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WORLD ASSOCIATION FOR PSYCHOSOCIAL REHABILITATION
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# WAPR Bulletin

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**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.

This report will summarize my activity from Board Meeting in Seoul until now. The main points 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, 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:
EDITORIAL COMMITTEE.
Under the direction of Marit Borg (Norway) chair of our standing Editorial Committee, and support of Barbara D’Avanzo, Tae Yeopn Hwang, Michael Amering and Ricardo Guinea, the bulletin is being released with regularity. Some other Board Members, 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 near 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 weak 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.

Members of the committee are:
- Co Chair: Marianne Farkas.
- Alok Sarin.
- Georgina Fumero.
- Paola Carozza.
- V Radakrisnan (VP)
- David NDeeti.
- Guadalupe Morales.

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 wards, 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.
Norway. Center for Mental Health and Substance Abuse (CMHSA)

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.

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 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 DeP. 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 significate 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. 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.

2017, 1-2 April; Cairo, Egypt. 4th Annual Conference of Rehabilitation in Egypt, Egyptian branch of WAPR; Egyptian Association of Psychosocial Rehabilitation and Abu- El - Azayem Hospital. Reg. Vp. Medhat Elsabahi. Organizer, Hannan


2018, January 11-12. RSP4 International Conference on Recovery-oriented Services and Policy Planning in Mental Health, Successful Stories, Sustainability and Challenges; | Lecture Hall II, Centennial Campus, Hong Kong University

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; in Chile (Contact person, Carolina Vergara), Portugal, (António Marques), Saudi Arabia (Abdulhameed Alhabeeb) and Hong Kong.

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.
In July next year many of us will get together in Madrid. The international WAPR congresses are great events for human contact and establishing friendships, for sharing experiences and getting inspiration, for discovery of new places and ways of thinking about mental health issues and helpful help. The title of the upcoming congress is “Recovery, Citizenship, Human Rights; Reviewing Consensus”.

We will meet in the Palacio de Municipal de Congresos, Madrid, Spain from 5th – 7th of July 2017. The congress themes are comprehensive and invites to critical discussions about a variety of topics within psychosocial rehabilitation. Citizenship, human rights, perspectives on mental health issues and recovery, user involvement, professional roles, political, cultural and social contexts and models of understanding and knowledge, are some topics in focus.

In relation to the congress title and main topics, we present in this Bulletin some key messages from the “Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” from the United Nations Human Rights Council. This report expands on the issue, “Mental health as a global health priority”. It introduces some of the core challenges and opportunities for advancing the realization of the right to mental health of everyone. In order to understand the unmet need for rights-based mental health services for all, and assessment of the “global burden of obstacles” was conducted; some areas are identified as contributing factors. In this Bulletin we also present a paper about Recovery Colleges, we introduce a new column entitled “Recent research” and one of the WAPR Collaborative Centers for Research and Training (WAPR-CCRT) is presented.

We are also sad to inform that two dear Italian colleagues and supporters of WAPR and international psychosocial rehabilitation in general have recently died, Ernesto Muggia and Giorgio De Isabella. Many are experiencing a severe loss of two friends and colleagues.
Rarely has an idea in the mental health arena been taken up so widely or so quickly as that of a ‘Recovery College’. The first Recovery College was established in South West London in 2010, based on a pilot project conducted in 2009. Since this time some 70 Recovery Colleges have been established in the UK and other parts of the world from Australia to Japan, Singapore and Hong Kong. All started small, with maybe eight or nine courses, but many have grown rapidly to offer dozens of different courses in multiple locations and serve thousands of students each year.

**Why a Recovery College?**

Everyone who experiences mental health challenges (or other long-term health conditions, physical impairments or other difficult events and life challenges) faces the challenge of rebuilding a meaningful, satisfying and contributing life. This journey of recovery is not about ‘getting better’ but “a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness. … a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles.” (Anthony 1993). The process of developing a new sense of meaning and purpose in life as one grows beyond the catastrophic effects of what has happened.

Specialist assessment and treatment may alleviate problems and distressing symptoms. However, they represent only a small part of what mental health services do and what people need if they are to rebuild their lives and many people experience ongoing or recuring challenges that must be accommodated. If mental health services are to assist people in their journey of recovery, a major change in culture and practice is required in the form of a redefinition in the purpose of services – from reducing symptoms to rebuilding lives – alongside a transformation of the relationship between mental health services and relationship between services and the people they serve (Repper and Perkins, 2012). This transformation involves:

Mental health professionals using their expertise differently: from being ‘on top’ to being ‘on tap’ – supporting self-management rather than fixing people by making their expertise and understandings available to those who may find them useful rather than prescribing what people should do.

A recognition of the equal importance of both ‘professional expertise’ and the ‘expertise of lived experience’ and the breaking down of the barriers that divide ‘them’ from ‘us’.

A different relationship between services and the communities they serve. The opportunity to be a part of, and contribute to, our communities is central to recovery so we need to create communities that can accommodate all of us. This means that services
must work as part of their communities: recognise the possibilities, resources and resourcefulness that exist within communities, share their expertise with those communities and support individuals and agencies within them.

Recovery Colleges embody this transformation and can be central to driving broader organisational change (see Perkins et al, 2012).

What is a Recovery College?

The Recovery College is specifically designed to enable people to rebuild their lives: to make sense of, and find meaning in, what has happened; discover a new sense of identity and purpose in life; explore their possibilities; and develop the skills and confidence they need to become experts in their own self-care, do the things they value in life and manage their own journey of recovery (see Perkins et al, 2012).

A Recovery College adopts an educational rather than a therapeutic approach. It focuses on reinforcing and developing people’s strengths, enabling people to understand and manage the challenges they face so they can do the things they value in life. Mental health practitioners, alongside ‘peer trainers’, share their expertise in a range of workshops and courses. They become trainers, tutors or mentors and those who attend are not ‘patients’ or ‘service users’ but students. Courses range in length from an hour to a day per week for several weeks; however, within these, it is not assumed that the trainers have a monopoly on expertise: students also have a wealth of experience, expertise and insights. Students are not passive recipients of the wisdom of the trainers; the emphasis is on a participative, discovery style of learning where students explore and learn together and from each other. Everyone is considered an expert.

A Recovery College explicitly recognises the expertise of lived experience alongside professional expertise in a process of co-production. All aspects of running a College are co-produced; all courses and workshops are co-designed, locally, and are co-delivered and co-received by people facing mental health challenges, the staff who support them, the people who are close to them and others from the local community.

Courses and workshops typically cover a range of areas – those directed towards understanding different mental health issues and treatment options (e.g. understanding a diagnosis of depression and understanding psychological therapies).

Recovery Colleges are considered vehicles for sustainable organisational transformation eroding the ‘them’ and ‘us’ barriers by facilitating partnership working and learning. Unhelpful practice, attitudes, behaviour, stigma and prejudice are all challenged by modelling a different conversation and understanding; a different way of working and learning together. ‘Co-production’ inspires a change in the nature of day to day conversations, encouraging shared decision-making.

Recovery Colleges change the relationship between services and communities, promoting inclusion, breaking down the prejudice and discrimination that divide people facing mental health challenges from their friends, families and communities and contribute to the creation of communities that can accommodate mental distress. Students can attend courses designed to help them develop the knowledge, skills and confidence to participate in all facets of community life. A Recovery College recognises that mental health workers do not have a monopoly on ‘professional expertise’: agencies and individuals in other parts of our communities possess a wealth of knowledge that may be important in rebuilding a life. For example, employment agencies are best placed to co-produce courses about returning to work; college tutors are better placed to provide programmes to assist people to return to study; and the police and fire-brigade are better placed to contribute to workshops about keeping safe in the community. In addition, Recovery College courses are open not only to people using statutory mental health services and the staff providing them, but also to friends, families, neighbours, and people in the broader community.

A Recovery College drives recovery focussed practice within an organisation. Recovery Colleges are considered vehicles for sustainable organisational transformation eroding the ‘them’ and ‘us’ barriers by facilitating partnership working and learning. Unhelpful practice, attitudes, behaviour, stigma and prejudice are all challenged by modelling a different conversation and understanding; a different way of working and learning together. ‘Co-production’ inspires a change in the nature of day to day conversations, encouraging shared decision-making.
making and a ‘coaching approach’ back in the clinical setting. Employment of Peer Trainers is also a tangible step to transforming the wider workforce.

**Defining Features of a Recovery College**

An understanding of the importance of recovery education predates the Recovery College (see Perkins and Repper, 2017). For example, in the UK the ‘Expert Patient Programmes, to help people to manage a range of long term health conditions, began in 1999 (see Department of Health 1999, 2001, 2006). However, while peers with lived experience co-facilitate these courses, unlike a Recovery College, the content is largely prescribed by professionals and is largely prescriptive and manualised. They focus on symptom management rather than the broader issues involved in rebuilding a life and only those with long term health conditions can attend.

In the USA, the Boston Centre for Psychiatric Rehabilitation offers a recovery education programme that grew out of rehabilitation skills training approaches: “an adult education program that offers students the opportunity to choose a range of wellness courses that support their rehabilitation and recovery efforts”. Developed from the Boston model, the Recovery Education Centre in Phoenix, Arizona, provides “trained peer facilitators [to] help individuals develop skills and tools that can lead to success in all aspects of wellness and daily living.” However, these US initiatives differ markedly from the Recovery Colleges developed in the UK. For example: they are deliberately separate from clinical services and are not designed to address clinical issues of diagnosis and treatment. They offer a discreet number of courses that are typically manualised and run over several weeks, rather than the wide range of learning opportunities ranging from one off workshops to fully accredited courses. They offer recovery focused education but do not bring together the expertise of lived experience and professional expertise in a process of co-production or co-learning. They are based on a largely didactic model of learning rather than a more democratic learning environment in which the expertise of all is valued and shared.

