2nd Asia Pacific Conference on Psychosocial Rehabilitation

July 28-30 2011

Manila, Philippines

World Association for Psychosocial Rehabilitation
Asociación Mundial de Rehabilitación Psicosocial
Association Mondiale pour la Réadaptation

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The 2nd Asia Pacific Regional Conference on Psychosocial Rehabilitation was held on July 28-30, 2011 at the Dusit Thani Manila, Makati City. This was co-sponsored by the World Association for Psychosocial Rehabilitation –Philippines and the Philippine Psychiatric Association.

The conference had as Keynote Speaker, the President of the Philippines. His message resonated with the theme of the Conference which is “Reaching the Unreached: Islands of Hope”, when he said, “Our administration similarly wants to reach the unreached- we want to give livelihood to all Filipinos from those dwelling in the streets of Manila to those in ramshackle houses in far flung provinces. We want a nation that is united by hope. We know the important role you play in the lives of millions of people around the world, and in that regard, we not only give our support, but we are working to make your jobs easier. We are indeed behind you”

The conference organizers have chosen as theme of this Conference: Reaching the Unreached: Islands of Hope, drawing attention to the fact that the Philippines being the host country has not only undertaken studies and has gained actual experiences in community mental health programs that have shown that patients can recover and their families can be helped to give them the social support they need. Other mental health experts from other countries in the Asia Pacific region presented similar experiences. These countries include Pakistan, India, Thailand, Mongolia, Cambodia, Laos Fiji, China and Vietnam, and the Philippines. These presentations echoed what is now increasingly accepted, that there is hope for those with mental health problems. Despite all these however, mental health and psychosocial rehabilitation services for these patients remain low in the priority of the health care delivery system in most countries in the Asia Pacific Region.

There were 650 participants to the Conference. These included a multisectoral group of psychiatrists, psychologists, social workers community health workers, consumers of mental services who participated in the plenary lectures and symposia, parallel symposia and workshops. The topics ranged from presentation of concepts perspectives and strategies of psychosocial rehabilitation enriched by the presentation of papers describing actual programs and experiences from experts from the United States, the United Kingdom, Australia, Italy, Pakistan, India, Thailand, Indonesia, Mongolia Laos Cambodia, Fiji South Africa, Timor d’este as well as those from the Philippines. Several questions were address in plenary lectures. Among these that caught much attention were” “What is the consensus on psychosocial rehabilitation? Should there be a broadened view on PSR; Is psychopharmacology research necessary in PSR.

In addition, there were presentations on Correlates to Mental Illness which included topics on Genetics and Mental Illness, The Interplay of Biological Factors and Social Factors and Globalization and Mental Ill. Updates on Mental Disorders as PSR programs impact on them were presented by clinical psychiatrists as well as updates on psychosocial intervention programs in extreme life experiences which plague most countries in the Asia Pacific Region (disaster, children in difficult circumstances. adversities of overseas employment, were well attended and generated lively discussions from the floor. The session on Mental Health Legislation with the presentation of MH Laws in South Africa, Malaysia and Australia provided evidences that indeed MH laws that provide a balanced system of a strengthened community mental health program and hospital based system can be attainable despite the barriers imposed that still prevail in many developing countries. Most of the participants echoed the satisfaction in the presentation of a balanced scientific program which filled the 3day conference. There was felt an evolving network of MH and PSR workers among the foreign and Philippine based participants and new friendships were formed.

The Fellowship night on the 2nd day was hosted by the members of the Phil Psychiatric Association.
Speech of the President of Philippines
During the 2nd Asia-Pacific Conference on Psychosocial Rehabilitation

When I was listening to the opening prayer, I was slowly getting very depressed. But I assure you, the problems that you face—I will have a lot more to face as the day progresses. So, it is sometimes—in this case—it is greener where you are rather than where I am. And, perhaps, the speech that was prepared today by my writers really is appropriate. So let’s proceed with it.

Over a hundred million people around the world are diagnosed with debilitating mental illnesses, such as depression, schizophrenia, alcoholism, or even Alzheimer’s, among other complications. I can only imagine the difficulties these people must feel; but at the very least, I can acknowledge that they need all the help that they can get—to be supported, empowered, and, ultimately, to be allowed to believe in themselves once again. And so as President of this year’s host country of this conference, allow me to express my pride and honor to be around leading experts who have devoted their professional careers to making life better for all these people. As you share your experiences and your ideas with your colleagues from different parts of the globe. I hope this conference renews your commitment to your patients.

As much as I want to share some ideas of my own, I am not a psychiatrist. But I do see that there are some similarities between your jobs and mine, in that we are both trying to mend damaging attitudes: you on an individual level, and us, on a national level. This is rooted in the same idea I shared when I addressed my countrymen three days ago. For the past years, our people had been mired in a damaging pessimism—the idea that government is not there to help them; and the idea that, no matter how hard they work, things will not change. This is the attitude we seek to change.

As many of you may know, changing a mindset cannot be done overnight, nor can it be achieved through empty words and mere rhetoric. As it is in your field, the government must do what it can to empower its people and to foster an environment in which each and every one of them can thrive. To do this, we have chosen to change the system into one that is more capable of empowerment—one that saves our people from the fatalism and the so-called crab mentality that has for so long stunted our progress as a nation.

We are investing in significant interventions and social services in order to help the most disadvantaged, and in order to give the means with which they can improve their situations. We are also continuously pursuing the corrupt, who have not only redirected public funds to their own bulging pockets, but have also given our countrymen the notion that the powerful are above the law. We want to change this notion. We want our people to change their mindset.
toward corruption—from one that acknowledges it as a harsh reality, to one that expects the corrupt to be tried and put behind bars. These are the small psychic shifts we want our people to take, because however small they may be, they teach our countrymen once again how it is to hope.

We are also working with a number of different sectors and groups in order to address the specific needs of our people; and it only seems fitting for me to express my gratitude to both the World Association for Psychosocial Rehabilitation – Philippines and the Philippine Psychiatric Association for the support you have shown our endeavors. You have worked with us to further the development of mental health programs, as well as to provide supplementary instruction in mental health training, to our local government unit health workers in, for example, Infanta, Quezon and Naga City. Inter-sector cooperation like this only strengthens my belief that we will be able to realize our dreams of a better life for our people.

This is why I believe that the theme for this year’s conference is indeed apt: “Reaching the Unreached: Islands of Hope.” I know that this is a conference on psychosocial rehabilitation, but I believe that this is a theme that resonates with us. Our administration similarly wants to reach the unreached—we want to give livelihoods to all Filipinos, from those dwelling in the streets of Manila to those in ramshackle houses in far-flung provinces. We want a nation that is united by hope. We know the important role you play in the lives of millions of people around the world—and in that regard, we not only give our support, but we are working to make your jobs easier. We are indeed behind you.

As you continue to treat people who might have difficulty finding hope in themselves and in the world, you can rest assured that we will continue to do our job as well. We will continue to give our people a reason to hope, and we will not allow their hopes to remain unfulfilled.

