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COMING CONFERENCES:

LINKS.

BOARD and Committees.
I am pleased to report that WAPR has continued its normal functioning with a good level of global activity and many local meetings.

The main points to date are:

REGISTRATION AS AN INTERNATIONAL NGO.

As I announced in Seoul, one of my priorities as President would be to strengthen our structures as an organization. So, as it was announced in our networks, after many bureaucratic actions, WAPR is finally registered as an International NGO in the Spanish Home Affairs Registry for Associations. This means now we have full legal capacity as an Organization, including the possibility to apply and receive funding from international donors for our activities. This is an important action that solves a previous vulnerability and gives us the possibility to face one of our pending weaknesses, that is our week financial structure. Now, after some conversations, we can face the creation of a Fund Rising Committee, with the target of create a more solid way of funding our activities.

WEBSITE AND SOCIAL NETWORKS.

As it was announced in Seoul, first Board Meeting of this term, we needed to renew the website. The rapid changes in technology, and the evolution of our structures made necessary to face that project. It was proposed that we would need to create a new site that could be easily managed by us, with latest and full compatible technology, and with the possibility to be easily transferred to another Webmaster when necessary, i.e. when the presidency goes to India next term. Now this has been done. We have a new site, easy to handle, and highly connected with different networks (Facebook, Twitter and Google+).

The new site includes some very convenient features. First, a private section for members that requires password, so we can publish documents in restricted area, only for WAPR members. Second a secure payment gateway, so dues can be very easily paid easily, including the possibility of payment with a simple credit card transaction. We expect that this will ease our life in this aspect of our associative life. And third, the updates in the news sections of our site will be automatically published in Facebook, Twitter and Google+. This feature is already active, and our social networks are gaining dissemination and presence. Just as a simple example, the greeting video in the last Mental Health Day had more that 3000 hits.

For reference:
Website: www.wapr.org
Facebook: www.facebook.com/WAPR
Twitter: @wapr_amrp

COMMITTEES:
The proposed list of standing committees and members that needs to be passed in Cesena are:
(subject to approval or modification):

Membership:
Co-Chair: Solomon Rataemane (Sec. General)
T Murali (Pres. Elect)
A. Fergusson (VP)
V Radhakrishnan (VP).

**Congress:**
Co-Chair: T Murali (Pres. Elect)
Solomon Rataemane (Sec. General)
Tae-Yeon Hwang (Chair Org. Com previous congress)
Antonio Maone (VP Region from region the next congress will take place).

**Constitutional Ammendments:**
Co-Chair: T Murali (Pres Elect)
Afzal Javed (Immediate Past President)
Solomon Rataemane (Sec. General).

**Nominations:**
Co-Chair: T Murali (Pres. Elect).
Solomon Rataemane (Sec General)
Afzal Javed (Immediate Past President)
Alberto Fergusson (VP)
V. Radhakrishnan (VP)
Gabriele Roca.

**Editorial:**
Co-Chair: Marit Borg.
Tae-Yeon Hwang
Pedro Delgado.
Peter Yaro.
Rao Sathyanarana
Bárbara D’Avanzo.
Michaela Amering.

As agreed in Seoul, we will have a reduced number of committees, keeping only the active ones.

**EDITORIAL COMMITTEE.**
Under the direction of Marit Borg (Norway) chair of our standing Editorial Committee, and support of Barbara D’Avanzo and Ricardo Guinea, the bulletin is being released with regularity. Some other Board Members, as Barbara D’Avanzo (Italy), have been collaborating. It should be noticed that the Bulletin is increasing its quality, and is very informative of the many activities that happen around WAPR and its branches.

We have had some conversations about how to coordinate the management of the website in the Editorial Committee, and we will probably have some agreements in the next future about this, to optimize our coordination and share the workload.

**COMMITTEE OF TRAINING, AND GOOD PRACTICES.**
Training is one of the most remarkable queries formulated in WAPR meetings in many countries. However, WAPR’s structure is still too week as to be able to provide systematic training wherever it is requested, there is something we can certainly do: to agree in a basic training program in PSR, able to be delivered in a limited time, that would include the basic requirements to work in this field. This project has already been initiated, under the direction of Marianne Farkas (Boston, US), and hopefully will present in Madrid World Congress a consensual proposal.

**HUMAN RIGHTS COMMITTEE.**
This committee is a very important element of our agenda, since HHRR is one of the fields that
have received more attention in the last years from several relevant international agencies. Michaela Amering, will be chairing the committee, assisted by Guadalupe Morales; a work plan has been sent. We are all aware that in our field, in many interventions there is an important risk of collision with HHRR principles, in issues like advocacy and protection, interventions on acute yards, interventions in forensic institutions, guardianship and other forms of substitute / supported decision making, etc. Moreover, the promulgation of the UN Declaration of Rights of Person with Disabilities has received a lot of attentions and some technical discussions. Again, therefore we will pay attention to this important field and will propose a Special Symposium in our World Congress specially dedicated to it.

**TASKFORCE FOR WAPR-CCRT.**
This taskforce has agreed in general criteria for accepting Collaborating Centers for research and training. Procedures and templates for applying for new centers, have been passed.
So far, we have the following accepted Collaborating Centers.
- Chile: University of Concepción, Department of Psychology and Department of Psychiatry and Mental Health.
- Colombia: Consultorio de Atención Psicosocial – CAPsi, Universidad Icesi, (Psychosocial Consultation Centre – CAPsi, Icesi University).
- Kenia: Africa Mental Health Foundation (AMHF).
- UAE: Psychiatric Rehabilitation Unit, Behavioral Sciences Pavilion, Sheikh Khalifa Medical City – PRU, BSP, SKMC.

Egypt: Institute of Psychiatry, Ain Shams University Hospitals, ASUIP.
A special Symposium about the role and future of these centers will take place in WAPR World Congress, Madrid 2018.

**Other proposed committees.**
Some committees have been proposed, however we have no news about its level of activity. My proposal is that if these committees succeed in offering some outcomes, they will be offered a space or symposium in Madrid World Congress.
The Board meeting in Cesena will be a timely opportunity to consider these committees.

**COMMITTEE FOR SITUATIONS OF EXTREME SOCIAL TRAUMA.**
There is an increasing interest in WAPR this kind of social determinant that is living in conditions of extreme social trauma, due to natural disaster or human made conditions. Two of our officers have expressed interest in working in this line within WAPR framework: Alberto Fergusson (Colombia) and Khalid Mufti (Pakistan).

**EARLY INTERVENTIONS.**
Early intervention is one promising field in PSR, since it describes the process of the onset of symptoms, explores ways to shorten the time lapse until appropriate treatment is established, and if providing research about the best evidence based approached to for treatment. WAPR is aware to the increasing interest in this and Ricardo Guinea will chair a Special Committee about this, focused in organizing a special symposium in Madrid WAPR World Congress, 2018. Solomon Rataemane expressed also interest in it.
FORENSIC ISSUES.
Since psychiatry has a role in assessing the legal system in many situations, forensic issues are in narrow connection with living conditions of many users. Legislation some many countries still need revision (i.e. to adapt to UN Convention of Rights of People with Disabilities). The situation of users under legal measures about mental illness (i.e. forensic mental hospitals) needs attention. Gabriele Rocca, WAPR De. Secretary General, expressed his interest in leading this committee.

FUND-RISING COMMITTEE.
We have discussed that our current way of getting funded will not be sustainable in the mid-term. In a situation of economic crisis, Congresses are not likely to provide significant income in the future. Some actions have already been taken. The legal status of WAPR has been issued, since it is already full registered as an International NGO in Spain. So, WAPR will be entitled to apply for funding from donors. In a conversation with our Thyloth Murali, our Pres-Elect we agreed to explore this way, assisted by Carmen Ferrer (Treasurer), Solomon Rataemane, and Alberto Fergusson.

CONFERENCES:

WAPR has been involved / sponsored 14 Conferences.

Past conferences.
Reports and Information has appeared in Bulletin and social networks.
2016, April. Johor; MALAYSIA, 20 – 22 APRIL 2016. Metamorphosis of Mental Health Services: an innovative approach, 8th Johor mental health convention, Hospital Permai. Dr. Abdul Kadir abu Bakar, Director of hospital Permai, Malaysia.


