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TABLE OF CONTENTS

Editorial:
- P. 3 : Greetings from the President. Afzal Javed.
- P. 4 : Greetings from the new Editorial Team. Marit Borg.

Highlight:
- P. 12 : Comparison of Psychosocial Rehabilitation in Europe. Derkaks, M.

Reports:
- P. 15: Botswana Association for Psychosocial Rehabilitation. Mistelske, J.
- P. 17 : Psychiatric Rehabilitation Status in the Arab Countries. Elsabahi, M.
- P. 18 : Report from the 2012 Dubay meeting. Javed, A.
- P. 20: WAPR Philippines holds Annual Mini-Olimpics. Soriano, F.
- P. 21: Fiji: Stress Management Daycentre opens in Labasa. Deva, P.
- P. 23: WAPR UK meeting 132th. day 22012. Javed, A.
- P. 23: WAPR UK meeting on Recovery Model of Mental Health. Javed, A.
- P. 24: Belarus. From exclusion to inclusion with social Participation.
- P. 24: Bosnia Herzegovine. Workshop in partnership for better mental health.
- P. 25: Spain. FEARP Congress. Guinea, R.
- P. 26: WAPR Congress Milano (Italy) 2012. Barbato, A.
- P. 27: Seoul will host the WAPR World Congress 2015. Hwang, T.

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Greetings from the President.
Dr. Afzal Javed,
President WAPR

I am deeply honoured and pleased for writing this welcome message for the first issue of WAPR Bulletin for the term 2012 -15. I congratulate and thank the editorial committee for their hard work for bringing the current issue of the Bulletin in a new and impressive format. I am sure we will now be able to reach many friends around the world and would be able to spread the message about our WAPR activities in a remarkable way.

Professionals, families, patients, service users and the policy makers play an important role in setting directions for our future practices and their involvement is vital in bringing a real change in different areas of mental health. WAPR is certainly an international organisation that takes all such stakeholders on board and gets their expertise in bringing a change in different domains of mental health. I feel honoured for being elected as President WAPR and I assure all my friends & membership of WAPR that I and the new Board will try our best to uphold the vision and philosophy of WAPR and continue our work and links with all those who are involved in the care and service delivery for the mentally ill. I am privileged that the new Board consists of dedicated and keen workers working in different fields of mental health and are committed to maintain a policy of openness and clarity of operations as it is greatly required in an association of this size and importance. I will also ensure full accountability during my entire Presidential period and it is ultimately my goal and objective to make WAPR grow and succeed with its growing international roles and commitments.

You will be pleased to know that in our first Board meeting, we discussed and finalised an action plan for the current term. You will find the details of this plan in the Bulletin. This plan gives an overview of our proposed activities and also reflects our vision for leading this organisation with a clear and focussed agenda.

I am also delighted that we started our term with a positive note by celebrating the success of Milan world congress. This congress gave us a lot of confidence as we saw a record number of participants attending this meeting. The congress organisers certainly did a marvellous job and we are thankful to Angelo Barbato for putting up an excellent organisational show and Benedetto Saraceno for presenting an exciting, stimulating and very impressive scientific programme. Their respective team do need a lot of appreciation from all of us and we hope that our next congresses will also witness a similar success.

During the past few months we have been very active in finagling some of the organisational tasks,
shifting the head office of the association and updating the website. I must acknowledge the work done by Philippines WAPR and Lulu Ignacio, our immediate past president, in sorting out many administrative issues that have not happened before. We now operate on a fair and transparent organisational & financial system and also look forward having our Board members especially our regional vice Presidents and other Board members playing an important role in the future functioning of this Association. Once we get a clear picture about the financial contribution from Milan congress, we will plan some projects especially for setting up PSR activities in low income countries.

Last but not the least I need your active support and help in running this organisation. Let us make sure that we continue playing our role in making WAPR an organisation that truly reflects the aspirations of our professional colleagues and also meets expectations of our patients and their families in their untiring efforts for providing users of mental health services the highest quality of care.

Afzal Javed
President World Association for Psychosocial Rehabilitation

Greetings from the New Editorial Team.
Marit Borg.
WAPR Bulletin Editor.

The WAPR Bulletin is the members’ and other colleagues’ communication forum and a context for learning from and getting inspired by each other. Among our readers and contributors are people with lived experience from mental distress, family members, interdisciplinary professionals and policy makers. The Bulletin publishes contributions related all aspects of rehabilitation and recovery for people experiencing severe mental health problem, following the mission of the WAPR to disseminate a solid knowledgebase for psychosocial rehabilitation. This implies strength and resource oriented principles and practices both in supporting individuals’ competencies and introducing environmental changes in order to improve quality of life and a more socially inclusive community.

In WAPR Bulletin 1-2013 we are happy to present a paper about the process of implementing Illness Management and Recovery (IMR)–programs in Israel and a paper discussing psychosocial rehabilitation and recovery-oriented services in the UK and in Hungary. Furthermore there are world wide reports informing about WAPR - activities and services for people living with mental health problems. We also have a Scientific and organizational report form the 11th World WAPR Congress, Milan and greetings and welcome to the readers from our new WAPR President Afzal Javed. And more.

We wish you all a very happy reading!
Promoting Recovery in Israel: A decade of efforts to implement Illness Management and Recovery (IMR)

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Like many countries that have seen developments in psychiatric rehabilitation and recovery, Israel has undergone far-reaching progress in the field in recent decades (Aviram et al., 2012). These developments went hand in hand with advanced legislation, leading to more equal perception and practice of the rights of people with serious mental illness (SMI) (Roe et al., 2012). In addition, more attention has been paid to evidence-based practices (EBPs), which are an effective and meaningful way of promoting the quality of the services (Drake et al., 2001; Mueser et al., 2003). A prominent example of this type of intervention is Illness Management and Recovery (IMR).

In this paper, we describe the implementation of IMR in Israel over the last decade, referring to several stages of the process including addressing the key barriers and recruitment of facilitators. This process, which has had its ups and downs, will be reviewed retrospectively, followed by recommendations for disseminating EBPs as a means to promote recovery. The stages presented reflect key landmarks of a journey that originated in a small local initiative of a handful of academics and reached widespread implementation of the intervention under the auspices of policy makers, the academic community and the various training authorities.

Before describing our implementation journey, we will briefly describe IMR, which has been implemented in recent years in several countries around the world.