While learning from these recovery education initiatives, Recovery Colleges represent a departure in terms of models and approach. They offer a comprehensive range of courses based on the wishes and needs of those who use them and form a core part of mental services. They embody a shift from a focus on therapy to education and explicitly bring together the expertise of lived experience and professional expertise in an inclusive learning environment in which people can explore their possibilities. Based on the theory and values that lay behind the development of the first UK Recovery Colleges in South West London, Nottingham and Central and North-West London a briefing paper outlining a series of 8 key principles of a Recovery College was produced by ImROC in 2012 (Perkins et al, 2012). The aim of these was not to prescribe what people should do, but to offer a framework for creativity.
They are founded on co-production: they bring together the expertise of lived experience and professional expertise in all aspects of their design and operation from initial planning through decisions about operation and curriculum design through to the development of courses and workshops, delivery of training and quality assurance. Such co-production is not a ‘one off’ exercise but an iterative process of review and recreation that involves not only the tutors but also those attending the courses. Typically, a College will have a small team of peer and mental health practitioner trainers employed directly by the College, supplemented by a larger group of sessional peer trainers and sessional mental health practitioner trainers drawn from among staff within mental health services and from community agencies.

They reflect recovery principles in all aspects of their culture and aspiration. This includes not only the content of courses and workshops, but also a physical environment that conveys messages of hope, possibility and empowerment and recovery language that highlights strengths and possibilities rather than deficits, problems and shortcomings. A Recovery College is a place where success is celebrated both with students (for example, certificates of achievement) and in the working practices of staff.

They operate on college principles. Students are not ‘referred to’ the Recovery College or assessed for their ‘suitability’ to attend. Instead, they select the courses from a prospectus. There is no selection based on diagnosis or clinical condition and they do not offer treatment, care co-ordination or perform risk assessments. If the person is considered safe to leave a ward by the clinical team, then they can attend the Recovery College. If they are not, then a member of staff may accompany them as a fellow student or courses are organised within the ward. A co-produced ‘student charter’ describes what students can expect from the College and what the College expects in terms of attendance and behaviour.

They are for everyone. This includes people who use mental health services, people who are close to them, staff from mental health and related agencies and people from local communities who are outside the mental health system. The ethos is that everyone learns together and from each other.

There is a Personal Tutor (or equivalent) who can offer information, help people develop a learning plan based on their wishes, hopes, interests and aspirations and select courses in line with these.

There is a physical base. A building with classrooms and a library so people can do their own research. Most Recovery Colleges adopt a ‘hub and spoke’ approach with a central base, offering a focus for the College, and satellite courses in different locations. The Recovery Library is not intended to replace local libraries; rather it contains materials and information which
supports recovery and, most importantly, internet access.

They are not a substitute for the specialist assessment, treatment and therapy offered by clinical teams. However, they may replace and extend a variety of less specific groups, individual work and psycho-education. Blending lived and professional experience can increase people’s understanding of their problems, how they can manage these and make informed choices about the support and treatment they want.

They are not a substitute for mainstream colleges. However, they may run ‘return to study’ courses to enable people to access mainstream education and training opportunities, if this is their wish, and enable people to gain the confidence and skills to manage their mental health challenges in other educational settings.

In the light of their experience, the Nottingham Recovery College has developed a set of ‘critical dimensions’ for success of a Recovery Colleges within the 8 key principles (McGregor et al, 2014, p8-11):

“Educational. The development and provision of Recovery-focused knowledge/understanding, coping strategies, skills and application of learning is facilitated through a Recovery-focused curriculum.”

“Collaborative. Lived, life, professional and subject expertise and experience are brought together in co-production, co-facilitation and co-learning.”

“Strengths based and person-centred. For all students and staff, achievements, strengths, skills and qualities are identified, built upon and rewarded. Adjustments and supports are put in to overcome challenges.”

“Progressive. Students work towards goals, and/or to overcome personal challenges. Courses and support are agreed through an ILP [individual learning plan] which is regularly reviewed.”

“Community focused. The college is community facing with active engagement with community organisations and Further Education colleges to co-produce relevant courses and facilitate pathways into valued roles, relationships and activities.”

“Inclusive. The college offers learning opportunities to students of all abilities, cultures, ages and experiences. A sound differentiation policy ensures that everyone has equal access to learning and the contribution that everyone can make is recognised and valued.”

Possibilities and Pitfalls

To date there are no formal controlled trials exploring the effectiveness of Recovery Colleges, and given the iterative nature of the core co-production process on which they are founded, there may be significant problems in adopting such a methodology. However, although Recovery Colleges are more than the sum of their parts, there is a separate evidence base for the core components that Recovery Colleges include and build on like peer support, self-management and psycho-education (see, for example, Rinaldi, 2002; Foster et al, 2007; Cook et al, 2011; National Institute for Health and Clinical Excellence, 2011; Repper and Carter, 2011).

There is a strong and consistent body of evidence from several prospective, uncontrolled studies of Recovery Colleges (see Meddings et al, 2015 for a summary):

Quality of life and well-being significantly improved after attending a Recovery College.

Students report significant improvements in their personal recovery, feel that they have been helped to progress towards their personal life goals and feel more hopeful about the future.

Recovery Colleges promote social inclusion. Students show increased social networks and increased engagement with community activities, employment, voluntary work and education.

Those who attended Recovery Colleges show decreased use of hospital and community mental health services.

Students who are mental health practitioners feel that the Recovery College had changed their attitudes towards mental health and recovery, given them increased empathy and understanding, positively influenced the way they support people and improved their own well-being (Perkins et al. 2017).

However, it is not easy to adhere to the principles on which Recovery Colleges are based, and many of the criticisms that have been made of them result from failure to respect these underlying principles (see Perkins and Repper, 2017). For example, genuine co-production is not easy and can take time. It is too easy for one type of expertise to take precedence and result either in
professionally developed courses with only token peer input or peer designed courses that exclude the expertise of lived experience. Dealing with differences of opinion can be a challenge if it is assumed that a conclusion must be reached about who is ‘right’: sometimes it is necessary to present differing points of view and leave students to decide what makes sense to them.  As well as such process issues, practical challenges have arisen, both around securing ongoing funding and restrictions imposed by the source of that funding. For example, if funding comes from secondary services then it sometimes requires that students are drawn from those services thus violating the principle of inclusion - Recovery Colleges are for everyone - and meaning that those who are discharged must cease attendance.

The agency providing the College can also be an issue. UK Colleges invariably involve partnership working across agencies, but the lead agency may be a health service, non-statutory organisation or, more rarely, an educational facility. Each model offers possibilities and challenges and questions remain about the relative merits of different locations and organisational links. For example, is it better that they are located within mental health services because of their potential to transform the way in which these organisations work, or is it better that they are located in community settings where ‘stigma’ is reduced? Some Recovery Colleges have also begun to extend their remit beyond mental health to include people living with long-term health conditions, dementia and learning disabilities and have developed spokes in primary care. Such developments appear promising but clearly require further evaluation.

However, perhaps the most striking thing about Recovery Colleges is the way in which they are valued by those who use them. Many struggle to keep up with demand with over 95% of students rating the courses they have attended as ‘good’ or ‘excellent’.

“I have moved further in my recovery in one term here than I have in the past two years in the mental health team.”

“I can’t believe what you have done for my son. I used to have to push him out of the door and he would cover his face. Now he goes out with his head held high.”

“I have discovered ... a wonderful, helpful and hopeful place that I know will be of tremendous help to me in moving forwards in my life.”

References


Rachel Perkins BA, MPhil (Clinical Psychology), PhD, OBE is a Senior Consultant with ImROC, co-editor of *Mental Health and Social Inclusion* and Acting Chair of the Equality and Human Rights Commission Disability Advisory Group. She led the development of the first UK Recovery College in South West London.

Jane Rennison is Head of Occupational Therapy (Mental Health & Allied Specialties) and Recovery Lead for Central and North-West London NHS Foundation Trust and a Senior Consultant with ImROC. She led the development of the third UK Recovery College in North West London.

Julie Repper BA, RGN, RMN, MPhil, PhD is Director of ImROC, Recovery Lead at Nottinghamshire Healthcare Trust and co-editor of *Mental Health and Social Inclusion*. She led the development of the second UK Recovery College in Nottingham.
The Experience Panel of mental health and substance abuse services in Bergen, Norway.

Linda Garvik.

Introduction

The mental health services in Bergen, Norway is working towards becoming more recovery oriented. A few years ago, they took the initiative to start an Experience Panel (EP). In this paper I will present this panel. My name is Linda Garvik, WAPR Norway Board member, lived experiences with mental health issues and recovery. I am currently working in the mental health sector as a peer support worker. I have been a member off the EP since it was established.

Why this panel, and what is it?

Else-Mari Løberg, who was Chief Adviser at the Division of Psychiatry, Haukeland University Hospital, identified the need for more user involvement in the development of mental health care division in Bergen (CMHC). Therefore, she invited employees and persons who used the services to a kick-off seminar. Invitations were sent out with the aid of local networks, Bergen municipality, user organizations and users of the health care services. More than 90 people attended the seminar. People were selected into groups consisting of practitioners and service users. In groups, they discussed how to start an EP and how an EP could be of use to create a constructive cooperation between the mental health professionals and people with lived experience with mental health issues.

The aim of the EP was, and still is, to improve the services provided within the mental health care sector. As a result of Else-Marie Løberg’s initiation, and following the kick-off seminar, the EP was established and members were selected. The EP board had its first official meeting in March of 2015 and it started with 17 members. Today meetings are held approximately each sixth or seventh week.

Else- Marie Løberg, the initiator of the EP, got a new job as Director at the Department of Addiction Medicine, Haukeland University Hospital. Here she started a similar EP, consisting of members with lived experience with substance abuse. In a meeting
between members of the EP at the Division of Psychiatry, and the EP at the Department of Addiction Medicine, it was decided that both panels should merge and become one. The new EP now consist of 22 members. Furthermore, the new EP is able to work with a broader field. Today we are proud to call the new EP, the Experience panel within mental health and substance abuse, division Bergen.

Who are the members, and what is lived experience?
The group EP consists of men and women between the ages of 35 to 60. The members have various experiences with mental health and/or substance problems, a great variety of diagnosis, recovery processes and life experiences. Three of the members are next of kin to someone suffering with mental health and/or substance problems. All members have both good and bad experiences with treatment, coercion, medication, recovery, hospitals, doctors, institutions and meetings with health care workers, services and systems. Most of the members work as peer support workers. Some have attended the MB-program (peer support program). Others have a variety of jobs, and some are on disability benefits. All of the knowledge and experiences in this panel is acknowledged, and aids in the development of recovery-oriented healthcare services. The kind of knowledge derived from the EP is unique, because you cannot obtained it, by reading a textbook.