Thank you. Good day.
A meeting which Dr Xinagdong Wang WHO/WPRO/RA/MNH referred to as a “Brainstorming Session on the Mental Health Program of the WHO in the Western Pacific Region was held on July 30, 2011 at the Dusit Thani Hotel Makati City. He acknowledged the opportunity to present the WHO/WPRO regional program on mental health to the participants of the ongoing well-attended 2nd Asia Pacific Conference on Psychosocial Rehabilitation.

The meeting was attended by WAPR Board Members Dr. L. L. Ignacio the President, Afzal Javed the Pres-elect, Thyloth Murali the Vice President, Tae-Yeon Hwang the Deputy Sec-General, Eugenio Ladirdo the Treasure, WAPR-Phil Board Members Corazon de Leon Lucita Laxo Tan Cho Chong, Sally Bongalonta, Nadja Trinchera and Jasmine Vergara. The other participants in the meeting were representatives from 10 countries in the Western Pacific Region. This included Harry Minas and Carol Harvey (Australia), Chit Sophal (Cambodia), Chenh Jia (China), Akisha Carroll and Cristine Erasisoto (Fiji), Manivone Thikeyo (Laos) Nasansengel Lhagvasuren (Mongolia), Wilfredo Reyes (Philippines), Andrew Moheran (Malaysia). Also represented an international NGO Christoffer Blinden Mission (CBM).

After he presented the MH situation of countries in the WPRO, Dr Wang, outlined the over-all goals of the MH program which are 1) reducing treatment gaps, 2) preventing suicide; 3) humanizing health care. Humanizing health care generated much discussion and it was agreed by all present that this is one particular area where the mental health field can best contribute not only in the health care delivery of a country but in its over-all development. It was agreed that this needs a sustained advocacy.

Dr Wang capped his presentation with his proposed slogan: “Mental Health for all and by all”. All those present agreed that this meeting could be a good start of a fruitful collaboration. It was noted that the WHO/WPRO has extended financial support to representatives from 5 countries of the Western Pacific Region to the present 2nd Asia Pacific Conference on PSR. Dr. Ignacio pointed out that the representatives of the WPR countries have had formal and informal links with the World Association for Psychosocial Rehabilitation, and that coming together for the on-going Asia Pacific Conference has already started the discussions on how to formalize the organization of WAPR branches in these countries. WAPR will sustain its communication and consultative relationship with Regional offices of the WHO.
Board members of WAPR including Lurdes Ignacio, Afzal Zabed, Zeb Tainter, Thyloth Murali, Corazon de Leon, Eugenio Ladrido, Tae-Yeon Hwang had a 2nd board of directors meeting on July 28, 2011 at Dusit Thani Manila, Makati city. The meeting was held during the 2nd Asia Pacific Regional Conference on Psychosocial Rehabilitation.

Here 1st announcement about World Congress of WAPR, Milan was released by Barbara D’Avanzo and draft topics and other technical issues were discussed. Also 2015 World Congress Bid Issue was addressed, which will be done during Milan Congress.

Regarding Membership Policy, 3 types of membership were proposed: 1)Individual Membership 2)Life-time Membership 3)WAPR branch membership. Draft of Membership policy will be circulated to board members by Secretary General for review.

It introduced several regional projects. Preliminary Video-documentary of the WAPR-Phil- HELP Project was showed before the board meeting and received good feedback for the contents, but the sound and quality of video should be improved for the final version. Proposal for 2011 Pakistan Project was explained by A. Javed. It will be done by Lahore Fountain House with support of US$5,000 from WAPR. Vocational Project with Microfinance will be done by 15 mentally ill members next year.

Next board meeting will be on September 22, 2011 at Buenos Aires, Argentina.
WAPR Asia-Pacific Taskforce on Project Development and Dissemination

Vision
The vision of the Taskforce is in support of WAPR’s vision, which is that every person with mental health problems will, according to need, have access to readily accessible, affordable, high quality psychosocial rehabilitation services, and to social arrangements that enable and support recovery.

Mission
The WAPR-TF will promote the development and dissemination of projects that contribute to achievement of the vision of the WAPR.

Objectives
The objectives of WAPR-TF are:
- To map innovative PSR projects that have been or are being carried out in the Asia Pacific region
- To promote the development of PSR projects that will contribute to the achievement of the vision of WAPR
- To promote the rigorous evaluation of PSR projects
- To promote the dissemination of information about innovative and successful PSR projects
- To establish an independent and transparent process for evaluation of applications to WAPR for small scale funding support for PSR projects
- To develop a strategy to expand the capacity of WAPR to provide small scale financial support for promising PSR projects
- To promote the publication in peer-reviewed journals of PSR case studies and evaluations of PSR projects
- Together with suitable partners to promote the development of capacity building programs (e.g. training, mentoring, collaboration) for PSR in the Asia Pacific region

Organisation of the Taskforce
1. The creation of the Task Force, an ad-hoc committee, is provided for in the WAPR Constitution which authorizes the President to organize such a committee/taskforce and to appoint its Chair.
2. The President of WAPR appoints the Chair of the TF, and unless terminated by the President will serve in the TF during the entire term of 3 years of the President.
3. The Chair in consultation with the President and Executive Committee recommends the members of the TF. It is suggested that every country in the Asia-Pacific Region in which WAPR has presence
should have a member in the TF. The members of the TF will serve for 3 years, unless terminated by the President.

4. The members of the TF upon the recommendation of the Chair will be appointed only if they indicate that they have the interest and the time to make an active contribution to the work of the TF.

**Work Plan**

1. Assist in the development of a project proposed by WAPR-Pakistan which has been submitted for consideration for WAPR funding support.

2. Develop a proposal to implement the collaborative intent expressed by representatives of member countries participating in the recent joint meeting of WAPR and WHO WPRO, held in Manila on 30 July 2011.

3. Develop and submit for WAPR Executive approval a more extensive and longer-term work plan. The possible components of such a work plan may include the following:
   3.1 Propose a practical method for identifying and mapping existing PSR projects
   3.2 Develop a communication strategy that will enable dissemination of information about such projects, and about psychosocial rehabilitation and recovery more broadly
   3.3 Develop a strategy for the promotion of innovative PSR projects
   3.4 Develop a proposal for the independent and transparent evaluation of applications to WAPR for funding support for PSR projects
   3.5 Develop a strategy to expand the capacity of WAPR to provide funding support for innovative PSR projects
   3.6 Identify, among WAPR members, consensus priorities for PSR development projects
   3.7 Develop a PSR and recovery research agenda for the Asia Pacific region
   3.8 Identify and communicate education, training and capacity-building opportunities for PSR practitioners
   3.9 Track the development of PSR projects and activities in the Asia Pacific region
The Danish Association for Psychosocial Rehabilitation (DAPR) was founded in 2008. In the values statement DAPR state that in Denmark there is an urgent need to change opinions and values towards those suffering mental distress so that they will cease to be seen as chronically ill, marginalized citizens. This is something that DAPR wishes to play an active role in. In this short article we present some of the main discussions and activities that our association has been busy working with since we came into existence three years ago.