IMR is an evidence-based standardized psychosocial intervention. It was developed to help people with SMI acquire knowledge and skills to manage their illness better and to identify and work toward achieving personal goals (Mueser et al., 2002; 2006). IMR is based on five empirically-supported self-management strategies: acquiring psychoeducation about mental illness and its treatment; taking cognitive-behavioral approaches to medication adherence; developing a relapse prevention plan; strengthening social support by social skills training, and acquiring coping skills training for the management of persistent symptoms. These self-management strategies are incorporated into eleven modules that cover these key areas (Gingerich & Mueser, 2005). Research conducted internationally has consistently supported the effectiveness of IMR. Indeed, studies in the United States (Levitt et al., 2009; Salyers, et al., 2009a, Pratt et al., 2011), Australia (Mueser et al., 2006), Japan (Fujita et al., 2010), Sweden (Fardig et al., 2011) and Israel (Hasson-Ohayon et al., 2007) have reported a positive impact of IMR on coping, social relationships, psychosocial
functioning, perceived social support, quality of life, and decrease in symptoms.

Despite substantial evidence of the efficiency of IMR and other psychiatric rehabilitation interventions, and the growing awareness of their importance, there is a notable gap between the accumulated knowledge and its degree of accessibility and implementation (Drake et al., 2001). This paper describes an attempt to narrow this gap and to bridge between the body of knowledge and practical implementation. The following section describes IMR implementation in Israel over the last decade, while pointing to several major processes that occurred. Further on, we describe the impact of these processes and discuss the implications that might assist with future dissemination of the interventions.

1.- Getting started: A pilot group following the learning and familiarity with the intervention.

The effort to implement IMR in Israel began following exposure to the intervention via the publication of the first article on the subject in Psychiatric Services a decade ago (Mueser et al., 2002). The article generated interest and curiosity among a couple of Israeli academics, who spent a summer in New Hampshire with one of the developers, Professor Kim Mueser. There, they learned about the intervention and met with people, in a range of settings, who were involved in developing, training, providing and consuming the newly developed intervention. On return to Israel, they translated the manual into Hebrew and one of these academics (the third author of this article) collaborated with the Rehabilitation Department of the Shalvata Mental Health Center, which became the venue for the first IMR pilot in Israel (Roe et al., 2006).

The success of the pilot was followed by further efforts to expose stakeholders to EBPs in general and IMR specifically via lectures and publications in local journals (Roe et al., 2006, 2007).

These efforts eventually led to cooperation between an academic institution (Bar Ilan University), the Ministry of Health and the Council for the Rehabilitation of Persons with a Psychiatric Disability in the Community in opening the first IMR training course attended by a dozen directors of psychiatric rehabilitation services, who received ongoing supervision and support while conducting IMR groups. The intervention’s implementation was accompanied by the first IMR randomized control trial (Hasson-Ohayon et al., 2007), and a qualitative one-year follow-up (Roe et al., 2009), which helped to generate further interest and exposure.

Despite this good start, no emphasis had yet been placed on building an infrastructure for ongoing implementation of the intervention. As a result, activities petered out and IMR implementation in Israel stagnated. It can be understood, in retrospect, that the encouraging beginning was dependent on several interested parties, who “pushed” for implementation of the intervention, with no steady organizational support and with inadequate human resources or funding that would ensure ongoing implementation rather than a one-time event.

2.- Developing an extensive program for implementation in the rehabilitation system

Renewed cooperation, this time between the University of Haifa and the Ministry of Health, led to a significant turning point in the form of two large-scale implementations in two specific geographical areas. The IMR delivery was tailored to the sociocultural context and to the unique requirements of each rehabilitation service. The innovation of the project lay in its broad scope, its implementation in defined geographical areas and in its training of professionals, paraprofessionals and peer-providers to carry out the intervention. As already mentioned, the implementation consisted of two separate projects that are described below: The first was held in the Central-Southern catchment area within the community-based rehabilitation
services and the second was held in southern Israel at the Beer Sheba Mental Health Center, which included staff from the health center, the community health clinic and community-based rehabilitation services. These two initiatives are described briefly below.

2. A. The Central-Southern catchment area project

Based on the New Jersey IMR Implementation Project Model (Meyer et al, 2010), IMR was implemented on a wide scale through 2010 and 2011 within rehabilitation frameworks in the central-southern catchment area in Israel.

This project began as collaboration between Ministry of Health representatives and a team from the University of Haifa, which allowed directors of rehabilitation frameworks to have initial exposure to the intervention and engagement in the project. The project included 60 facilitators (31 professionals, 13 paraprofessionals and 16 peer-provider consumers), who were enrolled from approximately 30 different agencies. All practitioners who ran the IMR groups completed two days of IMR initial training, which included theoretical and practical aspects of the intervention, and incorporated use of the toolkit. They also attended bi-monthly two-hour group supervisions, and three additional training enrichment days during the nine months in which they carried out the intervention. Also, all practitioners turned in weekly progress notes for which they received written feedback from the supervisors. As part of the training process and about a month after its initiation, the practitioners started 34 IMR groups for people with SMI (approximately 300 participants). The project lasted about a year (from October 2010 to September 2011). Staff from the Center for Community Mental Health Research, Practice and Policy at the University of Haifa led the training and supervision. A team of six experienced mental health professionals (which included the authors) conducted the training and supervision. The implementation was accompanied by research that revealed that IMR participants showed significant improvement compared to a control group. In addition, no statistically significant difference on consumer outcome was found regardless of whether the groups were led by a professional, a paraprofessional or a peer provider, who all implemented the intervention with good fidelity (Garber Epstein et al, under review).

2.B Beer Sheba Mental Health Center project

At the same time, implementation of IMR began in southern Israel at the Beer Sheba Mental Health Center. This project was on the initiative of the center’s administration, staff from the University of Haifa, Israel Psychiatric Rehabilitation Association (ISPRA) and the Ministry of Health. A total of 30 practitioners, with various professional and paraprofessional backgrounds, who worked in diverse units, received IMR training and supervision. This led to the opening of approximately 20 IMR groups, which were attended by 150 consumers.