The panel’s main purpose
The EP’s main purpose is to improve and develop services on an individual level, and on the service/system level. The panel is an advisory group for the division. The panel members attend different development- and service transformation-groups and workshops, and are often the initiators to changes, which can make life better for patients and their families.

Work they do and fields attended
Some of the members are working with the “Learning and coping center”. Here they contribute in the development of evening classes for patients, family members, partners and friends. Courses are held six times a year. The courses consist of a variety of topics, such as living with schizophrenia, experiences of substance abuse, anxiety and much more. Members who have experience with the topic area, participates in the teaching by sharing their own experience. Other members are representatives in a work group trying to develop a drug-free treatment course. Some members teach at universities and colleges for nursing students and other healthcare students. One member is working with the County Medical Officer of Health with quality assurance of outpatient services. Members are often invited to health conferences and seminars, and asked to present their own experience with recovery. Likewise, directors of hospitals and community mental health centres are invited, and often present during EP meetings. The panel is also working towards reducing the important and disputed subject of preventing compulsory treatment and coercion. The panel invited the division for cooperation, and have been contributed to new procedures regarding the use of mechanical force and how used when all other solutions tried.

The EP’s achievement
The panel has noticed that their knowledge is needed for the development of recovery-oriented
services—at all levels. It has already been an important influencer in some developments of recovery-oriented services. The panel has made its mark within the healthcare system in different ways. For instance, the panel is now frequently asked to attend advisory boards and seminars. The panel offers advices and suggestions for service improvements on all levels, from management to clinical.

**Hope and aim for the future**

The EP hopes to raise more awareness of its existence, so it can be more used within the services. Our aim is that our experiences will be used in the development of the health care services on all levels, all the time. The panel wants to be the voice of those who have difficulties with being heard. We also hope to be role models for other cities, mental health divisions in Norway, and throughout the world. In the future, we hope to be the voice and help for more hopeful and caring services on all levels.
ARTICLE

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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The global mental health crisis is firmly rooted within a biomedical model. Another alternative is the psychosocial model, which looks beyond (without excluding) biological factors, understanding psychological and social experiences as risk factors contributing to poor mental health and as positive contributors to well-being. HRC (2017) argues that for mental health systems to be compliant with the right to health, the biomedical and psychosocial models and interventions must be appropriately balanced.

1.2 Power asymmetries
A redistribution of power in the clinical, research and public policy settings is necessary in order to promote and protect human rights in mental health (HRC, 2017). The professional group in psychiatry is seen as a powerful actor in mental health governance and advocacy (ibid). The Special Rapporteur welcomes open and ongoing discussions within the psychiatric profession about its future, including its role in relation to other stakeholders. HRC (2017) is convinced that the active involvement of the psychiatric profession and its leaders in the shift towards rights-compliant mental health policies and services is a crucial element for success in positive global mental health changes.

1.3 Biased use of evidence in mental health
Scientific research in mental health and policy continues to suffer from a lack of diversified...
funding, and remains focused on the neurobiological model (HRC, 2017). This biomedical bias also dominates the teaching in medical schools. Consequently, knowledge transfer to the next generation of professionals is being restricted (ibid). Furthermore, because of this bias there exists a worrying lag between emerging evidence and how it is used to inform policy development and practice (ibid).

2.0 Evolving normative framework for mental health

The evolving normative context around mental health involves the intimate connection between the right to health, with the entitlement to underlying determinants, and the freedom to control one’s own health and body (HRC, 2017). Furthermore, it is linked to the right to liberty, freedom from non-consensual interference and respect for legal capacity (ibid). The right to health also includes a right to integration and treatment in the community with appropriate support to both live independently and to exercise legal capacity (ibid).

At present, due to the different interpretation by international human rights mechanisms, there is an impasse over how obligations in relation to non-consensual treatment are implemented in the light of the provisions of the Convention on the Rights ofPersons with Disabilities (ibid). The Special Rapporteur is following these developments, and may report on the progress achieved (ibid).

Right to mental health framework

3.1 Obligations

States parties have an obligation to respect, protect and fulfil the right to mental health in national laws, regulations, policies, budgetary measures, programs and other initiatives (HRC, 2017). In terms of the right to mental health, that translates into the development of a national mental health strategy with a road map leading away from coercive treatment and towards equal access to rights-based mental health services (ibid).

3.2 International cooperation

International treaties recognize the obligation of international cooperation for the right to health (HRC, 2017). Yet mental health is still neglected in development cooperation and other international policies on health financing (ibid). The Special Rapporteur welcomes recent support by the World Bank and WHO for moving mental health to the center of the global development agenda. However, he cautions that such global initiatives must incorporate the full range of human rights (ibid).

3.3 Participation

The effective realization of the right to health requires the participation of everyone. In decision-making at the legal, policy, community and health service level (HRC, 2017). A multisectoral and inclusive engagement with stakeholders, such as users and former users of mental health services, policymakers, service providers, health workers, social workers, the legal profession, the police, carers, family members and the wider community, is needed for this to occur.

3.4 Non-discrimination

International human rights law guarantees the right to non-discrimination in the access to, and delivery of mental health-care services, and the underlying determinants of health. Yet discrimination continues to influence mental health services, depriving users of a variety of rights. Recognizing the diversity of human experience, and the variety of ways in, which people process and experience life is crucial to ending discrimination. Peer-led movements and self-help groups, which help to normalize human experiences that are considered unconventional, contribute towards more tolerant, peaceful and
just societies.

3.5 Accountability
Accountability for the enjoyment of the right to mental health depends on three elements: 1) monitoring; 2) independent and non-independent review, as well as by social accountability mechanisms; and 3) remedies and redress.

3.6 Beyond mental health services towards care and support
The right to mental health requires care and support facilities, goods and services that are available, accessible, acceptable and of good quality. Rights-based care and support for mental health is an integral part of health care for all.

3.7 Informed consent and coercion
Informed consent is a core element of the right to health, both as a freedom and an integral safeguard to its enjoyment. The right to provide consent to treatment and hospitalization includes the right to refuse treatment. Justification for using coercion is generally based on “medical necessity” and “dangerousness”. These subjective principles are not supported by research and their application is open to broad interpretation. A change is necessary, and in the rapport, the Special Rapporteur proposes five deliberate, targeted, and concrete actions.

3.8 Underlying and social determinants of mental health
The final report of the Commission on Social Determinants of Health was a pioneering piece that brought greater visibility to social determinants. Nonetheless, in order to take full account of the evidence around the determinants of mental health, the right to those determinants must expand beyond inequities, discrimination and the physical environment. Furthermore, it must move to reflect the documented importance of healthy psychosocial environments. That includes developing public policies that promote non-violent and respectful relationships in families, schools, workplaces, communities and health and social services.

Shifting the paradigm
HRC (2017) argues that although psychototropic medications can be helpful, not everyone reacts well to them, and in many cases,
they are not needed. Prescribing psychotropic medications, not because they are indicated and needed, but because effective psychosocial and public health interventions are not available, are understood to be incompatible with the right to health (ibid).

Public health and psychosocial interventions are seen as essential components of a rights-based mental health system, and not a luxury (ibid). This is based on the understanding that individual and social factors, cultural values and the social experiences of everyday life in families, schools, the workplace and communities influence the mental health of each person. Likewise, a person’s mental health affects life within those domains and is integral to shaping the health of communities and populations (ibid). A population-based approaches to mental health move health systems beyond individualized responses towards action on a range of structural barriers and inequalities (social determinants) that can negatively affect mental health (ibid).

A paradigm shift that is recovery and community-based, promotes social inclusions and offers a range of rights-based treatments and psychosocial support at primary and specialized care levels is needed (ibid). The recovery approach, when implemented in conformity with human rights, has helped to break down power asymmetries, empowering individuals and making them agents of change rather than passive recipients of care (ibid). Tremendous strides have been made in this area. For instance peer support, when not compromised, is an integral part of recovery-based services. It provides hope and empowers people to learn from each other, including through peer support networks, recovery colleges, club houses and peer-led crisis houses (ibid).

**Recommendations**

At the end of the report, a list of recommendations is presented. Recommendations regarding how: 1) to address the imbalance of the biomedical approaches in mental health services. 2) To ensure that social and underlying determinants for the promotion of mental health for all are addressed. 3) To ensure that international cooperation secures the right to mental health and the 2030 Agenda. 4) To ensure that health-care services guarantee the right to mental health for all are provided.

Full text: [http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx](http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx)
Recent Research
By Esther Ogundipe.


Background: Recovery-oriented practice requires a paradigm shift in attitudes to care. Obtaining a better understanding of staff perspectives is a step in the right direction. This study explored the experiences of staff working at a recovery-oriented community-based residential mental health rehabilitation unit in Australia, called a community care unit (CCU). Their aim was to support consumers with severe and persisting mental illness to achieve personal recovery through recovery-oriented rehabilitation care over a 6 – 24 month. The unit provides 24-hour care around living skills and community integration. Furthermore, the CCU provides opportunities for engagement in evidence-based therapies.

Key definitions: This paper defines personal recovery as “being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues”.

Recovery-oriented practices as care entails: recognizing and embracing the possibilities for recovery and well-being, created by the inherent strength and capacity of all people experiencing mental health issues. It is about maximizing self-determination and self-management of mental health and well-being. Furthermore, it includes assisting families to understand the challenges and opportunities arising from their family member’s experiences.

Methods: The present study reflects one component of a longitudinal mixed-methods evaluation. Please refer to Parker et al. (2016) for a full description. In this component, 8 staff voluntary took part in semi-structured interviews. The interview schedule explored four topics: 1) understandings of what the CCU is, 2) how working at the CCU compares to other mental health settings, 3) expectations prior to commencement at the CCU and 4) reasons for continuing to work at the CCU. The interviews were transcribed, and a pragmatic approach to ground theory was used to analysis the transcripts.

Results: Four key themes emerged from the analysis: 1) rehabilitation is different from treatment, 2) the CCU is a positive transitional space, 3) consumers have to be ready to engage and 4) recovery is central to rehabilitation practice.
**Conclusion:** Several barriers to realizing and maintaining a recovery-oriented rehabilitation model of service was noted. The barriers included characteristics, staff attitudes and burnout, as well as external constraints. Active vigilance is needed to maintain a rehabilitation focus that is distinctive from treatment and sustain moral to support consumers and the team to realize recovery outcomes.