2017, 24-26 March, AFPA World Congress, Abu Dhabi.


Coming Conferences:
2017, June 9-10th. 2017. Cesena WAPR European Conference (Italy), “Right and duties”. This meeting will host a WAPR Board meeting. http://www.wapr.org/cesena-italy-4th-wapr-european-conference/ A board meeting has been scheduled.


2017, June 29th 30th. Florianopolis, Brazil, under the leadership of Ana Pita, will take place the 3rd Forum of Human Rights in Mental Health, 2017. www.direitoshumanos2017.abrasme.org.br

2017, 1-3 September 2017, Bangkok, Thailand: The 5th Asian Congress of Schizophrenia Research in conjunction with the 2017 Asia Pacific Meeting of WAPR. www.acsr2017.com


NEW BRANCHES.
We have appointed in this period some National Secretaries with the mission of creating new branches in Latin America:
Mariusz Wolonziej for Ecuador, and
Daniel Matzman for Uruguay.
We expect to have new branches in the next future. We can expect new branches in Chile (Contact person, Carolina Vergara), and Portugal, (Antônio Marques).

WORLD CONGRESS MADRID 2018.
Organization is already started. (Committees, scientific program). The focus: “Recovery, Citizenship, Human Rights: revising consensus”.
Main participation from WAPR is intended to be channelized by WAPR active committees.

FINANCES.
A full report about finances will be presented in Cesena Board meeting and circulated t the Board.
But on this regard, it is important to realize that A) WAPR has now a better potential to get funded for our current activities, and b) it will be necessary to re-think the way WAPR is funded in order to achieve a more balanced and stable way of functioning.

PROJECTS.
An initiative to edit a book with updates in our discipline has been launched by Pres. Elect, Dr Thyloth Murali.
An initiative to make an educational video about WAPR and Psychosocial Rehabilitation in the world has been proposed by Ricardo Guinea, in sponsored by Fundación Manantial (WAPR Affiliated Organization).
An initiative to elaborate some agreed criteria on training in PSR is being conducted by the Training and Good Practices Committee, co-chaired by Ricardo Guinea and Marianne Farkas.
Europe is facing a dramatic flow of migrants coming mainly from areas of war. In 2015 about 2.7 million people immigrated to Europe from Non-European countries. Eventually all who come from middle or low-income countries and from areas of war arrive at the borders of the most easily accessible countries, Greece and Italy. Many want to move to richer countries in Germany and North Europe, but only a part of them will have their application for asylum accepted (http://ec.europa.eu/eurostat/statistics-explained/index.php/Migration_and_migrant_population_statistics).

Hence, European countries face different types of challenges, which depict a very complex picture. The border countries have to support the effort of the emergency: the enormous arrival and immediate help to people in extreme conditions - often witnessing the death of hundreds of people. However, they also have to face the integration needs of those who remain. The other countries, particularly those where the per-capita income is higher, have to support the effort to give opportunities to the high numbers of people who want to settle there. Therefore we have to do with a multifaceted problem, since there are issues related to those who arrive in extremely hard conditions and completely deprived, those who remain illegally and therefore with extremely limited opportunities to integrate into the society, and the second or third generations, connected with previous waves of immigration, which show specific problems.

These challenges are extremely hard and costly, and they do not seem to produce the expected results. Moreover, the hosting European countries are all dealing with internal conflicts, due to the different political positions with respect to immigration policies, and inter-country conflicts, also enhanced by the weak governance of these problems exerted by the European institutions.

Studies have highlighted that problems, difficulties and risks are different according to the country of origin and color of skin (Bhugra et al, 2014). It is also revealed that second generation are showing higher risk of psychosis than the majority population or the first generation (Hollander et al, 2016) and status of refugee or non-refugee, with refugees having worse mental health than non-refugees (Patel et al, 2017). Most migrants are exposed to severe and prolonged traumas and to the risk of the related mental disorders, besides experiencing the physical consequences of malnutrition, maltreatment and tortures. Whereas post-traumatic stress disorders are more prevalent in the adult population and are more apparent at their arrival in Europe or after a short time, many children and adolescents are at risk of developing psychotic disorders because of neglect experienced before, during and after the immigration process. Moreover, the increase of severe mental illnesses in the second generations indicates that the problems should be
seen and faced in the long-term, and in their continuously changing manifestations, indicating a combination of long-term perspective should be accompanied by a regular monitoring and assessment of needs at local level.

From a social point of view, the inclusion of migrants in the community is still limited and sometimes absent, and migrants and local populations still know each other very little. Therefore, feelings of being threatened physically and socially and fear to be overwhelmed by the migrants, worries for the maintenance of cultural identity are very common in the majority populations. These should be effectively fought, also through psychological and educational means.

Information that is more thorough and more research, in order not to produce and perpetuate misunderstandings and misleading information, are needed.

Mental health professionals can play a crucial role in increasing awareness and designing and offering interventions aimed to improve the well-being of the hosting population and migrants, fighting stigma, and delivering tailored interventions for prevention and treatment of mental disorders to the diverse groups of migrants.

Is the answer given to the young and very young sufficient to restore at least part of their resilience to answer to the prolonged traumas they have experienced? Experiences of hospitality are diverse in approach, quality and effects, but the institutionalization-like approach seems common.

How can mental health professionals answer to this? The European Psychiatric Association have developed a guidance (Bhugra et al, 2014) for the mental health care of migrants. This underlines the need to have services accessible from the cultural, geographical and emotional points of view; to regularly determine the local needs and perform audit; include cultural mediation or other models to facilitate access and communication. It also indicates that clinicians should have clear information about the mental health problems of the population served, and follow mandatory training in cultural awareness, better if embedded in the academic curriculum. Policy makers should make resources for living arrangements and employment more available, and should provide public mental health and public education about migration, migrants and their needs and obligations.

A few more prompts for the mental health professionals and researchers can be added here:

- information based on figures and facts and on the awareness of the reasons of fear and social distance: mental health professionals should have a strong
asset of information and knowledge to address fear in the general population, and the reasons at the ground of it;

the issue of identity should also be addressed by social psychologists, and have it understood in its deep meaning: rather than closure and particularism, a more flexible value of identity can help trascend group boundaries;

too much attention is given to differences amongst people and populations, which are often based on stereotypes: these should be challenged in education and community psychology settings, and basic similarities should be identified and valued; being present: psychologists and psychiatrist specifically trained in these issues are needed and their interventions should be embedded in the whole process of integration, and not only in the clinical settings; one size does not fit all: post-traumatic issues are different from other common disorders and psychotic disorders; population groups should be monitored for different problems, refugees would need specific attention in the short and medium terms, and second generations should be monitored and supported in the social environments where they live; more culturally sensitive models of psychological interventions should be designed, taught and implemented;

priority to social inclusion, with particular attention to the young, should be given and institutionalization avoided; “work with them”: social and public health actions and psychological interventions should be developed with the collaboration of ethnic minorities and their representatives.

The European Union is going through very hard times, and several hard matters threaten its unity, immigration being one of this. The global nature of the WAPR warrants that this issue is taken into consideration. The next opportunity to do this might be the European congress organized by the Italian Branch in Cesena on the 9-10 June. Shall we take this opportunity? European branches might commit themselves to discuss possible proposals taking advantage of the dialogue with all the other countries, which make the WAPR a truly international and global organization.

References


Lessons learned from an experience of community coalition addressing prevention of severe mental illness in Italy: background, achievements, limits and promises

Barbara D’Avanzo
National Secretary Italian WAPR Branch
IRCCS Istituto di Ricerche Farmacologiche Mario Negri, Milan

Prevention of severe mental illnesses and mental health issues at risk should be done in the services and in the community

There is evidence that many mental health problems have their onset at young age (Jones 2013), and that their early identification allows intervening, also non-pharmacologically, with a meaningful favorable impact (Das et al, 2016). Early intervention can influence psychopathology and functional outcomes even of psychoses, also acting on the possible biological vulnerability, preserving the social development of the person, pivotal to an adequate psychological and social development in adolescence (McGorry et al, 2015). Many factors influencing mental health are not health-related. We know that biological vulnerability can be enhanced by stressful life events in childhood and adolescence, by the absence of adequate social support (Sheikh et al 2016), use of substances (Carney et al 2016; Buchy et al 2015), stress and social exclusion (Chaumette et al 2016). Also perceived stigma acts as a risk factor for onset of a psychotic condition in persons with at risk mental states (Rüschi et al 2015).