The implementation project in Beer Sheba was unique in that it integrated community-based and hospital-based staff involved in treatment and rehabilitation. This led to a fruitful discourse and the opportunity to hear different points of view from along
the therapeutic-rehabilitation continuum. The Beer Sheba project included three implementation stages. The first stage lasted about a year and a half, and included the same implementation model that was described earlier (initial training that was immediately followed by implementation accompanied by bi-monthly group supervision). The second stage included ongoing implementation while starting a second round of groups alongside ongoing monthly supervision. Finally, implementing the intervention in the acute hospital setting generated ongoing collaboration with the hospital staff, while preserving fidelity to the model to ensure effective intervention.

3. The impact of wide-scale implementation of the intervention

The wide-scale IMR implementation led to the four meaningful processes described below.

The first process addresses the way in which implementing the intervention in the different services created a meaningful discourse on complex and controversial issues, e.g., the question of different consumers’ capacity to set and accomplish personal goals and of consumers’ desire and capability to learn about the illness and self-management strategies. These issues were addressed in an atmosphere of communication, attentiveness and mutual respect, which enabled an open, honest discussion of these charged and meaningful subjects. IMR helped put these subjects “on the table” in the midst of an honest dialogue and shared learning, which both the consumers and the facilitators experienced as empowering and informative.

The second process included creating a common “recovery-promoting” language. The IMR model “speaks” the recovery language and emphasizes personal choice, empowerment and self-management. Learning and implementing the intervention created an opportunity to use this common language and to adopt concepts that express recovery values among people with SMI and among workers in the rehabilitation and hospital-based settings.

The third process that we identified included an increased sense of hope among both facilitators and consumers. The experience itself and the opportunity to set goals and to learn strategies to accomplish them led to the discovery of the ability for change and renewal, which, in many cases, neither the practitioners nor the consumers had believed existed. Thus, for example, consumers set themselves goals which they would never have dared to dream of realizing in the past and were often surprised to discover that, through acquiring illness-management skills, progress and occasional accomplishment of these goals became possible. Members of the therapeutic staff were frequently surprised to discover strengths and resources among people with SMI, as described by one of the facilitators: “I have come to know the residents over the last two years and have never heard them express the desire for change or advancement. They always said that they were content just as they were and wished to remain in the same framework . . . but in the group, I am repeatedly moved to see and hear the extent to which they do want this. Suddenly they have wishes! And hopes! And they dare to aspire to something that they thought they would never achieve.”

The fourth process involved acknowledging, sharing and combining the professionals’ and participants’ different types of knowledge. Knowledge derived from the participants’ personal experience, and their expertise regarding their illness and their individual recovery process was recognized as valid and useful. Out of the different types of knowledge that the professionals and the participants brought to the discussion and out of the involvement itself, an ongoing dialogue was held, respecting and recognizing the importance of advancing the participants’ recovery process.

4. Creation and development of training programs to learn the intervention

The development of training and IMR implementation programs includes three main components. One is the development of a unified training, supervision and dissemination model that will ensure standardization and high quality training, supervision and dissemination with good fidelity to the model.

A second component includes official recognition by providing certification for practitioners who complete the training and fulfill all its requirements. The third component includes creating continuation supervision groups for the facilitators who completed the training.

The wide-scale implementation of the intervention in Israel in recent years has led to the development
of a unified training model for IMR intervention, which draws on four major components:

1. Learning. 2. Training and practice. 3. Supervision throughout the entire practical implementation period. 4. Immediate practical implementation. Our cumulative experience has proved that by combining these four elements simultaneously in the training process, it is possible to create a high quality, theoretical and practical learning process, which enables optimal acquisition of expertise in facilitating the intervention.

The training courses offered in leading academic institutions in the mental health rehabilitation field are based on this model. At the end of the training, participants are issued with an intervention facilitator certificate. The certification represents policy makers’ and training institutions’ official recognition of the knowledge and tools acquired and of the importance of implementing the intervention. The Ministry of Health’s subsidization of the training course serves as additional recognition of the importance of learning the intervention and of encouraging professionals to develop recovery-oriented skills. The development of a training course is a way to create standardization and to preserve the knowledge acquired for practical implementation in the future.

**Discussion**

Implementation of the IMR intervention in Israel over the last decade is testament to the growing trend, in Israel and around the world, of introducing innovative evidence-based interventions, whose effective promotion of rehabilitation and recovery has been proved. The aforementioned IMR implementation process can be viewed as a test case from which much can be learned about mobilizing and establishing implementation of evidence-based interventions and promoting recovery. Like other evidence-based interventions, the IMR intervention implementation appears to be a process that requires synchronized activity involving different factors (Rapp et al., 2010; Torrey et al., 2001). Implementation demands follow-up, monitoring, observation, documentation, learning and ongoing inquiry for continued development and implementation of the intervention.

The present article described an ongoing process that began about a decade ago as a local initiative to “import” IMR intervention to Israel and continued with wide-scale implementation alongside official recognition and the development of organized training courses for learning and implementing the intervention. The process described had its ups and downs and even periods of temporary stagnation, which were followed by renewed growth that still continues today. As mentioned, this process is still underway and includes many challenges, such as the need to tailor the implementation model to the mental health system in Israel, including hospital-based arrangements and target populations with unique characteristics (e.g., the Arab sector and the Russian-speaking population).

A retrospective examination of these processes shows that implementing new working methods that draw on the recovery-oriented rehabilitation approach demands time, perseverance and forbearance. Introducing wide-scale use of IMR in Israel has posed challenges to policy values and professional perception, and has led to the need for openness to change and to learning new methods that differ from those previously accepted. Nevertheless, despite the challenges, both past and present, the reality shows that this is possible and can become an integral part of the rehabilitation scene and the professional discourse within it.

An analysis of the process reveals that, for the change to take place, the field had to undergo an adjustment period that occurred with the broadening of the dialogue around the recovery approach in the Israeli context. This developing dialogue led to the search for implementation tools for translating the recovery-oriented ideology into practice. Identifying the need for learning and renewal, coupled with the desire for professional development in the different sectors was an additional factor in preparing the ground for implementing the IMR model in Israel. Identifying
interested parties and each of their individual needs has assisted in creating cooperation for the intervention’s successful practical implementation. In retrospect, it can be seen that appropriate cooperation between academics, policy makers, users, family members and influential workers in the field was a prerequisite for mobilizing the implementation and for leading change. This can be compared to a wagon that requires all its wheels for stability, to avoid getting stuck on a hilly road. Regarding the IMR, the involvement and cooperation of all the “wheels” has brought stability in the face of the pitfalls on the long road and has been a source of joint support during the difficulties, indecisions, fears and objections that have arisen as a result of this change.