**Reference**


**Background:** Both in Norway, and internationally, it is becoming more and more normal to employ people with lived experience with recovery (i.e. peer support workers), in mental health services. To date, there is a considerable amount of research highlighting the positive contributions associated with employing peer support workers in services. Nonetheless, more knowledge about the relationship and collaboration between peer support workers and service users is needed.

**Research questions:** From the perspective of service users, this study sought to explore: 1) what kind of experiences service users had with collaborating with peer support workers? 2) In what areas and ways hasthe collaboration between peer support workers and service users, been supportive and/or unsupportive? 3) Do service users have any experiences, both positive and negative, they believe they would not have in an encounter with a health professional? 4) What are the differences in collaborating with peer support workers and other health professionals?

**Method:** A mixed method design with user involvement was conducted. The qualitative component consisted of five focus group interview, while the quantitative component used the recovery questionnaire INSPIRE (Le Boutelier et al., 2011; Leamy et al. 2011). INSPIRE is designed to assess a service user’s experience of the support they receive from a mental health worker for their recovery, which in this context were peer support workers. A demographic questionnaire was developed in order to access demographic information regarding the participants.

User involvement throughout the research process was ensured by recruiting a co-researcher with lived experience. Furthermore, a competence group and a steering group were established. Both groups consist of people with relevant user experience.

**Ethical considerations:** The study has been reviewed and was granted ethical approval by the Norwegian Social Science Data Services (NSD). It is noteworthy that this study has been carried out on behalf of the Nasjonal senter for erfaringsskompetansen innen psykisk helse at the Center for Mental Health and Substance Abuse, at the University College of Southeast Norway.

**Results:** Four key themes emerged from the qualitative analysis: 1) “I listen more when they talk” 2) peer support workers are bridges 3) it depends on the peer support worker and 4) a place where you can be yourself. Each theme consisted of sub-themes. The quantitative findings are displayed in various tables.

**Conclusion:** Overall, the findings shows that service users see their collaboration with peer support workers as something positive. Nonetheless, some challenges and differences relating to working with peer support workers, and other health professionals are noted.

**Further research:** More knowledge about peer support workers role, support and collaboration with people with a different cultural background...
and age group is warranted. Further areas of research needed includes: 1) What is distinctive about lived experience, and what categorizes good use of lived experience? 2) Regulations surrounding peer support workers. 3) Health professionals’ experiences with collaborating with peer support workers. 4) Peer support workers role in facilitating social inclusion and participation. 5) In what ways, can one validate and apply health professionals’ life experience in service?


**Background:** In Nigeria only ten percent of the people with a mental illness are seen in the health care system. Very little integration has taken place, despite the World Health Organization (WHO) recommendation to integrate the care of people with a mental health problem into primary care services. Attitudes of primary health care workers is considered to be one of the barriers to this.

**Methods:** One hundred and twenty primary health care workers located in Osun State, Southwest Nigeria, voluntarily took part in a cross-sectional survey using the Community Attitudes towards Mental Illness (CAMI). CAMI is a self-report scale designed to measure positive and negative attitudes towards mental illness in the community. Attitudes are divided into four dimensions. 1) Authoritarian, which corresponds to the view that the mentally ill is inferior. 2) Benevolence, which gives paternalistic or sympathetic view of the mentally ill. 3) Social Restrictiveness, the belief that the mentally ill are a threat to society and should be avoided. 4) Community Mental Health Ideology, which is concerned with the acceptability of mental health services and mentally ill persons in the community. Both descriptive and inferential statistics were used in the analysis.

**Results:** The primary health care workers in this study, showed less authoritarian attitudes towards the person with a mental illness. Longer length of services seems to make the care workers less authoritarian. The care workers were in agreement with the attitudes listed in the Benevolence subscale. For instance, they agreed that the community need to be more tolerant of the mentally ill. In the Social Restrictiveness subscale, most care workers reported that a person with a mental illness is a danger to themselves and others around them. Furthermore, that it would be foolish for a woman to marry a man who has suffered from mental illness. Noteworthy is the finding that care
workers who had worked for more than ten years, had less socially restrictive attitudes. In regards to the Community Mental Health Ideology, they would rather have the mentally ill cared for at other levels of care, than at the primary health care center.

**Discussion:** The overall attitude is that of pushing the care of the mentally ill to higher, or more specialized facilities. Thus, while accepting the need for the mentally ill to be properly cared for, most primary health care workers would rather not take on such responsibilities.

**Conclusion:** This study has shown that primary health care workers still have concerns and fears, which need to be addressed in order to integrate mental health care into primary health care services, as recommended by the WHO.


**Aim:** This article describes Amaudo Itumbauzo (AI), a community based psychosocial project, located in Southeast Nigeria. AI provides psychosocial services to homeless individuals with a mental illness.

**Background:** In 1989 Rosayn Colwill, a social worker, founded AI, as a response to the absence of services for citizens with a mental illness living on the streets in Southeast Nigeria. Colwill believed that an essential part of therapeutic intervention is to the re-establishment of community ties, while living in a strong vibrant and caring community.

**Methods (i.e. treatment process):** AI’s holistic approach to mental health includes the use of: observation, stabilization with psychotropic medication, counselling, engaging residents in spiritual activities, vocational skills training, and eventual discharge back to their families and communities. Upon discharge residents are referred to one of the 73 community clinics for follow-up care. While family members are offered psychoeducation and resources for ongoing care.

**Results (i.e. resident demographics):** To date, AI has provided services to more than 833 individuals from different states across Nigeria. Currently, AI can house up 65 residents. Residents’ age ranges from early 20s to mid-60s. The average length for AI residents ranges from six months to two years.

**Discussion:** Some of the challenges AI is currently facing are garnering sustainable resources, as well as limited resourced within AI itself. Such as lack of space, outdated computers and software programs, lack of consistent electricity, staff support and incentives.

**Conclusion:** AI has provided holistic mental health services to homeless individuals with a mental illness in Nigeria. Currently, there is limited data about how effective psychosocial services can be developed and delivered in sub-Saharan African settings. A comprehensive and systematic examination of AI could help narrow this gap. By offering insights that can guide development, improvement and expansion of mental health services.


**Background:** Oxford House (OH) is a recovery home, founded by Paul Molly and a group of men in recovery from alcohol problems. While Molly lived in a halfway house, he saw 12 fellow residents being forced to leave the house because they had reached the maximum length of stay. 11 of these men relapsed within 20 days.
**Method (i.e. setting):** The basic rules of conduct for OH, were and remain, simple: operate soberly and democratically, with each member paying his or her rent and doing all assigned chores. At Oxford Houses (OHs) there are no professional staff members. All costs of the programs are covered by the residents. Houses consist of multi-bedrooms for same-sex occupants. Located in low-crime and residential neighborhoods. There are rarely more than 12 residents in a house, and they have the freedom to decide whether or not they want to seek treatment. Regardless of their choice, residents receive constant support and guidance within an abstinent, communal setting.

**Results:** Several studies on OHs has been conducted. Benefits such as support for abstinence from fellow residents, fellowship, stability, and opportunities for personal growth are reported by residents in OHs. There is also evidence that relapse occurs less among OH residents, when compared to people receiving usual care.

**Discussion:** In Nigeria, substance abuse disorders (SADs) and mental health treatment is often left of primary health care planning. OHs might be a key to recovery for Nigerians suffering from alcohol and substance abuse, and in need for long-term aftercare in affordable supportive residential housing. Similar to the OHs in Ghana, some employment opportunities should be included in the development of OHs in Nigeria. Firstly, because employment aids in recovery. Secondly, because in Nigeria most of the national resources are channeled into primary health care through government systems, and as previously stated SADs and mental health treatment is often left of primary health care planning.

**Conclusion:** Despite the high prevalence rates of SADs in Nigeria, there is a lack of effective treatment and recovery programs. Given the benefits associated with OH models, especially those that include employment opportunities, there is a need to introduce this type of recovery home in Nigeria.
The XIII Congress of the World Psychosocial Rehabilitation Association (WAPR), will be held in Spain, in Madrid, from the 5th of July to the 7th of July 2018. It will be held at the Palacio Municipal de Congresos. The Congress will be organized by two credited organization. The Spanish Federation of Associations of Psychosocial Rehabilitation (FEARP), and the Spanish Association of Neuropsychiatry (AEN). FEARP represents WAPR’s Spanish branch. It consist of groups and organizations from different regions of Spain. AEN is a centennial organization. It is known for its contributions to the Spanish Psychiatric Reform, and for its rigorous and progressive attitude.

To date, the Congress has received support from global organizations such as the World Psychiatric Association (WPA), and the World Federation for Mental Health (WFMH). The Congress has also received support from regional organizations in Asia, Africa and Latin America. As well as multiple national organizations (e.g. ABRASME from Brazil, or Russia) and the Spanish organization of families and carers.

As usual, we will convey a message of friendship and collaboration to colleagues from all regions and countries. This is the first WAPR World Congress to be held in a Spanish-speaking country under the presidency of a Spanish-speaking President. We will use this opportunity, to project our discipline, to offer cooperation and exchange of competence to Latin America, and to strengthen and expand our spaces of exchange with colleagues from the region.

We have been informed about the interesting developments that have been taking place, and still is, in countries such as Peru, Argentina, Uruguay, Chile, Mexico and Brazil, by our regional delegations. We will do our best to bring awareness to these new developments.

Organization
As organizers, we are working on an austere and sustainable congress. A congress, which will facilitate the access of delegates from developing countries, enhance the spaces of exchange, and reduce unnecessary cost for organizers and delegates.

Madrid is a cosmopolitan city. The city is hospitable, attractive and safe. It brings together the best characteristics of international accessibility. It has a large international airport, which is very close to the city center. The airport is also close to the venue that we will be using. The airport offers direct flights to most countries. There is also a high-quality and diversified hotel nearby. All these features, is seen as beneficial, as it will help reduce
transportation and living expenses. We will also try to offer some accommodation at the university.

**Scientific Program**

This year, the focus will be on the latest scientific and social developments in the field of Psychiatry, Psychology and Psychosocial Rehabilitation. The title and the focus for this year is "Recovery, Citizenship, Human Rights, reviewing the consensus".

Our bio-psycho-social discipline is currently in a very crucial state. It is time to review concepts. We also need to be aware of how these concepts are being used and presented in the media and social network. Right now we are facing several issues relating to etiology, diagnosis and treatment of serious mental health problems.

