotto) are obsolete 19th-century institutions, with heavy use of custodial staff. Only one (Castiglione delle Stiviere) is run by the National Health System and employs only health staff. Apart from Castiglione delle Stiviere, living conditions and quality of care were so poor that Italy received a warning by the Council of Europe in 2006 for violation of human rights. Many user associations, psychiatric scientific societies, psychiatrists working in OPGs, and also political parties demanded radical reform of this sector. The movement culminated in transferring the responsibility of these hospitals from the Minister of Justice to the Minister of Health and to the National Health System, while at the same time it was established a progressive downsizing and
closure of the six OPGs. Shortly after that, an Italian Parliamentary Commission, after visiting all six OPGs, produced a "Report on the living conditions and care in forensic psychiatric hospitals", recommending that those hospitals should be rapidly closed down.

In 2012, a new law (Law 9/2012) established that new residential facilities had to be developed to better meet the needs of providing intensive and high-quality mental healthcare to socially dangerous individuals with mental disorders under proper secure conditions. These specialized high-security small-scale residential facilities (REMs) (no more than 20 individuals, up to 4 patients per bedroom) were intended to replace admissions to forensic psychiatric hospitals.

The Law 81/2014 established 1) the extended closure dead-line of the OPGs at March, 31, 2015; 2) the assessment of the social dangerousness of offenders with mental illness only on the basis of their subjective qualities, without taking into account their life condition, and their family and social context; 3) a term of "treatment" commensurate with the crime committed by the psychiatric forensic patients and not more extendible, limiting the so-called "white life sentence"; 4) several deadlines to force the Italian regions to speed up the process of discharging OPG inmates (those patients not more socially dangerous), and to transfer the offenders in the REMs (those patients still assessed as socially dangerous); 5) the creation of a monitoring Commission in contact with the Parliament.

At September 30, 2014 there was a population of 826 psychiatric offenders, around 58% of them assessed as "ready to be discharged", but still without a specific individual rehabilitation planning.

The numbers of forensic psychiatric patients have decreased during the year 2014, from 880 at January to 761 psychiatric offenders at the end of November.

Nowadays the Italian forensic psychiatry is living a transitional period: the REMs are not ready in most of the Italian regions and the regions are trying to identify alternative provisional residential solutions.

The responsibility of psychiatrists should remain primarily a responsibility of care, and not turn into a custodial attitude, urging an active commitment of scientific societies.

The scientific societies, and mainly the psychiatric and psychosocial rehabilitation societies, as the multi-professional WAPR, are involved in the challenge of identify patterns of a "good" forensic psychiatric and psychosocial rehabilitation, allowing people to come back to their context of life and promoting their social inclusion.

**Essential References**


Persons in Rehabilitation:
Persons rehabilitated from psychosocial conditions supported to engage in horticultural activities in Ghana.

Compiled by: Bernard Azuure, Project Officer, BNGh

Ghana, BasicNeeds-Ghana and Mental Health in Ghana

Ghana is a West Africa English speaking country with some 27 million inhabitants. Mental health is one of the neglected non-communicated disorders. This is because there is high stigma and negative perceptions about mental illness resulting in low political commitment and investment in the sector. There inadequate trained specialist and community health workers, infrastructure and logistics to address treatment and rehabilitation services for person living with mental illness. Mentally ill people are therefore among the most marginalised and discriminated, and poorest in the Ghanaian society.

Most often than not, persons suffering from various kinds of psychosocial conditions are left to their fate in Ghana. Families of such clients sometimes perceive that their conditions are as a result of curses from the spirits or ancestors and as a result, see it as a waste of resources to rehabilitate them. Many of such clients are discriminated and stigmatized against in their homes and communities.

BasicNeeds-Ghana is a non-governmental development advocacy organisation working with people with mental illness and epilepsy and their carers and families to improve their wellbeing. The organisation has been working in Ghana since 2003 and now covers 94 district across 9 of the 10 regions of Ghana. Operations of BasicNeeds-Ghana cover some 27000 people with mental illness and epilepsy.

BasicNeeds Ghana has been working very closely with the government of Ghana to set up community psychiatric units in the lower levels of health care service facilities. This is aimed at bringing community mental health services to the door posts of majority of persons suffering from various kinds of psychosocial conditions in eight (8) regions and eighty-three (83) districts of Ghana.

At the community level, persons suffering from mental illness or epilepsy (service users) are brought together to form Self-Help Support Groups that meet regularly to discuss issues that will promote the wellbeing of their members in their communities.
The groups have leadership who have been trained to effectively manage their affairs and engage with local and district level authorities on issues that concern their members.

The concept of the Self-Help Group system has enabled Community Mental Health Officers (CMHOs) to easily reach out to service users to administer medication to them in their communities. It has also facilitated easy access to some government social intervention schemes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme (NHIS). Under the LEAP scheme, households of service users are supported with monthly allowances to cater for their food and medication whiles the NHIS offers free registration of service users (under their indigent facility) to enable them access free treatment in health facilities in or close to their communities.

The intervention of BasicNeeds Ghana in our target districts and communities, in collaboration with the Ghana Health Service, has improved the conditions of many persons suffering from psychosocial conditions many of who are now engaged in various kinds of economic activities to earn some income that will improve upon their food and income security.

Supporting rehabilitation of persons stabilised from mental illness or epilepsy

Realizing that most of the stabilised service users needed some kind of intervention to enable them secure some kind of livelihood, BasicNeeds Ghana secured a three (3) year funding from the Government of Canada (through the Ministry of Local Government and Rural Development of Ghana) to support rehabilitated persons suffering from psychosocial conditions to engage in dry season vegetable production. The project titled, ‘Food Security for Empowerment and Poverty Reduction Project (FOSEPREP)’, is aimed at supporting 2,000 stable service users and vulnerable women headed households in Northern Ghana increase production of organic vegetables, through sustainable and environmentally friendly sound agricultural practices, to improve their household food and income security.