Background and thinking

Many years ago it was decided that people suffering mental distress should be treated differently than those who suffered physical and/or social problems. This belief system came about due to the erroneous public viewpoint, supported by the dominant medical opinions of the time, that those who suffered mental distress should be isolated in large psychiatric institutions based on the principle “out of sight out of mind”. This viewpoint unfortunately even today continues to affect our approach when helping those who suffer mental distress. As a result of this the general population tends to view these distressed people with fear based on ignorance, a viewpoint often supported by the media which results in the promotion of stigmatization. Working towards developing a more humane practice within psychiatry has been slow and uneven in Denmark. Decentralizing psychiatry, seen as a positive move, has unfortunately not resulted in better quality or the hoped for results for the mentally distressed. Working practice is still very much influenced by a professional approach that mainly focuses on reducing symptoms rather than helping people learn to cope with life and becoming a part of society again. This approach largely ignores the resources and personal opinions of those suffering mental distress. This group of people is still exposed to isolation, stigma, lack of understanding and abuse of human rights. The community services put in place when many of the institutions closed have become institutions themselves. Often they are promoting continued social exclusion and in some instances actively recreating social isolation and reinforcing the community beliefs that those suffering mental distress are different and need a professional treatment system which is separate from other services within society. Research from the rest of the world has shown that it is possible to develop effective and humane services for those suffering distress which helps improve level of daily functioning and the possibility of being reintegrated into society. Humanitarian approaches also affect the myths and stereotypical views that exist in local communities resulting ultimately in less stigmatization towards these individuals. There is a need in Denmark for a change of viewpoint and praxis so that those suffering distress are not seen as chronically mentally ill and different from the rest of society. We must acknowledge that we can all become victims of mental distress and that the help and support we need in these situations are as individually personal as we are unique. There is a strong correlation between a good psychiatric system and the local community’s willingness to be involved in finding new possibilities which helps improve people’s mental health and wellbeing.

Current challenges

Thus in Denmark we are faced with a variety of challenges. Economic pressure is being put on psychiatry and yet the media is clamoring for more beds, in other words a continuation of the “old fashioned” institution orientated type of psychiatry. Our opinion is very clear on this: people with
mental distress spend most of their lives outside of psychiatry therefore investing in peoples everyday lives will reduce the pressure on this demand for more psychiatric beds as well as contribute towards recovery orientated praxis. Instead of focusing exclusively on the institutional forms of psychiatry there is a huge need to focus on an overall change within society away from institutionalization and towards acting prophylactically in other words, preventing people from coming into the system, as well as putting in place viable solutions for coming out again and rejoining society. This requires openness and acceptance within society so that those suffering distress can remain in their own environment rather than being excluded from it. Rehabilitation should be orientated towards helping the individual navigate the requirements of society. Examples of this could be support helping the individual keep or restart their education, likewise support and/or flexible solutions in relation to the work market is another important area. However here exists the problem of a lack of knowledge and insight within the employment offices and job agencies when dealing with these individuals which makes things very difficult for them. Then there are also the economic problems facing those individuals seeking to extract themselves from the pension system… Denmark is faced with the challenge of realizing that it is not the individual who must be moved around depending on where they are in their treatment program, instead these individuals should be supported in living life in their own homes with flexible support possibilities including emergency help and access to retreats.

**Possibilities to move on**

In Denmark there are many people suffering psychosocial problems living in halfway houses which are often still functioning in many ways as old traditional institutions. These halfway homes are expensive yet they are not often a good solution for people and certainly not in the long run. Those suffering mental distress need help to move on, not maintenance! What is of great help for a successful transition out of these halfway houses is access to housing. Under normal circumstances when a person gets on a waiting list for a home the waiting time can become inordinately long. Therefore local communities should have in mind those people who wish to move out of these half way houses when they create rules regarding the admittance criteria for “acute” homes. Another important criterion is that the person gets the necessary support in connection with moving. The logic of the Danish system is such that when a person moves from one type of care system to another the person involved must say goodbye to their old key workers and establish new relationships with new key workers. This is not what people want. Our knowledge tells us that a good move is one where the person can continue to get support and remain in contact with their current support workers. A meaningful every day is very important when a person is to develop a more independent way of life. A key word here is connection, connection to society outside of the halfway house. This ability to connect is just as important as is being able to manage the household chores customarily viewed as highly important in many halfway houses. In the future, contact to family, friends, work, studies hobbies etc., must be of equal importance when giving support as is traditionally given towards cleaning, shopping, washing, cooking etc. No person should be trapped in a support system that works against their best interests and hopes and dreams. Working towards ensuring this does not happen is one of our goals.

**Poor economy works against development**

We see that the economic pressure put upon the municipalities prevents and blocks development. To develop new ideas and ways of working requires that there is a breathing space in the everyday praxis so that ideas can be properly tried out, documented and incorporated if successful. This has become even more difficult in Denmark since the reform two years ago which resulted in fewer and larger municipalities having to take over more of the responsibility for caring for those suffering severe psychosocial distress. The municipalities have after the reform experienced a considerable economic burden especially within certain specialized areas. This is not caused by the half way houses becoming more expensive yet it is in these areas that the spot light is pointed when it comes to cuts in the budget. From a top down perspective it is easier to cut down in this area or demand more beds than saving by changing the funding criterion for services within other areas. The economic pressure on the half way houses and therefore the potential profits for development is reduced and is highlighted as the question of price becomes more and more important for each visitation. Today all half way house must be registered on the internet with information on price, if they have room, as well as what services they can offer. The idea here is that every social worker in the whole of Denmark
can go in and immediately see what people can potentially expect in these half way houses. The idea is a good one. The problem is the half way houses have not developed a collective language to compare their services resulting in the only realistic comparison being the price. DAPR worries when we see that the challenges that these half way houses face since they traditionally represent social psychiatry which in Denmark is separate from treatment psychiatry. Such challenges are therefore accompanied by increasing difficulties in being able to continue to develop a better praxis. Deinstitutionalizing people should be high on the list as research shows us that it is stigmatizing and invalidating to live in reservation like surroundings. It is both cheaper and far more humane to create a meaningful life in an ordinary home with the desired help as opposed to living in an institution.

A holistic approach

In Denmark we like to say psychiatry is bio-psycho-social, but in reality there are many people who only ever get offered medication. For example only 8% of those who suffered from psychosis were offered psychotherapy in 2009! The existing campaign for equal opportunities for psychological help is therefore very important. If we are to get away from the paradigm of chronicity and work for inclusion, citizenship and equal rights we have to move away from only treating with drugs and supplying special care systems within social psychiatry and work towards a true psychosocial rehabilitation perspective based on cooperation between all the partners involved in working with the distressed individual. There is a need to invest in research and praxis documentation as well as a sharing of knowledge if we are to be able to demonstrate convincingly a connection between our professional support and the individual’s possibilities of recovery. We must avoid that the demands of “best practice” and standards of quality be used defensively in an attempt to prevent mistakes, and instead work towards creating the best, i.e. an individualized, personal plan in cooperation with the distressed individual where his/her life situation and preferences are the center of focus. There is a need to strengthen and develop existing social and humanistic research and their connections to each other so that this too becomes a focus of attention within psychiatry.

Fighting Stigma

Globally as well as in Denmark there is an increasing focus on stigma. DAPR feels it is extremely important that the many years of international research from anti-stigma campaigns is used in the up and coming Danish anti-stigma campaigns. It is also important for us to acknowledge that prejudice also exists within the professionals themselves, in fact some research shows a stronger prejudice among them compared to the ordinary man on the street. It is therefore imperative that international knowledge about recovery is available and that the principles for a recovery orientated help is widely advertised and that includes hospital psychiatry as well as within the social sectors.