Within our field there are many controversial contributions. These issues need to be further investigated, elaborated and discussed. Within our discipline, we need to explore ways to balance the biological, the psychological and the social perspectives, as they co-exist and overlap.

During this year Congress, we will be addressing a series of hot topics with top-level specialists. These topics are:

How to conceive the processes of getting sick?
What is the best ways to detect and tackle the problem earlier on?
What are the best ways of supporting the person and his/her social networks? What are the best possible treatment strategies and approaches (psychological, social, environmental, pharmacological)?
How to understand the recovery - processes, and what are its implication for the person, the family, the community and for services and treatments?
What design and what values require services from the most recent contributions of the different disciplines that converge in our field.

We will do it with maximum responsibility, with full awareness of the difficulty and complexity of our field, and the potential significance of our conclusions and recommendations in the lives of the people we serve. In addition, besides facts of science, there are values that converge directly in our field.

In recent years, in Psychosocial Rehabilitation and Psychiatry, Social Determinants and Human Rights have become more and more important. Because of World Health Organization commitment to bring more awareness to these perspectives. Since the publication of the New York Convention on Human Rights for Persons with Disabilities, attention to human rights in different settings has increased. The Declaration and its principles engages, in different ways, governments and politicians. It highlights the need to revise services, in order to provide citizens affected by disability from those perspectives. It highlights the need to review practices (such as coercive or forced treatments) that have been historically used in the psychiatric care. Protection through legal formulas that may collide with respect to the legal capacity also need further
discussion. It focuses on policies, and technical measures, that allow the full incorporation of people with mental health problems to citizen participation in conditions of equity will be an issue of the utmost importance.

We are looking forward to presenting some of WAPR’s achievements over the past few years during this Congress. The conclusions and recommendations of the WAPR Committee regarding training, good practices regarding the training of professionals, and the creation of WAPR Collaborating Centers for Training and Research, will be presented.

**Participation**

Apart from the scientific proposals, the Congress will pay close attention to forms of participation of groups of professionals, family carers and service users through discussion panels or training workshops.

The poster section and scientific communications, will provide delegates with the opportunity to present their research, work and perspectives. We will also provide agencies and providers with an opportunity to present their achievements with the aid of audiovisual presentation.

The working languages will be Spanish and English. We can also provide special symposiums in other languages if required. We already have several sessions in Portuguese, for colleagues from Brazil and Portugal.

As part of the social program, we will present cultural and artistic contributions from user and professional organizations. We will also present examples of anti-stigma activities.

**Miscellany**

The request for scientific accreditation is in process. Delegates will have the opportunity to prove their participation in the curriculum. Delegates will have an opportunity to visit Rehabilitation centers and facilities in Madrid. This way they can have a discussion with our Spanish professionals, and gain a insight into the current developments in our country. We also believe that the city of Madrid and its inhabitants will provide our delegates with a wonderful experience.

We want this to be an environmentally friendly Congress. We will therefore use new communications technology. Furthermore, we will try to limit the use of printed materials, as much as possible. Our aim is to make this Congress, as successful as the previous ones.

Sara E. Makowski Muchnik

Contrary to what happens in Mexico where the field of mental health is colonized by discourse and practices anchored in biological psychiatry and centered on a logic that consists of confining and isolating persons with mental suffering in psychiatric hospitals prevail, there is a community alternative that has been around since 2009. This alternative is geared at achieving de-stigmatization and social inclusion: Radio Abierta.

Radio Abierta is a psychosocial and communicational community intervention dispositive that uses radio and new technologies to create and strengthen social bonds between people with mental illnesses and society at large. Moreover, it challenges stigmas associated with madness and whoever suffers from it.

This pioneering initiative came to life in 2009 at the Xochimilco campus of the Metropolitan Autonomous University in Mexico City. Radio Abierta’s direct predecessor is Radio La Colifata, an experience created by Alfredo Olivera in 1991 at the Borda Psychiatric Hospital in Buenos Aires, Argentina.

While there are many experiences around the world that involve the use of radio programs conducted by people with mental suffering, Mexico’s Radio Abierta is the only one that takes place in a university garden.

Without a predefined radio script, people with mental illnesses take up the microphone every Wednesday and speak, express themselves and share their points of view with absolute freedom. The topics discussed are quite diverse, ranging from their personal experiences with mental suffering and discrimination, internments and crises, and erroneous psychiatric diagnoses to politics, the economy, ecology, feelings, music and the arts.

The program is open to the public and anyone who wants to can participate in these conversations.

Following the format of a one-hour recorded program, Radio Abierta is broadcast every week on FM 94.1 UAM Radio, the university radio station. In addition to this, the voices of Radio Abierta participants can be heard on other communication platforms in Mexico and around the world through other formats like micro-programs and radio spots.

Radio Abierta is also an internet radio show aired 24 hours a day, every day of the week (www.radioabierta.net). This online programming consists of segments on different topics that include cultural productions like poems, stories and musical performances by the participants themselves.

Meanwhile, Radio Abierta’s digital magazine TOING publishes texts and images of the participants in the Mexican radio show, as well as those of other like radio programs in Italy, Portugal, Russia, Argentina, Costa Rica, and Barcelona, among others.
Furthermore, Radio Abierta also produces audiovisual materials like anti-discrimination and anti-stigma campaigns, community videos and visual informational material. The participants collaborate in the script writing, the use of cameras and production in general.

This confluence of different mediums and platforms (radio, video streaming, digital magazine, audiovisual productions and social networks) make Radio Abierta genuinely transmedia that produces narratives of recognition and social inclusion with the help of the different communities and audiences that follow Radio Abierta.

Besides the weekly production of Radio Abierta at the university, in 2011 we developed a mode called Mobile Radio Abierta that consists of taking radio devices from the university garden and setting them up in other institutions and public spaces.

For instance, Mobile Radio Abierta has been used in psychiatric institutions so that a larger number of people might benefit from the positive effects that come from this radio experience. Thus, Radio Abierta took place in a garden at the National Psychiatric Institute for almost five years. We have also been making radio programs with recently discharged patients at the Fray Bernardino Álvarez Psychiatric Hospital in Mexico City. The material recorded at these radio sessions are edited to be aired on FM radio and online.

Other versions of Mobile Radio Abierta have taken place in public spaces and cultural centers so as to interact and dialog with the general public to then initiate public conversations aimed at the visibility and de-stigmatization of people with mental suffering. These open interventions have been very successful in terms of creating greater awareness and proximity between people, so much so that they has ended up undercutting prejudices and barriers.

In August 2017, we began a radio experience in Guadalajara, a city some 500 km from Mexico City. This project is in collaboration with a community for social and workplace integration called Guadalajara Club House. In this case, the first phase of Radio Abierta’s approach consists of setting off and accompanying a radio experience for the social inclusion of people with mental illnesses in Guadalajara. The members of this community will then be ready to independently operate their own radio show in the second phase.

One of the core premises of the Radio Abierta dispositive is that of bringing the subjects who suffer from some kind of mental disorder to the foreground: their voices, their experiences, their worlds and their realities take the floor in their own right.

Radio Abierta becomes a sounding board for the word to circulate. Along its way through public space, it creates a social bond: a connection with others and the restoration of the human condition by being heard by society at large.
Radio Abierta is a space for listening, dialog, meeting and recognition as human beings. We do not adopt any label or psychiatric diagnosis. Thus, the participants are treated as persons. And in this context, they have found an opportunity to reconnect with their own lives, their own interests and desires, and to recapture the chance of being in the world beyond the encapsulation produced by a psychiatric diagnosis.

For over the eight years, Radio Abierta has encouraged physical contact, coexistence, and sharing ideas and knowledge. Essentially, Radio Abierta has greatly contributed so that people with mental suffering can experience an important reconfiguration of their social bonds and move forward along the path of social inclusion.

Since it is a community intervention in university space, it creates an effect of inclusion that “de-psychiatrizes” people and this makes them part of a community that recognizes them as persons.

In this sense, the university community space brings about an array of very positive effects.

On one hand, it broadens and solidifies the fabric of social ties of people with mental suffering because it enables interaction with members of the university community like students, professors, administrative personnel and security. These are social bonds woven outside the hospital space that is oftentimes the only environment of interaction for people with mental disorders.

On the other hand, it enables people with mental suffering to have access to university resources and cultural activities like the library, the choir, green spaces, forums, concerts and workshops. Thus, they can incorporate themselves into the university community, and more generally speaking, into cultural activities to which they have a right as members of society.

Lastly, it has encouraged several Radio Abierta participants to go back to their truncated university studies or start new university degrees. This has had very powerful effects on their redefining their life trajectories.

Radio Abierta leads the way to the reinstatement of a person’s status by recovering their own voice, their say, and their right to speak and be heard in a tolerant and respectful context.

More specifically, the flow of ideas in the public sphere (radio and internet) makes it possible to break through the walls of silence and neglect that society imposes on people with mental illnesses. Therefore, the incorporation of their voices and presence into the public sphere results in the visibility and social inclusion of those who until then had been obliterated and marginalized from society.

What is interesting about Radio Abierta is that the hitherto silenced voices not only circulate on the radio and the internet, but there are also people
listening to them and taking part in the participants’ discussions through messages and comments on social networks (Facebook and Twitter).

In this way, participants’ discussions on various topics (art, ecology, feelings and politics, among many others) are transformed into public conversations shared by the audience who, in turn, can enhance them with insights and experiences.

The reverberation of these voices in the public sphere has at least two very positive effects on social inclusion. First of all, it makes the people who had until then been exiled and obliterated from society visible. When their voices are heard on the radio or online and they are acknowledged for their contributions to public conversations, these people sort of return to the common world we all live in. At the same time, the boundaries of tolerance and respect expand to include the differences that strengthen the demand for a more equitable and inclusive society.

The people participating in Radio Abierta have regained human dignity and an existence in the world as people with resources and skills, bearers of a biographical history, actors with human rights and members of society.

Within the context of mental health in Mexico, a field of discourse, practices, regulations and public policies entrenched in confinements and medical prescriptions that silence the person, Radio Abierta has proven the effectiveness and power of –psychosocial and communicational– community intervention for the visibility, the de-stigmatization and the social inclusion of people with mental suffering.

Radio Abierta subverts the prevailing logic of the psychiatric rationale that isolates and silences, and places value on the experience and contributions that people with mental disorders can give to society at large.