So far 542 beneficiaries (out of which 380 are stable persons who were suffering from psychosocial conditions) have been supported with fencing materials, hand-dug wells fitted with robe pumps, organic fertilizers, garden tools, vegetable seeds and technical support from the Ministry of Food and Agriculture to undertake all year round vegetable production in three (3) districts. The rest of the beneficiaries are carer givers of service users and female headed household heads from the target communities.

The beneficiaries have been trained on compost preparation, neem extract formulation and good agronomic practices in vegetable production to enable them produce fresh vegetables for sale and home consumption. Thirteen (13) acres of land has so far been fenced and is being cultivated in ten (10) different communities for vegetable production in the West Mamprusi District in the Northern Region, and Talensi and Buialsa North Districts in the Upper East Region of Ghana. Some of the vegetables being cultivated are tomato, onion, pepper, amaranthus, cabbage, lettuce and garden egg.

The beneficiaries are guaranteed of reliable markets for their produce as buyers from nearby markets in the three (3) districts compete for fresh vegetables from the fields. As a result, beneficiaries are always assured of regular income so long as they continue to produce vegetables in the fields.

The initiative has created the spirit of togetherness between rehabilitated persons.
suffering from various kinds of psychosocial conditions and the so-called ‘normal’ persons who collectively work in the vegetable fields. Service users are now considered as persons who can contribute significantly towards the socio-economic development of their families and communities. This has significantly reduced the issue of discrimination and stigmatization of persons suffering from these conditions which we have been battling with.

Considering the fact that the project is being sponsored by the Ministry of Local Government and Rural Development (MLGRD), the District Assemblies of the target districts have actively been involved in the implementation of the project. In one instance, the Talensi District Assembly (in the Upper East Region of Ghana) provided tractor services for the Wakii group to plough a three (3) acre piece of land on which they are currently using for their vegetable farming activities.

BasicNeeds Ghana continues to work with and empower persons suffering from various kinds of psychosocial conditions with various kinds of livelihood support to enable them live dignified lives in their communities.

It is the wish of BNG that this initiative will be expanded to cover many districts and communities so as to contribute to the reduction of this (stigmatization and stigmatization) among service users.
The XII WAPR World Congress was successfully celebrated in Seoul, Rep. Of Korea, November 2-5 2015.

The general impression was that the congress was excellent, the venue very comfortable and adequate, and the organisation was impressive in all aspects. The congress was organised by Dr. Tae-Yeon Hwang, WAPR Vice-President leading an impressive Korean team. A special mention is well deserved by Dr. Jonghook Lee, chair of the scientific committee, who played an outstanding role in the international coordination.

The international scientific committee was integrated by leaders in Mental Health attention from 14 countries in the region (including Malaysia, Australia, Singapore, Japan, Indonesia, etc.) The local organisational and scientific committees were integrated by more that 60
Afzal Javed, on behalf WAPR expressed its deep acknowledgement for the great effort and the big success of the meeting, that was a very good sample of the international relevancy of the perspective of Psychosocial Rehabilitation in the current state of the art of Mental Health services provision for the mentally ill.

The main conclusion of the meeting could be summarised in the idea that Psychosocial Rehabilitation, as a complex philosophy of attention, remains a very active and lively perspective, that is still receiving interest from researchers and practitioners, consumers and carers. Some innovative perspectives, as the “recovery perspective” still attracts attention and offer innovative aspects that will require further research and discussions in the coming years.

The congress ended in a very warm closing ceremony, where Dr. Tae-Yeon Hwang passed the baton of the WAPR World Congresses to Dr. Ricardo Guinea from Spain, which will organise the next congress in 2018.

Dr. Javed and Dr. Murali.

outstanding members form different Korean organisations, from the academy, health care and civil society.

The list of proposed topics included assessment, planning and evaluation, networking, consumer’s perspectives, economic issues in care, innovative services, legal issues, training, programmes, community support, cultural perspectives, human rights, research, stigma and role of the media, vocational rehabilitation, and more.

The conference included 66 invited speakers, 112 different sessions, 297 oral presentations and 171 posters. The organisation provided 15 of travel awards, and 4 best poster awards. The number of attendees was 1529 (407 international visitors from more that 20 countries). A wide list of different professional and roles in Psychosocial Rehabilitation were represented, including 387 social workers, 269 physicians, 263 nurses, 104 family carers, 55 psychologists and 88 consumers.

The congress hosted the WAPR Assembly and Board meeting, in which Dr. Javed, WAPR outgoing president presented his report, the new president presented his views for future plans, and the WAPR Board was renewed.

The social programme was very carefully prepared and included many option for exchange and networking, and a very well served array of formal and protocol acts, which offered a very warm and comfortable welcome to all attendees. Performances of local artist in pop music, opera and Korean traditional opera were offered to the assistance.
The protocolary toast.

Dr. Tae-Yeon Hwang passing the baton of the organisation of World Congress 2018 to DR. Guinea. (Spain)

A plenary session.
Reviews

Book review: Pamela Fuller’s, “Surviving, Existing or Living” (2013)

Psychosocial Rehabilitation is a philosophy of attention that involves a great many of actions at different levels. Policies, legal structure, organisation of services are parts of that array of actions. The final aim of all these is to create a supportive environment in which the ill people have the chance to “recover” and overcome the remaining symptoms and disabilities to be able to reorganise his or hers mind as to be able to cope with the usual and everybody’s challenges in life.

Whatever it is the quality of the supportive environment achieved, the final goal is a very unique and personal subjective process of overcoming, lived by the affected person. In this regard, there is a long tradition of technical approaches that have considered how to best help in this aspect of the recovery process.

In Pamela Fuller’s book “Surviving, Existing or Living”, published by Routledge for the collection of ISPS (International Society for Psychosocial and Social Approaches to Psychosis), the author offers a proposal of how a phase-specific therapy for severe psychosis can help to move form a “artificial experience of living”, as described by people under long institutionalised treatment, until a more fulfilling and personal live, as proposed in the recovery model.

The author offers an integrative vision that incorporates different psychological approaches (cognitive- behavioural, psychodynamic informed, and family therapies) onto a “strategic approach to care and recovery that strives to enhance alignments between therapeutic interventions and the individual’s psychological state and psychological readiness”.

