EPA CONGRESS NEWS

The official daily newsletter of the 20th European Congress of Psychiatry **Monday** 5 March 2012 **Day 3**

Inside today

Welcome to a new era in European psychiatry

Welcome to the third day of the 20th European Congress of Psychiatry. As with the first two days, this high-level psychiatric congress will unite, under the theme 'Beyond Diversity, Towards Harmony', a diverse groups of specialists from a wide range of countries and cultures to explore all the important aspects of psychiatric and neuropsychiatric diagnosis, research and treatment through a wide-ranging and comprehensive scientific programme, as well as offer an opportunity to share experiences and network.

As ever, the EPA 2012 scientific programme delivers a rich mix of symposia, debates, state-of-the-art sessions, workshops and update sessions, as well as the Early Career Psychiatrists' Programme, all of which underlines the commitment of the European Psychiatric Association (EPA) to furthering clinical practice, scientific understanding and knowledge-sharing in an open and engaging environment.

Highlights of the EPA 2012 programme over the next two days include, among many others, an examination of the latest results from the groundbreaking EU Consortium MOODINFLAME, a timely and important series of presentations on the size and burden of mental disorders in Europe and the associated implications, a fascinating debate over whether the concept of mental health is, itself, misleading, an in-depth discussion as to whether early intervention in psychiatry is a valuable waste of resources, an examination of recent challenges in the treatment of depression and a symposium on the challenges of maintaining reliability in psychiatric clinical trials.

However, there is much more to this year's congress. Not only does EPA 2012 represent an opportunity for attendees to immerse themselves in the latest research findings in mental illness, as well as the most innovative approaches to its management, but also to participate in the next stage of European psychiatry, as we move towards a new era in standardisation of care and a unified approach to policy making.

The main goal of this year's congress is the definition of a new EPA, the main objectives of which are for it to be identified as the sole European organisation for general psychiatry, which translates into a strengthening of the influence of psychiatrists in Europe, and to address the major issues related to psychiatric practice in Europe. This development, which will be reinforced by changes to the EPA statutes, is very important because it is the current policy of the European Commission for each speciality to be identified by one body, responsible for its own area. This has already been achieved with some societies for any matters related to the definition of standards of practice. Our goal is to do the same for psychiatry, and to have the EPA as the reference organisation for general psychiatry in Europe.

Patrice Boyer speaking at the Opening Ceremony

In order to be able to address the major issues related to psychiatric practice in Europe, we need to be as efficient as possible when dealing either with the European commissions or the European Parliament. This goal has been occupying our thoughts for the past few years, and it is clear that there is only one way to achieve it: to have closer links and relationships with national psychiatric associations, and even to ask their representatives to constitute a full council inside the EPA in order to benefit from their advices and their expertise. In this way, national psychiatric associations will be a part of the EPA, and the EPA will be able to speak with one sole voice for psychiatry in Europe.

We hope that you enjoy the next two days of EPA 2012, and we look forward to seeing you again in 2013.

Patrice Boyer
President of the European Psychiatric Association

Attendees at the Opening Ceremony

Programme

Monday 5 March

08:00-09:30

Hall A

Innovative and more efficient management systems for co-morbid diabetes and depression
Prof. Norman Sartorius Geneva, Switzerland

Hall B

Developing the ICD-11 Classification of Mental and Behavioural Disorders: Progress and Prospects
Prof. Wolfgang Gaebel Duesseldorf, Germany
Dr. Geoffrey Reed Geneva, Switzerland

Hall C

Social adversities and genetic volnurability in first episode psychoses *Dr. Craig Morgan* London, UK
Prof Domenico Berardi Bologna, Italy

Hall D

ePoster Session - Bipolar Spectrum and Related Disorders *Pavel Mohr* Czech Republic

Hall E

EPA Workshop on Training in Ethics
Prof Danuta Wasserman Stockholm, Sweden
Prof. Silvana Galderisi Naples, Italy

Hall F

Similarities and differences in evidence-based psychotherapies of Borderline Personality Disorder (Section Symposium) *Klaus Lieb* Mainz, Germany
Prof Stephan Doering Vienna, Austria

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EPA CONGRESS NEWS

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Live from EPA 2012

Hearing both sides of the argument in polypharmacy

Hans-Juergen Möller

Sunday morning saw the first of the Pro and Con Debates at EPA 2012, when two leading experts took oposing views in the question as to whether polypharmacy is necessary in psychiatry.

Hans-Juergen Möller (Munich, Germany) presented the argument for polypharmacy in this fascinating and highly relevant session, while Stefan Leucht (Munich, Germany) took the Con stance in front of a packed audience in Hall B.

Professor Möller began by emphasising that, while serious and important issues will be discussed during the debate, the very nature of a Pro and Con discussion mean that it should be "a game, where we find arguments on 'this side' and present them in probably a very extreme way, and then we find arguments on the 'other side', and at the end we probably find a consensus in the middle".

He added: "From my viewpoint, there is a need to find this consensus. It's not right to say polypharmacy, and of course I include comedications, is sometimes necessary. Without any doubt, its not only a bad medium for doctors who are not well trained or not very experienced. There are some good, rationale reasons for polypharmacy."

The reasons that drive clinicians to comedication/polypharmacy, Professor Möller stated, include delayed onset of drug action, limited drug efficacy, insufficient response in terms of remission or special syndromes with a complex symptomatology, non-response/treatment resistance, irrational expectations of treatment outcome, comorbidity and the use of drugs as an 'antidote' against side effects.

"There are a lot unmet needs in treating mental disorders," session chair István Bitter (Semmelweis University, Budapest, Hungary) commented to EPA Congress News in advance of the debate. Noting delay of onset of therapeutic action as a "major problem", Professor Bitter raised raised the issue of the adverse effects of drugs, which may be subjectively disturbing and/or objectively disturbing.

"What is surprising when you look at the two arguments is that, basically, both presenters – Professor Moeller and Professor Leucht – agree that, in cases of treatment-resistant patients, we do need polypharmacy, in spite of the fact that we are lacking evidence," Professor Bitter continued. "And when you look at prescription practices, especially in the case of schizophrenia, a significant proportion of patients are receiving polypharmacy."

He added: "The level of polypharmacy is quite different in different regions of the world and different countries, but usually about half or even more than half of patients with schizophrenia may receive more than one antipsychotic. In cases where polypharmacy is low, it is still one-quarter to one-third of patients, and that might go up to two-thirds in some regions or hospitals or outpatient practices."

Summarising Professor Leucht's points, Professor Bitter said: "What he was saying is that using polypharmacy would increase a number of problems, and number one

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is the side effects, in that we can expect more side effects in cases of polypharmacy than when using a single drug. Another problem is that drug interactions may change the drug plasma levels.

"In some cases, the interactions might actually decrease the plasma level of one drug, relative to another drug, and lower the efficacy of that drug. This is due to changes in metabolism of the drugs, so the second drug may increase the metabolism of the first drug and vice versa."

Professor Bitter added: "Then an additional point which he raised is that we know very little about the detailed mechanism of those drugs, so we cannot be sure what is happening – the exact mechanism of combining several drugs on the brain it is not clear and this might be an issue that we have to be very careful about.

"Considering the future – because for one of the current questions we have an excellent example in the field of epilepsy – some of the combinations have been tested very, very carefully in double blind randomised studies and some of those were found to be efficacious and safe. Some of these combinations gained a license, and they are included in the summary of the product characteristics, or 'the label'. So now these combinations are recognised, supported by the regulatory agency, and both prescribers and the patients know the advantages and disadvantages of those combinations.

"I think that would be one way to go that would limit tremendously untested combinations, which carry a pretty high risk because each doctor can try a different combination, different dosages of different drugs and they may find which combinations might be useful in cases of resistance. Actually, some studies have already been done, most of them, for example, in the field of schizophrenia with clozapine. Some drugs were added to clozapine and it was found that some combinations might be useful. They do not decrease its efficacy, but might decrease the side effects, and some combinations were found to be more efficacious than the single drugs alone."

Offering a final point, Professor Bitter said: "Certainly we could avoid polypharmacy if we more often used therapeutic drug monitoring like blood levels, because a number of patients actually have very low blood levels or they do not take the drugs, and their doctors just add a second medication without checking whether the patient has a proper plasma level from the single drug that was prescribed earlier."

One area of debate featuring at EPA 2012 is that of early intervention in schizophrenia (see page 16). Does Professor Bitter think that polypharmacy in schizophrenia would be reduced if there was more focus on early intervention, or is it an inevitable part of treating schizophrenia once it reaches a certain point? "Well, I do not believe that polypharmacy should be indicated as part of the early intervention," he replied.

"That is especially in case if the diagnosis is questionable. I would even question the usage of an antipsychotic, so it is still a big debate. Actually, antipsychotics are licensed and indicated for the treatment of schizophrenia or other psychotic disorders that fulfil the diagnostic criteria that were defined in ICD 10 or DSM-IV.

"The problem is, as you addressed it: What happens once some people are beyond early intervention and they do not respond to a single drug? Will we change, let's say, from one drug to the second, from the second to the third, and then to the tenth or eleventh drug, with less and less hope that the patient would respond? Or, after some trial, do we try an add-on strategy, or a combination? However, as most researchers point out, there is still under-utilisation of clozapine in most parts of the world, which might be useful as a single drug and help in avoiding unnecessary polypharmacy."

That raises the question of the application of recognised standards of treatment. Does Professor Bitter feel it is possible to achieve consistent standards of treatment across different regions, or even across Europe? He said: "I think it would be extremely difficult to apply the same standards all over the world for a number of reasons: one is the huge cultural differences; and the second is that treatment delivery is quite different for both cultural and financial reasons.