Beyond the stigmas and negative labels imposed on them, these people have their own opinions and knowledge that must be heard and taken into account as part of a more inclusive and democratic way of processing Otherness.
This year’s WAPR Norway Conference was held in Bergen on the date 4th of May. The theme of the day “Recovery-oriented mental health services. What does it really mean?” caught the interest among Norway’s and Bergen’s inhabitants, WAPR members and healthcare workers. This year the WAPR conference beat all earlier records of participants. There was about 230-250 persons present divided into groups of healthcare worker, students, relatives and users of the services. People from all over Norway attended. A wonderful exciting and educational day gathering potentially involved people in a person’s recovery process. In Norway as in many other countries, many professionals work for, and want to develop mental health and substance abuse treatment services to become more recovery-oriented. And typically a lot of healthcare professionals as well as service users and family members wonder what Recovery oriented actually means. This day we set focus on this issue.

My name is Linda Garvik and I have the lived experience with recovery from psychoses. I work at “Multidisciplinary Forum” in Bergen as a peer-support worker and have a coordinating management role here. As a part of this, I have been the overall manager for this yearly WAPR event. Today I also work as a Peer Support Worker at a Community Mental Health Centre, I am a member of the Experience-panel in Bergen and also a WAPR board member in Norway. This is what I learned from this year’s WAPR conference about recovery: “It seems that essential aspects of recovery is related to connectedness, identity, empowerment, meaning of purpose, hope and optimism”. Thus the knowledge, insights and lived experience-support of peer workers play an important part in a person’s recovery process. Recovery also means to give power back to the person, let him or her become more participatory in their own recovery-process. Many also find it reasonable to believe that family members and other important people may bring in information and knowledge that can be useful in the recovery-process. In order to develop stronger recovery orientation of services, there is need for a real power shift in the system and a change of attitude among professionals. The essence is more power to the person and more freedom of choice.

We are proud say that Bergen municipality is a bit of a pioneer and a role model when it comes to including peer workers in mental health and substance abuse services, both on municipality and specialist levels. This is much due to the education program of peer supporters in Bergen, the MB-Program. In Great Britain, they have developed
Recovery Colleges, and for years, they have made use of this teaching program to make changes on system level as well as on personal level. At the conference, WAPR Norway presented experiences from both England and Norway, and on that occasion there was invited several lecturers all specialized at the Recovery field in different ways.

The first lecturer of the day, Mike Slade, Professor of Mental Health Recovery and Social Inclusion -University of Nottingham invited the attendance of the day on a journey through his work with outcome assessment of recovery, on a clinical and personal level, measuring recovery rates in clinical populations as well as recovery on a personal and system level. Mike Slade also emphasised the importance of a power shift in services, to give power back to the person and the importance of the peer support work in the services.

Our second lecturer Jane Rennison, from England and Consultant at IMROC, presented Recovery Colleges as “a vehicle for driving recovery focused practice in organisations”. She focused on how organisations need to change in order to become more recovery-oriented. There is a need for recognition of the value of lived expertise and professional expertise to be available in service and be brought together in a process of co-creation and co-production. She also points out that there is a need for genuine wish for shared decision-making at all levels in order to talk about real recovery in the services.

The third lecturer, Camilla Viktoria Johansen, mental healthcare worker from Bodø, Norway, sets focus on how to meet relatives and their needs. She shared a very personal story about her childhood with her mother who suffered from a serious mental health issues. She talked about the experiences of being excluded from her mother’s treatment and recovery, how she and her grandmother experienced not to be seen, heard or met in a good way. Camilla is today very engaged in relative’s needs and rights. She emphasizes on the variety of ways relatives can be a resource in the person’s recovery process.

Fourth lecture was by Marit Borg, professor at University College of South-East Norway and Tommy Sjåfjell, working at the same place. He is also mental healthcare worker and peer support worker. They presented the findings in the research project about service users’ experiences of help and support from peer support workers. Central findings here were experiences of peer support workers as holders of hope, flexibility in their support, building bridges within services as well as towards the community, careful listeners and taking dreams seriously. They also provided important practical help. A finding was also that there was not automatic that peer support works were important. Some were experienced as being
too involved in their own recovery and personal solutions. Like one participant had said: “it depends on the peer-worker”

Fifth lecturer, was Solveig Bartun Rob, peer support worker at in a Community Mental Health Centre and vice-president of the “Experience panel” in Bergen. She was invited to present Bergen’s Experience- panel, that was established in 2015. The panel consists of 17 people, all with the lived experience with mental illness and or relatives to one that have such experiences. The panel’s main purpose is to improve and develop the services on individual level, service level and system level. The panel is advisory organ for the division management and they work to highlight the service users’ and relative’s voices.

In addition, and in between all the presentations we had a wonderful cultural event by Espen Stokmo, a peer support worker with experiences from rehabilitation within substance abuse to show some other sides of his talents, in fact his beautiful voice filled with empathy power. He and his guitar friend sang and played three songs for the audience. So beautiful that there fell a tear from the attended author’s eye.

I hope I have been able to lead you through our yearly WAPR conference in a way that you wish you were present this year, and want to attend next. At this WAPR conference, we have tried our best to live as we preaches and open up for broad understandings of Recovery.

Welcome to Bergen May 2018!
Cesena hosted the IV European WAPR Meeting, June 9-10th, “About rights and duties: Institutions, Citizens and Services in mental health field”. The meeting was organised by the WAPR Italian Branch with sponsorship of WAPR Central Office. Many WAPR European board officers and WAPR Italian members participated, including Ricardo Guinea, Afzal Javed, Gabriele Rocca, Barbara D’Avanzo, Antonio Maone from WAPR side and Massimo Cassachia, Angelo Fioritti, Roberto Bossio, Paola Carozza, Anna Felcher, Rita Roncone and others form the Italian side.

The conference revised current challenges in Psychosocial Rehabilitation, including topics as “The right to be treated and mental health services: organization, training and programmatic guidance within a real context marked by crisis” Academic training of medical staff and vocational health in psychiatric rehabilitation” The right to be treated and social health determinants: from prevention to inclusion”, Getting over the special status of an offender with mental disorder and internment measures in the everyday routine work in a Mental Health Department: practices and contradictions, or the Symposium: “Appropriate use of antipsychotics: actual debate between research and practices”

The Meeting also hosted an encounter of representatives of WAPR European branches, and considered the possibilities of carrying on specific common activities in the European framework.

As previously mentioned, in the conference program and in the previous meeting in Torino, WAPR is currently exploring and trying to define a shared feasible policy for WAPR Europe which can be implemented in Europe next year.

Overview of current proposals: Research Network. Create a network and join efforts in research and research funding. 

Euro-Parliament. Try to connect with Euro-
Parliament and become a stakeholder in our areas of expertise.

**A European Observatory.** This is seen as important as mental health systems in European countries are currently dealing with several fundamental issues, which needs to be accurately and continuously monitored. Some of these issues are:

The real size of re-institutionalizations’s phenomenon across Europe, and/or surviving of “old institutions”;

People living in psychiatric residential facilities and quality of care, human rights, opportunities for self-determination, agency and/or recovery.

Mental health funding. How and where are financial resources allocated? This is an important issue, as it influences which policies is developed. Clinical versus personal/social recovery outcome.

The role of next of kind, and caregivers, of people with severe mental illness. Do they need treatment and support, or are they co-providers of services?

These issues represents some potential focus areas for an observatory. At least for some countries. The topic areas can be managed, and updated by European WAPR members. Findings could be presented at the WAPR Word Congress in Madrid. Furthermore, findings can be presented as drafts for a monographic issue, to a Journal in the field of community mental health.

It was agreed that the meeting will have an open agenda. All present are invited to present their views on this matter.

**Proposal 1: Research Network**

Everyone acknowledged the importance of networking, and funding for research. During the meeting, it was emphasized that it could be extremely difficult to find funding. Applying for EU funding was epically seen as problematic and time consuming. Therefore, and in order to support those interested in research, developing a repository of key European documents was suggested. This document could provide: 1) a base of basic evidence relevant for the EU, 2) be located on WAPR’s website and 3) updated on a regular basis. A separate section for “Best Practices” will be available on WAPR’s website. This will allow visitors to contact the organizer.

**Proposal 2: Euro-parliament**

When discussing ways to connect with the Euro-Parliament and become a stakeholder in our areas of expertise, we agreed that network working regarding mental health in European already exists. Esko Hahinnen reported that he is well-connected with these networks. Therefore can do an exploratory approach to them a report. We are happy to accept his suggestion. Furthermore, we would like to thank him for his effort.

**Proposal 3: A European Observatory**

A European observatory with high standards would be difficult to accomplish. Furthermore, such an observatory is most likely being done by other European stakeholders. Nevertheless, establishing a European Observatory made by WAPR Europe is seen as beneficial. As gathering reliable data from different countries in Europe,
where WAPR have representatives, can provide us with evidence-based knowledge, which can be used to make a political statement.

Some members emphasized the need to keep this initiative simple, in order for it to be achievable. Using a survey to collect basic and reliable information was therefore suggested. The European Regional Vice President and Deputies will be asked to draft this survey. Afterwards, this proposal will be evaluated and further actions will be identified.

We would like to be able to present the current situation of Psychosocial Rehabilitation in Europe at the Madrid World Congress.

After some discussion, it was decided that a regular contact should be maintained among European WAPR delegates and the Regional Vice President will take the lead for further actions.

A fourth proposal was received by e-mail from Guadalupe Morales. Highlighting the need to enhance user participation by providing financial support for traveling expenses. This proposal will be taken into consideration in next meetings.
I, as the Regional Vice President for Southeast Asia and President of WAPR Thai Chapter, would like to thank all delegates participating in the 2017 Asia Pacific Meeting of WAPR. The conference was held in conjunction with the 5th Asian Congress of Schizophrenia Research (ACSR) last September at Asia Hotel, Bangkok, Thailand with great success. We received an honored opportunity to welcome more than 300 delegates from 23 countries. I greatly appreciate their interest and participation in the conference. Without their attendance, the conference would not have been as successful.

At the congress three pre-congress workshops, four plenary lectures, two plenary symposiums, and 18 regular symposiums were successfully carried out. There were in total 72 guest speakers from 19 countries (46 overseas speakers and 26 local (Thai) speakers), making this congress full with diverse and interesting psychiatric topics. The congress also held the WAPR poster presentation contest which consisted of 51 contestants. The first prize was granted to Taekwan Kim (Republic of Korea). The second and the third prizes went to Sohei Kimoto (Japan), and Huai-Hsuan Tseng (Taiwan), respectively.