Working for real change

We believe that for recovery to win through requires changes not just in the periphery of psychiatry but throughout psychiatry. If we are serious about continuing to build on the existing knowledge of recovery then it will require a fundamental change in the whole way we work both on an individual level as well as politically. There is a long way between the writing of the words and the actual implementation of recovery oriented practice on every level. There is a vast amount of available knowledge but there appears to be problems when it comes to spreading this knowledge as well as finding ways of sharing experiences. Finally and most importantly, it is not possible to establish evidence based praxis’s without the involvement and the experience of the service users themselves. It necessitates the empowerment of the service users and user organizations so that they can be active, critical players in the psychiatric arena on all levels. Thus they must be involved in the planning, implementation and evaluation of all the levels of the recovery process. We, as an organization will do our best to be a part of this change and currently we are organizing a conference “From Values to Action” which is being held 27 -28 October 2010 where we have invited key players in the field of recovery from the UK and USA as our key note speakers. Almost 300 people from all over the country will attend the conference and participate in its discussions of how we will be able to increase recovery orientation in the Danish society. In the future we look forward to sharing experiences and working together with other members of WAPR worldwide. We are very happy that we are now members of this international organization and accepted as the Danish chapter!
Many have observed that service user voices are marginalised in research and service development. This is despite the value of direct experience as a source of knowledge. However, including and involving people with experience of using mental health services can mean exposure to not just the positive experiences but also the negative aspects. These are not always easy to hear or respond to. Research experiences are shared here, as examples of how to respond to the challenges of user involvement. There are several ways to make this process easier for everyone involved. One is bring service users together, so that they can speak with a stronger, collective voice. Another is create different ways of making their experiences accessible, using research methods with an emphasis on action. And yet another is to work collaboratively from the very beginning, so that the focus for projects is mutually agreed, with a fundamental understanding of different perspectives. Here in West London, our research programme involving service users has covered all these possibilities, starting with an initial focus group study (Bryant et al 2005) and travelling a full circle through innovative and participatory approaches to return to focus groups this year. Bringing people together is the essential purpose of focus groups, where discussion is structured around a specified topic (Krueger & Casey 2009). Locally, service providers wanted to engage with service users, carers, staff and managers and focus on day services, which at the time were mainly based in three resource centres. The fear that people might get stuck in day services was fuelled by fears about social exclusion. Social policies shifted focus to alternative provision beyond the resource centres. The twelve focus groups enabled people to share their perspectives, finding common ground in their fears about the lack of alternatives but also differences in their ideas about the future. Recruitment to the focus groups was high, as service users and staff felt empowered by the group setting and the independence of the researchers (Bryant et al 2005). However, people only had one opportunity to contribute to the debate in the focus groups, so that those who were unwell or unable to be present missed out. The focus group discussions revealed areas for improvement, generating recommendations, which were taken forward by a forum of staff, service users, managers and community organisations. The research evolved into a participatory action research project, with the forum agreeing a focus on social networking, as the social links between people using day services were seen as an important source of support (Bryant et al 2010). This focus was developed in forum meetings and an Action Day, which gave many an opportunity to explore and discuss their ideas and experiences. Three themes were identified: (1) current use of the resource centres; (2) service user knowledge of the local community for social networking; and (3) the potential of self-help groups. While these themes could have been explored in the forum, it was agreed to set up separate research strands to investigate them, using different methods to engage as many people as possible. The first strand used PhotoVoice, an emancipatory method using photography (Wang et al 2000). An action research group, consisting of service users, a member of staff and the researcher, worked in cycles of action and reflection, taking photographs of the social areas of one resource centre. Analysis drew on the images and group discussion to identify the central importance of a safe space for recovery (Bryant et al 2011).

Another research group was formed for the second strand, which looked beyond the resource centres to the local community. Initial work had begun during the first Action Day, providing information which service users had developed into an index of local places and set up a weekly telephone helpline to share the information on request. For the research, members of the research group agreed to gather more information about local places where they liked to go, designing a checklist to ensure everything was covered. They encouraged other service users to share their knowledge by filling out checklists. The group collated all the responses, analysed the data and identified important findings to share locally. They specified that posters should display the findings in all local resource centres and hospital wards, so that
many people had access and could use the information as a basis for a discussion about their own preferences and interests. This strand was later repeated in another area of London, successfully engaging people with enduring mental health problems, sharing knowledge and highlighting the importance of personal choice in social, recreational and leisure activities. Self-help groups were encouraged as a way of gaining peer support so the third strand of the research, where ten members of three self-help groups were individually interviewed. The focus of the interviews was on gaining insight into how the groups came into existence, survived and thrived. The interview data were subject to narrative analysis, to build stories of the groups. Service user and staff members of the forum were involved in recruitment and publicising the research, and debating the findings. The research revealed a problem with the location for one group which demanded a rapid response from service providers. Other themes indicated the importance of support from mental health services to assist with recruitment, resources and supervision for group leaders. The groups were valued by service users. The findings from the three strands of the research were shared with the forum as a regular part of the discussions, feeding into the new design for day services in the area (Bryant et al 2010).

Some members of the self-help groups then became involved in a university-based collaborative research group, Researching Psychosis Together, which was set up during the final meetings of the forum. So far, research had been initiated by service providers wishing to reconfigure services in response to policy changes. Opportunities had been created for service users to investigate their own ideas within this context. In contrast the university-based group started with detailed discussions to agree a research focus emerging directly from service user experiences. The project, Living with Psychosis, was designed, approved and undertaken by group members, recruiting a masters student to collect data. Over the past four years, Researching Psychosis Together has been a partnership between up to eight service users and two occupational therapists (one clinical and one academic). Their collaborative work generated a research question focused on the experience of living with psychosis, investigating what service users found helpful via two focus groups. It would seem like a full circle, to return to focus groups as a means to collect data, yet a major difference between this project and the first one reflected the nature of involvement of service users. The participants were service users, as before, but the questions they discussed were created by service user researchers, who also acted as co-facilitators for the focus groups. The masters student was working on behalf of Researching Psychosis Together, who acted as her steering group and ultimate decision-makers in the research process. This empowered service user researchers, who perceived that their knowledge of every aspect of the research was valuable to the student. Development was not restricted to the student as each group member has evolved during the process. Two further projects have emerged which continue to be refined and another student has been recruited to collect data from two more focus groups, on the group’s behalf. For these research projects, the primary resources for user involvement have been time and commitment from individuals and organisations. Small amounts of funding have been obtained for specific elements of the work. In particular, funds were obtained from Brunel University knowledge transfer secondment scheme to support the phase of refining the Living with Psychosis research proposal and approval documents, acquiring skills in data collection and analysis, and identifying other possible sources of funding. Some of the funds released the clinical occupational therapist for a day a week over four months. Unsurprisingly, phases of designing research, data collection and data analysis offer a more rewarding possibility of involvement for service user researchers than the largely bureaucratic processes of applying for funding and ethical approval. Respect for this fact combined with the understanding that funding bodies and approval committees remain doubtful about the capacity of mental health service users to work as fully equal research partners. When research is based on personal commitment, these issues are important. Research is essentially a process of development: of knowledge and understanding. Everyone involved, whether as a one-off participant or as researcher, cannot avoid being developed too. The potential importance of enabling people with long-term and direct experience of mental health services cannot be underestimated: not only could services develop in a ways particularly helpful to them and future service users, but also individual service user researchers gain sustainable personal benefits from being involved.
References

Developing a WAPR National Branch in Spain
A 10 years experience
Ricardo Guinea M.D. 1

Summary
WAPR advises to create a National Branch as a way to develop PSR policies in a country. This paper summarises how this process was possible in Spain. When a reliable leader was identified by WAPR in the country, a National Secretary was created as a mean to give it support towards the goal of creating a national association, further acknowledged as WAPR National Branch. Major milestones of its work are, as well as the some immediate challenges.