The book presents a practical “how to” view, where the intervention is conceived as specifically oriented in the progression in a 8 dimensional model in three phases, from a “surviving” situation (characterised by a “complete loss of awareness of the existence of the self”) to a “existing” mode where the person gains in awareness of him-herself and in the existence of others, and to a “living” stage where the person achieve a more differentiated experience of self and of the others, with increased self reflection, increased expression of emotions and increased adaptive and goal directed behaviour.

The author aims to build a model of approach to highly disabled person considering the “parallels” with the recovery model, with modern trauma treatment models, to “expand the mental health professionals’ understanding of how maltreatment can contribute to psychosis”. Trauma is presented in a very interesting way as a factor of the psychological state of clients the needs to be addresses and is often neglected.

And, in the psychodynamic tradition, also explores the importance of fortifying the mental health professionals who work with individual with severe psychosis.

The book also offers a useful section for “phase-specific group therapy”, with descriptions of how groups can be tailored in the proposed phase model.

The author emphasises that “facilitating recovery from psychosis requires appropriately and effectively matching the time and timing of interventions to client readiness and capabilities”. There is also an interesting section that examines the way professionals engage with the client and with the task and the kind of subjective challenges has to overcome in order to be maintain an effective and lasting professional attitude, avoiding the risk of offering ritualistic and non emphatic responses.

The author correctly points out the need of future research in assessing the effectiveness and efficiency of the model in real practice.

This book is in the long tradition of the psychotherapeutic approach to psychosis, and provides useful and practical ideas not only for
those who are interested in psychotherapy itself, but for other professionals like nurses or social workers interested in reflecting on how to relate in an appropriate and constructive way to clients. Pamela Fuller is a clinical psychologist with extensive experience working in the continuum of care with children, adolescents and adults with severe psychological problems. She currently works in Evanston, Wyoming, USA.

Ricardo Guinea.

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Recovery is a concept that for many commentators – and also in my own opinion-travels in a paradigm shift time. A concept that goes beyond the medical model, revealed insufficient to describe the complexity of the process that people living with mental illness live and cope. A concept that appears in a time where the current diagnostic models are under discussion, where subjectivity reveals to be an unavoidable domain to understand the whole process, where there is a significant trend from a “modern” to a “postmodern psychiatry paradigm”. This transition reveals the increasing awareness on the limitations of the classical scientific model, that have failed to offer comprehensive answers to the lived challenge of people living with mental illnesses. Recovery is a concept built on the realisation that many of the necessary answers come from others sources rather than from hard science. So: values, rights, lived experiences reveal new sources of evidence to build practical solutions for people.

Antonio Maone and Barbara D’Avanzo, WAPR board members, have coordinated a book on Recovery, collecting writings form first line authors on the topic. The book covers a wide and systematic revision of the state of the art of the topic.

The 15 chapters of the book examine the main topics in the discipline: the core complexity of the concept, the perspective of users, the subjective perspective of the process, the role of the insight in the process, research, models (the competence model, the strength model, the psychiatric rehabilitation model), new views on the role of psychopharmacology, human rights, empowerment, and a revision on the community model. The array of authors is very relevant: Marianne Farkas, Marit Borg, Mike Slade, Angelo Barbato, Geoff Sheppherd, Roberto Mezzina, Germana Agnetti, Michaela Amering, Larry Davidson and some others compound the list of contributors.

In a time where recovery sometimes operates as a “talisman word” that summarises a cluster of expectancies, and good wills, this book represents a very outstanding revision of the concept of Recovery and its implications, from a critical an evidence based perspective, not forgetting a values based perspective.

The book provides many different insights, some from “evidence” from the assessment of 20 years of evolving experience; some from a revision of the current state of the art form the perspective of outstanding protagonists of the recent history of Psychosocial Rehabilitation in different continents.

As a sample, G. Sheppherd tells the result and challenges of the recovery services in UK, the way “recovery” comes to change the scope of many participants in the process, and an ambitious institutional plan aimed to change the way professional incorporates and understand the recovery process, and the way the whole system of attention operates to be able to meet their role. On the other side of the process, the role on insight and of the subjective aspects of the process is described in a chapter by Lysaker&Vergo in a critical way.

This book is a significant contribution to our field that deserves a wide dissemination.
Cairo, Egypt; 3rd. Annual Regional Conference

Multi-axial Psychotherapy Approach, Recent Therapeutic Approaches in Mental Health
Integration of Drugs and Psychosocial Rehabilitation Approaches

Cairo, March 26; 2016.

Under the Presidency of Dr. Ahmed Saad, and the Organisation of the Egyptian Branch of WAPR, leaded by Dr. Hanan Ghaderi, in collaboration with Dr. Medhat El-Sabbahy, WAPR Regional Vice President, and Dr. Ricardo Guinea, WAPR President, the Egyptian WAPR Conference took place in Cairo, Egypt, in March 26th. 2016.

The programme included a general presentation of the current state of the art in Psychosocial Rehabilitation by Dr. Guinea, including references to the current trends in PSR (the community model, the recovery perspective and the prevalent attention to Human Rights). Dr. Saad, presented a comprehensive and useful overview Culture Pathoplastic & Pathogenic effects in Psychiatric Practice, a vision of transcultural psychiatry, with many references to psychosocial rehabilitation. Dr. El-Sabbahy presented on Psychiatric Rehabilitation and Neuropsychology.

The programme was completed with an array of interventions on Dialectic Behavioral Therapy for Borderline Personality Disorder (Prof. Mohamed El Mahdy), Moral and Self Management in Psychiatry (Prof./ Yaser Abd El Razek), Gene – environment interactions in Schizophrenia (Prof. Magda Fahmy), Adult ADHD and Addiction (Prof. Sohier Al Ghonaimy), Remedial Education (Proph./ Adel Abd Allah), Neuroscience and Learning Difficulties (A.Prof./ Shoikar El Bakry).