Stefan Leucht and István Bitter

"When you look at a developing country or a low–medium-income country or a high-income country, then certainly the possibilities for delivering care are quite different. Then the usage of some formulations might be different in different regions and patients may not accept, for example, depot preparations in one part of the world as easily as in other parts of the world.

"So I think that just to say 'this is the standard' may not be realistic, because some countries may not be able to cover the cost of an extremely high level, high standard protocol and other countries may say: 'Well, this protocol does not satisfy the needs of our customers.' Then, in some countries, state insurance would cover the costs; in other countries, it would be private insurance or a combination thereof."

He added: "Unfortunately, we hear more and more about the impact of budgets, and they do not seem to be increasing for the care of psychiatric patients in most countries."

Returning to the notion of diagnostic criteria, ICD 11 and DSM-V are on the horizon. What impact does Professor Bitter think they are going to have on diagnosis and management? He replied: "I would like to mention a major concern that has been discussed already within the psychopharmacology section of the EPA for two years, and we keep discussing it: The criteria for a number of major disorders will be changed."

He asked: What is going to happen to the labels, to the summary of product characteristics? Drugs are licensed for a diagnosis. But antipsychotics are not being used anymore like they were 30 or 40 years ago. If we can use them against psychotic symptoms, they have to be separately licensed for schizophrenia, for psychosis in bipolar disorder or for psychosis in the elderly, or whatever. Once they change the diagnostic criteria, what is going to happen?

"Let's say that we change the diagnostic criteria of schizophrenia, then how will we use the drugs that are being licensed today for schizophrenia? Will they be automatically used for DSM-V-based schizophrenia, as we use them for DSM-IV-based schizophrenia? Or do they have to be re-licensed? It is unrealistic that all the studies will be rerun. I do not believe it's realistic that even the statistics can be rerun, because most of the companies that developed these drugs have lost patent protection.

"I think they may face major issues in the pharmacologic treatment of a number of disorders once the new criteria come out. And if off-label prescription will be strictly controlled, as it is now, then a number of patients may not get appropriate treatment, I am afraid."

Continued from page 2

Hall G

New aspects on roles of antidepressants and antiinflammatory agents: Latest results from EU Consortium MOODINFLAME

Dr. Norbert Mueller Munich, Germany
Mrs. Veerle Bergink Rotterdam, The Netherlands

Hall H

Writing, publishing, reviewing and reading a clinical scientific paper (Part I)

Povl Munk-Jørgensen Denmark

Hall I

Taking care of ourselves: Managing stress, preventing burnout *Prof Wulf Rössler* Zurich, Switzerland

Hall J

Free Communications - Biological Psychiatry

Room 220

ePoster Session - Basic and Applied Research of Schizophrenia

Daniela Řípová Prague, Czech Republic

9:30 **Coffee Break, Viewing Posters & Visiting the Exhibition**

10:00-11:30

Hall A

Pro and Con Debate: The concept of Mental Health is Misleading *Prof. Norman Sartorius* Geneva, Switzerland

Hall B

New horizons in neuropsychopharmacology: Updates on two key ECNP initiatives - Joint Symposium with ECNP

Joseph Zohar Israel
Patrice Boyer France

Hall C

Social cognition in schizophrenia: From neurobiological correlates to treatment

Wolfgang Wölwer Duesseldorf, Germany
Dr. Eric Brunet-Gouet Versailles, France

Hall D

Psychiatric Emergency: urgent treatments and hospitalization(Section Symposium)

Prof Piermaria Furlan Orbassano, Italy
Prof. Cornelis Mulder Rotterdam, The Netherlands

Hall E

ePoster Session - Depression Spectrum and Post-Traumatic Stress Disorder

TBC

Hall F

Complex therapy of schizophrenia – Accepted with modification

A/Prof. Jan Prasko Olomouc, Czech Republic
Dr. Jan Pecenak Bratislava, Slovak Republic

Hall G

Pathogenesis of mood disorders and suicidal behaviour *Prof. Peter Pregelj* Ljubljana, Slovenia
Dr. Mark Agius Cambridge, UK

Hall H

Writing, publishing, reviewing and reading a clinical scientific paper (Part I)(cont.)

Povl Munk-Jørgensen Denmark

Hall I

Taking care of ourselves: Managing stress, preventing burnout (cont.) *Prof Wulf Rössler* Zurich, Switzerland

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Live from EPA 2012

‘Prolong rather than switch antidepressant treatment’

Prolonging the duration of treatment with one antidepressant mechanism of action is more beneficial than the common practice of switching drug class, delegates were told yesterday in a session on recent developments in treatment-resistant depression (TRD).

The findings, presented by Siegfried Kasper (Medical University of Vienna, Austria), from the ongoing multi-centre project ‘Patterns of treatment resistance and switching strategies in affective disorder’, challenge notions in medical textbooks advocating switching as the preferred practice in cases of non-response.

“Changing from a serotonergic to a noradrenergic mechanism of action, or vice versa, has limited benefit,” Dr Kasper told *EPA Congress News*. “We found that dosage needs to be increased as well as duration of treatment with the same mechanism of action,” he pointed out. These conclusions have triggered a revision of the 2002 EMA (European Medicines Agency) criteria. The current EMA 2011 guidelines report that switching classes is not beneficial.

Drug and class switching patterns were analysed both prospectively and retrospectively. In the retrospective analysis, of the 340 patients that failed to respond to the first antidepressant, 59 were classified as within-class switched and 281 were classified as across-class switched. In all, 41.18% were responders to a following treatment, and 58.82% were non-responders. Remission was achieved by 14.14% of patients, while 85.59% failed to achieve remission. No significant difference between across-class and within-class switching groups was found in response or remission rate.

In the prospective study, 189 patients who failed to respond to a previous antidepressant and scored 17 or more on the 17-item Hamilton Depression Rating scale (HAM-D), were randomised to receive either citalopram or desipramine for a period of four weeks. Non-responders to these treatments were treated for a further four-week period with either the same antidepressant or switched to the alternative antidepressant with a different mechanism of action (citalopram-desipramin and desipramin-citalopram).

Notably, Professor Kasper and his colleagues found that switching treatments from one antidepressant class to another did not improve response compared with staying on the same antidepressant, but actually produced a significantly worse outcome on the HAM-D score.

Run by the Group for the Study of Resistant Depression (GSRD), which consists of eight European centres in Belgium, France, Greece, Italy, Israel and Austria, the project has also developed a staging model to sub-categorise resistant depression and provide clinical and genetic characterisation of treatment-resistant depression.

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Siegfried Kasper

Resistant or non-resistant status was assigned to patients based on data collected on the outcome of antidepressant treatments received during the last episode of major depressive disorder.

“We have collected clinical and biological data from over 1000 patients,” said Professor Kasper. “We have also carried out a number of research protocols with psychopharmacology, and based on this, we

> *“TRD is a big challenge in the management of depression and we need to define resistance very carefully. In the past, all patients that failed to respond were classified as treatment resistant. Nowadays, we have clear distinctions based on data for those who fail to respond.”*
>
> *Siegfried Kasper (Medical University of Vienna, Austria)*

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have interesting results."

The staging exercise produced the following categories: 'insufficient response' (patients who fail to respond to one form of treatment, administered for 6–8 weeks); 'treatment resistant depression' (patients that fail to respond to two or more adequate antidepressant trials of different classes); 'treatment refractory depression' (patients who have failed to respond to at least three treatments including electroconvulsive therapy); and 'chronic resistant depression' (CRD, patients being treated with several antidepressants for more than 12 months).

Professor Kasper pointed out: "It is important we have these distinctions because, when we communicate with clinicians or conduct trials, we can ensure that we are talking about the same subgroup of patients."

He added: "TRD is a big challenge in the management of depression and we need to define resistance very carefully. In the past, all patients that failed to respond were classified as treatment resistant. Nowadays, we have clear distinctions based on data for those who fail to respond."

Regarding the primary findings of clinical variables associated with treatment resistance, the group identified four factors as the most discriminative variables associated with TRD: comorbid anxiety disorder (in particular comorbid panic disorder and social phobia), current suicidal risk, melancholic features and nonresponse to the first antidepressant treatment lifetime.

Professor Kasper then moved the discussion on to the project's gene studies, which comprise the largest range to date of candidate gene studies investigating associations with treatment response. With the ongoing research of the GSRD, the current findings hold promise for understanding disease mechanisms and providing a tool for clinical practice.

Significant associations with major depression were found for three COMT SNPs, and another SNP was associated with antidepressant treatment response. Furthermore, drawing on the reported associations between genetic vulnerability to suicidal behaviour and COMT, Professor Kasper and his colleagues further elucidated the impact of COMT on suicidal behaviour in TRD patients, finding a significant single marker and haplotypic association with suicide risk in patients not responding to antidepressant treatment, an association that was not observed in responders.

> *"In future, we might not blame the antidepressant for suicide, but clinicians might note that particular patients in the treatment-resistant group with this variant potentially have a higher risk of suicidality and may need extra care."*
>
> *Siegfried Kasper (Medical University of Vienna, Austria)*

Professor Kasper acknowledged that the genetic findings were important but that further, larger studies were required to confirm or refute the GSRD results. "We collected genetic variables related to the serotonin transporter polymorphism and the COMT gene. We hope these biomarkers will provide some indicators. However, our current studies are not designed to answer this question because our patients were not pre-defined according to genetic marker."

"We found that one specific genetic variable might be associated with suicidality in this group," he continued. "In future, we might not blame the antidepressant for suicide, but clinicians might note that particular patients in the treatment resistant group with this variant potentially have a higher risk of suicidality and may need extra care."