The general target of WAPR is to improve the situation of the mentally ill globally1. Depending of the country, the political and economical situation of each country, this goal can to be implemented through many different activities. We need to fix the priority of this health item as according to the health situation of the county, disseminate the corpus of evidence-based knowledge that supports PSR as a feasible and socially valuable task, we need to facilitate training to an array of professionals (psychiatrists, nurses, social workers, social educators, monitors…). We need policy makers to allocate funds to start and run PSR programmes at the level each country can afford in order to offer equity to the mental patients. We need to promote values so we can meet human rights principles and fight stigma and change the distorted vision that society usually holds about the mentally ill. Since PSR is, more that a practice, a social strategy, it has been also underlined that it requires an alliance among many different actors: families, users, professionals, policy makers, universities, employers, social leaders, and community in general. But when you want to begin change the status quo in a country, as PSR intends, you need to start somewhere. And this question is often made by people interested in PSR in countries where there is not a WAPR national branch that approach WAPR for the first time. This article will offer some ideas about how to do if, taking as background the experience of my country, Spain.

The beginning
Spain is a country in the south of Europe. While all countries in Europe were organised as parliamentary democracies from the ’40s, Spain had an authoritarian politic model until the late ‘70s. We had a very intense political change in the early ‘80s in our evolution to a full democratic county, and a generation of Spaniards felt that many things needed to be done. A new Constitution was enacted, and the State was widely updated, including a deep fiscal reform. As a part of this process, we had an
Emerging project for a public health system, which included a new mental health system³⁴ (As in many countries, the old mental health model of attention was based on the old mental institutions). In 1986, the new “Ley General de Sanidad” (General Health Law) was enacted. It included a special chapter for mental health, with included the principle of the psychiatric reform. The aim of the new law was to establish a public health model based on the principles of equity, quality and accessibility, and fully funded by taxes. The new law normalized the mental health attention, that no more was based in mental hospitals, but in a fully integrated community network (crisis units were ordered to be allocated in general hospitals). A movement for des-institutionalization was promoted. Usually, the first step to establish a WAPR national branch in a country is to appoint a national secretary. Dr. R. Blasi, leader of ARAPDIS, a local Association in Barcelona, was the first person from Spain who contacted WAPR and organised the first meeting (the first “ARAPDIS Congress”, in the late ´90) devoted specifically to PSR in Spain. He was then appointed as national secretary for Spain (which is the official acknowledgement of WAPR towards a local leader, and often the first step for establishing a national branch). Soon, as a part of the training programmes for the new vision promoted by WAPR, some of our experts to them, and send delegates to WAPR congresses: we sent delegates to Milano, Hamburg, Rotterdam, Paris, and New York. Some of our scientific meetings received small sponsorship from companies, but under with very clear directives, whether the services would be managed by government agencies or by private companies. Finaly, this network was managed by private companies, but under with very clear directives, strict inspection, and close coordination with the mental health system. The system worked very well and experienced a steady growth.

Meanwhile, AMRP kept on its activity, facilitating training opportunities to the new professionals and monitoring all the process. AMRP had very limited sponsorship. Its main income has always been the members’ dues. But despite the very limited resources, the local organisation was able to organise meetings, invite some foreign experts to them, and send delegates to WAPR congresses: we sent delegates to Milano, Hamburg, Rotterdam, Paris, and New York. Some of our scientific meetings received small sponsorship from the regional government, from the companies that managed the services or from pharmaceutical companies. The relationship with the industry has
always been controversial for us. On the one hand, since we are an interdisciplinary organisation, the industry doesn’t seem very interested in sponsoring our activities. (They seem always more willing to sponsor activities that involve more specifically “psychiatric treatments”) On the other hand, a part of our associated doesn’t feel comfortable with this sponsorship, due to the fear that it would imply a bias of understanding to the overall task.

Taking into account the interest we felt about WAPR, we decided to start official contacts. And so, we contacted the WAPR presidency (then Zeb Taintor), who gave us a very warm response, but explained that in order to establish partnership with WAPR, we needed a national Spanish branch rather than a local association. So we did: we began contacting professionals in other regions of Spain, and soon we found a similar interest. Soon, some new associations were created in Basque Country, Catalonia, Aragon, Canary Islands, and Castilla Leon, following the model of AMRP, and we had a network, took a formal registered shape as a National Federation. Then in New York WAPR Congress 2003, we officially were accepted as FEARP, the WAPR Spanish National Branch. 5

Looking back, it may be interesting to explain how was it possible for us to develop a national federation with so limited economical resources (less that 1000€/year, which in Spain is indeed a very modest sum for an organisation). However, a few circumstances have helped. First of all, there was a shared feeling in a generation of professionals of a shared task that needed to be developed. Second, a group of very committed professionals have worked hard and altruistically to make it possible and offer the necessary leadership. Third, the Internet has allowed very fast and cheap communications. Forth, there was a synergetic impulse among professionals, some policymakers, and family’s movement to keep things marching. And last, but not least, we have lived in a time of good functioning in the national economy. The result was been a very huge (but uneven) development of investment and services for the mentally ill in many different aspects, including treatment, housing, supported employment, and support for social inclusion.

As WAPR encouraged us to create a national federation, the Federation encouraged many professionals in different parts of Spain to develop their own local associations, and has created a network for local training and meetings. In addition, some political activities began to take place: our local associations were called to contribute to the design of local mental health plans and this constituted a important part of the steady consolidation of PSR as an activities and as a framework for scientific exchange. Now, FEARP is integrated by 18 regional and local different organisations.

The present

The functioning of the FEARP, the Spanish WAPR Federation includes a lot of different small issues and of information exchange, but some tasks that can be underlined.

Meetings and Congresses

As in any other scientific organisations, congresses are very important activities. Congresses give visibility to the organisation and are a very powerful tool for training, but also are social events and a very good help in maintaining the motivation of the professionals. We have organised three National Congresses, in Madrid, Bilbao and Valladolid. In all the congresses we have been able to invite significant international speakers, which is a good way to keep mind open to have new perspectives. As a contribution to WAPR, in all the congresses, we have been able to host 3 times WAPR Board Meetings. But the local associations, allocated in smaller cities have also been able to organise very successful meetings. This has been good to facilitate updates and training for practitioners that are not willing / able to afford the expense of participating in a meeting in a distant city. This leaves a balance of more than 20 meetings in different cities of Spain in the last 10 years, which is a great success.