After the scientific meeting, an organisational brainstorming meeting took place with presence of WAPR officers and local WAPR members, on the purpose of elaborate a shared action plan for the WAPR branch with the support of WAPR International. In an excellent spirit of collaboration, the agreements were:

To draft a preliminary report on the situation in Egypt on PSR practices, in order to establish a baseline level and to outline next step actions.
Within the hostage of the International Conference on “Men’s Health”, the especial WAPR Symposium took place in Abu Dhabi, UAE.

The symposium “Psychosocial Aspects of Men’s Health” was organised and moderated by Dr. Medhat ElSabbahy, WAPR Regional VP, with the participation of Dr Ricardo Guinea, WAPR President (Depression in men, an underdiagnosed threat”), Dr. Murali Thyloth, WAPR President Elect, (Alcohol Dependence Syndrome: Challenges in Treatment), Dr, Mathew Varghese, WAPR Board Member, (Psychosocial Aspects of Healthy Ageing & Cognition in Men),and Dr Tara Rebeca, WAPR India (Psycho Social Impact of Globalization on Male Employees). IN an adiciona Sesion, DR Brunda Amruthaj (WAPR India) presented on Management of Stress Among Male Employees.

It was an excellent opportunity to present on a well served international audience of distinguished specialists in different areas of health a panel of psychosocial problems on mental health. This action emphasizes the idea that mental health is a key aspect of health.

It was also an opportunity to discuss some ongoing actions within the WAPR Executive Committee, and to exchange in the preparation of an International WAPR meeting to be celebrated in Abu Dhabi 2017.
WAPR Americas.

LAUNCH OF WAPR COLOMBIAN BRANCH.
Miguel Gutierrez, Chair WAPR Colombia and Alberto Fergusson, WAPR VicePresident.

WAPR Colombia branch was officially launched on Thursday, 27th September 2015 at an impressive ceremony held at Rosario University, Bogota, Colombia. The event was a part of a conference that was organised by WAPR in collaboration with Rosario University, Bogota, Colombia. The theme of the meeting was “Peace & Post Conflict reconciliation”. Speakers included Maria Victoria Uribe, Fredy Cante, Miguel Gutiérrez, Afzal Javed and Frank Pearl who gave a very detailed account of psychosocial needs during the post conflict periods and proposed plans for psychosocial rehabilitation of the effected individuals.

A formal meeting of the WAPR branch was held the following day, Bogota, Colombia. Miguel Gutierrez who has been appointed as the first National Secretary of the branch discussed various objectives and agreed to start working on enrolment of new members and also planning some activities in the near future.

Alberto Fergusson, Regional Vice President for American Region needs special thanks for his efforts and hard work to get Colombian branch organised and launched with support from José Manuel Restrepo, Rector, and Gustavo Quintero, Dean of Rosario University and many mental health professions.

In the months of September and October, the Colombian Branch and the Psychosocial Investigations Group of Rosario University have been stressing alliances with the Agencia Colombiana de Reintegración, ACR (Colombian Agency for Reconciliation) working as a think tank for difficulties faced by the agency regarding mental health problems in former members of guerrilla and paramilitary groups who begin a process of reconciliation. We have held meetings with former members of guerrilla and paramilitary groups, meetings which have been a fundamental input for the intervention programs we are designing and which are starting to be implemented. We look forward to an important participation of WAPR in the psychosocial interventions derived from the peace process being held between the Colombian Government and the FARC guerrillas.
Participants of the first meeting of Colombian Branch (from left to right, back: Emilio Herrera, Alberto Fergusson, Afzal Javed, Miguel Gutiérrez and Fredy Cante. Front row, left to right: Irene Barbieri, Silvia Rivera and Luisa Ramírez)

Speakers of the conference (from left to right: Miguel Gutiérrez, Alberto Fergusson, Jose Manuel Restrepo, Afzal Javed, Frank Pearl and Fredy Cante)
Here in Paraguay we are not an official branch, but I am the contact person. I am an occupational therapist and director of a center of psychosocial rehabilitation for persons with severe mental disorders in Asuncion, Paraguay. I try to keep informed about WAPR together with a small group of colleagues and co-workers, but we are not an organized group yet.

The strategy of psychosocial rehabilitation is not very common in this country, and it is hard to realize, because of the lack of a mental health network with different levels of intervention. It literally does not exist outside of the urban area of Asuncion.

In our center we support about 60 users from Monday to Friday, mostly former patients of the psychiatric hospital of Asuncion. They participate in different group activities, according to their personal needs and interests. An important strategy for us is practicing and learning to communicate: individually with the psychologist, within the group of users and together with the family. Strengthening the courage to participate in social events is also central. All that involved in constant psycho-education together with users and their families.

In the past two years Paraguay began with efforts related to inclusion of handicapped persons and there is a new legislation about inclusive education and employment. Some of our users are applying for training, internships or jobs. However there is a long way to go until this will be considered as a regular possibility for persons with mental disorders by professionals, their own families and society.

In September 2015 I had the opportunity to share our experiences with the participants of a psychiatric congress in Asuncion. Also in September 2015 a group of our users took part in a Festival of Art and Mental Health in Argentina.

Eva Insfran.
Centro de Rehabilitacion Psicosocial “EL PUENTE
Asuncion, Paraguay
Report from Venezuela.
Community Integration in mental health.
Caracas, October, 30th. 2015.

Dr. Alberto Colina. WAPR Correspondant in Venezuela.

The Centre for Community Comprehensive Daily Attention (Centro de Atención Diaria Integral Comunitaria, CADIC, in the Hospital Centro de Salud Mental del Espe, “El Peñón”, celebrated its first meeting after then years since its foundation.

The introductory words were offered by Dr. Danel Grau, Director of the Centre. Dr. Colina explained the structure and functioning of the Programme, after that a numerous intervention from staff users of the Service, carers and relatives and members of volunteer collaborative organisations were pronounced, sharing the lived experienced in the Programme,

Prof. Carmen Forn received a well deserved honor for her life contribution in the field of mental health in Venezuela during 38 years.