In his conclusion, Professor Kasper asked the audience to stay tuned because the GSRD was an ongoing project with further insights expected in the near future.

EPA Guidance Project

Guiding psychiatry to improved quality and outcomes

Balancing the differing priorities of optimising the diagnosis and management of psychiatric disorders and working with available resources to meet healthcare policy demands, whilst promoting the standardisation of practice across Europe, is one of the key missions of the EPA.

To this end, the EPA has initiated a Guidance Project, which has been formulated 'to improve quality of mental health care in Europe by disseminating written information based on best evidence and psychiatric practice', as well as facilitate learning between countries. The objectives of the Project are: to provide information on good clinical practice, using problem solving examples, guidelines, and quality standards of care to European practitioners, national societies and health authorities, and; to address health care gaps and give advice on developing respective research questions.[1]

The Project was first agreed upon in 2008, at the 16th European Congress of Psychiatry in Nice, France, after which a questionnaire was sent out to national psychiatric associations to ask for proposed topics, the preferred methodology of guidance development, the suggested format and whether the association would like to participate. From the findings, a clear ranking of proposed topics emerged: quality of service structures; clinical experience; suicide attempts/behaviours; ethical and legal issues; prevention; forensic issues; and conflicts of interest. Once the methodological approach of a systematic literature search plus reviews by the Steering Group, the EPA Board and the EPA Executive Committee, the first six guidance documents were prepared and published.[1]

The published guidelines focus on the prevention of mental disorders, the quality of mental health services, conflicts of interest, strategies for health promotion, the value of antidepressants in the treatment of unipolar depression and suicide treatment and prevention.[2-7]

All six guidance papers were published in February 2012 in a dedicated issue of the journal European Psychiatry, and the remain topics to be covered will be prepared and published in a second series.

As Wolfgang Gaebel (Heinrich-Heine-University, Duesseldorf, Germany) and (Ludwig- Maximilians-University Munich, Germany) say in their introduction to the issue: "It is hoped…that these guidance documents will contribute – along the lines of the EPA guidance project's mission and objectives – to improving the practice of psychiatry in Europe to the best of those who are in need of professional help and support."[1]

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6. Moller HJ, Bitter I, Bobes J, et al. Position statement of the European Psychiatric Association (EPA) on the value of antidepressants in the treatment of unipolar depression. Eur Psychiatry 2012;27:114-28.
7. Wasserman D, Rihmer Z, Rujescu D, et al. The European Psychiatric Association (EPA) guidance on suicide treatment and prevention. Eur Psychiatry 2012;27:129-41.

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Hall J

Publications in psychiatry and the role of the European Psychiatry journal

Conversation with Prof. Philip Gorwood

Olivier Andlauer France
Dr. Olga Paravaya Minsk, Belarus

Room 220

ePoster Session - Specific Challanges in Psychiatry

Eva Češková Prague, Czech Republic

11:30 **Short Break**

11:45-12:30

Hall B

Genetics of ADHD *David Ben-Dor* Israel

12:30 **Lunch Break, Viewing Posters & Visiting the Exhibition**

13:15-14:45

Hall A

Satellite Symposium sponsored by LUNDBECK

Reduction of alcohol consumption - a new treatment paradigm in alcohol dependence

Hall B

Satellite Symposium sponsored by SERVIER

Challenges in the treatment of depression: the circadian approach

Koen Demyttenaere Leuven, Belgium
Frédéric Rouillon Paris, France

Hall F

Satellite Symposium sponsored by ASTRAZENECA

Evidence and expectations in the treatment of bipolar depression and major depressive disorder

Guy Goodwin Oxford, UK

14:45 **Short Break**

15:00-16:30

Hall A

Section Symposium

Intersection Symposium of the EPA Section on Child and Adolescent Psychiatry and the EPA Section on Suicidology and Suicide Prevention

Prof Danuta Wasserman Stockholm, Sweden
Prof Gil Zalsman Tel Aviv, Israel

Hall B

(15:00-15:45) Understanding and Treating Depression

Prof. Jules Angst Zurich, Switzerland

(15:45-16:30) Update on pathophysiology of Schizophrenia *Jiri Horáček* Czech Republic

Hall C

Mental Health Care across Europe (Part I)

Patrice Boyer France
Prof. Mariano Bassi Milan, Italy

Hall D

Management of Resistant Psychosis

Dr. Fiona P Gaughran London, UK
Prof Peter F Buckley Augusta, USA

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Live from EPA 2012

Collaborate, integrate and lobby to drive research forward

Collaborate, integrate and avoid isolation at all costs if you want to get ahead in research, the President of the European Psychiatric Association (EPA) told attendees during the round-table discussion 'Research in psychiatry today: how to do and what to do'.

He drove home the message that, if early career researchers wanted to get a head start in research, they had to see themselves as a team player, with something advantageous to bring to the research group. He focused on the strength of networking that had developed significantly in recent years.

"Over the past 20 years, the way we conduct research in Europe has changed dramatically," remarked professor Patrice Boyer, professor of clinical neurosciences psychopathology and psychiatry at the Université Paris Diderot – Paris 7, France, and professor of psychiatry at the University of Ottawa, Ontario, Canada. "Even if you belong to a reasonably sized research team you cannot work on your own but you need to integrate with a research network," he added

Appealing to the early career research psychiatrists gathered, he advised that the onus was on the individual to plan and integrate into existing networks before striking out alone.

Professor Boyer added: "The best way to do research now is to be responsible for a work package inside a schematic network. The network comes first. It is a help to be able to bring something advantageous to the research network, for example, an asset or technique to offer. Avoid duplicating research already being conducted elsewhere."

He explained that a young researcher might offer to help with a specific aspect of the research project. "When you are very junior you need to participate in a project that is ongoing rather than try and start something new." People are always overwhelmed by the amount of work, so they are always very happy to have somebody help with the analysis, for example."

> *"The best way to do research now is to be responsible for a work package inside a schematic network. The network comes first. It is a help to be able to bring something advantageous to the research network [and] Avoid duplicating research already being conducted elsewhere."*
>
> *Patrice Boyer (Université Paris Diderot – Paris 7, France)*

Europe already has many networks, such as in the field of schizophrenia or obsessive compulsive disorder, but Professor Boyer pointed out that they are often in competition. This is unfortunate, he explained, because, ideally, these networks needed to draw on each others' strengths.

A Google search will uncover these networks, or alternatively, details of many networks can be found on the websites of various European societies, for example those of EPA, the European College of Neuropsyhopharmacology, the Society for Neuroscience, or alternatively on the website of the main national psychiatric associations. There are others that adopt a less formal status but are easily accessible through their websites (see below).

These websites are an essential source of information for the young researcher, Professor Boyer emphasised. "You need a clear understanding of the research activities of a network," he said. "Contact each network's leading person directly, find out exactly what is required for an application in terms of CV, and summary of your achievements and, importantly, identify which part of the network is most appropriate to you and pinpoint what you can bring to that particular team."

The problem for an unknown researcher is the Catch

Live from EPA 2012

22 nature of entering the research environment. "Researchers need to generate a good reputation with good studies and data to be recognised before they can successfully integrate into a network," Professor Boyer pointed out.

However, he added, there was a way around this. He advised less experienced researchers to contact an expert in the desired field of research activity in their own university or a university in their home country. He said: "The key word form the beginning is 'collaboration', and to avoid isolation. This is the main problem for most young researchers: they think they can research alone, conduct a small study and publish, and obtain a reputation. This is a waste of time."

He agreed that this should happen automatically if the post-graduate already works in good laboratory. However, many researchers are less fortunate. "If you are an independent psychiatrist in a small university, you may find yourself too isolated to recruit enough patients. You cannot succeed if isolated," added Professor Boyer."

"If this is the case, approach another group in your country, offer to help, to analyse, to create a questionnaire, to test a technique. Then publish with them."

"Collaborate from the very beginning. Be a hand in a larger team with which you can collect data and offer to analyse a subset of that data. Publish with that team, after which you can propose your candidature for a larger project. It is a stepwise procedure."

According to Professor Boyer, the most important practical steps for an early career researcher are: 1) to identify and research the network you wish to work with using your existing contacts and websites; 2) to contact the relevant, leading people and tell them about your specific research interest, defining a precise domain; 3) to articulate both qualitatively and quantitatively your local capacity, and means to conduct the research in a feasible way that can be delivered; and 4) to identify what you can offer the team; for example, analysis of a data subset or provide patient recruitment

He summarised: "All of the above need to be stated clearly and before submitting any proposal. Overall, collaborate, integrate, analyse a subset of data, publish and then progressively build a reputation before applying to other networks."

Patrice Boyer

In addition to money for research itself, which often runs to millions of Euros, many networks now ring-fence funds to help researchers meet the costs of attending conferences, where they can make the all-essential contacts to drive their careers forwards.

Finally, Professor Boyer turned the discussion to fashionable trends for research funding, and how it is a fallacy to believe that political and societal agendas do not influence funding decisions.

"It might seem odd to label scientific research as fashionable or not, but this is the case," he said. "For example, if your interest is pure biochemistry or psychopathology then it is, unfortunately, unlikely to receive much funding. But if it's neuroimaging, genetics, translational research, brain stimulation techniques or new therapeutic avenues, then there will be far more opportunities and networks available."

Professor Boyer explained that lobbying plays a significant role in determining which fields of psychiatry win the bulk of funds. "Recently, the study of conduct disorders in children and adolescents has received a lot of funding," he said. "In terms of therapeutic approach, very little had been done so far; as a consequence the European Commission decided to dedicate a lot of money to this through the Seventh Framework Programme [FP7]. There was a significant amount of funding and not so many people applying for it."