Two additional factors helped achieve successful implementation. One was the creation of geographical accessibility to the training courses. Holding the training in the workers’ localities rather than in distant academic institutions made the courses accessible and advanced the learning and implementation, as described by one of the participants: “Academia has come down to the people.” In addition, concentrating the implementation in a defined geographical area created additional impact, by instilling a unified recovery-oriented language among rehabilitation workers with different professional and training backgrounds, who could create a discourse based on these shared values, perceptions and language. The other contributing factor to the process was recruiting a senior team of leading rehabilitation figures in Israel, who were reputed for training and developing recovery-oriented interventions, to be the vanguard for implementing the intervention. It appears that this team’s involvement enabled the policy makers and directors of services to show interest and express their trust in the process, even before it started.

Challenges for the future

The work is far from finished and many challenges remain in making the IMR intervention and additional recovery-approach interventions an integral part of the rehabilitation and therapeutic services in Israel. The many challenges include several central issues, such as the need to establish the training courses in the various learning frameworks and to develop channels for future implementation. An additional need is to continue to develop and tailor the implementation model to hospital-based arrangements and unique target populations. For this purpose, a professional team due to lead this process is currently brainstorming the issue. Adaptations are necessary in the Arab sector, for example, where rehabilitation activity is lacking. One way of creating access to these services is by adapting the language and cultural context of the interventions (Gearing et al., 2012). A proposal has been submitted for developing a project to tailor the intervention to the Arab sector. To set the process in motion, a professional committee has been formed including key figures from different fields alongside experienced Arab rehabilitation workers.

To conclude, it can be said that we have come a long way in the last decade, as the IMR intervention that began as a private local initiative has evolved into an accepted intervention, which is studied and implemented on the national level in many varied rehabilitation services. Despite its success to date, the implementation process is facing many challenges and demands continued leadership, development and research. Regularizing dissemination and implementation of evidence-based recovery-oriented interventions needs a determined guiding hand as well as recognition backed by budgets allocated by policy makers.

Our vision for the foreseeable future is that consumers will be able to choose the intervention that suits them best. The possibility of such a choice will be a genuine manifestation of the right to freedom of choice among people with SMI regarding tailored and accessible services based on recovery approach values. We have a long way to go before realizing this vision, but it is a definite possibility.

References


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Outcome and Fidelity in a Illness Management and Recovery Intervention.


Comparison of Psychosocial Rehabilitation in Europe

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All mental health professionals have the obligation to provide the highest possible quality of care. According to the old-fashioned approach mental health services were – usually – focused on what was 'wrong' with a patient. Psychiatrists typically described a patient as having a particular illness; this label then (as a stigma) became important.

The relationship between the psychiatrist and the patient became concentrated on what was defined as an ‘illness’. This approach had to be changed. In order to provide the highest possible quality of care we professionals all have to seek after the highest standard. Several years of experience in the Mental Health Services in the UK and in Hungary made me realise that an important way to improve is that we learn from each other. This idea inspired me to write this article.

Modernised patient care

Patients have the right to the highest attainable standard of physical and mental health, including dimensions such as: appropriate services, access to individualised treatment, right to rehabilitation and treatment promoting autonomy, community-based services, right to the least restrictive services, protection of human dignity, privacy and confidentiality.

The Recovery Model

The Recovery Model has a lot to offer mental health services in order to develop a modernised patient care as discussed above. A central element in recovery models is supporting the person in taking control over his/her life, and explore how the person experience the life situation.

Service users have to step out of the 'sick role' and regard themselves as autonomous people with the capacity to come through a period of mental distress and develop their individuality, self-awareness and self-acceptance. Professionals need to stop being managers and start being facilitators. Professionals have to start looking at people's potential for development.

Recovery approach

The main aim is to see the service users holistically, as persons who have the capacity to cope with their distress and making decisions. The Recovery Model focuses on helping the person to identify realistic life goals enable him/her to achieve them. The Recovery Model concentrates on the positive aspects: what a person can do, what
do they want to achieve, how they can control their own life. The persons are able to participate in a full life, develop self-esteem and self-determination, being allowed to make their own mistakes and learn from them.

**Recovery Colleges can transform Mental Health Services**

Recovery Colleges deliver a peer-led education, treatment and training programmes within mental health services. Education is also provided as a route to Recovery. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals. Services are offered to service users, professionals and families alike, with people choosing the courses they would like to attend from a prospectus.

**Treatment and management in the UK**

Mental Health Services in the UK offer a very structured care at multiple levels adjusted to patient’s individual needs.


*Home Treatment Teams*, often called Crisis Resolution teams provide a gate function between in and outpatient services. The teams has an important role in supporting the patients and their families at home, reduce inpatient admissions, and prevent patients from long term problems.

The following *Community services* may also help persons in the process of recovery:

*Assertive Outreach Team* provides help and support towards recovery and community integration.

*Early Intervention in Psychosis Service* work with people who are usually between 14 and 35, and are either at risk of or are currently experiencing a first episode of psychosis. It is scientifically proven that early intervention services (compared to standard services) may reduce hospital stays, reduce relapses and suicide rates.

*Community Mental Health Team* offers mental health care and social care, which is run by local authority social services.

*Rehabilitation in the community in the UK* provides individualised standard and enhanced care plan designed by the MDT, involves patients and relatives. Service providers are the following: Community Development Worker Team, Diverse Cultures Community Support Team, Resource centres (Day Hospitals, Day Centres), Occupational Therapy, Social Inclusion Services, Employment Support Services, Vocational Services (Individual Placement and Support’ (IPS) model and specialised Housing system (well equipped in the UK): Hostels, Nursing Homes, Care Homes, Council Houses.

**SUN (Service User Network) Project in the UK**

is a unique project as it is offers peer support groups via self-referral. A network of peers providing support: within groups and through a telephone service. Groups are run for 2½ hours, three days a week. Inclusion criteria: those who lives in the catchment areas. Exclusion criteria: addiction.

A structured group with facilitators is led by service users, where they get feedback from each other. A project newsletter is written by service users, who have the opportunity to comment on the services provided. National involvement is also included, like evaluations, annual conferences, Personality Disorder Network, National organisations, speakers, training and consultations.