Funding congresses is always a difficult issue. Our congresses are funded mostly with registration fees. We always keep low fees to ease the participation of all the array of professionals that participate in PSR: psychiatrists, psychologists,
nurses, social workers, etc. Pharmaceutical companies usually help offering support to psychiatrist attending congresses. When a PSR system is already implemented, it is possible to receive some direct support from the agencies that are running services. The organisation of congresses is usually widely delegated to local associations. Congresses are planed on basis of non-profitable activity, trying only to cover expenses, and willing to maximise participation. So far, this policy has been very successful.

### The Observatory

As a part of our political job as a civil society organisation, we have created an Observatory of Mental Health. Its aim is to monitor the general situation: includes an index of available services, assessment of policies and their implementation, and a SWOT analysis referred to the general situation. Every two years, local delegates are asked fill in a survey based on the evolution of some general indicators (budget, places in services), which are evaluated. Finally, a committee issues a report every, which is presented in our National Congress and offered to media agencies. The Observatory can provide good information about how things go in different aspects: policies, budgets, met or unmet needs, can also provide also some media headlines and is published in our website.

So far, the findings in the Observatory have shown a significant increase (but unequal and insufficient) of resources in Spain in the last years, with wide differences among different regions. The SWOT analysis shows many different remarks about strengths (PSR and partnership has been consolidated as a model of care, institutional practices has been widely revised, a new generation of professionals have been trained in PSR model...) and weaknesses (PSR is still comparative undervalued, many people still remain out of the system, difficulties with co-morbidity (drug users), insufficient community services makes pressure on crisis units...) The Observatory gives good and useful information, and supports our credibility when we offer our offer advise to policy makers.

### Publications

One of our main goals as a scientific organisation is was to be able to select and provide our associated reliable information about research and good practices in our field. Publications are a very important tool if you want to present the society a social perspective as PSR is. Our policy in this regard has pursued a comprehensive perspective: that means to encourage publication about all the aspects that compounds the spectrum of PSR: medical or psychological issues as treatments or PSR psychological techniques, but also social issues as policies, housing, stigma, or employment.

We created the magazine “Rehabilitación Psicosocial”, in collaboration with a medical editorial, printed in paper, and distributed for free. It is also accessible in the Internet. Financing it has been possible in part thanks to the support provided by government agencies. We also accepted the request made by the Government to elaborate technical documents: “A model of attention for the severe mentally ill” constituted a big success, because a model fully based in PSR principles and philosophy received the official endorsement from the Ministry of Social Issues. We have also collaborated with the Ministry with a technical report about legal assessment of dependency for people with mental health condition. We have also published the book “Evaluación en Rehabilitación Psicosocial(Assessment in PSR)”. Recently, due to the economical crisis, we have decided to orientate our interest to Internet, as it is very a cheap and fully accessible mean of publication.

### Enhance users’ organisations

It has been repeated that PSR requires participation form many different actors. Families, professionals and families are the three legs of “trialogue”, the three perspectives of the dialogue that allow a comprehensive perspective over severe mental illness in community. Families have a very important role because they often bear an important part of the burden of care (obviously when the user has a family that cares for him). Professional’s voice is also important because they can provide technical views on how the problems can be faced and solved. But a critical part of a good empowerment policy is that that to gives support to users to raise their own voice. In Spain, users appear often as the weakest part of the chain due to the social risk of facing stigma. Many users are not interested in mental health activism issues, and consider that facing their own life is just enough. But some of them do feel interested in assuming the task of social activism as part of their recovery pathway, and these users can be (and should be) supported to do it. Users organisations are a very good scope for them.

In Spain, families have a very strong organisation, with many local associations linked in a national
federation. In the family carers organisation scope, they are already representing the users’ voice. But this is only partially true. Many users live independently or don’t receive from their families the appropriate support, and they do have their own perspective. Our organisation has encouraged users organisations to present their views independently, hosted them for meetings in our congresses, and always given them relevant place on our professional meetings to express it. The result has been the creation of many different local users organisations.

The future: New challenges

Legislation and Human Rights

We, mental health practitioners, need to be aware that users of mental health services are at extremely high risk of human rights abuses. Advocacy in human rights has to be a part of our performance as a professional association, because many of these facts are surprisingly considered routines. While the fact that a large amount of people may not receive the adequate support can be easily ignored, there is a high sensibility to any unusual or violent event related to mental health condition. Psychiatry is often requested to be consultant in social control issues. In Spain, legislation has already regulated many aspects of it, in the last 30 years, evolving towards a greater respect of civil rights of patients. It has been understood that social control should be considered not only at the expense of patients.

Compulsory treatment is in Spain accepted in acute situations. Under a judge’s authority, it is possible to force admission in a psychiatric unit before the situation deteriorates by accident, or suicide, to ensure crisis treatment in acute wards. Recently, some stakeholders (from family carers and professionals sector) advocate for wide implantation of compulsory outpatient treatment. Unfortunately, this issue is called every time a person with mental illness appears related with any violent or unusual event, and it makes difficult a calm debate that takes into account all legal and technical aspects.

In our view, we need to harmonize users full protection in the field of human rights, with the protection of users and his or her environment from the unwilling consequences of crisis situations. Our position as a professional organisation in this sensitive issue is that we have to acknowledge that we should try to avoid its use as much as possible, focusing also the need of measures aimed to enhance therapeutic alliance and other preventive strategies, and not only social control. We think that as a civil society organisation, we must be permanently aware of the remaining risks. They include often not reception of the needed help, or receiving it out of the context of human rights or good practices, or being included and isolated in institutions, instead of receiving help to live independently included in society. It is increasingly common that people with mental health condition and misbehaviour are first considered as offenders (instead of ill persons) and imprisoned.

Research has showed that in regular practice some routines, as mechanical restriction, seclusion, or other forms of coercion, present a substantial between-ward variance and require closer attention and control. Stigma attached to mental health problems keeps on leading to discrimination and lack of equal opportunities in access to employment, health and social services, education/training, housing, transport, or leisure activities. Our Federation has created a special committee of Human Rights to monitor all these issues.

Recovery orientation

While the professionals or the family carer’s perspective has been increasing considered, the service user’s perspective has been underestimated, and this bias needs to be revised. The “recovery perspective”, emphasizes that we need to take into account our better understanding of how people with mental health condition live their lives. We need to services able not only to provide quality care orientated to independent living, but to provide users a positive guidance for a sense of hope and of living meaningful lives. Recovery orientation which is now widely accepted in international statements, is requiring the implementation of some new actions. It is recommended that services find a way to give voice to the service users in critical issues as organisation or assessment of services are. It has been also recommended to monitor practices to ensure that they are “recovery oriented”.

In this context, recovery oriented implies that services have to be person centred and person oriented, be able to transmit hope and a positive scope, allow self-determination and personal choices for service users. The recovery perspective has deep implications because its implementation implies not only knowledge (that can be taught), but also values and attitudes (which have to be transmitted and accepted). The recovery perspective is becoming more known, and discussed but the
application of its implications is uneven. More efforts will be necessary in the future.