Professor Boyer advised researchers to understand which research areas are elicited by politicians as being research priorities. He said there was often a disconnection between what politicians and researchers considered to be important in mental health. Suicide for example, from a political and economic perspective, is an unbelievable burden for society. Research is ongoing, but there is insufficient lobbying to explain the funding priorities for research and therapeutic approaches.

Finally, further to collaboration and integration, Professor Boyer stressed the importance of lobbying to all researchers in psychiatry. "Generally, researchers are not lobbying enough or are insufficiently in touch with people who are responsible for political orientation of research issues. Undoubtedly, you have to campaign. It's a myth that you will be recognized and doing important things if you do not make it known," he concluded.

Professor Boyer's talk was given as part of the roundtable discussion: 'Research in psychiatry today-how to do and what to do', held on 4 March, 2012. 15.00-16.30. Other speakers at the session included: Domenico Giacco, Naples, Italy; Norman Sartorius, Geneva, Switzerland; Celso Arango, Madrid, Spain; and Alexander Nawka, Czech Republic.

Further reading
www.europsy.net/
cordis.europa.eu/fp7/home_en.html
www.sfn.org/
www.ecnp.eu/

Continued from page 6

Hall E

Free Communications - Childhood & Adolescent Disorders

Hall F

Neural mechanisms underlying psychiatric disorders: EEG-based imaging
Prof. Cyril Höschl Praha, Czech Republic
Prof. Silvana Galderisi Naples, Italy

Hall G

21st century approaches to psychiatric genetic research *Prof. Thomas Schulze* Göttingen, Germany
Prof. Pablo Gejman Evanston, USA

Hall H

Integrated Dual Disorder Treatment (IDDT) for patients with severe mental illness (SMI) and substance abuse
Prof Geert Dom Boechout, Belgium
Dr. Albert Dijkhuizen The Netherlands

Hall I

Section Symposium

Towards the Centennial of Karl Jaspers "General Psychopathology" *Giovanni Stanghelini* Italy
Prof Michael Musalek Vienna, Austria

Hall J

EECP Pro&Con Debate: Early intervention in psychiatry: a valuable waste of resources? *Sameer Jahuar* UK

Room 220

ePoster Session - Psychotic Disorders
Jan Libiger Czech Republic

16:30 **Coffee Break, Viewing Posters & Visiting the Exhibition**

17:00-18:30

Hall A

Practice of Psychopharmacology: To switch or to combine? (Section Symposium)
István Bitter Budapest, Hungary
Prof J. Bobes Oviedo Asturias, Spain

Hall B

"Food for thoughts" - the role of diet in psychiatric disorders and treatments
Prof. Philip Asherson London, UK
Janet Treasure UK

Hall C

Mental Health Care across Europe - Part II
Patrice Boyer France
Prof. Mariano Bassi Milan, Italy

Hall D

Section Symposium

Nature and Narratives of Time
Prof Michael Musalek Vienna, Austria
Dr. Pedro F C Varandas Lisbon, Portugal

Hall E

Free Communications - Cognitive Processes and Dementia

Hall F

Resilience to Psychopathology: Biological and Societal Determinants *Prof. Silvana Galderisi* Naples, Italy
Sophia Frangou London, UK

Continued on page 10

Child and Adolescent Psychiatry Training in Europe Hall E Tuesday **10:00**

Fostering a consistent approach to child and adolescent psychiatric training

The challenges of and opportunities for training in child and adolescent psychiatry in Europe will be explored in a special session on Tuesday morning that will not only focus on the current situation but also look to future possibilities.

The symposium, which will be driven in large part by the work of trainees themselves, will highlight that, although national and regional differences may necessitate different approaches to training, the aims of that training, and the application of clinical standards, can and should be the same across Europe.

Co-chairs Sue Bailey (Greater Manchester West Mental Health NHS Foundation Trust and President of the Royal College of Psychiatrists, UK) and Florian Riese (Psychiatric University Hospital Zurich, Switzerland) spoke to *EPA Congress News* to discuss the aims of the session, the application of child and adolescent psychiatry training in Europe and the wider implications of the research underpinning the presentations.

Professor Bailey began by summarising the current state of training in Europe. She said: "I think, overall, it's healthy, but it's very diverse across Europe. In some countries, it's recognised as a stand-alone specialty and, in others, it's part of the larger family of psychiatry.

She added: "Obviously, as with adult psychiatry, the concepts and thinking behind child psychiatry in the recent accession countries is somewhat different to that in the rest of Europe. So, at the moment, there is really a major task to develop common standards in training. Not that training will be the same everywhere because, for instance, I think in somewhere like Estonia, there may only be one or two child psychiatrists; so obviously it's got to be done differently. But we don't think that will stop us developing core standards and what we'd expect from all trainees. I think training is not without its difficulties, but I think we're definitely moving in the right direction."

Sue Bailey

Dr Riese agreed with Professor Bailey's assessment. "I think the principal challenges in the area are that there are several countries where there is no formalised, structured training in child and adolescent psychiatry at all," he said. "Also, what many people would consider important parts of child and adolescent psychiatry training do not exist in certain countries; for example, psychotherapy, which is an essential part of child and adolescent psychiatry training. So I think these are our major issues. Also, on harmonisation, child and adolescent psychiatry training in one country in Europe differs widely from child and adolescent psychiatry training in another country."

Dr Reise continued: "In some countries, it's part of postgraduate specialisation that first you train to be a general psychiatrist, then you specialise in child and adolescent psychiatry later on. In other countries, it's completely different, in that it's a separate track of specialisation.

"It's probably not necessary that we do it the same everywhere, but we should have some kind of minimal quality standards, that actually ensure that child and adolescent psychiatry is being done in a quality way everywhere."

Turning to Tuesday morning's session, Professor Bailey said: "What I'd like to emphasise is that the drivers to this are the trainees themselves. They've done an international survey to look at the similarities and the differences in training. They were a very active group within the European Psychiatric Trainees group, and they were very well represented on our UEMS [European Union of Medical Specialists] group, which is the European body for training and professional standards. So I think it is importance to emphasise that we're working very much in partnership with the trainees themselves."

Dr Reise explained that the wider aims of the symposium extend beyond training in isolation. He said: "Our symposium mainly focuses on the training aspect, but the purpose of training is not for itself, but for the purpose of

Child and Adolescent Psychiatry Training in Europe Hall E Tuesday 6 March **10:00–11:30**

improving mental healthcare in childhood and adolescence. Of course, that is the eventual hope in child and adolescent psychiatry: that, with interventions early in life, it can promote mental health in the long run, thereby maybe lowering the burden of disease overall.

"Of course, it would be nice to have long-term study designs, cohort studies of interventions that would start in an early age and then follow people throughout their lives in order to verify that argument. But, really, the main point of our symposium is the training aspect."

Florian Riese

Discussing aspects of the training initiatives currently underway, he continued: "I think one thing is, I would say, the grassroots aspect. The people speaking in the symposium and myself are organised via the EFPT, the European Federation of Psychiatric Trainees. That is the mother organisation of the national child and adolescent psychiatry training organisations.

"It's bottom-up training, such that people talk to each other under the umbrella of, for example, EFPT, and then see what is going on, why we don't get similarly well trained like colleagues in another country. I think this broadening of the perspective actually helps a lot. It helps trainees ask for more or for some kind of minimal quality standard.

"The other thing is that the EFPT also has representatives on the EUMS board, and we hope that, by coming top down, also to influence child and adolescent psychiatry training."

Both Professor Bailey and Dr Riese were agreed on the importance of putting child and adolescent psychiatry on the political agenda. Professor Bailey said: "It's quite difficult sometimes to get as strong a voice as we'd like in the commission and in the EU about the importance of child psychiatry. In fact, I've just done on a paper on it for the European Policy Journal, on wellbeing. There's still a little bit reluctance to recognise that children may have mental illness.

"I think one of the key things to get over to the congress is that two-thirds of mental disorders start before the age of 14, and most of patients have an onset before age 21. Therefore, there's a huge cost–benefit argument to say: 'If we got in early with health promotion and prevention, and early intervention, we could lessen the burden on adult psychiatric services.'"

Professor Bailey continued: "I think, in understanding the importance of child mental health and the lifelong disease burden of child mental illness, we've still got a long way to go compared with our adult colleagues. And I think one of the areas where we would like to work more closely with our adult colleagues is around transition in young people."

This, she emphasised, encompasses not just young people with mental illness, such as early onset psychosis, but also those with physical illnesses. She explained that there is a mental health component in a range of physical illness, and long-term physical conditions such as diabetes are becoming relatively common in childhood. "We'd like to do some specific work, for instance within the EPA, about developing better transitional services for children with mental illness, but also for the group that nobody wants to do anything with: children with emerging personality disorder," she said.

Why, in Professor Bailey's opinion is that an area that people are reluctant to focus on? "Because some people say it's not an illness," she replied. "So why are psychiatrists involved with it at all? Others don't want to label young people as having an emerging personality disorder, whereas children who have conduct disorder or difficulties do get quite good care in different countries.

"There isn't a natural place to send them to adult mental health, so what tends to happen is they get lost to services and then they reappear often as emergencies, often with substance misuse problems.

"I think there needs to be a whole think about how we to help people with not just mental illness, but people with personality disorder and substance misuse problems. I think there's going to be a good focus in Europe for that, which is very positive. Again, the EPA are involved and is doing emerging work on ICD 11, which is going to be very different from, and I think much better than, DSM-V."