At the meeting there was a great deal of collaboration from the WAPR representatives. Dr. Ricardo Guinea, the current president of WAPR, gave us such a great honor by hosting a plenary lecture entitled “Psychosocial Rehabilitation for Persons with Psychotic Disorders: A Global Challenge” and a workshop entitled “Implementation of Psychosocial Rehabilitation Practices: A Practical Approach” Also, Dr. Afzal Javed, the immediate past president of WAPR, updated us on the topic of “Empowerment and Financial Autonomy for Schizophrenic Patients: An Experience from a Developing Country” in one of the plenary lectures. In addition, Prof. Solomon Rataemane, the secretary general of WAPR set aside his valuable time to arrange a regular symposium with the topic of “Keeping Patients Well in Primary Health Care in South Africa”. Not to mention another great support from two other members of the WAPR, Dr. Murali Thyloth and Dr. Medhat Elsabbahy successfully co-hosted the aforementioned workshop with Dr. Ricardo Guinea. The meeting would not have reached its objective without the kind involvement from these notable professors. The ACSR-WAPR collaborative model has been proven efficiently successful and will certainly be of great use for our future meeting to be held in China in 2019. I earnestly look forward to
meeting many participants at the upcoming conference.

Report by Ricardo Guinea.

Under the direction of Dr. Pichet Udomratn, WAPR’s Regional Vice-president of South-East Asia Region, WAPR co-hosted the 5th Asian Congress of Schizophrenia Research. As well as the 2017 Asia Pacific Meeting of WAPR. Together with the Asian College of Schizophrenia Research. This was the first time this alliance had taken place. Ricardo Guinea, on behalf of WAPR and Prof. Hai-Gwo Hwu, the Asian College of Schizophrenia Research, were very satisfied with the outcome.

The conference had many auspices: Asian Federation of Psychiatric Associations (AFPA), Pacific Rim College of Psychiatrists (PRCP), Asian Network of Bipolar Disorder (ANBD),

The following people were present at the conference: Dr. Ricardo Guinea WAPR’s President (Spain), Afzal Javed (UK), WAPR’s former President Murali Thyloth (India), WAPR’s President Elect Solomon Rataemane (South Africa), WAPR’s Secretary General & Dr. Medhat Elsabbahi (UAE), and WAPR’s Reg. Vice-President in Eastern Mediterranean Region.

More than 60 presentations and over 100 posters were submitted. WAPR granted a poster award from Thailand, Japan, Taiwan, Singapore, Australia, USA, Spain, India, South Africa, China, Hong Kong, Malaysia, Indonesia, South Korea, Russia and Austria.

The presentations covered current research in schizophrenia and other mental health problems. From different perspectives: biological, developmental, genetic, neuroimaging, immunologic and social. There was also a WAPR Workshop, which presented current developments and updates in our discipline.

Several topic areas were highlighted such as suicide, caregivers, comorbid diagnosis and cross-cultural psychiatry. Other areas included practical and social aspects of people with mental illnesses; clinical and scientific problems regarding first episodes and onset of mental illness; and issues relating to the elderly. The issue of discontinuation in the use of neuroleptics in psychosis was also a dominant theme.

The conference was a success. It demonstrated how biological, psychological and social aspects of mental health can, and should walk together, in order to provide a better approach to those suffering from mental illnesses.
WAPR co-sponsored the 1st. Latin-American Meeting on Human Right and Mental Health, June 27-30, 2017. The meeting was organized by ABRASME, Brazilian Association on Mental Health, and Santa Catarina University, and was supported by many local and regional organisations. The meeting received attendees from neighbouring countries as Uruguay, Argentina, or Chile.

ABRASME, Brazilian Association of Mental Health, is a non-governmental organization, founded in 2007. It is located in Florianópolis and already has branches in more than 10 states of Brazil, and is already forming branches in all other states. Among its main purposes are the support in the articulation between training centers, teaching, research and mental health services; the strengthening of the member entities and the expansion of the dialogue between the technical and scientific communities and with the health services, governmental and non-governmental organizations and civil society.

The association has started with about 200 founders and the prospect is an audience that will bring together thousands of health professionals from various disciplines: doctors, psychologists, nurses, occupational therapists, physiotherapists, social workers and others.

Ana Pitta, WAPR officer had a leading role in the conference, as well as other relevant local and regional leaders as Walter Oliveira, and Paulo Amarante.

The main topics of the conference were focused on Human Rights, Recovery Model and Community Model.

WAPR contributed in a Special Workshop about the Recovery Model, given by Marianne Farkas (Boston) Guillem Homet (Barcelona) and Ricardo Guinea (Madrid). In addition, a special WAPR Session ass delivered, elaborating the topics of Human Rights, Recovery and implementation of Psychosocial Rehabilitation Services.

The 3 days meeting included plenary session, workshops, lectures and many individual presentations, as well as an exhibition area and books presentations, and other contributions, including artistic presentations.
Marcia Tiburi, philosopher from Rio Grande Pontificia University gave a very touching lecture on the conception of “otherness”, and its relationship with human relationship in different situations, as slavery or stigma in mental health.

As the organisers wrote in the announcement:

“The central objective of the conference was to problematize the violations of Human Rights and the Mental Health policy that happens in different scenarios of Brazil, while witnessing the growth of violence and crime against vulnerable segments of communities that are against the normative standards of contemporary societies. “Such phenomena become more serious when they are reinforced by institutions that should protect and promote respect for diversity and citizens”.

Since the cultural, ethnic, sexual orientation, and religious multiplicities, among others, constituents of the Brazilian civil society, reactive attitudes to alleged disturbances of public order become frequent and cause controversy, such as those that demand aggravation of prison sentences and repression, the reduction of the criminal majority, compulsory hospitalization for mentally ill people, alcohol and other drug users and the street population; military occupations in popular areas; expulsion of populations from certain geographic areas for purposes of real estate exploitation, genocide in prisons ... are neoliberal expressions of social space disputes in favor of hegemonies and big capital, contradicting the principles and constitutional rights in the country”.

The 3rd Forum on Human Rights and Mental Health was an important space for reflection and agreement on actions aimed at mobilizing the various social actors to fight against growing fear, hatred and intolerance in an unjust and unequal society.

Ricardo Guinea.
DECLARATION OF FLORIANÓPOLIS.

Declaration of the First Latin American Meeting on Human Rights and Mental Health: "Resist is conscience".

June 27, 2017.-

RECOGNIZING
The setbacks in the field of mental health and human rights in our countries.
That territorial systems of care and attention to mental health, as well as community practices are undermined and limited, reproducing asylum logic.
That the violation of human rights persists in the current model, which justify actions that represent a clear violation of human rights.
That lack participation, accessibility and equality of the people who are protagonists of the mental health system.
That the hegemony of the psychiatric hospital and the manicomial logic has not yet been eliminated.
That legislative initiatives are lacking to guarantee the full exercise of the legal capacity of the people, definitively eliminating the interdiction.

CONVINCED
Of the necessity and importance of the participation and articulation between the participants of this Meeting, coming from different countries.
That the progress in the implementation of rights is expected from the promotion of active citizenship.
The need to empower users of mental health services and respect their decisions in the implementation of public policies.
To have strategies that are effective in preventing this setback.
To have laws that guarantee the dignity of the people, both in the approach and in the recognition of their rights.

WE DECLARE created in this act the: LATIN AMERICAN NETWORK FOR HUMAN RIGHTS AND MENTAL HEALTH (AND PROBLEMATIC CONSUMPTION OF SUBSTANCES).

To promote the active exchange among its participants, to strengthen the struggle for the defense of human rights and the mental health of our peoples.
To create and / or strengthen the laws of mental health and human rights, in our countries, that effectively guarantee the dignity of the people.
To Strengthen the development of the community model and the community logics in the mental health services, eliminating the manicomial practices.
To Support training and research initiatives that contribute to the content of reform processes.
To Prepare reports and documents that influence the development of public policies on mental health.
Under the direction of Dr. Medhat Elsabahy (WAPR’s Regional Vice-president), Prof. Ahmed Okasha (Honorary President) and Dr. Tarek A. Darwish, Abu Dhabi Hosted the first WAPR International Conference.

More than 500 delegates were present. In addition 67 speakers and 277 attendees in workshops. These speakers included Dr. Javed (WAPR’s former President), Dr. Murali (WAPR’s Pres. Elect), Dr Ferguson (WAPR’s Vice-president), Dr Solomon Rataemane (WAPR’s Secretary General), Dr. Marianne Farkas (WAPR Board member) and Dr. Carmen Ferrer (WAPR Board member).

The topic at the conference was “Mind and Body – bridging the gap”. This described the atmosphere of the conference. The conference consisted of three components: 1) Psychosocial Interventions, 2) Biological approaches and 3) Arabic presentations, which honored regional contributions.

This is what the Honorary President of the Conference, Dr. Okasha said in his opening talk:

“The overall philosophy of psychiatric rehabilitation in mental disorders comprises two intervention strategies. The first strategy is Individual-centered and aims at developing the patient's skills in interacting with a stressful environment. The second strategy is ecological and directed towards developing environmental resources to reduce potential stressors. Most disabled persons need a combination of both approaches- Symptom control does not necessarily have the highest priority, as some side effects of pharmacological treatment can weaken a person’s ability to perform his or her social roles and impair vocational rehabilitation”.

This was the first time WAPR lead an international conference in this region. This is an important milestone for WAPR, in regards to becoming a key international stakeholder, within this region.

In this conference, WAPR had the opportunity to establish new links with delegates in Oman, Iran, and Saudi Arabia. We hope for more opportunities, in order to recruit more and new WAPR delegates. WAPR was also invited to come and visit the new
facilities at the National Rehabilitation Center in Abu Dhabi.

During the conference, senior professionals raised issues relating to principles in social psychiatry and psychosocial rehabilitation.

Young professionals and trainees seem to be very committed to the development of better services for the people in the region. We also noted some cultural particularities in the region, which needs to be considered when developing services.

WAPR Board members, Marianne Farkas and Veronica Carey (PRA), ran workshops where people could get training in specific Psychosocial Rehabilitation interventions.