**Rehabilitation in Hungary**

*Inpatient care* offers acute and subacute wards and rehabilitation units.

*Out patient care* (community psychiatry) include: outpatient clinics, rehabilitation day hospitals, supported employments and accommodation, social assistance at patient’s home, temporary social housing (maximum for one year), nursing homes, care homes (for 100 people).

There is a plan for implementing similar supported housing system as in UK. Instead of the large sized nursing homes, it is planned to open more specialized, smaller houses in the community. Three different types of care are planned according to patients skills: Council houses, for 6 or 10 patients and Care Homes, for 40 people.

**Outpatient Services in Hungary**

According to the National Survey of outpatient services in 2011, the statistics are like this: Community Psychiatry Services - 35%, Nursing Homes - 28%, Day hospitals - 23%, Care Homes - 9%, Rehabilitation Centres - 3% and Temporary Social Housing - 2%.

**Rehabilitation services in Eastern Europe**
Mental Health Services in Eastern European countries are usually located in Departments of Neuropsychiatry. Rehabilitation services have a rather mixed profile. Social Care Homes provide a 24 hrs support by mental health professionals. Residents of these homes suffer from variable conditions: longterm mental illness, learning disability or physical impairments.

**Several factors effecting recovery**

Quality of care has an important impact on recovery. Aspects like professional qualifications and number of staff, regular, specialised training for staff members involving the bio- psycho- social modell have an impact. Individualised care plans for patients are also central parts.

Severity of mental illness, characteristics of service users and timing of admission into rehabilitation services also have an influence on recovery. Early admission in a person’s illness may improve outcome. Positive outcome for outpatients is associated with less supported placement in the community and earlier discharge for inpatients. The provider’s experiences of and attitudes to recovery oriented services and to consumer-led services are reported equally to have as positive outcomes for their clients as traditional services.

**Conclusions**

Psychosocial well being, ability and opportunity to work and safe housing all contribute to a healthy life. Persons who suffer from a mental illness do have a particular disadvantage as only about 8-40% of them are employed. General problem that we are facing in Hungary is the reduction of inpatient treatment without sufficient support in the field of community mental health services and difficulties of funding.

Further research is required in order to improve Evidence Based Practice in the field of rehabilitation.

**Challenges and difficulties**

Service quality is a complex, multidimensional construct, extends beyond evidenced based treatments and it is difficult to operationalise.

Relationship between service quality and clinical outcome remains unexplored.

Due to low participation rate in RCTs in the field of rehabilitation, results have low generalisability. Barriers such as underfunding can continue to limit the use and evaluation of consumer-led services.

**Recent improvements**

Until recently there were no standardised comprehensive measures available to assess the quality of care in longer term mental health facilities. As a result of a successful European collaboration of 10 countries, the [QuIRC Quality Indicator for Rehabilitative Care](http://www.quirc.eu) toolkit was developed from review of international literature and review of care standards in those countries in June 2012. (United Kingdom, Germany, Spain, Czech Republic, Bulgaria, Italy, Netherlands, Poland, Greece, Portugal).

It was concluded that the ratings of quality of longer term mental health care were positively associated with service user’s autonomy and experiences of care. Interventions that improve quality of care in those settings may promote service user’s autonomy.

Standardised outcome measures are invaluably useful as validated toolkits and help us to produce valid and reliable results in research. Examples of these are: [MINI](http://www.mindinform.org) Mental Illness Need Index: rating of psychiatric morbidity in the area, [RCS](http://wwwresidentchoice.org) Resident Choice Scale: autonomy was assessed, assessment of Quality of Life, [YTC](http://www.yourtreatmentcare.org) Your Treatment and Care questionnaire, [GMI](http://www.gmi.org) General Milieu Index: satisfaction with life, [GAF](http://www.gaf.org) Global Assessment of Functioning.

**Suggestions for improvement**

In order to maintain the highest possible quality of care some new directions in research are suggested. This would need to include:

1. international collaboration, communication, 2. review of care standards in each country, 3. work out regular international audit projects, re audits, 4. further international standards for rehabilitation, 5. regular assessments of longitudinal associations between the quality of rehabilitation services and quality of life, 6. research, especially cohort studies and RCTs to identify the aspect of care associated with improvements in social functioning.

Finally I would like to be optimistic and say that further international collaboration is going to lead to the development of an evidence based high quality care in the field of rehabilitation.
The end of June 2011 ended our contract with our major donor Project Concern International (PCI) under The Building Bridges Program. We were praying hard that we would not have to close BAPR’s afternoon program for the 100 Orphans and Vulnerable Children that included a nutritional meal for the children of our clients who are Care Givers of these children. They are very impoverished and this meal and Positive Living Afternoon Program gave the children a lot of hope. We have developed a holistic integrated approach over the last 7 years.

The Program Developer/Counselor Trainer, John Mistelske, had approached many of the local businesses and talked about our concerns for the children. We had to close the afternoon program for a few months but did not give up! There was a warm community response with at least Mr. Chopdat (Choppie), in August 2011, of Lobatse Cash and Carry Wholesalers was able to keep us going on a much-reduced level but at least the children received more food than they would have received at home each day. We also received in October 2011, a weekly donation of 5 KG’s for meat from Lobatse Meat Market. These donations have been ongoing until present. BAPR Children have been so grateful for this care and love. Every month there was uncertainty if we would have enough to feed the children and many times had to close for a few days during the week. Gas for cooking was another one of the unreliable items that cooking food depended on. Lobatse Gas Works donated a 48Kg gas tank every 3 months but this was not enough to keep us going since the gas usually lasted for 6 weeks. This was hard for all of us and we continued to pray that we could be sustainable in this noble program.

Pick n Pay supermarket a chain store from South Africa finally agreed through their head office in Gaborone to donate P600 each month for supplies but this still was not adequate to feed the children with a good balanced diet (Botswana Pula – USD Exchange Rate P7.00 = US$ 1.00). There was a lot of starch from Mealie (Maize or Corn) Meal and not enough fortified food with vitamins from a variety of vegetables, different cereal grains, beans, soup/gravy, cooking oil etc. for the children’s growth and mental development to do well at school. We also needed dish washing liquid and the things needed to clean after cooking each day. We continued to pray for an answer of sustainability instead of going month to month with this uncertainty. Some private individuals donated food over this almost 2-year period. All is greatly appreciated by the children.