One of the striking aspects of recent research into the progression of severe mental illness is that it is often accompanied by progressive brain changes, which might be characterised as almost 'hardwiring' the illness. Would Professor Bailey agree with that assessment? "It's nature and nuture," she replied. "The most amazing thing about this is that we know that there is a genetic vulnerability to some mental illnesses. We know that some things might go wrong whilst you're a foetus that are more likely to lead to one mental illness than another. We know that maltreatment and abuse will actually alter your brain. We know that, at the end of the day, there are common pathways. But I think the thing to remember is what Michael Rutter [Institute of Psychiatry, King's College London] would say to you, which is that the human brain up until mid-20s now has quite a lot of plasticity.

"Therefore, this is why, intuitively, interventions at this stage will work. There's still time to 'bring things back'. That whole area is really quite fascinating. Of course, the other thing that goes alongside that is what's bad for children is when they get lots of risk factors adding up. So, they have a genetic vulnerability and they've got very difficult social circumstances.

"That's the other thing I think that's different about child psychiatry from adult psychiatry, which is that we take a family focus and we work with all the other agencies sometimes in a much more holistic way. I'm president of the Royal College of Psychiatrists in the UK, and that's going to be my focus – working with families, as a family, across all parts of psychiatry."

Professor Bailey continued: "I am looking at resilience, because although the EU Commission are very keen on wellbeing, actually what this is about is resilience.

"There's now emerging evidence that resilience, which we all need, and recovery, which is the mainstay of adult mental illness, are actually very similar concepts when you deconstruct them. There's some very interesting research coming out from work in children and adults who withstand disasters on why some of them survive, literally survive, and some of them die, or why some of them develop post-traumatic stress disorder, and some of them don't.

"I would hope in the future the EPA would take resilience as a theme for one of their congresses. I put that challenge out to them."

> *"We'd like to do some specific work…about developing better transitional services for children with mental illness, but also for the group that nobody wants to do anything with: children with emerging personality disorder."*
>
> *Sue Bailey (Greater Manchester West Mental Health NHS Foundation Trust, UK)*

Professor Bailey and Dr Riese will co-chair the symposium 'Child and Adolescent Psychiatry Training in Europe: Challenges and Opportunities identified by the Child and Adolescent Trainee representatives of the European Federation of Psychiatric Trainees'

on Tues
Hall E.

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Hall G

Mental Health Promotion and Suicide Prevention through the Internet: The SUPREME Project
Dr. Vladimir Carli Stockholm, Sweden
Mr. Gergö Hadlaczky Stockholm, Sweden

Hall H

Integrated Dual Disorder Treatment (IDDT) for patients with severe mental illness (SMI) and substance abuse (cont.)
Dr. Albert Dijkhuizen The Netherlands
Prof Geert Dom Boechout, Belgium

Hall I

ePoster Session - Child and Adolescent Psychiatry
Michal Hrdlička Prague, Czech Republic

Hall J

State-of-the-Art: Forensic Psychiatry: from training needs to practice
Prof. Umberto Volpe Naples, Italy
Gregory Lydall

Room 220

ePoster Session - Aetiopathogenesis of Depression and its Management
Prof. Ladislav Hosak Hradec Kralove, Czech Republic

Tuesday 6 March

08:00-09:30

Hall B

The burden of migrants in a multicultural world
Dr. Hans-Jörg Assion Detmold, Germany
Prof Thomas Stompe Vienna, Austria

Hall C

Free Communications - LINKS BETWEEN PSYCHIATRY AND SOMATIC MEDICINE

Hall D

Section Symposium

Behavioral Addictions: gaming, gambling and beyond?
Prof Falk Kiefer Mannheim, Germany
Prof Michael Musalek Vienna, Austria

Hall E

ePoster Session - Gender and Metabolic Aspects in Psychiatry
Dr. Lucie Bankovska Motlova Prague, Czech Republic

Hall F

Recent challenges in the treatment of depression
Prof Konstantinos N Fountoulakis Thessaloniki, Greece
Prof. Per Bech Hillerod, Denmark

Hall G

Neurosurgery for mental disorders
Prof Sam Eljamel Dundee, UK
Prof Keith Mathews Dundee, UK

Hall H

Writing, publishing, reviewing and reading a clinical scientific paper (Part II)
Prof Christoph A Lauber Liverpool, UK

Hall I

The pharmacological management of mood disorders and psychosis in pregnancy and lactation
Dr. Angelika Wieck Manchester, UK

Hall J

ePoster Session - Memory, Cognition and Ageing
A/Prof. Ales Bartos Prague, Czech Republic

Continued on page 12

The concept of Mental Health is Misleading Hall A Monday **10:00-11.30**

'Brain disorders' not 'mental illness'

The argument that the term 'mental illness' labels patients for life and should be replaced with the term 'brain disorders' will be advanced by the President of the European Brain Council, Mary Baker MBE, on Monday during the pro-con debate: 'The concept of Mental Health is misleading'.

Matt Muijen, mental health expert at the World Health Organization's Danish office will present the case against the motion; Dolores Gauci will give the patient's point of view; and Norman Sartorius, President of the Association for the Improvement of Mental Health Programmes, Geneva, Switzerland, will chair the debate.

Speaking to *EPA Congress News* ahead of the debate, Dr Baker stressed that in today's society, mental illness carries an enormous stigma. She illustrated her point, saying: "If you interviewed two people for a job and both had been off work for a few months, but one said they'd had a skiing accident and the other said they'd had depression and a nervous breakdown, then there is a difference in your response to those situations."

She added that people with disorders of the brain or nervous system were more likely to experience discrimination and stigmatisation than people with, say, disorders of the heart and lung. "Chronic illnesses differ in their impact on people, including the differential impact resulting from the way friends, coworkers, and society-at-large react and respond to each illness," she said.

Core to Dr. Baker's argument is the fact that terminology has a major impact in the media and society. "I propose that the terms 'mental health' and 'mental illness' be abandoned in favour of 'brain health' and 'brain illness'," she stated.

Dr Baker explained that her point was not targeted at psychiatrists. She makes it abundantly clear she is a sociologist and not a clinician and that her eyes and ears are on how society reacts to mental illness. This, she said, intrigues her. "The reaction of society to mental illness is extremely harmful to patients; therefore, why don't they change the term."

"I believe very strongly that it's harmful to say brain disorders are not physical ailments but mental disorders. The world of mental illness would do better to call itself a representative of 'brain disorders'," she added.

Mary Baker

As a leading figure in advocacy for societal understanding of disorders of the brain, Dr Baker's history is admirable. She spent 18 years as Chief Executive of the Parkinson's Disease Society of the UK, and she is currently President of the European Brain Council, as well as immediate past President of the European Federation of Neurological Associations amongst other enviable titles. The European Brain Council brings together psychologists, psychiatrists, neurosurgeons, neuroscientists, neuropharmacologists, patient groups, industry, medical device companies and MEPs with an interest in the brain. Her key ambition is to make the term 'brain' better understood.

"Not medically – I don't want to give the message that 'brain' is more important than diabetes, or cancer or cardiovascular diseases, but I am trying to make the point that the brain is the organ that manages other illnesses, aids understanding of treatment and adherence to medication," she said. "This isn't rivalry, but the brain is the seat of executive function."

Regarding management of other illnesses, Dr. Baker pointed out that misleading terminology and its consequences can prevent people from seeking help from psychiatrists and neurologists. Insurance companies and access to information can discourage people from sourcing medical care.

She added: "We know from studies that

Pro and Con Debate: The concept of Mental Health is Misleading Hall A Monday 5 March **10:00-11.30**

diabetics are often depressed. Depressed people miss hospital appointments and their adherence to medication worsens. It's very hard to see the doctor and admit that one is depressed because in society depression carries with it a weight of other things."

Dr. Baker remarked that she thought mental illness was unscientific and a source of stigma. "Change needs to be driven by the patients, their groups, and society." Referring to the history of diseases she added that stigma had been around for many years. "Take tuberculosis and cancer. It used to be known as the 'C' word, nobody wanted to mention it. It's only by bringing this out into society and talking about it that we can we change it."

Dr Baker stressed that making these changes a reality was the real challenge, but the use of terminology that was free of negative connotation would be a crucial first step. She added: "Many patient groups refer to themselves as patients with mental illness. I refer to them as patients with neurological illness."

She remarked that legislation is required to effect change but that EU health systems were not integrated but separate. "Europe cannot therefore drive change through legislation. We need to woo society but, by pressing ahead with the term 'mental illness', we really don't make any progress," she said.

To emphasise her case, Dr. Baker illustrated her desire to see 'mental illness' regarded and treated as 'brain disorders' with a finding from a study she conducted in neurology clinics. She continued: "For Parkinson's, we found that the movement problems occupy 17% of a patient's quality of life, but 41% is linked to depression. In a consultation, a neurologist will say: 'You're not depressed are you? No (they provide the answer). Bowels alright? Sexual function OK? Now, let me see you walk.' Time is given to the movement aspect of the disease but everything else is dismissed because the one thing a neurologist can do about Parkinson's is help with walking. The patient's depression is not addressed."

> *"Change needs to be driven by the patients, their groups, and society. Take tuberculosis and cancer. It used to be known as the 'C' word, nobody wanted to mention it. It's only by bringing this out into society and talking about it that we can we change it."*
>
> *Mary Baker (European Brain Council, Brussels, Belgium)*

In contrast to Dr Baker's argument, Dolores Gauci, President of the Global Alliance of Mental Illness Advocacy Networks-Europe, Malta, says there is more to it than that, and that the brain functions on many levels.

"A psychiatrist friend described mental health as a computer where the brain is the hard drive and life experiences form the software," said Ms Gauci. "Neurology has an important place in understanding the brain, but the brain is affected by all that is happening around it. Research, in fact, is showing that life experiences such as trauma are having an impact on the composition of the brain as an organ. What makes us human is more than just the brain."