Left to right: Aux.TO. Victoria Uzcátegui, Lic. (Psicólogo) Daniel Grau, Director del Hospital, Sra. Reina Rodríguez (mantenimiento), Dr. Alberto Colina, Jefe de CADIC, Lic. Alida García (Enfermera) y TSU María Isabel Rodríguez. (Fisioterapeuta).
The board of directors of the FEARP usually holds three face-to-face yearly meetings in different cities in Spain. Last year 2015 the meetings were held in Las Palmas de Gran Canaria and Madrid while the General Assembly was held in Valencia. Between meetings they communicate frequently through a Google group.

The main subjects that were debated in the last year are:

The opening in Valencia of the State Reference Centre (CRE) of Care for Persons with Severe Mental Disorder by a Social Service Agency (IMSERSO) has generated significant internal controversy (partnership or no partnership with the CRE) on what differential role should be played by health and social agents in psychosocial rehabilitation. The FEARP has formalised a written statement defending coordinated action from all areas and always within a community care model.

The care model in psychosocial rehabilitation is a traditional debate within the FEARP. In Spain there is neither a unified model on rehabilitation care nor on responsibility from health and social services respectively. There is an autonomous organization in each region. The FEARP has participated in several documents with proposals for a model (for example the “Care Model for Persons with Severe Mental Disorder”); these proposals must be updated constantly as it was decided in our last meeting.

The Observatory of Psychosocial Rehabilitation in Spain of the FEARP has encountered many difficulties due to the heterogeneity of rehabilitation structures in different territories. It is an organisational chaos that has led the persons in charge of the Observatory (F. Villegas) to split up the activity by areas in the Working Groups of the FEARP where the task may be easier to accomplish.

The Working Groups of the FEARP represent areas of high interest within the psychosocial rehabilitation field. There are three groups that develop studies and specific documents: Vocational, Residential and Human Rights. For 2016 it has been proposed the creation of a fourth Working Group on the importance of including the gender perspective in psychosocial rehabilitation.

The "Psychosocial Rehabilitation Journal" of the FEARP is the flagship publication of this topic in Spanish-speaking regions globally. Its last published issue was Volume 12 (1) and is accessible freely and free of cost online from http://www.fearp.org/revista

The Committee of Users, led by Pedro Piburnat, promotes contact with the associative movements of users, participates in forums of associations of users and family members and it has coordinated their participation in our V National Conference in Valencia. It is an important line for the FEARP.

The FEARP participates in the WAPR mainly with the work of Ricardo Guinea together with the support of other fellows, such as Begoña Frades, who attended the meeting of the WAPR in Turin on 15 and 16 May on behalf of the FEARP.

The FEARP has adhered to the Declaration of the WARP Europe on the asylum crisis in Europe.

In the 12th world conference of the WAPR held in Seoul in November 2015 it was confirmed that Spain will host the conference of the WAPR in 2018. To this end have begun the preparations:
Skype connection with members of the AEN was made in relation to the conference of the WAPR in 2018 where both entities collaborate in its organisation.

FEARP participation in the Technical Drafting Committee of the Mental Health Strategy of the National Health System through our representatives Martín Vargas and Begoña Frades is an important boost to the development of strategic plans based on psychosocial rehabilitation. In December 2015 the final text was already available and sent for approval to the inter-territorial health council.

The third edition of the Master in Psychosocial Rehabilitation in Community Mental Health (October 2014 – September 2015) took place and the fourth edition was started from the University Jaume I. This online master is supported by FEARP in collaboration with other entities (AEN, FEAFES, etc.) where professionals from different Spanish-speaking countries are trained. [http://www.ujie.es/ES/infoest/estudis/postgrau/oficial/e@/22891/?pTitulacionId=42151](http://www.ujie.es/ES/infoest/estudis/postgrau/oficial/e@/22891/?pTitulacionId=42151)

The FEARP maintains a policy of collaboration with related entities. Ricardo Guinea attended on behalf of the FEARP the Memorial Day of the World Mental Health Day “Put yourself in my place. Connect with me”, organised by the Mental Health Spain Confederation on 6 October in Madrid. He was also representing the FEARP in the XXVI Conference of the AEN, etc.

The FEARP website displays FEARP activity and interests. It publishes information of interest in the field of psychosocial rehabilitation. [http://www.fearp.org](http://www.fearp.org)

The V Conference of the FEARP in Valencia held on 1, 2 and 3 October 2015 is the culmination of two years of organisation of our fellows in Valencia led by Begoña Frades. Within the Conference we find professionals, users and family members exchanging impressions, views and good moments of relaxation and leisure. All of it is essential for good mental health and recovery of everyone, all users, family members and professionals.

Translation: Claudia Sánchez Kilder
December, 2015; Trieste, Ricardo Guinea.

Under the direction of Roberto Mezzina, the conference “A community without seclusion” took place in Hospedale Santo Iovanni, Trieste, Italy. The conference had very good attendance from political representatives and leaders of services from many different countries.

The main topic of the conference was to explore how to make real the challenge of the open door, open discourse, open access, in mental health care and services through practices of freedom; in other words, the implementation of an inclusive and high quality community psychiatric attention, avoiding any form of coercion on the patients.

The intellectual framework of this topic was explored in different ways. Débora Kestel, PAHO representative and Ricardo Guinea, representing WAPR presented confluent visions, emphasizing the intellectual framework of Human Rights as the source of enforcement of this vision.

Sashy Sashidharan, from UK, presented an evidence-based statement on risk assessment in psychiatry. Since modern societies are averse to risk, risk assessment becomes a topic that receives greater attention. Under this pressure, risk assessments are made with much prejudice and in a highly conservative way. In a contrast to this, evidence shows that despite we have to consider that risk is everywhere, no particular traits of risk can legitimize to be attributed to person with mental health condition. Moreover, risk should be considered contextual to situations, meaning that risk as an attribute cannot be associated with particular person. Evidence shows also that professionals are not better in predicting risk that non trained people.

Thomas Emmenenger presented the result of the assessment of two new teams in Trieste, specially designed for intervention in situations where usually physical contention is considered. After 5 years, the results show that physical contention can be effectively reduced to “0” with no increased appearance undesirable events. The teams consist of voluntary staff together with two psychiatrists and 15 staff. The teams are receiving special training in communication skills, de-escalating techniques and is highly motivated. The interventions are based in careful communication,
non judgement of situations and no time constriction. Results show that in the last two years, no contention has been applied, and the average duration of interventions are two hours.