**Building policies**

A target activity of our members in Spain is to participate in management meetings where policies are defined. We have witnessed along the time that policy makers are required in many different ways, and that when they ask for advice, they receive many different suggestions from groups with many different beliefs and values. They are required and concerned about budgets, media, security issues. It is important that they receive also the input from PSR professionals, family carers and users. We encourage our members maintain an active attitude to participate in public discussions, and decision making processes.

At national level, our Federation has been able to act as adviser to the Social Affairs Ministry and made efforts to be in contact with the Health Ministry. But since many important decisions are made on the local level, we encourage our local member to participate in experts group, where local plans and policies are designed. This activity is time consuming, and needs committed people, and not always successful. But we have found in Spain it is possible to work successfully, specially when it is possible to pursue common targets in coordination with family carers and service users organisations.

**Conclusions**

It was possible to develop a WAPR national branch in Spain with very limited resources, but it required a network of very committed and altruistic professionals from different regions, and wide access to the Internet and e-mail. It was possible to find some limited support from regional al national governmental authorities. PSR has been widely disseminated by meetings, publications, and an Observatory, and has been influential in some areas (design and recovery orientation of some new services, training of new professionals) It has been also possible to develop a significant editorial activity, and to support the creation of users’ organisations.

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Much of the disability associated with Schizophrenia is accumulated in first two years in the course of illness, termed as “critical period” (Harrison et al, 2000). It is estimated that the average duration of untreated psychosis is about two years. Longer delay in getting treatment DUP is associated with a poorer response to treatment, increased disability and mortality spiraling costs and poverty(Farooq, 2009). A significant proportion of those suffering from First Episode Psychosis(FEP) are unable to return to their jobs due to stigma associated with such a serious mental illness and this further contributes to their social exclusion, low self esteem and poor mental health. There are hundreds of Early Intervention for Psychosis(EIP) programs in most of industrialized countries(McGorry et al, 2008). In contrast, low and middle income countries with more than 25 million people suffering from Schizophrenia have almost no organized programmes for the EIP.

This programme will combine a well established approaches for providing treatment in the community called STOPS(Supervised Treatment in Outpatients for Schizophrenia) and successful microfinance scheme organized by one of the largest microfinance providers, the Akhuwat in order to provide employment for the persons suffering from Schizophrenia to assist recovery. The treatment will be provided in the STOPS programme which is an innovative approach involving family in treatment supervision and administration.

We will aim to achieve a sample of 50 patients presenting with FEP in health facilities in Lahore. The inclusion criteria will be:

1. Age - 17 to 60 years
2. Diagnosis of First Episode schizophrenia or schizoaffective disorder based on the ICD-10 RDC
3. Residence in the areas of the service being provided.

Eligible patients will be first screened by the trained psychiatrists and subsequently assessed by the project team to satisfy the ICD-10 criteria for the diagnosis of Schizophrenia and Schizoaffective disorders. The patients will be treated using the STOPS approach (Farooq, 2010; Farooq, 2009). In STOPS model, a Key Care Supervisor defined as any family member living with the patients for at least six months and providing support for the treatment as identified by the patient is supposed to be trained in regular supervision. Specific education will be provided to the Key Care Supervisor about the nature of the illness, misconceptions about the treatment, relationship between the supernatural and biological causes of illness and importance of continuing the medication and basic skills in how to administer and supervise medication.

The baseline assessment will include diagnostic confirmation, demographic data, illness history, Duration of Untreated Psychosis, GAF, PANSS, and burden on family questionnaire. The follow up assessments at monthly interval will include GAF, PANSS and medication adherence. At six months to 12 months period, the patients achieved remission and who have achieved the GAF score of at least 80 will be introduced to the Akhuwat. They will be given detailed explanation of the Microfinance. A representative of the Akhuwat will assess the suitability for a microfinance project. Ten patients who are willing to start microfinance will be selected to start a small business with the help of Akhuwat. All the patients will be assessed for further one year using the assessments as mentioned earlier.

Poverty alleviation, improvement in physical health, and the attitudes and stigma associated with the illness will be used to evaluate the project.

The project has been approved by the local ethics committee.
The WHO Mental health GAP programme Forum was celebrated in Geneva on September 10, 2011, and was attended by the WAPR board-members, Dr. Tae-Yeon Huang from South Korea, Dr. Stelios Stylianidis from Greece and Dr. Ricardo Guinea from Spain, who presented a statement on behalf WAPR.

Dr Ala Alwan, Assistant Director-General, Noncommunicable Diseases and Mental Health, who expressed a warm welcome, chaired the Opening session.

The Mental Health Atlas-2011 was launched by Jody Morris, who manages projects that focuses on the assessment and strengthening of mental health systems in low and middle-income countries.

Mr Kjell Magne Bondevik, Founder and President, the Oslo Centre for Peace and Human Rights and former Prime Minister of Norway, he stated that mental health problems will affect in lifespan to 1 from 4 people, explained how people with mental health problems can and do recover, expressed the need of rehabilitation and protection of human Rights as a part of treatment, the need of reliable information from and for countries to monitor how the Gap between resources and needs is evolving, how disability or death from suicide. Explained the extreme situation in lower income countries, where extreme differences in availability of professionals are evident and the need of allocating more resources is critical. As a personal contribution to the fight of stigma, Mr. Bondevik included a heart-touching reference about how he suffered from depression when Prime Minister on Norway, and how he was able to overcome from it and become a recovered with the help of the treatment. A video showing new achievements on Mental Heath in Jordan counties was showed.

Dr. Shekhar Saxena, Director, Department of Mental Health and Substance Abuse, offered an overview of progress on mhGAP implementation. Explained that commitment of policymakers is slowly increasing, and opined than global momentum for a better prioritization in mental health is growing globally; that some current challenges are the need of scaling up resources, more and better training for professionals and combating the barriers of stigma; explained that in the logic of mhGAP programme, the relationship burden/budget has to be balanced, underlined the need of rational organisation in MH services, defended community principles as more efficient in the use of limited resources, in a scaling priority that begins in the teaching of self care, supporting informal care, and giving appropriate care in primary settings, general hospitals and community mental health services and last in the care in mental health hospitals.

Dr. Saxena said also that human rights abuses are to be stopped, launched the intervention guide 2010 with material based in pilot implementations, and introduced statements from stakeholders from Nigeria, Jordan, Brazil, Panama, Belice, India, Laos, Thailand, Uganda, and Pacific Islands that showed significative progresses. Introduced the initiative from WHO oriented to research with five challenges: the increase of screening in mhGAP packages, the reduction of the cost of medicines, the seeking of effective and affordable community cares through research, the increasing of children care, and the strengthening of mental health as a part of health care.

Jodi Morris introduced the key recent findings of Atlas Project, launched in 2000, and updated in 2005. With 98% of responders to the surveys, the data indicated that resources for treatment and prevention remain insufficient, inequity distributed, inefficiently used (the more, allocated in institutional settings and the less in community
settings) and slowly decreasing, while mental health disorders cause the 13% of burden (in DALYS) only 3% of expenditure in health goes to fight them.

Half of World population has less that one psychiatrist for 200,000 inhabitants. 62% of beds are allocated in mental Hospitals, where is also allocated 67% of the funding in institutions.