In summary, Ms. Gauci stressed that suggesting that the words 'mental health' and 'mental illness' should be encompassed into the brain and diseases of the brain was too simplistic and follows a medical model rather than the biopsychosocial–recovery model.

The debate: Pro and Con Debate: The concept of Mental Health is Misleading will take place on Monday 5 March, 10:00-11.30 am.

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9:30 **Coffee Break, Viewing Posters & Visiting the Exhibition**

10:00-11:30

Hall B

Pro and Con Debate: Haloperidol is the best ever
Jan Libiger Czech Republic

Hall C

Addictive Internet Use: Research on clinical aspects and risk factors *Dr. Klaus Woelfling* 55131, Germany
Dr. Oliver Bilke-Hentsch Frauenfeld, Switzerland

Hall D

Integration of different aspects of research in suicide prevention (Section Symposium)
Prof. Marco Sarchiapone Campobasso, Italy
Dr. Vladimir Carli Stockholm, Sweden

Hall E

Section Symposium

Child and Adolescent Psychiatry Training in Europe: Challenges and Opportunities identified by the Child and Adolescent Trainee representatives of the European Federation of Psychiatric Trainees
Prof. Sue Bailey Nottingham, UK
Dr. Florian Riese Zurich, Switzerland

Hall F

Innovative Health Care services for Immigrants (Section Symposium)
Dr. Iris T. Calliess Hannover, Germany
Dr. Meryam Schouler-Ocak Berlin, Germany

Hall G

Violent offenders: prevalence, diagnosis and treatment - Joint Symposium with the Czech Psychiatric Society
Prof. Cyril Höschl Praha, Czech Republic
Prof. Jiri Raboch Prague, Czech Republic

Hall H

Writing, publishing, reviewing and reading a clinical scientific paper (Part II) (cont.)
Prof Christoph A Lauber Liverpool, UK

Hall I

The pharmacological management of mood disorders and psychosis in pregnancy and lactation(cont.)
Dr. Angelika Wieck Manchester, UK

Hall J

EECP Symposium: Managing stress, inducing well-being and preventing burnout *Dr. Amit Malik* UK
Dr. Silvia Ferrari Modena, Italy

11:30 **Short Break**

11:45-12:30

Hall B

Individualized Therapy of Alcoholism
Prof Philip Gorwood Paris, France

12:30 **Lunch Break, viewing posters and visiting the exhibition**

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Results from the EU Consortium MOODINFLAME Hall G Monday **08:00–9.30**

Inflammatory markers point to

The latest results from an EU-wide research project, to be presented on Monday morning, promise to shed light on novel aspects of the use of antidepressants and anti-inflammatory agents in the treatment of mood disorders.

The symposium will highlight findings from the the EU Consortium MOODINFLAME, and *EPA Congress News* spoke to session co-chair Veerle Bergink (Erasmus MC, Rotterdam, The Netherlands) on the background to the project, and the implications of its findings for future mood disorder management.

She said: "The head of MOODINFLAME, Professor Drexhage [Erasmus MC, Rotterdam, The Netherlands], started this project because research has revealed more and more links between the activated immune system and mood disorders in general. For example, we do know that cytokines in blood are elevated in around half of the cases of major depressed or bipolar patients. We also know that patients with mood disorder suffer more from autoimmune diseases, and the other way around: patients with autoimmune disease often suffer from mood disorders.

Veerle Bergink

"So one of the aims of MOODINFLAME is whether we can identify inflammatory-related

Cimicoxib plus sertraline effective in severe depression

Cimicoxib, as an add-on therapy to sertraline, achieves superior remission rates in patients with severe depression to sertraline alone, results to be presented by Norbert Müller (Ludwig-Maximilians-University Munich, Germany) this morning will show.

Kicking off the day at 8am, the session – New aspects on roles of antidepressants and anti-inflammatory agents: Latest results from EU Consortium MOODINFLAME – will provide an opportunity to discuss different approaches to managing major depression related to inflammation. Professor Müller is both chairing and speaking at the session.

Speaking to *EPA Congress News*, he explained that inflammatory markers have been measured in depressed patients for nearly 20 years, and that there is evidence of an immune activation in at least one sub-group of depressed patients. "We are working with animal models of major depression, measuring cytokines and other inflammatory markers and also using different anti-inflammatory compounds, including COX-2 inhibitors," Professor Müller told *EPA Congress News*.

The presentation will look at some of the immunology behind the activity of COX-2 inhibitors in depression. Professor Müller will explain the role of COX-2 inhibition in restoring the balance between the type 1 and type 2 immune responses. "It does this by reducing prostaglandin E2 and modulating interleukin-10 [IL-10] production. It also may increase the in-vivo IL-12 production by antigen-presenting cells," he explained.

In the study to be presented today, cimicoxib's activity in major depression was investigated in a 6-week, double blind, randomised, placebo-controlled trial conducted by Professor Müller and his colleagues from the MOODINFLAME consortium. Cimicoxib is a selective COX-2 inhibitor and, in this investigation, it was added to sertraline therapy in 106 patients with major depression. Sertraline plus placebo was administered to the control group.

Cimicoxib is currently being developed by Affectis Pharmaceuticals (Germany) as a treatment for depression and schizophrenia, but was originally developed for dental pain. Cimicoxib is not the first COX-2 inhibitor to demonstrate activity in major depres-

Results from the EU Consortium MOODINFLAME Hall G Monday 5 March **08:00–9.30**

novel therapeutic approaches in mood disorders

markers for mood disorders and, secondary to this, of course, how you could use this in diagnostic and therapeutic approaches."

Have the results so far borne fruit in this regard? Dr Bergink explained: "Of course, this is not only the work of our group, but many groups in general, and it is important to know that there are both preclinical and mouse model groups, and also groups studying the microglia, which are cells in the brain. The clinical groups purely focus on the patients' care and analysing the patients' blood.

"I'm a psychiatrist, so I'm from the clinical groups. We have just ended patient inclusion, so what I can tell is only about some preliminary results in the first pilot groups because we have not, of course, analysed the whole data set yet."

Nevertheless, Dr Bergink was able to say: "We found signs of immune activation in the blood and the expression of inflammatory-related genes in monocytes. And we also found abnormalities in the serotonin metabolising pathway, which is also linked to immunity."

She added: "The immune changes were identifiable in subgroups of patients. So, probably psychiatric diseases like depression or bipolar disorder could be subdivided into those patients with changes in their immune system and those patients in which immune system changes do not play a clear role. Of course, we know that psychiatric diseases are really heterogeneous. In what we call, for example, depression, there are so many different types of depression, so I think in this way this research will also really be helpful."

This represents quite a different approach from some of the more traditional investigations into mood disorders. Does Dr Bergink think that the study could lead to changes not only in the way mental illness is treated, but in the way it is regarded in terms of policy-making? "Well, it depends," she replied. "Theoretically, of course, it could help to see psychiatric disease more as biological disease. But, among psychiatrists, we do not make this distinction anymore. Most psychiatrists agree that, for example, schizophrenia and bipolar disorder or autism are severe brain diseases.

"Let's put it this way: We do not need the proof of immune system involvement to consider these diseases as brain diseases. Of course, in general, it really helps. Every really concrete finding, whether it's in imaging or biomarkers, proteomics, or immune-related work – which are of course all interconnected – really helps to show differences between patients and to detect those patients who may benefit from medications that target their activated immune system.

"We will present evidence that such medications can be classical anti-depressants, that have immune suppressive effects, but also medications that are classical anti-inflammatory drugs, such as COX-2 inhibitors."

Moving onto the EPA 2012 programme in general, is there anything that Dr Bergink is looking forward to in particular at this year's meeting? "I'm a perinatal psychiatrist, so I would like to attend on the sessions on perinatal psychiatry and bipolar disorder, because bipolar disorder patients generally have problems during pregnancy and in the postpartum periods," she said.

New aspects on roles of anti-depressants and anti-inflammatory agents: Latest results from the EU Consortium MOODINFLAME will be held in Hall G at 08:00–9.30, Monday 5 March.

Norbert Müller

sion. Celecoxib (Celebrex, Pfizer), initially approved for the treatment of osteoarthritis and rheumatoid arthritis in the United States in 1998, has since demonstrated a statistically significant therapeutic effect on reducing depressive symptoms in a number of studies.

One randomised, double blind, pilot add-on study was conducted by Professor Müller. He said: "We found that celecoxib might have a better effect in depression because, with celecoxib, an effect was seen not only in severely depressed patients but in a group of unselected depressed patients. Other studies support this."

The evidence suggests that cimicoxib also holds promise in treating major depression. In the current study, the group of severely depressed patients with a Hamilton Depression Rating Scale (HamD) >25 showed an effect in favour of the cimicoxib group. A 2.6-point advantage was found over placebo in the cimicoxib group for HamD-17 at week 6. Using the MADRS score, a 5.8-point advantage over placebo for MADRS at week 6 was found in the cimicoxib group. Effectively, a 54% remission rate in cimicoxib group was achieved (MADRS of ≤10) at week 6, versus 20% for the control group. These findings were statistically significant.

However, the effects might be limited to the most severe patients. When results were analysed from the whole group of 106 depressed patients, no difference was found between the sertaline plus placebo group.

"We only saw an effect in the severely depressed patients and less so in the mild to moderately depressed patients," Professor Müller pointed out. "This phenomenon is not unusual in studies in depression due to the high placebo effect in all depression trials. However, in more severe depression the placebo effect is lower and therefore it is more likely to find larger effect in severely depressed patients."