In order to early identify these conditions it is necessary that the mental health services are easily accessible and attractive for the young. It is also urgent to develop strategies of collaboration with the community, given that health and mental health are the product of the interaction between individual and social environment. As a consequence, we believe that health and mental health can be promoted and improved through collaborative actions based in the community (Anderson et al, 2015).

Community involvement is therefore necessary owing to the social nature either of many stressors and protective factors, which can play a major role in the onset of illness.

It is therefore necessary for the mental health services to modify the way to look at community involvement: rather than one among the possible actions in public health, it should be considered as central in any public health issue (South & Phillips 2014). Consequently, we should promote and enhance sensibilization, information, and education, either conducted by professionals, experts by experience or peers, and have the community more aware of the social determinants of mental health problems. This work is in turn an asset available to the services, which can see and plan themselves with a better understanding of the community needs, opinions, positions. A more suitable language, less technical and more useful, can be achieved for a better collaboration in new projects.
The Community Coalition Model

A way to achieve this is the community coalition model. The background can be seen in experiences like the “health promotion and disease prevention coalition” (Green 1990), the “community development models” (Chavis 1992); and theories of organisational behaviour - network and "open-system theories", social capital, community empowerment and social ecology (Kreuter 2002, Stokols 1996; Wandersman 1996).

According to the model proposed by Butterfloss (2002, 2007), a community coalition realizes a structured collaboration among subjects representing different stakeholders, agencies, organizations and institutions, as well as private citizens, volunteers, who explicitly share a common objective. For instance, the community coalition can become a subject for planning actions and possible solutions for problems such as identification and management of severe mental disorders in the young, populations at risk, with mental health services and the community coalition collaboratively indicating the problem to be addressed and defining the ways to address the problems.

Starting such actions entails difficulties related either to mixing different cultures and types of knowledge, changing the perspective of the services from a rehabilitative and clinical ones to a more community and prevention-centered one, and the need to keep high motivation and participation of the community coalition subjects.

The evaluation of the effectiveness of community coalitions is nonetheless quite hard. A Cochrane review (Anderson et al, 2015) indicated that we do not have valid tools. We know anyway that some features of the community coalitions are related to community coalition success (Mizrahi 2001, Lippman et al, 2016), like the clear definition of the mission, a defined and strong leadership, well established structures of the governance, education and technical support, development of adequate communication style and tools. The quality of such factors can facilitate or hinder the capacity of a coalition to mobilize resources and implement interventions (Kadushin 2005; Zakocs 2006).

In this frame, we present here a project named "Integrated interventions to improve early identification and treatment of severe mental disorders in people aged 15-24 years in at risk population groups", funded by the Italian Centre for Disease Control and conducted in the areas of six Departments of Mental Health in three Italian Regions, the CDD Project.

The CDD Project in six Italian areas

The CDD Project developed specialized teams in identification of mental states at risk of psychosis, which, differently from what usually done, gathered specialists from the Child and Adolescent mental health services and from the Adult mental health services in order to combine expertise. This integrated type of service should be accompanied by the development of the community coalition as the base of the real preventive work. This represented a proactive attitude of the services, with the services going out of their settings and competences and establishing contacts with the places where the community life takes place. As said above, this attitude can allow a more effective communication and translation of the knowledge about mental disorders and their risk factors, make the community more informed and more aware of the social determinants of mental disorders and more active about them. This meant leaving aside the paradigm where the subjects of the community are just recipient of the expert knowledge and make the community more responsible of health and well-being of all the citizens.

The project acquired competences and resources in order to make a link between the community subjects and the integrated teams. The personnel worked to build or enrich the map of the organizations active in the areas involved, which were invited to a first meeting for the project presentation. There were five phases:
1. Identification of the organizations: the six DMH identified between six and 33 organizations in the community as potential or actual partners (June-September 2014);

2. Meeting with and presentation to the organizations, and exchange about experiences of management of cases and relationship with the treatment agencies (October-December 2014);

3. People who attended two or more meetings were then invited to establish a Board which could promote informative initiatives, aimed to sensibilization and planning of activities for the prevention of severe mental disorders, leveraging on the concept of mental states at risk and behavior and conditions that possibly represent important risk factors. The Board had to consist of no more than 10-12 people, with enough experience and interest to involve and attract a larger array of interested organizations and subjects. This larger number of potentially active subjects is the Community Coalition. The Board had several tasks: prompt to establishing opportunities for community mobilization, being a support to other community subjects in the issue of mental states at risk and severe mental disorders.

4. Specific attention was paid to second generation immigrants, because of the evidence of an increased risk of psychoses in this population group, and in order to get in touch with them in a more suitable and efficient way. Associations of ethnic minorities and associations aimed at the social inclusion of such minorities were therefore included.

5. The project coordination provided support and guide to the professionals of each centre, in the perspective of having them later more autonomous, and also offered some education in mental health issues. In particular a. what are psychoses and mental states at risk; b. risks associated to the duration of non-treated psychosis; c. primary prevention and the challenges it poses; d. non-pharmacological interventions as first line interventions for mental states at risk and psychoses in the young; e. communication skills to be used with people showing difficulties and mental stress; and f. ethnic and cultural differences in the illness symptoms and signs.

Achievements of the CDD Project

During the CDD Project, the Boards established in each centre had ten meetings on average. More attended at the beginning, with about twenty people motivated to actively participate, the Boards then got smaller, with a mean of 4-5 people. In all the Boards there were secondary school teachers and representative of ethnic minorities associations or churches.

The participants expressed the need to discuss in particular:
- how to identify emotional and mental disorders in young people they are in touch with, and establish a potentially helpful relationship;
- fear to "substitute" the mental health professionals, i.e., to go out of one's own role and skills;
- tools and skills to have a dialogue with the families of young people, often willing to reject the idea of mental illness and help seeking, especially, but not only, in the immigrants;
- prompt and tips about how to translate ideas and knowledge into actions and projects;
- how to recognize and distinguish signs of mental stress from culturally determined behavior or beliefs.

The activities of the Boards were:
- developing a leaflet to present the team for the young established in the six DMH;
- issue of a call in the schools for a visual or art product about the perception and the idea of mental disorders in the young;
- education and dissemination of the concepts of mental states at risk, severe mental disorders and prevention, with attention to ethnic minorities;
- recreational and sport activities aimed at ethnic minorities involvement;
- recreational moments centered on issues related to mental health;
- establishment of a place devoted to listening and free conversation about emotional hardships young people might experience;
- informative meetings about mental health issues with students;
- a multiethnic group of young people specifically committed to disseminate a mental health disorder sensible culture.

These activities took from mid 2015 to mid 2016.

How can the Community Coalition be assessed?

It was necessary to assess the quality of the project. Whereas this could not be done in terms of effect on prevention of psychoses, we could understand how the process of involvement and establishment of the Board and the coalition worked. In order to do this, we used two tools: a meeting of the members of the six Boards, reported
with a qualitative-like approach, and a survey of the Board participants by means of a questionnaire. Using a Likert scale from 1 to 10, we investigated satisfaction about several aspects, with 1 representing lowest satisfaction and 10 highest:
- clarity explanation of mental states at risk;
- clarity about the project objectives;
- clarity about what the project expected from the participants;
- implementation of what the project asked for;
- actual usefulness for the community of what done in the project;
- perception of being an active part in the project;
- usefulness of the informative sessions received;
- education about mental states at risk;
- usefulness of contacts with the teams;
- interest to continue the activity;
- most important activities;
- most important prompts received;
- most important difficulties.

The survey revealed that the mean age of participants was 51 years, which mirrors the age of people active in the third sector and volunteer sector in Italy, at the same time showing no involvement of young people, though these were the project target.

The most appreciated aspects were understanding of the project objectives, feeling to be an active part of the project with scores higher than 8. The least appreciated aspects were the informative sessions about mental states at risk and the contacts with the teams. The most appreciated activity was network building, and then the improvement of knowledge about severe mental disorders. The most meaningful prompts were attention to mental and emotional disorders in the young and a better understanding of how to conduct preventive activities in the mental health field. Finally, the most meaningful difficulties were seen in the limited opportunities to meet young people with mental states at risk, and the too short or incomplete training about at risk mental states and severe mental disorders.