In early November, Mr. Sharif of Lobatse Gas Works decided to help us with 48Kg of cooking...
gas every 6 weeks. This was a Godsend! The beginning of November BAPR had a visitor Mr. Dilip and his wife from Flo-Tek a plastic water pipe and tank manufacturer based in Lobatse. He had heard about BAPR’s program for the Orphans and Vulnerable Children. He donated a 2-burner cooking stove in cases where we run out of gas like the day he visited before Mr. Sharif from Lobatse Gas Works came to our rescue. He returned and told us that the owner, Mr. Vee-jay, of Flo-Tek was interested in meeting us. On November 14, 2012, we were in a Board meeting that afternoon. Mr. Vee-jay and Mr. Dilip came as we were meeting. They were introduced to the Board. The Project Developer/ Counselor Trainer gave a brief description of what BAPR is doing and the services provided. They were especially interested in the afternoon Orphans and Vulnerable Children’s Program. Mr. Vee-jay asked if the Project Coordinator, Mrs. Lily Qobo, and the Project Developer could meet him and Mr. Dilip at his Office in the morning of November 20, 2012.

This meeting was a very good meeting and spiritual. We all shared our life stories as well as our spiritual motivation to serve God in Love and Care for our children and their families. Mr. Vee-jay also shared that he had been on a meditation retreat in Johannesburg. There he discussed with the Guru the mandate of serving the needy children with nutritious food. He then set up the Children of God Trust Fund. He asked us to send the BAPR Constitution, Profile, Association Registration Certificate and the names of the registered children. They also asked for a list of all the groceries we need for each month to feed the average 100 children that attend every weekday afternoon program. They said this would be an ongoing donation. God has and is blessing us all each day at BAPR.

On November 22, 2012 (American Thanksgiving), we had so much to be thankful for and celebrated with a Stuffed Turkey. Cooked by the Project Developer, and all the trimmings including a pumpkin pie cooked by the US Peace Corps Volunteer with BAPR Ms. Kelly Abraham. The mother of the Project Developer, Mrs. Margene Mistelske, made this great Thanksgiving dinner possible. It was a real family affair!

On Friday the 23.11.12 the Project Developer met Mr. Vee-jay and Mr. Dilip at Trans Africa Wholesales in town. All the food for the month was on trolleys; prepared to for delivery to the BAPR Center. The food, which will be delivered, each month ongoing comes to P3,200. The donation also includes an extra 50Kg vitamin fortified powdered drink for even a more nutritious meal worth P500 a bag every 4 to 6 months that was ordered and delivered on 05.12.12. The children, their Care Givers/Families and Staff at BAPR thank the Almighty for God’s Care and Love through all the donations that has made a better life for the children! This is our way of preventing substance abuse for the kids.
Psychiatric Rehabilitation Status in the Arab Countries
Dr. Medhat Elsabbahy, Head of Psychiatric Rehabilitation Division, Arab Federation of Psychiatrists; Head of Psychiatric Rehabilitation Unit

Currently there are few psychiatric rehabilitation units in the Arab countries that are not collaborating together. We initiated the psychiatric rehabilitation division in the Arab Federation of Psychiatrists in June 2010 under supervision and patronage of Prof. Dr. Ahmed Okasha the president of Egyptian Psychiatric Association, the Emeritus President of Arab Federation of Psychiatrists, and the President of WPA (2002–2005). Today I have the position as head of the psychiatric rehabilitation division of the Arab Federation of psychiatrists and also as a member of the international committee of the United States Psychiatric Rehabilitation Association (USPRA). We are currently trying to initiate the CPRP subspecialty in the Arab Region and in collaboration with USPRA we designed a training program to prepare trainee to be eligible to set for CPRP to be certified as a psychiatric rehabilitation practitioner. In order to work onwards with this we need financial support. Now being Deputy Regional Vice President for Eastern Mediterranean Region for WAPR an important priority is to work together with colleagues in the region. We are trying to establish a WAPR branch in the Emirates and in Bahrain as well as re-establishing the Egyptian

Our psychiatric rehabilitation unit in Abu Dhabi consists of two teams running 4 services; day care team running day care and hotline services and Community case management team (CCMT) is running community services and Crisis intervention.

Our day care serves 45 patients and CCMT serves 150 patients in the community covering Abu Dhabi city and Suburbs.

The rehabilitation department, Abbassia mental hospital, includes several units for rehabilitation using the available tools that help us involving patients in different activities so that they can enjoy their time as well as enable us to offer support and help with their psychosocial problems and in general improve the quality of life for them during their admission time. The activities includes; art, singing, playing music, theatre activities, needle activities, agriculture, different social activities with people outside hospital, celebration for different occasions with volunteers from NGOs inside and outside hospital, and general group and behaviour therapy. Our rehabilitation activities are essential parts of offering the individuals help them in overcoming and living with residual symptoms, increase their compliance to the treating team and increase self-esteem so that they can enjoy Ramadan Celebration in Abbassia Rehabilitation department.
Pakistan Psychiatric Research Centre (PPRC) & Fountain House, Lahore organised their 7th International conference at Dubai in July 2012. www.pprc2012.com

This was a WAPR co-sponsored meeting and was also held in collaboration with SAARC Psychiatric Federation (SPF), World Association for Social Psychiatry (WASP), and South Asian Forum UK, Pakistan & Bangladesh chapters.

The meeting was attended by WAPR branches from Pakistan, Bangladesh and UK and Presidents of WPA national societies from Pakistan, India, Bangladesh & Australia and representatives of societies from Kuwait, Jordan, Sri Lanka, Nepal, Malaysia and UK were there as well. More than 300 delegates who came from Pakistan, India, Bangladesh, Iran, Sri Lanka, Malaysia, UAE, Gulf States, Qatar, Kuwait, Australia, US & UK participated in the scientific deliberations of the meeting. The scientific programme was very informative and covered many relevant topics related to the theme of the conference.

Cooking group in PRU Abu Dhabi

Sports Activities in Abbassia Rehabilitation department

Report from the 2012 Dubai meeting

Dr Afzal Javed
Chairman Pakistan Psychiatric Research Centre, Fountain House, Lahore, Pakistan
Cognizant of the fact that psychosocial rehabilitation needs to broaden its concepts and strategies for intervention, and therefore must address the needs not only patients but their families, WAPR Philippines held its 13th National Conference on Psychosocial Rehabilitation with the theme: “Parenting in the Midst of Global Crisis: the significance of Foster Care”. The Conference was held at the Valdez Hall of the Veteran’s Memorial Medical Center in Quezon City on November 26, 2012.