Professor Müller said that there were many anti-depressants that were effective in depression, but they all have different side effects. "The important point is that, if inflammation plays a role, then there is a totally different approach to treating depression. Not only the serotonergic and noradrenergic drugs but also anti-inflammatory drugs," he added.

The MOODINFLAME consortium also looks at biomarkers of depression. Cox-2 inhibitor responders were found to have a parameter related to the immune–kynurenine metabolic pathway. This has potential as a predictor in depressed patients for response to COX-2 inhibitors or other anti-inflammatory therapies.

Other speakers in the same session will include Carmine Pariante (Institute of Psychiatry, London, UK) who will speak on 'Antidepressant action: role of glucocorticoid receptor'. He will review his clinical and cellular study implicating a reduced function of the glucocorticoid receptor in key, depression-related phenomena, such as the increased HPA axis and inflammation, the reduction in neurogenesis and the therapeutic action of antidepressants.

Aye Mu Myint from Munich, Germany will discuss 'Antidepressants and anti-inflammatory agents on immune-kynurenine pathway: results from in-vitro studies'. Finally, before Professor Müller's presentation, Veerle Bergink, from Rotterdam, The Netherlands, who is also co-chairing the session, will discuss activation of the mononuclear phagocyte system in patients with mood disorder and the putative usage of anti-inflammatory agents as anti-depressants.

New aspects on roles of anti-depressants and anti-inflammatory agents: Latest results from the EU Consortium MOODINFLAME will be held in Hall G at 08:00–9.30, Monday 5 March.

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13:15-14:45

Hall B

test

13:15-14:00 Progress in understanding and treating of Addiction *Prof. Karl Mann Mannheim, Germany*

14:00-14:45 Deep Brain Stimulation in Psychiatry *Pavel Mohr Czech Republic*

Hall C

Free Communications - Suicidology and suicide prevention

Hall D

The maintenance of reliability in psychiatric clinical trials: what are the challenges and solutions?
Prof Mark Opler New York, USA
Prof Gil Zalsman Tel Aviv, Israel

Hall E

Free Communication - Treatment

Hall F

Section Symposium

Primary Care Medicine and Consultation-Liaison - Psychiatry - how can they collaborate?
Prof Albert Diefenbacher Berlin, Germany
Dr. Dan Georgescu Brugg, Switzerland

Hall G

Combining psychotherapy and pharmacotherapy
István Bitter Budapest, Hungary
Jiri Horáček Czech Republic

Hall H

Interpersonal Psychotherapy of Depression (IPT)
Dr. Torsten Gruettert Krefeld, Germany

Hall I

How to write a successful Grant Application for EU funded research projects
Dr. Vladimir Carli Stockholm, Sweden
Prof Danuta Wasserman Stockholm, Sweden
Christina Hoven

Hall J

Training Workshop: How to improve communication with persons with psychosis
Dr. Domenico Giacco Naples, Italy
TBC

14:45 **Coffee Break, Viewing Posters & Visiting the Exhibition**

15:15-16:45

Hall B

Course of mood and anxiety disorders: results from epidemiological and clinical studies (Section Symposium)
Prof Christine Kuehner Mannheim, Germany
Prof Martin Preisig Prilly, Switzerland

Hall D

ePoster Session - Psychosomatic, Ethnical and Forensic Aspects in Psychiatry
Filip Španiel Prague, Czech Republic

Hall E

ePoster Session - Genetic and Epidemiological Approaches in Psychiatric Research
Jiri Horáček Czech Republic

Continued on page 16

Recent challenges in the treatment of depression Hall F Tuesday **08:00–09:30**

Tackling the challenges in treating depression

The issues underlying the current challenges in treating depression will take centre stage on Tuesday morning, when four speakers will call into question some of the current assumptions surrounding drug usage in a range of patient groups.

Per Bech (Mental Health Centre North Zealand, Hillerød, Denmark), who will chair what promises to be a fascinating and insightful session, spoke to *EPA Congress News* about the key arguments that will be set out by the four speakers, including what he will discuss in his own presentation on treatment-resistant depression.

Professor Bech began by looking at the work of two experts into the effectiveness and role of placebo treatments in clinical trials. He said: "Two of the speakers – Konstantinos N Fountoulakis, from Thessaloniki, Greece, and Hans-Juergen Moeller, from Munich, Germany – are concerned about how to provide evidence that our drugs against depression are better than placebo. That is the test that the authorities are using when, in the end, they approve a drug."

When using placebo in patients with a very mild to moderate degree of depression, it can appear effective because, if you are more severely ill, you might have suicidal thoughts, Professor Bech explained. These more mild patients are, of course, included when such trials are performed, at least in Europe, he added. Therefore, there have been a lot of comments as to how effective the new drugs really are, because they have to be tested in patients who might be not especially ill from a clinical point of view.

Per Bech

Professor Bech continued: "Both of those speakers try to claim that drugs really are better than just giving a placebo. They are trying to say that placebo only works in the very mildly depressed patients, whereas antidepressants actually work independent of severity. That is their message. Furthermore, Dr Moeller will try to claim that there is no alternative – there are no other ways to treat depression."

He added: "Then, the last speaker, Professor Nolen, from The Netherlands, will focus on patients who are called manic depressives, or bipolar patients. In this group of patients, it has been discussed, especially by our American colleagues, that antidepressants might present a risk for developing mania. The American psychiatrists say that these drugs can actually activate the illness if you have a predisposition to manic depressive illness.

"Dr Nolen is trying to reassure us that there is no such risk when speaking about bipolar II and bipolar I disorder. He is focusing on bipolar II – that is patients who only develop a mild degree of mania called hypomania."

Professor Bech summarised "The conclusion of these presentations is interesting: that on the one hand the two speak-

> *"Both of those speakers try to claim that drugs really are better than just giving a placebo. They are trying to say that placebo only works in the very mildly depressed patients, whereas antidepressants actually work independent of severity."*
>
> *Per Bech (Mental Health Centre North Zealand, Hillerød, Denmark)*

ers are trying to claim that the drugs are actually working in depression, and Dr Nolen is trying say in response to those conflicting views that they might activate the illness that the risk is not as high, or non-existent, in his point of view."

Professor Bech's own presentation focuses on the factor structure of treatment-resistant depression. "I have said that a drug is not working when at least 25–30% of patients do not respond to it," he said, adding: "The problem of response is that you might have a partial response but, if you look at the patient restoring his or her social functioning, so that they can return to work, then up to 25–30% do not have such a remission recorded.

"I have been looking at those patients because, from an economic point of view, for our society, those patients can go a long, long time without being able to return to work. I have tried to look at the symptom profile of those patients, and I have shown that it is patients who have a sleep problems, concentration problems or memory problems, and tiredness."

He went on to explain that it appears that this syndrome is the catalyst in patients who have what is termed treatment-resistance depression.

Overall, these presentations, and the questions that they raise, as much as answer, would suggest that, although we know a lot about the effect of drugs and theoretically how they work, there is still quite a long way to go to refine our understanding of how patients respond to antidepressants. Would Professor Bech agree with that?

He replied: "We have no sufficient explanation of how they work. We do know that most patients will have a good outcome, but of course those patients who are more resistant are much more costly for society."

"More than 50% of our expenses on treatment for depression is caused by those patients, and so we have focused on which kind of treatment will they need."

Specifically, Professor Bech is looking in his work at the benefits of a treatment for treatment-resistant patients called transcranial magnetic stimulation, which is a noninvasive method of causing depolarization or hyperpolarization in the neurons of the brain.

Professor Bech will chair the 'Recent challenges in the treatment of depression' symposium on Tuesday 6 March at 08:00–09:30, Hall F.

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Hall F

Medication related suicidality in children and adolescents: assessment, information and ethics
Dr. Paramala Santosh London, UK
Dr. Ulrike Schulze Ulm, Germany

Hall G

Care pathways in European forensic psychiatry: outcomes and economic issues (Section Symposium)
Prof. Kris Goethals Edegem, Belgium
Dr. Birgit Vollm Nottingham, UK

Hall H

Interpersonal Psychotherapy of Depression (IPT) (cont.) *Dr. Torsten Gruettert* Krefeld, Germany

Hall I

How to write a successful Grant Application for EU funded research projects (cont.)
Dr. Vladimir Carli Stockholm, Sweden
Prof Danuta Wasserman Stockholm, Sweden
Christina Hoven

Hall J

EECP Symposium: Is a new agenda needed for early career psychiatrists *Dr. Andrea Fiorillo* Naples, Italy
Dr. Florian Riese Zurich, Switzerland

Early intervention in psychiatry Hall J Monday 5 March **15:00–16:30**

Is early intervention in schizophrenia a waste of time or just in time?

The question as to whether early intervention is an essential tool in the prevention of schizophrenia progression or simply a waste of valuable resources will come under the spotlight on Monday afternoon.

During a special Early Career Psychiatrists' Programme session, Craig Morgan (King's College London, UK) and Anthony Pelosi (University of Glasgow, UK) will enter into a pro and con debate that promises to not only examine all the main issues in this controversial area, but also be a highlight of EPA 2012.

Session chair Sameer Jauhar (a Glasgow psychiatrist, in the process of starting a research post in Psychosis Studies at the Institute of Psychiatry) spoke to *EPA Congress News* about the debate, beginning by examining Professor Pelosi's arguments for why early intervention in psychiatry may be a waste of resources. He said: "Tony's been debating for at least the last 10 years psychiatric services in general, predominantly in the UK, but also making comments on what's been happening internationally, specifically with regard to Australia, where psychiatric services have changed significantly, and throughout Europe recently.