Several indications derived from the survey were then tested and discussed in light of the meeting of the six Boards which took place in June 2016, few months before the project closure. Participants defined the Board experience as a “project more difficult than others”, meaning the novelty and the interest, together with the commitment necessary. They highlighted how meaningful and useful contacts with the mental health teams and specialists were, outside a context of care or facing a particular problem. This was useful either to help the mutual understanding between professionals and non-professionals and to mitigate the self-referring attitude that sometimes characterizes the volunteering organizations. From this point of view, the Board represented an experience of prompt, orientation, enrichment of competences, a
very "healthy" relationship with “more expert” competences.

An acknowledged difficulty was the uncertainty about how to translate into practical objectives the general aim of the projects: a more aware and orientated approach to severe mental health and support to young people at risk in the community. This hardship was also represented by the relatively long time, and several meetings, to find the way towards the implementation of actions consistent with the aim. This difficulty was probably greater in this project than in other, usually aimed at behavior more easily identified, well-known to people, often socially unacceptable, such as substance abuse or other at risk behavior, whereas the commitment here was on problems characterized by being the tendency to withdrawal, and therefore less apparent.

**Pitfalls of the CDD Project: lessons learned for the future**

As expected in surveys like this, conducted in the same context of the activity to be evaluated, the scores were highly positive, with scores lower than 5 eventually absent. However, we cannot should always consider that only 25 people participated to the survey. Moreover, it is likely that the respondents were people particularly satisfied with the project. In fact, we know that many people initially interested, later interrupted their participation. This means that the critical points raised are important prompts which we want to carefully consider in re-thinking and re-planning the project. One of the most important issue was the insufficient training and informative session about mental states at risk. Though this can be partly due to the inherent difficulty of the problem, we should offer informative sessions more based, for instance, on examples, and introducing more and more clear issues of psychopathology. Having few opportunities to meet and have relationship with young people with at risk mental states, and therefore the relatively limited “concreteness” of the problem addressed and the possibility to make real experiences and test how the initiatives taken could be meaningful.

Although in the meeting the participants witnessed the importance of the contacts with the specialist teams, the meetings were rather rare, and these was mirrored in the low scores given to the usefulness of contacts with the team in the survey. This should be taken as an utmost useful prompt, in order to have the relationship between professionals and non-professionals that really overcomes separation and differential of power and help to find a real common language. When this happened, it represented a real success for the professionals and the non-professionals.

The high appreciation for the network building can be considered a non-specific factor, consisting of the offer of new room and aims for social participation. We think that this result deserves careful thinking. It is possible that it is related to the need for the community subjects to identify issues that can represent a reason for their activity and mobilization. In this way, mobilization is in itself important, and more important than the objectives to be achieved.

We acknowledge that the project had not planned any tools to assess whether the objectives of information about mental health issues were accomplished, neither whether and to what extent the Board could contribute to the identification and referral of young people with mental states at risk to the specialist teams.

The ethnic minorities communities brought the issue of their growing worry for a double identity repeatedly challenged, that needs to be continuously defined and protected, with the possible risks of violent solutions, besides mental health problems. For these communities, the participation to the projects was an opportunity to sensitize to mental health issues, often neglected and feared by families, and as an opportunity to prevent the withdrawal of isolation, sometimes exposing to the risk of being attracted by groups of extremists.

The school was an essential actor in this experience. Secondary school teachers identified the need for better knowledge and skills in front of the mental disorders and suffering, in order to accept a responsibility in recognizing such suffering, and to see their commitment not just as confined to referral to the mental health services.

The notably absentees were the young themselves. Although they welcome the offer to produce videos and ideas about emotional suffering and they were in the first line in some ethnic minority associations, they were eventually neglected, and our effort to have them involved on a more structured base, in planning and giving meaning to the project since the beginning, was insufficient.

To these pitfalls we also add that we could not “measure” how large the mobilization was, and how many people got in touch with the issues addressed by the project. We could not
empirically assess which factors contributed to the greater or smaller activity and participation of the different Boards. We want to be aware of these limits and have them discussed and, hopefully, overcome in next experiences of community coalition.

**Is optimism reasonable?**

In spite of important limits, several elements made this experience unforgettable. In all centers new activities were started, more people were made more aware that mental disorders and suffering can be approached and benefit from an informed and well conceived non-specialist approach.

Young people in schools had the possibility to commit to a common reflection about mental suffering. In the video produced in a secondary school, a short story of isolation, sorrow and illness was presented, as a dialectical exchange between what can be seen and what cannot be seen in the disorder manifestations. Although approximate, the understanding of the condition of suffering represented in the video, was nonetheless sufficient to see it as an attempt of communicating and asking for help. Closeness among people, willing to listen to, were also presented as keywords for future and hope.

Also the services deserve some thoughts. Several professionals defined this experience as the “coming true of a dream”, an opportunity of mutual influence between professional and non-professional experiences, to see mental disorders with the eyes of people – not patients. They could experience from a closer position the hardship of mental illness and its prodromes, between fear, stigma, insufficient competences. Ultimately, we think that the services could test how they might modify their perspective, moving the centre towards prevention with the community, working systematically on such projects and measuring and assessing their achievements. This experience allow the professionals gain new and direct knowledge to enhance preventive action in mental health and community empowerment.

We have made a short but meaningful piece of the way to empowerment and prevention, which many start and then leave rather early, owing to the obstacles met and the uncertainty of success. We can only gather and organize experiences and the lessons we gain from them, to try again, confident to make some more steps.

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The concept of recovery has multiple definitions (e.g. Anthony 1993; Farkas 2007; SAMHSA 2012; Ellison et al., 2016), which mostly coalesce around the idea of a journey by individuals with mental health conditions in claiming or reclaiming a meaningful life. Over the past 25 years, it has become the predominant paradigm for delivering mental health and rehabilitation services in the United States and around the world (Farkas 2007).

The **Toolkit of Recovery Promoting Competencies for Mental Health Rehabilitation Providers** (Farkas, Hutchinson, Forbess, Restrepo Toro & Russinova 2016) has two versions, one in English and an introductory version in Spanish. It is based on previous research done on recovery and is comprised of three components: Self-Assessment Tool, Strategies and Resources, and Online Course on Core Competencies.

**The Self-Assessment Tool:** The **Recovery Promoting Competencies Tool - Self Assessment (RPCS)** is based on the psychometrically valid Recovery Promoting Relationships Scale (RPRS) (Russinova et al., 2013), used in agencies to measure the perspective of the individuals served, providing direct feedback to practitioners. The 24 items included in the Self-Assessment Tool are based on two indices: a) Core interpersonal skills, and b) skills to utilize recovery-promoting strategies.

**Strategies and Resources:** The strategies are designed to enhance critical aspects of an individuals’ recovery journey; hope, empowerment and self-acceptance (Russinova et al, 2013). Individual strategies were identified by sending a request through Boston University’s Center for Psychiatric Rehabilitation’s eCast’s, to 12,000 subscribers (i.e. providers, individuals with lived experience, family members, educators, administrators and researchers). These subscribers were asked to share simple tips and practical strategies they had used or experienced to promote a sense of hope, empowerment and self-acceptance, that did not require a specific credential or professional background to accomplish. 56 of the 500 responses received were focused on actions of providers of any discipline. These responses were grouped into the categories of enhancing hope, empowerment or self-acceptance. 20 unique strategies for providers were identified as a result of this exercise.

In addition to strategies for providers, 44 tips and suggestions were received which were found to be more relevant to the organizations, rather than providers. These practical tips for introducing and sustaining a recovery orientation are divided into two categories: one for **Program Managers/Supervisors** and one for **Administrative/Executive Directors**. Both the provider level and
organizational level strategies and tips were field tested, revised and field tested a second time to identify those that were the most relevant to introducing and sustaining a recovery orientation.

Finally, resources were collected to support Providers, Managers/Supervisors and Executive Directors. The listed resources include links to materials and websites where more information on providing a recovery-oriented service can be found. The Toolkit was designed to continuously be updated as new strategies and resources are identified through input from its users over time.