The conference included 24 workshops with participation of Allen Frances (USA), Afzal Javed, Anna Pitta, Barbara D’Avanzo, Antonio Cassaccia, Antonio Maone, Gabriele Rocca (WAPR- Brazil), John Jenkins, Paul Baker (Hearing Voices network, UK), and many more delegates.

In the conference, the book compiled by Antonio Maone and Barbara D’Avanzo “Recover, nuovi paradigmi per la Salute Mentale was presented, and received with a lot of interest.

The conference was organised as an activity of the Trieste WHO Collaborating Centre, was sponsored by The Mental Health department of Trieste, WAPR and IMHCN.
APRA (Association of Psychosocial Rehabilitation Albania) had its first introduction meeting. Foundational members introduced to each other and later discussed the aims and the objectives of the association and the way we should follow to reach these aims and objectives.

We found reasonable as the first step of our work to conclude a study on the mental health system in Albania. This in order to create a map of the actual situation here in Albania. First by studying the legislation and policies and current services. As of now there is not any database created by any institution regarding the number of persons with mental illness and the number of professionals who treat them. Identification of practices on this sector and the evaluation of basic needs of mental health in Albania is one of the priorities on which we have based our study. In addition we agreed on a foundational document.

We think that knowing all the issues regarding mental health in Albania and by evaluating all the priorities and needs we can later generate ideas which can help us on our future work.

In April 2015 discussing with our team about the activities of the organisation, we decided to work on a project in which we focused in understanding the attitudes toward mental health in Albanian Community. The aim of this project was to make the first step, which would help us to understand the situation of mental health in Albanian community and the necessary works to do.

The project lasted 6 months and during it we interviewed 900 individual from 12 main cities of Albania. This project helped us so much with all the important findings. On, 22nd of March 2016, in order to promote our organization as a new branch of WAPR and the project we started the last year, we organized the first workshop with theme "Mental Health in the Community". The participants were very interested in our organization and in WAPR, and some of them asked us to join the organisation and to be part of future projects, as volunteers.

We believe that this first activity was a good step towards the work that we have to make in our community with the important support of WAPR.
This document is a consensus statement on psychosocial rehabilitation produced by APRA (Association of Psycho-social Rehabilitation Albania) with the collaboration of the (WAPR) World Association of Psycho-social Rehabilitation.

ACKNOWLEDGEMENTS

The production of this document would not have been made possible without the decisive support from World Association of Psycho-social Rehabilitation (WAPR), more particularly from its President, Dr Afzal Javed, to whom we are especially grateful. We also want to thank Dr. Ricardo Guinea and Dr. Ida Kosza for the great ideas and all the support to make this possible.

The main interest behind the production of this document was, to reach a degree of consensus in which the Association of Psychosocial Rehabilitation Albania, (APRA) wants to declare that its aims and objectives endorse some of the most important aims and objectives of the World Association of Psychosocial Rehabilitation, (WAPR) in the context of cooperation between the two associations through the creation of WAPR branch in Albania, a role which will be carried by APRA.
M.Sc Anissa Zeqja, President, APRA, Rr. “Joklin Persi”, Tirana, Albania

BACKGROUND

Psychosocial rehabilitation is a process that gives the opportunity for individuals with mental disorder and their families to reach the optimal level of independent functioning in their community, improving the individual abilities in order to offer a better quality of life. PRS aims to provide the optimal level of functioning of individuals and societies, to minimization of disabilities and handicaps.

The principles and values of the WAPR Albanian branch (endorsed by APRA) will improve the quality of life of people with a mental illness and their families, through the integrated approaches that enhance the positive aspects of the people, promoting their well-being. These goals are:

1. The prevention of onset of mental illness and strategies to prevent chronic diseases, through early intervention on the school, the general population and Mental Health Services.
2. Dissemination on the concept of the recovery process that sees the needs of the user at the center of the operation of services.
3. Programs focus in the present of discrimination that is still present or people with mental illness.

Based in the principles and values of the WAPR, the directors of the Albanian Branch, provides an internal representation of users and family members.

AIMS OF APRA

The Association of Psychosocial Rehabilitation, Albania (APRA) has this aims:

1. Promotion of national legislation, policies and programs to meet the basic and special needs of people with a mental illness.
2. International exchange of experiences in the field of rehabilitation of mental disorders.
3. Promotion of the participation of users and family members in the management and evaluation of mental health services and support their full potential profits to take actions aimed at fighting the stigma, the promotion of civil rights, and to the continuous improvement of the quality of services and of inclusion policies.
4. Organization of training for health professionals to introduce strategies for psychosocial rehabilitation in specialist and primary health care services.
5. Consultation to local, national and International agencies to promote improved care, rehabilitation and services for people with a mental illness.
6. Organize a national congress every two years
7. Encouraging programs to raise public awareness and technical improvements to the
mental health promotion based on the return and protection of the rights of citizenship for people with psychiatric problems.

8. Collaboration with national and international organizations that move in defense of human rights for people with mental health problems.

9. Receiving of contributions, donations and eventually collection of funds to be used for the achievement of its statutory objectives.

STRATEGIES

• At individual level, with the interaction of pharmacological treatment, independent living skills and social skills training and psychosocial support to patients and their families.

• At mental health services level, with the interaction of mental health service policy, improvement of institutional and residential settings and training of the staff.

• At social level, with the interaction of the improvement of the legislation and public opinion and attitudes toward mental health.

RESEARCH

Given the various aspects involving mental health and PRS and the lack of studies in the Albanian context, it is necessary to develop research covering the most important items mentioned previously. Universities, research institutes and professionals will be invited to develop research in these areas.
Under the hospitality of Permai Hospital, took place the 1st Johor International Psychiatric Conference & 18th Johor Mental Health Convention, "METAMORPHOSIS OF MENTAL HEALTH SERVICES, INNOVATIVE APPROACHES".