The Conference was organized by WAPR-Phil Board Members. It attracted a hundred participants among them psychiatrists, social workers, nurses, psychologists, parents and caregivers, whose programs have been run in collaboration with WAPR Philippines as it develops community mental health programs in areas of the country especially where there are no mental health professionals. These are also the areas that have been struck by adversities especially relevant to the theme of the Conference, which include continuing disasters and overseas employment. These two specific situations have generated significant concern for children that have been orphaned, internally displaced or left behind, because of the evolving recognition that these adversities have rendered these children to be mentally and socially disadvantaged.

The Conference featured the recently enacted law “Foster care Act 2012 of the Philippines”. It was opened by Dr Felicitas A Soriano, Vice-President of WAPR-Philippines who spoke in behalf of the Director of the Veteran’s Memorial Medical Center. The Welcome Address was given by Dr Lourdes L Ignacio, President, WAPR. The Keynote Speaker, Ms Maritoni Labajo spoke on “Foster Care and its Importance for Children in Need of Alternative Parental Care”. This was followed by the presentation of the Republic Act 10165 or the Foster Care Act of the Philippines, by Atty Eric Mallonga. The other papers were: “Foster Care as an Intervention for Child Protection” by Ms Sonia Cueto, “My Experience as a Licensed Foster Carer” by Ms Lydia Beto, “Foster Care: the viewpoint of a Child and Adolescent Psychiatrist”, by Dr Georgina Oliver.

The Conference also featured the presentation of the book: “Foster Care: My Family, My Home” by Ms Maripaz de Guzman, the National Secretary of WAPR Philippines. The
participants expressed their realization that children in these situations as losing valuable time without their parents and there is the urgency to help them “to grow with care and protection so that they can navigate the adult world”. The presentation by the foster care-giver showed how foster children can overcome these challenges and lead successful adult lives. Psychosocial rehabilitation as applied to child mental health takes the form of child protection and prevention of psychosocial problems and impairments in adulthood.

WAPR Philippines Holds Annual Mini-Olympics
*Dr Felicitas A Soriano- VP WAPR Phil*

The last week of November every year marks WAPR Philippines activities, being looked forward to by its collaborating agencies, their staff and clients. This is the annual “Mini-Olympics” where groups from psychiatric home care services for the mentally challenged and disadvantaged, day care centers and rehabilitation wards of psychiatric hospitals, and other consumers come together for a day of sports and fun is organized, by WAPR Philippines.

This year it was held at the Elsie Gaches Village run by the Department of Social Welfare and Development. Starting with the lighting of the torch, and parade of the participating teams from the Elsie Gaches Village, Nazal Halfway Home, Haven for Children, Haven of Hope, University of the Philippines-Philippine General Hospital and the Veteran’s Memorial Medical Center Departments of Psychiatry, an all-day competition in basketball, volleyball, table tennis, board games like chess and Filipino games like “agawang panyo” provided fun among the participant-athletes. There was also a lot of dancing for those who did not participate in the games.
Fiji: Stress Management Daycentre opens in Labasa, 6th November 2012
Dr M P Deva: parameshvara24@yahoo.com

The Babasiga Ashram- site of Stress Management Day Centre In Labasa

The first places that detained persons with mental illness were called asylums – places of refuge. These Mental Asylums (also mistakenly called Lunatic Asylums) soon were over-crowding as the community were unable to care for people with these health challenges.

In the absence of specific treatment and rehabilitation services, the conditions in mental asylums soon deteriorated into chaos. Many of the staff was unsuitable for the care of the patients and abuse was widespread. These asylums later called mental hospitals were frightening places with bars, locks and grilles and barbed wire. Even after the introduction of chlorpromazine which reduced the most challenging behaviour, the culture of incarceration, locks and cells has continued to this day, although very effective treatment programs and medications are widely available.

The culture of ignorance, fear and prejudice that surrounds people with mental health problems extends to the medical and nursing professionals. Hence they are not able to offer qualified assessments, make accurate diagnoses and give appropriate psychosocial treatments and medication. The move to non-institutional or asylum settings such as general hospital wards has been the exception rather than the rule in most Pacific countries. But the need for a stigmatised Psychiatric ward is also not really essential as what are required are:

1. An acute 4 bed – emergency unit for those with acute psychotic illnesses to be supported with stabilisation within a week or less in every general hospital
2. A Day stress management centre for follow up, treatments and rehabilitation 5 days a week from 9 to 5. The Day Centre is based in the general hospital or in the community primary health centre and is run by 1 or 2 registered nurses with psychiatric nursing training, at least 2 orderlies for about 12 patients (called members). The centre has Outpatient services, follow up Day rehabilitation using psychological group therapy, social therapy and occupational
therapy. There is also emphasis on relapse prevention and family education. The following pictures shows the Stress Management Day Centre, in Labasa, Fiji that opened in November 2012.

The Day Centre starts with prayers, singing of popular songs, occupational therapy, cooking and gardening. Out of the 10 members of the day centre 4 are from the 5 bedded stress management ward of Labasa Hospital just 400 meters from the day centre and 4 from the community and 2 from the Ashram itself. The day centre is open 3 days a week and a daily meal and teas are provided. Plans are underway to provide transport for those unable to come by themselves. A weekly follow up on medication is provided.
WAPR UK Branch organised a meeting on “Recovery Model of Mental Illness” at Cannock, South Staffordshire, December, 2012. Professor Tanvir Ahmad Rana from Staffordshire University, UK, was the guest speaker.

Professor Rana emphasised that recovery was part of the rehabilitation programme, and it is designed to improve physical, mental, emotional and social skills. He said that hope is central to recovery and the main aim is to enable patients a transition back into society and the workplace. He explained that recovery is not just the cessation of symptoms and resolution of associated difficulties or impairments, but entails growing beyond the catastrophic effects of mental illness, regaining active control over life, and finding a meaning and purpose. He was of the view that recovery is an important means of promoting social inclusion. He suggested that clinicians should put patients at the centre of their care, and the recovery model should be at the centre of mental health services. He also spoke about stigma and elaborated that unfortunately stigma still existed. He advocated that consistent efforts educational programmes were needed to challenging marginalisation, stigma and discrimination within health services and wider society. In his concluding remarks, Prof. Rana presented evidence for the recovery model.