**Online Course:** Recorded lessons teach providers of any discipline, about core concepts and competencies needed to promote recovery with individuals in mental health recovery. The goal of the course is not to develop expertise in the core recovery promoting skills, but rather to give participants a clear image and understanding of them through brief presentations, demonstrations and exercises. It is self-paced and includes five modules, each of which is divided into short sessions. The first module provides an overview of the fundamental concepts of recovery and the research behind the concept of recovery. The remaining four modules are designed to improve the recovery promoting relationship between the provider and the individual by teaching the skills of Inspiring, Partnering, Facilitating Choice and Teaching. The skills of Partnering, Inspiring, Facilitating Choice and Teaching are based on a synthesis of techniques and interventions derived from client centered psychotherapy, educational psychology, cognitive behavioral therapy, behavior modification, and positive psychology among others. It includes elements of practices based in these fields such as Motivational Interviewing (Miller & Rollnick, 2013), Psychiatric Rehabilitation (Anthony & Farkas, 2011, Anthony, Cohen, Farkas & Gagne, 2002) and Shared Decision Making (Deegan & Drake, 2006), among others.

The overall course takes approximately 14 hours, including time to complete the included exercises. Each of the modules is divided into component skills needed to perform the overall competency. Most skill components are then also divided into easy to absorb 10-40 minute individual sessions. Participants using the Toolkit can choose to take all five Modules or just one, based on their past experiences and/or the results of the Self-Assessment Tool.

**Recovery Promoting Competencies for Mental Health/Rehabilitation Providers Toolkit / Kit de Herramientas de Recuperación**

**Website:** [https://cpr.bu.edu/develop](https://cpr.bu.edu/develop)

Center for Psychiatric Rehabilitation, Boston University.

**References**


The Association of Psychosocial Rehabilitation Albania (APRA) was established in Tirana in September 2015, and is a branch of WAPR (World Association of Psychosocial Rehabilitation). The founding members are a group of psychologists, doctors and volunteers that had been involved or are still involved in European mobility programs, as Youth in Action and Erasmus Plus. The activity is directed toward initiation, integration, promotion of the volunteering activities, programs and politics about the social inclusion and respect of the human rights of people with limited opportunities. For this reason, we work in the provincial area, realizing projects for youth as well as in social and health fields in collaboration with others national and internationals non-profit organizations and public bodies.

APRA activities are:

activities (educational projects in schools and in other institutions focusing on health, citizenship, European awareness, work against racism, social inclusion, human rights);cultural events (conference, seminars, workshop)

The mission of education activities consists of providing non-formal education opportunities for young people involving as many as possible and trying always to involve others that has never participated before. Our aim is to help youngsters develop their competences (life skills) by using non- formal learning tools. We try to educate youngsters to a peaceful cohabitation with people coming from different cultures, countries and social conditions by giving them opportunity to meet and work with others in an crosscultural environment and thereby stimulate and promote social awareness.

To promote social and personal development through international voluntary programs, educational activities etc.

To organize scientific and professional reunions, seminars, conferences, professional meetings, training sessions and training information.

The main goals are:
Justice for all persons who suffer from social, political, economic and personal injustice
Break through the barriers between cultures and people
The principle of equality among cultures, nations and sexes
Helping participants to become aware of the issues and problems in local and national contexts
Provide experiences that will encourage international and intercultural understanding
Community in order to better understand world-wide, socio-economic-political issues and problems.

We have been an active NGO in this year by realizing these activities:

March 2016- Workshop "Mental Health in the Community" in which Association of Psychosocial Rehabilitation Albania presented the project about the Attitudes Toward Mental Illness in Albanian Community. The aim of this workshop was the creation of a moment of awareness and dialogue with the community, in order to promote mental health through finding new ways to fight stigma and discrimination towards individuals with mental illness.

April 2016- Training Course with the preschool teachers. Talking about "The importance of social inclusion of children's with autism".

June 2016 - Seminar of "Concrete Jungle: Urban Gardening a Youth Work Tool for Social Inclusion of Refugees and other Local Youths with Fewer Opportunities" Berlin Germany. APRA was a partner in this project funded by the European Commission.

June 2016 - Workshop "Substance Abuse and Mental Health " in which APRA present the project about the "Youth Risks Behavior" in Albanian Community. Special guest Andi Shkurti, Clinical Psychologist, Addiction Service! The aim of this
workshop was to understand the situation of youths that are addicted from drugs and to promote their mental health as an important component of their social inclusion.

**August 2016** - Training Course "Urban Gardening" in the frame of the project "Concrete Jungle", in Berlin, Germany.

**September 2016** - Workshop "Mental Health Awareness" Mental health disorders have been the focus of the public attention in Albania during the recent months. Many people who suffer from mental health issues are stigmatized by various social stereotypes. This workshop aims to raise awareness about mental health issues, understanding the causes, symptoms and providing assistance through acceptance and support of people suffering from such problems.

**September 2016** – Implementation/Coordinator of the project "International cooperation for Rehabilitation and Social Integration of refugee women in Turkey and Europe" and will implement some local activities in Albania. This Project will be carried out with the partnership of Poland, Czech Republic, Albania, Greece, Latvia, Romania and coordinating country Turkey. The duration of the project is 24 months, with beginning dates on (01.09.2016) and ends on (31.08.2018).

APRA is partner in the project "GloConnection Platform " founded by program ErasmusPlus. The project is implemented by Brain Crowd Idea an Project Community. This union was established with the partnership of Turkey, Macedonia, Kosovo, Albania, Kenya, Palestine, Armenia, Italy and Greece. GloConnection want to create a young society and consciousness that supports human rights and works for the benefit of different societies. The duration of the project is from 01.01.2017 till 31.12.2018.

**March 2017** – Training Course “Involving Marginalized Youth in International Projects” This Project will be carried out with the partnership Germany, Armenia, Turkey, Hungary, Greece, Ukraine, and Slovakia.

APRA plans to work this year in the following field: people with fewer opportunities (disabilities, health problems, social issues) childhood, youth participation.

To make this we have realized:
- Participation in ErasmusPlus projects
- International conferences, seminars, training courses
- Educational Training in University Hospital Center with youngest who suffer from chronic diseases
- National research in the field of mental illness, disabilities, social issues.
- Implementation of the project of HEALTH FOR ALL “Creating Health Promoting School Models” founded by the Swiss Agency for Development and Cooperation (SDC); Terres des Homes; Save the Children.

We are officially registered under the ErasmusPlus. We actively participate, during this years, as partners in three projects in Berlin (Germany); Antakya (Turkey) and Istanbul (Turkey).

APRA has been chosen to be the NGO that will implement the campaign “Mind the Mind- to Combat the Stigma of Mental Disorders” in 2017.
Mental health problems are as common in Belgium as in any other European country. Approximately 25% of the Belgians are experiencing some sort of psychological distress at this very moment. The lifetime prevalence of at least one mental disorder even reaches higher up to 30% of the population. Furthermore, like in most other countries, there is a significant treatment gap that both encompasses people not getting treated or people receiving treatment far too late. Stigmatisation, financial barriers, lack of collaboration between primary care and specialized care, poor accessibility and waitings lists are only some of the factors named to account for this situation.

Until 2010, the Belgian mental health care strongly remained a hospital-based system. With more than 150 beds per 100,000 inhabitants, Belgium ranked itself in the worldwide top 3. Although the late eighties and nineties nationwide gave rise to new housing initiatives, such as sheltered living and psychiatric nursing homes, this was only considered to be a first step in a further evolution towards a community-based approach. A transformation of a supply-driven residential mental health care towards a more differentiated demand-driven care was needed.

The Joint Declaration of all ministers responsible for Public Health in 2002 on the future mental health policy was an important next step. It stated that future acute and chronic care had to be organised through collaborating networks and circuits for 3 target groups (children and adolescents, adults and the elderly), bringing mental health care as close as possible to the needs and demands of people with mental health problems.

In May 2010, the Public Health authorities launched the ‘Guide towards a better mental health care’, thereby setting in motion the reform for adults. The Guide described a program and an organisational network model. A network coordinator was financed for each pilot project to facilitate the creation of the intersectoral networks, that had to establish 5 predefined functions:

Function 1: prevention and promotion of mental health care, early detection, screening and diagnostic activities.