New contacts were made, which might be useful for future events.
Introduction
Center for Mental Health and Substance Abuse (CMHSA) is a leading research center in areas of recovery. Our mission to develop a research environment in which, researchers can engage in research with involvement of and contacts with service users and mental health / social service practitioners.

CMHSA is a Center within the Faculty of Health and Social Science, at the University College of Southeast Norway (USN). USN has nearly 20000 students, over 1500 assignments (FTEs), 4 faculties, 8 campus, 8 PhD programs. The Department of Health, Social and Welfare Studies has 8 bachelor studies, 12 master programs and 1 PhD program in Person Centred Care. In addition to, a number of tailored postgraduate training.

Research profile
We believe that mental health problems and substance abuse needs to be understood from the contextual perspective rather than from the purely individualist or internalistic orientation. It is also believed that the most desirable mode of mental health care is through collaborative processes and is one developed within local communities. Mental health care must encompass commitment and support related to home, school, work,
personal economy and social situation. Public health perspectives valuing health promotion and social welfare at individual group, and societal levels are also emphasized as crucial for studying and understanding people’s mental health and mental health care.

The researcher at CMHSA includes those with educational, professional, and research backgrounds in nursing, occupational therapy, psychology, pedagogy, sociology, philosophy, medicine and social works. In addition, to people with lived experience.

Key competence areas

Subjective and contextual experiences of recovery and psychosocial rehabilitation
Professional practices in mental health and substance services
Interdisciplinary collaboration in psychosocial rehabilitation
Service development in psychosocial rehabilitation
Family and network orientation of services including Open Dialogue
Action research

Qualitative and quantitative methods
Collaborative user-involved research methodologies

Support for researchers and/or trainees
CMHSA can offer support and advice on
Development of local training programs within our key competence areas
Study design, ethics, research proposals and scientific writing
Be a visitors’ site for international researchers
Be a visitor’ site for people with lived experience and professionals interested in research.

Publications
An overview over recent and past publications can be found here: https://brage.bibsys.no/xmlui/handle/11250/191431

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COMING CONFERENCES.

http://www.mptpszichiatria.hu

www.wapr2018madrid.com

www.mental-health-congress.ru

In memory of Giorgio De Isabella.  
(1947-2017)  
Gabriele Rocca.

In July, after a few months of illness, Giorgio De Isabella left us. His entire career was spent within psychiatric institutions following two inspirational lines: the creation of innovative and non-coercive therapeutic programs and the enhancement of the Clinical Psychology.

He began his studies in Milan at the Faculty of Physics, but after a brief experience at the Institute of Psychology directed by Prof. Cesa Bianchi, in 1971 he decided to enroll in the Faculty of Psychology which had been founded in that year in Italy. Giorgio lived that period of social and cultural vivacity with great intellectual curiosity. He attended the school for mimes of the prestigious Piccolo Teatro in Milan; was interested in painting and soon gained experience in watercolor technique; above all, he devoted himself to photography, developing and printing his films.

Graduated in 1975, he quickly merged into the psychiatric world, which was passing through a series of deep institutional transformations.

In the early 80s, he embraced the task of thinking and managing the care of the last patients of the Cerletti Psychiatric Hospital (Milan) definitely closed in those years. The main target of this project was to set up different apartments without staff – an idea that really anticipated the organizing model of supported housing. At the same time, he inaugurated a new Day Center.

In these years, across different experiences, he met Angelo Cocchi and worked closely with him; their close working relationship was focused on the constant effort of put into practice the inspirational principles of the psychiatric law passed in 1978. It’s noteworthy that the implementation of the new law and the birth in Italy of a community-based psychiatric care trace their roots back to leading experiences like the one of Rho’s mental health service where Giorgio worked under the direction of Angelo Cocchi.

He was a founding member of the National Association of Day Centers, of which he will become the president from 1999 to 2003. Since the Day Centers were in those years the places offering the possibility of a true psychosocial rehabilitation – that was done outside of asylums, by young staff, without any form of physical and psychological coercion – they quickly became to represent, even symbolically, the transformation that was taking place inside the psychiatric care. Within this process, the National Association was able to involve a large number of people interested in becoming the protagonists of this significant change.

In 1992 he was appointed director of the Psychology Service of San Carlo Hospital in Milan and in this role he led some significant projects. One of these, carried out in the hospital context, aimed at assessing and treating the psychological consequences of traumatic events by so providing a continuous collaboration with the emergency service. This resulted in the improvement of the relationship between psychology and the health system according to a way of thinking that Giorgio has consistently followed during his working life.

Not by chance his last book (in collaboration with Giuseppina Majani) is titled: Psychology in Medicine: advantages and perspectives.

As a director of a Psychology Service he was very active in the institutional field and participated in the work of numerous regional commissions. Over the last few years, his commitment was focused on the debate to define the new social and health care system in Lombardy. He believed that clinical psychology could significantly contribute to the overall well-being of people and for this reason he worked to ensure that Psychology Services were included within the departments of mental health: a
Psychiatric Service alongside a Psychology Service. Giorgio knew from the inside both psychiatry and psychology, and I think that his experiences as a bridge between these two disciplines (sometimes in conflict) will help us to overcome this dualism.

For almost thirty years he had a dense academic and teaching activity. He taught at Postgraduate Schools of Clinical Psychology and Psychiatry of the Milan University. Furthermore he taught at two different Postgraduate Schools of Psychotherapy: the ASIPSE and SITCC.

As part of the WAPR National Board, he contributed for many years to the growth of our association; in particular as a member of the Steering Committee, between 2010 and 2012, he participated in the organization of the Milan World Congress, sharing with many of us the concerns, and then the satisfaction, for the outcome of the initiative.

Giorgio was a person with an acute intelligence that allowed him to make depth analysis and to define appropriate action plans. He was respectful of other people's ideas, but at the same time he was able to carry out his projects with quiet tenacity.

I greatly appreciated his irony with which he gave the interlocutors an additional point of view or, sometimes, could create a better relational climate in difficult moments.

All of us lost a significant colleague. I also lost a friend.
By Gabriele Rocca


Ernesto Muggia was born in Milan, Italy, to a middle class Jewish family. Before and during world war II, his relatives were actively involved in the DELASEM (Delegation for the Assistance of Jewish Emigrants). In 1943, with the German occupation of Northern Italy, DELASEM went underground and his members became target of persecution. Ernesto and his parents went to hiding in a rural village near Milan, other relatives managed to escape to Switzerland, but unfortunately his uncle and aunt were arrested and deported to Auschwitz. His uncle Leonardo, a doctor much loved by Ernesto, survived and wrote, in collaboration with Primo Levi, a report for the Russian army on health conditions of the prisoners in concentration camps. After the war, Leonardo bare witness in the trials of Rudolf Höss and Josef Mengele.

Such dramatic events and especially the accounts of his uncle Leonardo on his experience as an inmate greatly impressed the young Ernesto and undoubtedly played a role in his later commitment against any abuse.

In 1962 he graduated in Chemical Engineering and subsequently worked for many years in senior positions in a number of companies. However, a deep interest in social and human sciences led him to earn a degree in psychology as well. At first, his main concerns were work and organization psychology, but later he pursued clinical aspects, underwent a personal psychoanalysis and attended psychodynamic therapy groups led by the Argentinian psychoanalyst Armando Bauleo.

As a result of the mental illness of his brother, he made contact with the psychiatric establishment and was disappointed by the institutional psychiatric
approach. Therefore, he was a strong supporter of the closure of mental hospitals and the move in Italy towards a community-based care system. Moreover, he committed himself to paving the way for the birth of associations of relatives of mentally ill aimed at fostering the growth of community services based on evidence, collaborative care, respect of needs and rights of consumer and relatives, as well on rejection of violent practices. In this vein, he founded in the early 90s the UNASAM (Union of National Associations for Mental Health), later to be associated to EUFAMI (European Federation of Associations of Families of People with Mental Illness). He was president of UNASAM for more than ten years and was appointed for some years to represent Italy in the board of EUFAMI as well. Under Ernesto’s charismatic leadership UNASAM became an important stakeholder in mental health field.

Although he voiced sharp criticisms of the mental health services whenever he felt it necessary, he never took an adversarial stance towards the professionals, always framing his criticism from a constructive standpoint. He participated in a number of committees and provided consultations on mental health policy at regional, national and European level.

He had a broad view of the role of family associations in mental health, not limited to protest and advocacy, but including participation in research and service evaluation. He set up a collaboration with Benedetto Saraceno and his research group at Mario Negri Institute in Milan, promoting the organization of workshops for relatives, and later for consumers as well, on critical use of psychotropic drugs and the participation of UNASAM in research projects. I will mention here his membership of the scientific committee of a participatory research project funded by the Italian Ministry of Health, consisting in an opinion survey of relatives of the mentally ill on quality of community psychiatric services. More than one hundred relatives were involved as investigators and more than two thousand relatives were interviewed. The results have been presented in international congresses, published in peer-reviewed journals and widely quoted in scientific literature.

In 1994 he was among the founders of WAPR Italian branch and soon became an influential member of the Association. In 1998 he was included in the International Advisory Board of Hamburg world congress and at the end of the congress he was elected in the International Board of Directors as a representative of voluntary organizations. He remained board member in various positions for the next twelve years. His contribution to WAPR was especially important on two occasions: between 2003 and 2006, during my tenure as president, and between 2010 and 2012 as a member of the steering committee of the very successful Milan world congress, g. In both situations he took the role of treasurer, showing his excellent managerial skills in financial management coupled with a deep understanding of goals and mission of WAPR.

In the last years of his life he particularly focused on three issues. First, a nationwide campaign to ban in Italy the use of mechanical restraints in acute inpatients facilities, second, the closure of forensic mental hospitals, third, the growth of the consumers’ movement. He felt this as a turning point for the further development of community care. He stressed the need for autonomy of the users and the fact that users’ views did not necessarily correspond with the relatives’ views, thus overcoming the paternalistic attitude sometimes held by family associations.

He was an independent thinker, often able to swim against the mainstream. He was proud of his Jewish background, but he openly expressed his disapproval of the Israeli policy towards the Palestinians. Although we disagreed at times on some issues, this never undermined our close friendship. Last, I like to remember him as a charming and witty person, who loved good food, wine and brilliant conversations. You will be sorely missed, Ernesto.
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

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Contact Information</th>
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<tbody>
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