The talk was punctuated by a very interactive discussion by Dr Asaf Khan, Dr. Abid Khan, & Neil Carr which also continued subsequent to that talk.
Belarus.
From exclusion to inclusion with social participation.

The 3rd Young Psychiatrists’ Network organized their 3rd meeting in September 2012, at Minsk, Belarus. This meeting was organized in collaboration with European Federation of Psychiatric Trainees and the theme of the conference was “Stigma From The Young Psychiatrists’s perspective: Hopes and Challenges”.

During the meeting a workshop was organized on "From exclusion to inclusion with social participation". The speakers included Afzal Javed (UK) who talked on “Back to the community with rehabilitation psychiatry” and Henrik Wahlberg (Sweden) who spoke on “Social rehabilitation of people with mental illnesses”. The workshop participants were informed about WAPR activities and different aspects and approached of Psychosocial Rehabilitation were discussed.

Bosnia-Hercegovine
Workshop in Partnerships for better mental health worldwide: Best practices in working with service users and family carers.

WAPR collaborated with Bosnia-Hercegovine Psychiatric Association in their congress held at Tuzla in October 2012 and organised a workshop on “Partnerships for better mental health worldwide: WPA recommendations on best practices in working with service users and family carers”. The workshop was attended by a large number of participants including professionals, users, patients, carers and family representatives. The workshop was conducted by Prof Helen Herrman (Australia) and Afzal Javed (UK). The workshop generated a lot of interest and especially a need for establishing a WAPR branch in Bosnia.
WAPR Hungary organised an academic session in the 2012 Conference of Hungarian psychiatric association held at Debrecen, Hungary, in January 2012. The session was chaired by Ida Kosza, European regional vice president and was attended by a large number of mental health professionals. Information about the WAPR activities was given with emphasis on the importance of psychosocial rehabilitation in clinical practice. The key speakers included Dr Afzal Javed (UK), Ferenc Sule (Hungary), Albert Veress (Romania) and Ida Kosza (Hungary). This session also provided WAPR a chance to share current thinking and practices in the area of rehabilitation and generated a lot of interest in WAPR activities.

WAPR organised a Symposium in the WPA-WONKA meeting held in Granada in February 2012 with the following presentations:

Luis Galvez. The severely mentally ill: The view from the Primary Care.

Mikel Munarriz. The severely mentally ill: The View form Specialized Mental Health Care.

Afzal Javed, President Elect WAPR: The severely mentally ill: Psychosocial Rehabilitation (the view from WAPR).

FEARP, organised its 2012 Congress in the city of Zaragoza. The meeting was attended by more than 400 people, including professionals, caregivers and users. Relevant speakers from Spain and Europe participated in this active congress where the citizenship of the mentally ill was stressed and the barriers to its full implementation were discussed.
Registrations and attendance

The congress had 1538 registrations (1232 paid registrations and 306 free registrations, including consumers, invited speakers, members of the steering committee and scientific secretariat, exhibitors). 90 persons who registered themselves did not attend, therefore the participants have been 1448 from 70 countries. The distribution by country is shown in the attached table. Among the participants, 365 were doctors, 819 other professionals, 136 consumers, 73 relatives and 55 students.

Scientific program

The program was held in 9 halls, in 2 plenary sessions and 26 parallel sessions. It included 60 symposia, 9 special symposia, 3 keynote addresses, 2 roundtables, 50 thematic sessions with 184 oral presentations, 9 speakers’ corner sessions with 27 oral presentations, 15 meet with expert lectures, 3 video sessions with 14 video presentations, 2 special events and 236 posters. Simultaneous translation in English, French, Spanish and Italian was provided for plenary sessions and special symposia.

Exhibition area

The exhibition area accommodated the stands of 15 exhibitors: 9 cooperatives and social firms, 3 publishing houses, 1 foundation, the Department of Mental Health of Milan-Niguarda, the Government of Lombardy region.

Social Program

The gala dinner was attended by 230 people, including 72 invited guests.
WAPR Board Meeting in Milan, November 2012 decided Korean branch of WAPR (KAPR) to host the next 12th World Congress of WAPR in Seoul 2015.\nKAPR tentatively decided the date of the congress as Nov 13-16 at Grand Hilton Convention Center, which is located downtown Seoul and one and half hours from Incheon Airport.

KAPR was established in 1995 and its mission is to implement psychosocial rehabilitation for the chronic and severe mentally ill people to help them staying in the community and living their own lives. Current President is Dr. Tae-Yeon Hwang, who is also serving as vice-President of WAPR since 2012. KAPR already hosted regional WAPR conference successfully in Seoul 2007 that World Congress will be another historical moment for KAPR.

The organizer of Seoul Congress is Dr. Tae-Yeon Hwang and he already contacted Director of Mental Health, Ministry of Health and Welfare and got official support for the congress. Seoul Congress will be the first World Congress of WAPR in Eastern Asia that participants from Asian countries will present their own development of psychosocial rehabilitation and community mental health, which were far behind from many Western countries form many years. KAPR hope Seoul Congress will be the point of exchange knowledge and experience of the Eastern and Western member countries and contribute to the integration of Eastern and Western Model of PSR and community Mental Health.

KAPR is welcoming all WAPR members to Seoul Congress. For more information, please contact through lily.mh@gmail.com to the organizer and kapr2008@hanmail.net to secretary of KAPR.

Links

In this section we offer links important for our field. If you have suggestions for websites and links, please mail the editor: marit.borg@hibu.no

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

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

Mental Health reforms in Mexico: http://campaign.r20.constantcontact.com/render?llr=afbudccab&v=001yqHNAgdI3Xin6xOqqOxsWNr6BB2r_T39RRBNAmunyaDvCCHeijX-icXzQAJ8IRnPonGVTWRBnoV6pklZiD4lMShyKtV5S-9BIIZ2LbwhM_VkWJHNI3PuwsAJNZ12ltCzFibUTIh6g%3D
# WAPR Board 2012-2105

## EXECUTIVE COMMITTEE

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<thead>
<tr>
<th>Role</th>
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# Regional Vice-Presidents and Deputies Western Pacific

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# Representing Families

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# Representing Consumers

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# Representing Voluntary Organisations

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Board Meeting, Milano, Italy, November 2012.