Function 2: ambulatory teams offering intensive treatment for both acute and chronic mental health problems.

Function 3: rehabilitation team focusing on recovery and social inclusion.

Function 4: residential intensive treatment for both acute and chronic mental health problems.

Function 5: specific housing facilities.
Given the high number of psychiatric hospital beds, the program implicated a bed reduction, to accomplish by a reallocation of the bed-bound financial means to new mobile treatment teams (function 2) or hospital intensification.

In 2017, Belgium has 23 operational networks. Approximately 55 newly created mobile teams (‘function 2’) are active, together with a chronic bed reduction of 20%. Several additional ambulatory rehabilitation and recovery centres, focusing on housing and employment, were founded. The important attitude change in the sector, combined with the new facilities in the community, have been associated with a significant reduction in the duration of hospital admissions. Furthermore, the accessibility of specialized care strongly benefitted from the inter-sectoral collaboration (e.g. primary care, GP’s, housing corporations, etc).

Nevertheless, important challenges remain for the nearby future. Three scientific teams monitor the reform, thereby making a process evaluation of the geographical implementation of the networks, network governance, establishment of the functions, continuity of care, patient satisfaction and recovery-oriented practices. It seems that the networks have established all functions, but an even more integrated approach is needed to further improve the accessibility and continuity of care. This requires a formalisation and rethinking of the governance structure of the networks. Furthermore, generalization of the reform model is needed over the areas that are not yet served, while the other regions are deepening the changes and reinforcing the resources in the community.

To conclude: the Belgian mental health care has, in a short period of time, undergone profound changes in an ongoing transformation process towards a community-based mental health care. Inter-organisational networks and a recovery-oriented practice can be considered as key aspects therein.

Starting with the adult group, the aim is now to broaden and deepen the reform over the next years, for all regions and target groups. The reform for children and adolescents took a launch in May 2015 and a new Guide has been published and was communicated to the sector. Since inter-sectoral networks remain a key concept also in this reform, network coordinators have been selected in the past months. The next step for them is now to prepare and facilitate the regional strategic development in close collaboration with the key partners.

Last but not least, it is important to note that the professional sector, the authorities, the patient and family federations are undertaking this journey side by side.
An important Conference took place in Rome on January 27 and 28, 2017, co-sponsored by WAPR: “Recovery. Determining factors in mental health”.

The aim of this conference was to focus on effectiveness, limits and perspectives of bio-medical approach in mental health and at the same time to stress the determining role of personal and social factors linked to recovery paradigm.

Since the 1960s substantial changes have occurred in the mental health field: from dismantling the asylum to the development of community mental health services, from the availability of psychiatric drugs to innovative psychosocial interventions. Nonetheless, epidemiological studies show that prognosis of serious mental illnesses, presently among the leading causes of disability worldwide, has not improved to the extent that had been hoped for.

As important as the biomedical approach may be, it must take into account and integrate ‘non-technical’ factors in the long-term course of mental disorders, especially as regards the most serious illnesses. The social context and the resources that can be implemented in this context is important. This means taking advantage of the experiential knowledge of the users and their families, the capacity of mental health services to respond to the complexity of needs, and reflecting a holistic view of the person and confidence in their potentiality, beyond the illness.

This view is confirmed by studies on the pathogenesis of schizophrenia, which show how the disorder is characterized by cognitive and affective dysfunctions, for which pharmacological treatments are not available and which envision schizophrenia as a social dysfunction.

In line with this vision, the Fondazione Internazionale Don Luigi Di Liegro, in partnership with the Fondation d’Harcourt, has participated since 2014 in the project “Community support services to promote well-being of people with mental illnesses”. The project’s features was presented during the conference.

The Fondazione Di Liegro promotes rehabilitative social trajectories that accompany and integrate individualized therapeutic projects planned by mental health services. These trajectories consolidate the emotional and relational skills of people experiencing mental distress through their participation in activities based on methods such as the International Classification of Functioning, which aim at strengthening and supporting the persons’ potentials in ordinary roles as citizens. These activities are carried out with the help of volunteers trained by the Fondazione Di Liegro to achieve skills and competencies in mental health.

This involvement in social rehabilitation has been undertaken in collaboration with the Departments of Mental Health of Rome on the assumption that such a synergy will make possible to cope with the complexity of needs arising from social life, and to enhance interests, skills, independent life and work.
The conference agenda included a presentation of the first results of the research on “Networks on Mental Health and Distress” which involved various stakeholders in the metropolitan area of Rome.

This conference has been a key objective of both the Fondazione Internazionale Don Luigi Di Liegro and the Fondation d'Harcourt. It was organized in collaboration with the National Institute for Health, Migration and Poverty (NIHMP), a public agency of the Italian National Health Service. It is intended to be an opportunity for attending the most current themes of mental health – in relation to new national policies and in the light of state-of-the-art paradigms that guide it. This includes the human and civil rights of citizens suffering from mental distress, the knowledge and participative involvement of service users and their families as ‘co-builders’ for services, the efficient and safer use of psychopharmaca, and aspects to evaluate interventions in psychiatry.

Slides of the main presentations can be found at: [http://www.fondazionediliegro.com/category/convegno-internazionale-riprendersi/](http://www.fondazionediliegro.com/category/convegno-internazionale-riprendersi/)
Psychosocial Rehabilitation in Spain is a situation of great dynamism. Spain made its Psychiatry reform later than other countries in Europe, but joined the International Psychosocial Rehabilitation community enthusiastically in the last decades of past century. And now, shows an unequal but very active situation.

From the institutional perspective, Psychosocial Rehabilitation principles have been incorporated to the main state professional guidelines, both in the health and social sector.

Public sector has an important commitment in providing services, using different models on management: as main provider of services, or funding services provided by non profit actors in the third sector (associations, foundations, etc.)

Some samples of this implication and creativity may be:

- The great richness of expressions of experiences in social networks, in many different ways (arts, meetings, user’s participation, videos, etc).
- The incorporation of a new generation of professionals that are continuing the pioneer activity of their predecessors in a new and very creative way.
- The increased amount of services and resources available for users that are far from covering all the needs, but have improved greatly the situation.
- The implication of scientific organisations.

One more expression of this is the implication and contribution in WAPR of three different organisations: FEARP, the Spanish branch of WAPR (www.fearp.org), AEN (www.aen.es) an interdisciplinary professional organisation, that has joined WAPR some years ago, and Fundación Manantial (www.fundacionmanantial.org), a foundation created by the family movement that is now an important provides of services, a very creative actor in the field, and in addition has

Ricardo Guinea presenting the XIII WAPR World Congress to colleagues of AEN. www.aen.es
sponsored important actions in Latin America, including WAPR actions.
We can consider that these factors have contributed to Spain receiving from WAPR the commission of organising the XIII World Congress.
The three above-mentioned organisations will take part in the congress in different ways.
In a very exciting moment of Psychiatry and mental health attention, when many topics are under discussion, the organising is already working in a Congress that, we expect, will offer a framework to discuss the hot topics in our discipline, such as new evidences, recovery and recovery oriented practices, the role of the Human Rights perspective in Psychosocial Rehabilitation. We plan a very interactive congress with many opportunities for interaction among professionals, users and families from all continents.

Dr. Mikel Munarriz, president of AEN, and Dr Ricardo Guinea, president of WAPR.

Members of the Organising Committee of Madrid-2018.
Psychosocial Rehabilitation in Colombia’s Post-Conflict

Gutiérrez-Peláez, Miguel,
Universidad del Rosario, Director of the Psychology Program, School of Medicine and Health Sciences. Secretary for Colombia of the World Association for Psychosocial Rehabilitation (WAPR).

Post-conflict in Colombia and its Psychological Consequences

Colombia struggled between 2012 and 2016 to achieve a peace agreement between the Colombian Revolutionary Armed Forces (FARC-EP) guerrilla group and the government, which has led to a cease of fire and current demobilization of troops after more than fifty years of active warfare. Now, a great challenge continues for the psychosocial interventions needed to accompany the demobilized members of FARC to their transit to civil and democratic insertion. Currently, and since February 2017, a new peace process has begun with the National Liberation Army (ELN) and the challenges are not minor. Dr. Alberto Fergusson, WAPR’s Vice-president, is the government’s delegate to lead the humanitarian table in this peace process. A transformation of Colombia’s history and the conditions for its future will result in the decisions and agreements that as society we can reach during these processes.