In addition a slow decrease of expenditure in mental health is witnessed. The only good news is that this decreasing comes from the closure of institutional beds.

Dr Benedetto Saraceno, Adviser, Department of Mental Health and Substance Abuse, chaired an update about country implementation of mhGAP in Ethiopia, Jordan, Nigeria, Panama, Belize, Brazil, India, and Uganda. The conclusions were that when there is political commitment, changes are possible at the scale of the countries possibilities, that mhGAP Programme is a good basis, and that there is a need of assessment, stakeholders consultations (universities, government, civil society, professionals, families and consumers), good definition of targets, determination of barriers, implementation and assessment.

Dr Graham Thornicroft, from the Institute of Psychiatry, King's College London, chaired the discussion “Scaling up efforts of Partners”.

The last session consisted in a discussion about “The way forward”, chaired by Dr. Saxena.
The Korean Association for Psychosocial Rehabilitation (KAPR) has been very active during the first half of this year. The main activities are categorized to membership training, developing psychosocial rehabilitation program, research, education for general population and family members with mental illness, and mental health awareness campaign.

KAPR held membership training for 2010-2012 new board and committees members during Jan 7th to 8th for the following purposes: 1) evaluate last year activities; 2) each committee’s plans; 3) future fund raising. Through this membership training, new board and committee members planned whole year projects and activities.

Also, KAPR recruited psychosocial rehabilitation program/ research proposal to invigorate professionals to contribute psychosocial rehabilitation program/ research. Amongst proposals for psychosocial rehabilitation program and research, three teams got awards in program development, and three teams got awards in research. The followings are the list of selected psychosocial rehabilitation program: 1) Developing manual for alcohol addiction recovery, 2) Mental health media monitoring project leaded by people with mental illness, 3) Developing empowerment model for people with mental illness. For the selected psychosocial rehabilitation researches are as follows: 1) Siblings’ roles for the people with mental illness’ life span, 2) Guidance for Accreditation of Psychosocial Rehabilitation Facilities, 3) Development of Korean Model Mental Health Case Management - A Study on Level-of-Care Decision Supporting Tools and Guidelines in Korea. Those projects are now on progress and are expected to be presented the results on our Fall Academic Conference on September 23-24, in Jeonju City.

Regarding education activities, KAPR held a Spring Academic Conference on “Evaluation of Psychosocial Rehabilitation” in Seoul, on Mar 18th-19th. Over 300 KAPR members and mental health professionals participated in the conference.

Also, under the KAPR’ sponsorship, 2011 Family Link Basic Training Course was held at 16 sites in mental hospital and community mental health centers across the nation. Family Link is a psychoeducation program for families of mentally ill people, which was organized by Yongin WHO Collaborating Center for Psychosocial Rehabilitation and Community Mental Health since 2004. Through this program, many family members could acquire general knowledge of mental illness and the role of family. Also, they got empowered as they shared their stories and found a way to improve and manage their lives. Family Link program is a step by step education program; once family member successfully complete the Basic
Training Course, he or she is eligible to apply to the next lever, which is called a Local Intensive Course. Someone who fully participated in the Local Intensive Course, she/he can attend the Central Intensive Course. KAPR held the Central Intensive Course every year. During this Central Intensive Course, Family Link coordinators, which are consisted of psychiatrist and social worker, and family lecturers appointed qualified family lecturer who will teach knowledge and share their stories to other families of mentally ill people. Nowadays, there are 67 family lecturers in South Korea. They are working actively as family lecturers as well as facilitators of self-help support groups.

To enhance and protect mental health in the daily lives of individuals, families, groups, and communities, KAPR participated in the Mental Health Advocacy campaign during Mental Health Week from April 4th - 10th, 2011 in Seoul. During this campaign, KAPR disseminated general mental health information, had counseling for the citizen, and exhibited movie posters related with mental health problems to reduce the stigma associated with mental health issues. Also KAPR launched a slogan contest to reduce stigma against mental illness, and winners of this contest got award for their great ideas and contribution. The followings are awarded slogan for the contests: “The human rights of people with mental illness is not different from mine”, “The human rights of people with mental illness must be protected and promoted, just be considered is not enough”, “Ensuring the human rights of people with mental disability is the standard of mature society”.

Most recently, KAPR boards and committee members held 2nd meeting to evaluate current activities and plan for the second half of this year. We have a plan for Fall Academic Conference on “Developing Strategies for Psychosocial Rehabilitation Program” September 23-24 in Jeonju City. In addition, to encourage anti-stigma campaign, KAPR will produce and distribute video-based educational programs and related materials.

For more information, please visit our website at http://www.kapr.or.kr
Upcoming Events

WAPR Regional Congress, Athens 2012

The Greek Ministry of Health has accepted the proposal to fund the Regional WAPR congress in Athens during the April of 2012. This international congress will further promote the upcoming Milan WAPR congress and will play a major role in increasing the visibility of WAPR in Psychosocial Rehabilitation and other fields in Community Psychiatry. Professionals from the International Mental Health Collaborating Network will also participate along with WHO and WAPR professionals. There will be a specific round table for South Eastern European Countries enhancing the WAPR support for these areas.

KEY TOPICS

- Advances in drug treatments
- Caregivers support
- Cross-cultural issues
- Early detection and intervention
- Empowerment
- Epidemiological and ecological studies
- Evidence-based psychosocial interventions
- Funding of mental health care
- Good practices and practice guidelines
- Housing
- Human rights
- Integration of pharmacological and psychosocial interventions
- Media and communication strategies
- Mental health care in low resource settings
- Mental health services research
- Non-professional care
- Political social and cultural context of mental health care
- Psychosocial rehabilitation in primary care
- Psychosocial rehabilitation of offenders
- Rehabilitation and psychotherapy
- Recovery and resilience
- Residential care
- Role of non-governmental organizations
- Self-help and user-run services
- Social determinants of mental disorders
- Social inclusion
- Stakeholders, partnerships and social networks
- Stigma
- UN Convention of rights of people with disabilities
- User involvement in research
- WHO Classification of Functioning Disability and Health
- Work and employment
WAPR Bulletin

WAPR www.wapr.net is registered as a non-profit organization in France and Italy; it is recognized as a charity in Madras (India) and Edinburgh (Scotland, U.K.), registered as a voluntary, non-profit organization in New York State (U.S.A.). WAPR has a constitution approved at Vienne in 1986, amended at Barcelona in 1989, at Montreal in 1991, and at Dublin in 1993. WAPR is not responsible for the personal opinions written and subscribed by the authors of the articles.

WAPR HEAD OFFICE
Medical Center Manila Rm 318, 1122 Gral Luna St. Hermita, Manila, Philippines.
Tel/Fax + 63 2 525 1767    wapr_phil07@yahoo.com

EDITORIAL COMMITTEE (COMITÉ EDITORIAL)
Editorial Council (Consejo Editor)
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Edited in Yongin Mental Hospital WHO Collaborating Center for Psychosocial Rehabilitation and Community Mental Health.
4 Sangha-Dong, Giheung-Gu, Yongin City, Gyeonggi Province, Korea 449-769.
Tel. +82 31 288 0233    Fax. +82 31 288 0363    yonginwhocc@empal.com