The Conference included a panel of international speakers to deal with a very wide array of topics, including the concept and implications of Recovery, Human Righst in Mental Health, Supported Employment & Social Enterprise, Enhancing the Partnership in Community Psychiatry, Doctors In Court, Mental Health and School, Laughter Yoga and Happiness therapy, Interventional Psychiatry: ECT, TDCS. Delirium and Dementia Workshop, MATRIX Model, Medication Assisted Treatment in Addiction, Task Shifting on the Alternative Intervention in Depression, Grief Therapy, Burnout in Mental Health Workers, etc.

The special WAPR Workshop was seved by Dr. Ricardo Guinea (Recovery and Its Implication for Services, Human Rights in Psychosocial Rehabilitation in Thailand), Dr. Ahmad Rasidi Saring (Key Features of Effective Psychosocial Rehabilitation in Malaysia), Dr Marhani Midin, (Influence of Mental Health Service System in Development of Psychosocial Influence Rehabilitation in Malaysia), Dr Siti Hazra (Malaysian Rural Model of Partnership in Delivering Care to People with Severe Mental Illness), Dr Hazli Zakaria (Smart Partnership in Improving Care for People with Severe Mental Illness: Urban Model).

The mail learning outcomes from the workshop were The role of PSR in recovery of people with Mental Illness, Human rights issues in PSR, Community empowerment for PSR in Thailand, Key features that determine the success of any PSR in Malaysia, Factors in Malaysian mental health service system to be considered in developing PSR and Examples of partnership models in rural and urban setting in Malaysia.

The rich discussions within the workshop ensured a good outcome and resulted in a good exchanging experience promoted by Dr. Marhani Midin and the Malayan WAPR Branch.
Building on the WAPR Declarations of Kobe 2004, Athens 2006 and the Valladolid Statement 2010 and in line with the WHO-WAPR Plan of Action Advocates 2013, at the occasion of the WAPR World congress in Seoul November 2015,


Recovery describes an approach to mental health problems that – cognizant of the potential limits caused by a disability – enables autonomy, empowerment as well as integrity and equality of opportunity. The goals of recovery and its central elements intersect with those of human rights, while practices against human rights are factors that hinder recovery.

The UN Convention on the Rights of Persons with Disabilities (CRPD) for the first time in the history of the disability movement explicitly includes persons with disabilities from mental health problems. The CRPD with its 50 articles cover a wide range of key areas in which effective human rights protection and promotion now necessitate revisions of existing legal, health and social care situations as well as new actions in order to fulfill the principles of the treaty. Newly formulated long-standing rights to non-discrimination include key areas such as health, housing, education, employment, standards of living and social, political and cultural participation as well as the right to be free from exploitation, violence and abuse. In order to reach all these legitimate aims intense work over many years if not decades will be necessary and WAPR will stay committed to this work with special attention to the CRPD articles pertinent to the core tasks of psychosocial rehabilitation:

- Article 19 - Living Independently and Being Included in the Community
- Article 24 – Education
- Article 26 - Habilitation and Rehabilitation
- Article 27 - Work and employment
- Article 28 - Adequate standard of living and social protection
- Article 29 - Participation in political and public life
- Article 30 - Participation in cultural life, recreation, leisure and sport , (as well as those articles that focus on research, evaluation and international collaboration:
- Article 31 - Statistics and data collection
- Article 32 - International cooperation

The CRPD is based on a social model of disability with a focus on non-discrimination and social inclusion and the product of a truly participatory process. In a corresponding logic, it makes the consultation of its constituency an obligation: no policy development, no amendment of legislation or elaboration of new regulations shall be undertaken without including experts in their own right: persons with a lived experience of mental health problems and services.

WAPR will therefore intensify its long-standing policy of user involvement in the organisation and its activities in line with the clear aim of the CRPD as well as national and international user organisations: ‘Nothing about us without us’.

Also, WAPR will stay committed to empower family carers and will intensify efforts on working partnerships between users, family carers and mental health workers along the lines of the WPA Recommendations on best practices in working with service users and family carers and the Trialogue movement (www.trialogue.co ).
As described in the 2013-2015 report the WAPR Task Force on Ethics and Human Rights (page 44 of WAPR Bulletin Volume 37 November 2015) has participated in actual international developments and discussions concerning the human rights of people with mental health problems and disabilities. It also has organised and participated in WAPR congresses and WAPR congress presentations. Finally, the attached WAPR mission statement on Recovery-Orientiation, Triologue and the Human Rights of persons in psychosocial rehabilitation has been approved at the general board meeting at the World Congress of Psychosocial Rehabilitation in Seoul in November 2015.

The UN Convention on the Rights of Persons with Disabilities (CRPD) with 162 ratifications by February 2016 will continue to be a focus of attention of the work of the Task Force:

The task of formulating the main consequences of entitlements rights according to the UN-CRPD articles pertinent to the core tasks of psychosocial rehabilitation:

- Article 19 - Living Independently and Being Included in the Community
- Article 24 – Education
- Article 26 - Habilitation and Rehabilitation
- Article 27 - Work and employment
- Article 28 - Adequate standard of living and social protection
- Article 29 - Participation in political and public life
- Article 30 - Participation in cultural life, recreation, leisure and sport as well as those articles that focus on research, evaluation and international collaboration:
  - Article 31 - Statistics and data collection
  - Article 32 - International cooperation

in order to increase the effects of entitlement rights on an individual as well as on the health care system level (including effects of these rights on implementation of recovery-orientation of services and strengthening the awareness of the significance of social determinants of mental health).

WAPR wants to further a process of understanding and participating in shaping the effects of the CRPD in different countries and internationally with regards to accessibility and assistance needs and rights. Such a process concerns especially also, questions of Definition of psychosocial disability
Definition of reasonable accomodation
Assessment of assistance needs to replace current deficit assessment

Ideally, come up with a consensus on the main consequences of the rule of law of the CRPD for the field of psychosocial rehabilitation.

Cooperations with WHO as laid out in WHO-WAPR action plan including WHO QualityRights Tool Kit and the focus on Human Rights and Recovery orientation as part of the WHO Action Plan 2013-2020

Cooperation with WAPR Committee on “Forensic Issues”, chaired by Gabriele Rocca, which works on making use of the inputs from Italy and the reform in law of the forensic approach in this country.