Mental health issues are most relevant and arise in different levels, from the psychological consequences derived from violence and war traumas (Gutiérrez-Peláez, 2009, 2013 & 2015), to social conditions of exclusion, prejudice, deprivation, poverty and organized crime. However, other psychological effects are also at stake. As stated elsewhere (Gutiérrez-Peláez, 2017), apart from the psychopathological and mental health consequences of the armed conflict, which have been recorded in different studies (Ministry of Social Protection, 2015), there are great psychological demands and challenges for Colombians in the years to come. Firstly, the psychological challenge of recognizing that there are irreparable losses, ranging from the acceptance of the contents of the peace agreements between the government and the FARC, to the most crude consequences of the violence experienced during more than five decades and the corollaries for victims. Also, the psychological challenge of enduring and dealing with the intensification of a series of political and social conflicts that were overshadowed by the armed struggle. It is very likely that, far from reducing the social conflicts during the following years, these increase as the termination of the armed conflict exposes underlying social conflicts. We have evidenced the psychological challenge of confronting us face to face with the complexity of human behavior and with the evidence that the armed conflict has not been a conflict between good and evil (Briole, 2015). How to reconcile the goodness, the ideals and charisma of a subject with the fact of having committed atrocious crimes? There is also a great psychological challenge for our society as a whole, which consists in keeping alive the awakening of
civil society in the face of armed conflict and the peace processes, from passivity (in accepting or not the proposals from others) to the activity (proposing solutions and broadening the framework of possibilities) and being agents that propose solutions (Herrera-Pardo & Gutiérrez-Peláez, 2016). Students have had a leading role in the final stage of signing the peace agreements and maintaining that activism will be their challenge in the years to come. On the other hand, civil society faces the psychological demand to recognize that its passivity during the decades of armed conflict has not made it neutral, but rather permissive of the atrocious events of the war.

As society, we also face the psychological and moral challenge of recognizing the place of the other (Gutiérrez-Peláez, 2008), of otherness, giving voice and assuming the existence of a dissidence without weapons. The psychological challenge of understanding that the so-called "peace" or "post-conflict" is not the absence of conflict, but an elevation of that conflict, in addition to being able to confront it with words and through democratic paths.

Professional training for implementing Psychosocial Interventions
What conditions do professionals need in order to implement psychosocial interventions in armed conflict scenarios? We consider that there is a fundamental difference between the position of not knowing and that of not wanting to know and I believe this distinction has very important effects when thinking about punctual issues for psychosocial interventions in armed conflict scenarios. In an article entitled “Logical Time and the Assertion of Anticipated Certainty: A New Sophism” (2003), French psychoanalyst Jacques Lacan uses a case of logic (the case of the three prisoners and the black and white discs) to expose the distinction between three different logical times: 1) the instant of seeing, 2) the time of comprehending and 3) the moment to conclude. The conclusions derived from this logical problem reveal that it is not the same to see than to comprehend, much less to see and to conclude. It is not possible to force movements through these three logical times described. It is not possible to force someone to know or to want to know.

Different from not wanting to know, the position of not knowing is a fundamental clinical and ethic position, which has extensively been worked by different approaches, from Buddhism to psychoanalysis. We believe it is essential to be able to listen to he or she who speaks to us from a position of not knowing, that is, not to anticipate the other’s discourse or to prefix our own interpretations regarding that discourse. It is, without a doubt, a great challenge to train oneself not to know or, better yet, to be able to bare the position of not knowing. It is a clinical and ethic position of vital importance in order to be able to receive what the other tells us and be sufficiently
empty, or emptied, in order to accommodate that absolute singularity of the other’s discourse.

In consonance with this position, we must be very respectful of the logical times of the subjects concerned by armed conflict. We cannot force a victim to speak. A certain idea circulates derived from an inappropriate reading of the functioning of psychotherapy according to which it is always beneficial to speak and if a traumatized subject speaks that will help his or her recovery. This makes no sense if we do not take into account the logical times of each subject. Mass media are, at times, for example in the cases of subjects liberated from a kidnapping, the first to force a victim to speak, precisely of the hardest core of their experiences. Guy Brioie (2009), who was for many years the psychiatrist and psychoanalyst in charge of the military hospitals in France, was responsible for receiving French hostages liberated in different parts of the world. His clinical experience taught him that what was fundamental was to respect the logical times of each subject and be available to receive their words when they were prepared to pronounce them. He also learned that it was not possible to have a preconceived intervention plan that was necessarily the same for each subject. He saw, for example, that in the case of people that have been taken hostage or separated from their families for a long time, reuniting with them was also traumatic and that, in many cases, a liberated subject needed some time alone or a certain therapeutic intervention with others before reuniting with his or her families. During the separation a kidnapped person can forge many fantasies: will they recognize me?, what will they expect of me?, will there still exist for me a place in that family?, with they feel disappointed when they see me, will I fulfill their expectations?, will they fulfill mine?

This respect for the case-by-case, for the logical times of each subject and the insistence that mental health professionals assume and train themselves in a position of not knowing, seem to me fundamental indications for every psychosocial intervention with people who have experienced the effects of armed conflict in Colombia. I believe that with the one-by-one work and with different groups and communities, we can, as a country, pass from the drowsiness and perplexity of the instant of seeing, to a time to comprehend and that this understanding can start having effects that can rebound at a much greater scale. Moreover, if things go well, we can eventually aspire for a moment to conclude and that this may be an opening for new horizons in our history. As stated by the optimist haiku of Shigeji Tsuboi (1898-1975): “A storm comes from far/Cleans the heat that rests form the summer/A
celestial blue fills the atmosphere and we prepare for a new spirit”.

**Indications for psychological and psychosocial interventions**

As stated elsewhere (Fergusson & Gutiérrez-Peláez, 2017), “we do not know yet with certainty how the FARC or ELN guerrillas have dealt with cases of psychosis or schizophrenia. The possible effects of the militia lifestyle in the outcome of their symptoms is still no more than speculation and we do not know yet if they have had or not a proper treatment. The truth is that, as the implementation of the peace agreements takes place, a great segment of the population who used to be treated informally, will now be accessing the government’s official health services”. Well-trained professionals are needed that can overcome prejudices against guerrilla ex-combatants, as well as against people with psychosis.

Psychological and psychosocial interventions must recognize and take into account the successful inventions of each subject and each community. Interventions have to respond and value that unique response each of them has given to their experiences and difficulties. It will be starting from these experiences that we will be able to see if in any way our knowledge and our training can contribute to make more successful those interventions that have arisen from the subjects and/or the community. The listening that we offer to the subjects and to the community does not have to have the pretension of reconstructing the truth of the historical, legal or journalistic facts. We are interested in the subject's truth and we can allow all the complexity of their psychic experience to run in the psychosocial devices that we offer them. In addition, we must be very careful when using categories that establish a "we" that leave out a significant – and many times most vulnerable – portion of the population or, at least, be very aware of the segregating effects that our words and interventions can have. In the new emotionality that we are facing, and with our transitional mental state (Fergusson, June 2016), we can open ourselves to a new encounter with the other and, in that conversation, give a voice to a silenced population.

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WAPR Americas.

Psychosocial Rehabilitation in Peru.
Report from WAPR Editorial Committee.

In 2014, a delegation of WAPR, sponsored by Fundación Manantial, one of the affiliated entities to WAPR, organized a trip of work to several countries of Latin America that included Brazil, Peru, Uruguay, and Mexico. The delegation included Ricardo, President of WAPR, Francisco Sardina, president of the board of trustees of the foundation, and Alberto Ferguson, who was the regional vice president of WAPR for the Americas.

That trip coincided with a time when Peru's mental health authorities were considering the transition from the dominant institutional model to a community model inspired by the principles of psychosocial rehabilitation. As a result of that trip, Fundación Manantial established a collaboration agreement with the mental health authorities of Peru, under which it has been collaborating in the training of professionals who will begin to provide services in the new network of psychosocial services. Dr. Yuri Cutipe, Director of Mental Health of the Peruvian Ministry of Health (MINSA) led the process of transformation. Miguel Angel Castejón has headed a delegation of experts from Spain, sponsored by Fundación Manantial, that is systematically providing training to the new generation of professionals from Peru who will serve in newly created community centers.

From WAPR, we can only congratulate ourselves for having had the opportunity to contribute to the beginning of this project, and for the course that are taking the events. From now on, we will offer all our political and technical support that can be demanded for the benefit of the processes of transformation in care that are taking place.

We consider the reform in mental health that is happening in Peru is an event of the utmost importance, and that can serve as a precedent and reference for other reforms in other countries of the region.

WAPR President has been personally involved in support of this developments, in communication with the team of trainers, and sent an encouraging letter to the Minister of Health, in support of these policies.

We will ensure that this reform will be duly reported in our Madrid 2018 World Congress.
Miguel A. Castejón and Paco Aguado, in a training session with local professionals.
In continuity with the commitments established through the Declaration promulgated by the Mexican Branch, our activities have been extended to other areas of the country, specifically in Guadalajara, which is of great impact because it happens that care services are centralized in the capital and not relevance is given to what happens in the province; where there are also services for a significant number of the population.

In 2015, Mexico Branch provided training to the medical, psychology and nursing staff of the Jalisco Institute of Mental Health, which is responsible for the care of people with acute episodes of mental illness, through specialized clinics for mood disorders, childhood and adolescence, eating behavior, for the elderly (Psychogeriatrics), attending suicidal phenomenon and crisis intervention service through the Center for Comprehensive Mental Health Care in long stay, Comprehensive Rehabilitation Unit, Outpatient Programs: Therapeutic Villas, Supervised Residency, Community Modules of Mental Health and 8 comprehensive mental health centers distributed in the state of Jalisco. The training joined a forum of 700 people under the topic: "Psychosocial Rehabilitation in Mental Health."

In October 2016, the third "Mental Health Integral Symposium" was held in the framework of the International Day of "Mental Health" with the conference "International Experiences in Psychosocial Rehabilitation (WAPR) Perspectives in Latin America", as well as a Communication in Club House of Guadalajara.
Prof. Daniel Maltzman Pelta is a member of the National Assemblies of the National Institute of Human Rights and the Ombudsman’s Office (INDDHH) of Uruguay, integrating the Commission on Mental Health on behalf of the National Plenary of Organizations of persons with some type of functional disability.

On May 16th, a demonstration took place for a Mental Health Act in line with Human Rights perspective. Before the vote in the Chamber of Deputies, in October 2016, the organizations nucleated in the National Commission for a Law of Mental Health in the line of Human Rights, were mobilized in front of the Legislative Palace. The objective was to sensitize the legislators to integrate adjustments to the project to ensure that it complies with the various international agreements that our country has signed, as well as promoting a true paradigm shift in mental health care and conception.

“We saw many people with posters, banners, sound, lights, musicians, proclaims to give a new push the mental health law, that already has a sanction of the Senate, so that Deputies make some modifications and some additions that the 54 organizations, Nucleated in the National Commission by a Law of Mental Health in the line of Human Rights. We claim for a law that guarantees human rights and not a law that continues promoting biological, individual, and stigmatizing approaches”, emphasized Dr. Maltzman.

More info in:
https://parlamento.gub.uy/noticiasyeventos/noticias/node/84831
Under the President of Dr Ahmed Saad, and the coordination of Dr Mahmud El Azayem, Dr Ahmed Abou El-Azayem and Dr Hanan Ghaderi, and the participation of Dr Medhat ElSabbahi, of our WAPR regional vice president, and under the organization of the Egyptian Association Psychosocial Rehabilitation and Psychiatry Institute Ain Shams Hospitals, took place in Cairo, Egypt the “4º Conference of Integrated Psychiatry: neurobiological basis of rehabilitation”.

The conference enjoyed a large group of professionals and was followed by several workshops, where different specialists joined in discussion about the possibilities and the implementation of psychosocial rehabilitation techniques in Egypt.

From WAPR we would like to extend our compliments to the Egyptian colleagues that are able to compromise every year a high standard conference through all kinds of financial constrictions.
Invitation Letter from Dr Tarek Abdalla and Dr Medhat Elsabbahy

We are greatly honored to cordially invite you to attend and participate in the 1st International Congress of the World Association for Psychosocial Rehabilitation (WAPR) - Abu Dhabi which is scheduled to be held at Abu Dhabi National Exhibition Centre (ADNEC) in Abu Dhabi, United Arab Emirates from September 21-23, 2017 and hosted by Sheikh Khalifa Medical City - Behavioral Sciences Pavilion, SEHA (Abu Dhabi Health Services) & National Rehabilitation Center of UAE.

The program has been designed to provide a comprehensive overview and discussions of all the relevant issues concerning the care of people with mental disorders.

This will be the first time for the World Association for Psychosocial Rehabilitation (WAPR) to offer such an educational program in the region and the Middle East. This is considered a great chance for the attendees to update their knowledge, stimulate collaboration with each other and exchange experiences with distinguished line-up of experts.

The WAPR Congress is expected to be an exciting venue to hear and discuss the latest scientific advances in all disciplines pertinent to the field of psychiatric rehabilitation. The program aims to encourage the highest possible standards of clinical practice, to increase knowledge and skills about mental disorders and how they can be prevented and treated, to promote mental health, to promote the highest possible ethical standards in psychiatric work, to disseminate knowledge about evidence-based therapies and values-based practice.
The program will feature various psychiatric rehabilitation topics including current rehabilitation services and models of rehabilitation, cognitive remediation / rehabilitation, research in rehabilitation, incorporation of rehabilitation training in current education system, substance use disorders, rehabilitation in major psychiatric disorders. The program will also comprise other mental health related topics including, neurobiological aspects in bipolar disorders, psychopharmacology in bipolar disorders, neurobiological aspects in major depressive disorders, psychopharmacology in major depressive disorders, neurobiological aspects in schizophrenia, and psychopharmacology in schizophrenia, and many more topics.

Nationally and internationally renowned experts, world class scientists and thought leaders in the field of psychiatric rehabilitation and mental health are invited to give plenary and keynote lectures as well as symposia and workshops representing different fields of psychiatric rehabilitation and related disciplines to encourage exchange of knowledge, experience and best practices.

We hope that this meeting will be of great benefit to all participants in the region, we also hope and trust that you will enjoy your visit to Abu Dhabi, the capital of the United Arab Emirates and a vibrant and fast-growing city that combines state of the art facilities and infrastructure, as well as glimpse into an ancient and endless fascinating past.

http://menaconference.com/events/waprc/
1st. Latin American Meeting.
Human Rights and Mental Health.
June, 27th. Florianópolis. Brazil.

www.direitoshumanos2017.abrasme.org.br/
IV WAPR EUROPEAN CONFERENCE,
CESENA, ITALY, IN JUNE 9TH-10TH, 2017.

“ABOUT RIGHTS AND DUTIES: INSTITUTIONS, CITIZENS AND SERVICES IN MENTAL HEALTH FIELD”.

The Italian branch of WAPR has organized the 4th WAPR European Conference, “About rights and duties: Institutions, Citizens and Services in mental health field”, to be celebrated in Cesena, Italy, June 9th-10th, 2017.

The conference will explore contemporary discussions about recovery from mental illness, treatment conditions and citizenship. Programme.

The venue: Almamater Studiorum – University of Bologna Department of Psychology – Cesena Mental Health Department AUSL Romagna, Italy.

The meeting will also host a WAPR Board Meeting and a meeting of WAPR European Branches, where WAPR Europe will explore further possibilities and actions within the European Framework.

www.wapr.org/cesena-italy-4th-wapr-european-conference/

5º Asian Congress of Schizophrenia Research.

www.acsr2017.com/home/
In this section we offer links important for our field. If you have suggestions for websites and links, please mail the Editor: marit.borg@hbv.no

Convention on the Rights of Persons with Disabilities:

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

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

The WHO Mental health action plan 2013 – 2020:
http://www.who.int/mental_health/publications/action_plan/en/

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

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

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<tr>
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<th>Name</th>
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