Participate in the current international discussion on the need for reduction and the understanding of new challenges for the current legal basis for involuntary interventions

Working in partnership between Users, Carers, different mental health professionals, lawyers, human rights activists, WHO, and the general public and supporting this multi-stakeholder approach to all developments, discussions and decisions in the mental health field. Further empowerment and participation of stakeholders in mental health, including essential dialogical approaches such as Open Dialogue and whole life whole community learning sets.
In this section we offer links important for our field. If you have suggestions for websites and links, please mail the editor: marit.borg@hbv.no


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

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


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

Yale Program for Recovery and Community Health: http://www.yale.edu/PRCH/
COMING CONFERENCES.

www.congresso2016.abrasme.org.br

www.conferenciasaludmentalperu2016.com
Launching of the:
WAPR Collaborating Centres for Research and Training
(WAPR–CCRTs).

In Seoul it was finalised the process to create the WAPR Collaborating Centres for Research and Training.

The proposal is to establish WAPR Collaborating Centres in as many as possible of WAPR's regions, as a strategy that warrants strong support from all WAPR members. There has been a general agreement in WAPR 2012-15 that WAPR should support this plan and agree on a policy that endorses the idea and makes it sustainable.

It is agreed that there is already a considerable number of organisations in many parts of the world that could be designated by WAPR as a WAPR-CCRT.

WAPR Taskforce for CCTRs.
The approved members of the Special Taskforce are:
• Chair: Ricardo Guinea. WAPR Exec. President.
• Co-Chair: Harry Minas.
• PresElect. Murali Thyloth
• SecGen. Solomon Mataemane.
• Treasurer Carmen Ferrer
• VP Alberto Fergusson.
• VP VK Radhakrisnan
• VP Europe: A. Maone.
• VP Africa: Monique Mucheru.
• VP Americas. Pedro Delgado.
• VP EastMedit. Medhat Elsabbahi.
• VP SEast Asia Pichet Udomratn.
• Board:
  • David Ndetei.
  • Tae-Yeon Hwang.

The responsibilities of the Taskforce will include:

1. providing day-to-day organisational support to the WAPR-CCRT Committee in carrying out its duties;
2. establishing and maintaining a WAPR-CCRT website (which would probably be part of the WAPR website)
3. developing and implementing a WAPR-CCRT communication strategy
4. encouraging and supporting WAPR-CCRT projects
5. encouraging and supporting collaboration between WAPR-CCRTs
6. developing a WAPR-CCRT publications program
7. working with WAPR conference organising committees to develop WAPR-CCRT symposia.
8. The Special taskforce will report regularly to the Executive Committee.

CRITERIA FOR DESIGNATION AS A WAPR COLLABORATING CENTRE IN RESEARCH AND TRAINING.

1. The applicant organisation, which may be a public or private sector, or NGO or civil society, organisation, must:
2. provide organisation details;
3. identify the Director of the proposed CCRT;
4. provide evidence of capacity to develop and implement PSR research and/or training programs;
5. propose a 3-year work program for approval by the WAPR-CCRT Committee;
6. express a commitment to collaboration and information-sharing with WAPR and with the developing network of WAPR-CCRTs.
7. The Special taskforce will submit all developments, new criteria or any modifications from the above expressed to the Executive Committee for approval.

PROCESS FOR APPROVAL OF CENTRES:
WAPR Taskforce will receive and review requests for such approvals and monitor the future work in this area.

The suggested remit of this committee should be:
1. To agree on a process for designating organisations / centres as a WAPR-CCRT
2. To agree on criteria for designation / approval
3. To develop application process and formats
4. To receive annual reports from WAPR-CCRTs which will be submitted in a prescribed format
5. To liaise with WAPR Congress and Regional and National Conference Committees to ensure that WAPR-CCRT symposia are included in conference programs and to encourage pre- or post-conference training workshops conducted by WAPR-CCRTs
6. To work with WAPR-CCRTs to develop WAPR-endorsed training programs, curricula and materials
7. To encourage collaboration and information-sharing between WAPR-CCRTs & other WAPR components.
8. To report to the WAPR Executive on the activities of the EWAPR-CCRTs

9. Before the end of the period of approval & designation (3yrs?) receive and determine applications from WAPR-CCRTs for re-designation for a further period.

CONTENTS OF TRAINING, TEACHING & RESEARCH PROGRAMMES:

1. Each centre should prepare & submit proposals regarding Research & Training programme(s) depending on the needs in the region, their resources, possible funding and other logistics for endorsement by the standing committee.
2. Then centres should be independent suggesting format of such programmes but the contents and form of these programmes should be in line with WAPR philosophy and vision.
3. A WAPR Committee might establish general guidelines for such training programmes.

WAPR SPONSORED & FUNDED PROGRAMMES:

• WAPR should also start working on developing and organising WAPR’s specified programmes on Research & Training. This could be achieved by organising these programmes in WAPR-CCRTs or at any other reputable centres.
• WAPR should find funding and financial resources for such programmes and should explore support from other donors and supporting organisations.

4.
## EXECUTIVE COMMITTEE

<table>
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**MORE INFO IN WWW.WAPR.ORG**

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

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

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- Solomon Rataemane.

#### Training and Curriculum
- Co-Chair. V Radakrisnan (VP)

### WAPR TASK FORCES

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

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

#### WAPR-Collaborating Centres for Training and Research (WAPR -CCTRs)
- Co-Chair: Harry Minas.
- PresElect. Muraly Thyloth
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- VP Southeast Asia Pichet Udomratn.
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#### White Book: Strategies for Implementing PSR Services for Underserved Populations.
- Co-Chair: Medhat Elsabbhi
- Nadira Barkalil.
- Monique Muchunu.
- Georgina Fumero.

#### Rehabilitation Programmes for Adolescents & Young Children
- Co-Chair: Ricardo Guinea.
- Anisa Zeqja.

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

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

#### Physical Health in Psychiatric Hospitals
- Co-Chair: Gabrielle Rocca.

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