"The main thrust of his argument is that the sub-specialisation of psychiatric services tends to take away from the strength of generic services for patients and therefore, by sub-specialising, you are not providing a comprehensive enough service to all patients. He also says that people have focused on treating only this small cohort of patients, with no great evidence base behind it. There's an evidence base, but not a comprehensive evidence base, and his point is that it just doesn't seem to be a good utilisation of resources, which are scare at the moment as it is."

One of the most striking features of psychiatric disorders is the large number of comorbidities that patients experience. Does Dr Jauhar think that this is also an issue when it comes to the sub-specialisation of services? He replied: "You know, it's an issue on a number of different levels. It will be an issue at the individual patient level, it will also be an issue for the continuity of care. [Professor Pelosi's] main point has been that, if you look at it historically, psychiatry moved from the asylum to community care and then it's supposed to have evolved since then. But you're actually not providing a better service over the lifetime of these people. His argument is that you're actually forgetting some of the people with the greatest need, and they're not necessarily those people in the first two or three years of a psychotic episode."

Sameer Jauhar

If those are the arguments against early intervention, what has been driving the growth of early intervention in recent years? The father of early intervention is a man called Patrick McGorry [University of Melbourne, Australia]," Dr Jauhar

Continued on page 22

European Brain Council

Year of the Brain in Europe 2014

The European Brain Council has launched a call for 2014 to be made the Year of the Brain in Europe – to improve neurological and mental health.

- More than 190 organisations representing patients, their carers and families, scientific societies, healthcare professionals, scientists and industry in all areas of mental health (including depression, schizophrenia, anxiety disorders, addiction), neurological disorders (including stroke, Alzheimer's and other dementias, Parkinson's disease, migraine, epilepsy), neuroscience (understanding the normal and abnormal brain), neurosurgery (trauma and tumours) and basic research have joined this call
- A Year of the Brain has the potential to increase awareness, improve treatment and understanding of brain diseases and directly result in measurable economic outcomes for the European Union's Member States leaving a lasting legacy through a series of initiatives including:

1. Promoting a clearer understanding of the economics of brain diseases and their management and ways to improve them
2. Increasing the level of research funding and brain research
3. A longer term reduction in the burden of brain diseases by promoting brain health and encouraging the maintenance of good brain function
4. Improvements in the quality of life for patients, their families and carers through initiatives led by and delivered in all Member States

A Year of the Brain aims to realise significant benefits for patients and society through increased awareness of normal brain function, education and information on brain diseases, leading to increased funding for brain research. This should lead to better treatment and management of brain diseases, leading to a higher quality of life for a significant number of European citizens now and into the future, benefitting many millions of European citizens, their carers an families.

Brain diseases affect more than 150 million Europeans, a third of the European population, and pose a significant burden on society. In 2010, the total annual cost was €798 billion, a huge drain on the economies of Europe, and this is likely to increase progressively.

A Year of the Brain in Europe in 2014 will focus on the very many positive aspects of the brain and the role of the brain in creating, sustaining and building the economy of Europe through knowledge and innovation.

Ambitious plans include a comprehensive school and university programme, exhibitions which will travel to more than 900 cities and towns and a comprehensive digital and social media campaign.

Creating a long-lasting political and societal legacy will be at the heart of activities. Demonstrable support from key stakeholders will help make this all a reality

Developing the ICD-11 Classification Hall B Monday 5 March **08:00–09:30**

First look at psychotic disorder revisions in ICD-11

The latest update on the development of the International Classification of Diseases (ICD)-11 for mental and behavioural disorders will feature on Monday morning, when Professor Wolfgang Gaebel (Heinrich-Heine-University, Duesseldorf, Germany) provides an insight into the revision of psychotic disorders for the new code.

Since its first meeting a year ago, the psychotic disorders working group has been reviewing the scientific evidence for specific diagnostic criteria and more general issues pertaining to its classification. The World Health Organisation (WHO) reviews the ICD codes every ten years, and the new ICD-11 should be finalised by 2015.

Professor Gaebel spoke to *EPA Congress News* about the concepts have emerged and this accumulation of evidence needs to be reviewed. "While we do not expect changes of paradigms, optimisation of the current criteria seem to be feasible," he remarked.

One notable aspect the working group has started to review is the set of specific diagnostic criteria for schizophrenia, acute and transient psychotic disorders, schizoaffective disorder, delusional and brief psychotic disorders, and schizotypal disorders.

Professor Gaebel said: "The first issue was to consider whether novel pathophysiologic or genetic aspects may be advanced enough to warrant inclusion in the diagnostic criteria, but the Working Group on Psychotic Disorders found them to be insufficiently advanced at this stage."

After clarification of any appropriate new science, the group then selected particular disorders for major revision. Notably, the following changes will be implemented, Professor Gaebel revealed: "In schizophrenia, the classical subtypes will be omitted and various symptom dimensions will become specifiers. We will reorganise the acute and transient forms of psychotic disorders and more clearly define the diagnostic criteria for schizoaffective disorder."

Wolfgang Gaebel

In addition, several conceptual issues are under review, including the use of dimensional assessments, the role of functional outcome assessments, the definition of course and severity specifiers, and the reorganisation of the psychotic disorders.

Professor Gaebel said: "When no or only insufficient evidence is available, the guiding principle will be an expert consensus guided by the putative prognostic or therapeutic implications of any changes. ICD-11 will be much more open to more rapid changes in the future if new evidence becomes available."

By the end of March, a first draft of proposals will be available for viewing and for comments, which will be considered by the working group.

"We will now take some time to finalise the proposals for revision and, over the next few months, we will be seeing increasing numbers of suggestions for revised diagnostic criteria on the WHO ICD-11 Alpha Draft homepage," Professor Gaebel added.

He concluded: "These suggestions will be open for comments by the public and we will be constantly reviewing these. This shall lead to a final revision until 2014 with a view to publish a final version in three years time."

Professor Gaebel will give his presentation 'Classification of psychotic disorders in ICD-11' as part of the Developing the ICD-11 Classification of Mental and Behavioural Disorders: Progress and Prospects symposium on Monday 5 March at 08:00–09:30, Hall B.

Live from EPA 2012

Recent decisions of the European Court of Human Rights (ECHR) that have affected the concept of 'persons of unsound mind' and, consequently, forensic psychiatry came under the spotlight on Sunday morning.

In a special symposium, a senior judge from the ECHR, and leading clinicians from three countries in which cases have been referred to the ECHR, debated some of the difficulties in balancing an individual's right to freedom with the deprivation of liberty in cases of 'true mental disorder'.

Angelika Nußberger, who has represented Germany at the ECHR since 1 January 2011, focused on the intense discussions around the preconditions for detaining persons considered to pose a persistent danger to society that have arisen from the recent condemnation of Germany by the ECHR for retroactively applying a prolonged regime of security detention to convicted prisoners.

Citing several cases, she emphasised that the ECHR stipulation that only persons with a 'true mental disorder' can be deprived of their liberty requires a clear distinction between mentally sick persons and persons displaying simply antisocial behaviour. However, it is hard to precisely define the concept of 'persons of unsound mind', she noted, as its meaning is continually evolving with the evolution of psychiatry itself. Consequently many borderline cases are assessed differently by experts, which requires the further input of psychiatrists and human rights lawyers.

After discussing the potential consequences of that, and highlighting that recent judgements have left the definition of 'persons of unsound mind' open for debate and beyond the powers of the judicial arena, Professor Nußberger took several questions from the floor, in response to which she emphasised that a 'common sense' approach is adopted by the ECHR both to its statutes, which have been in continuous development since their initial codification in the late 1940s, and towards individual cases.

One question raised by Norbert Nedopil (University of Munich, Germany), who followed Professor Nußberger onto the platform to offer his perspective on the reactions and consequences following ECHR judgements in Germany, was that of how to approach cases in which prisoners have been diagnosed with mental disorders while in prison that would necessitate their detention after their sentence has expired. Professor Nußberger replied that, in many cases, it is possible to determine that the diagnosis has only become clear after a person was sent to prison and that they were suffering from the condition beforehand, rather than developing a novel disorder while in prison. However, if, in an example put forward by Professor Nedopil, a patient develops severe dementia while in prison due to old age, then it is reasonable that they should be further detained, as they have a true mental disorder.

Angelika Nußberger

Norbert Nedopil

Asenapine
– from pharmacology to clinical effect

Satellite symposium chaired by Michael Bauer
at the 20th European Congress of Psychiatry, EPA 2012

Prague Congress Centre,
Prague, Czech Republic

Sunday 4th March 2012
13:15 – 14:45

Sycrest® (asenapine)
sublingual tablets 5 and 10 mg

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Reliability in psychiatric clinical trials Hall D Tuesday 6 March **13:15–14:45**

Consistency essential to yield reliable clinical trial results

The importance of inter-reliability through the correct and consistent application of rating scales will be emphasised to attendees on Tuesday afternoon in a special session examining the challenges and solutions in maintaining reliability in psychiatric clinical trials.

The session will feature presentations on statistical methods for evaluating reliability in studies and the concept of surveillance in clinical trials, as well as offer an industry perspective on the importance of sample size, statistical power and protocol fidelity.

However, this Research Track workshop will begin with a talk by Gil Zalsman (Tel Aviv University, Israel), who is also co-chair of the session, on how best to achieve reliability in clinical trials from an academic perspective.

Professor Zalsman spoke to *EPA Congress News* about the importance of inter-reliability, how he achieves this through his training programme and the potential pitfalls, and gains, associated with this often under-recognised area of clinical research.

He began by explaining that his approach is based on his many years of experience in teaching rating scales to investigators, and his independence as an instructor. He said: "Together with Mark Opler from ProPhase [New York, USA], we go from study to study as a freelancers. We are not obligated to any pharmaceutical company; we come from universities. Mark from NYU [New York University], me from Tel Aviv University and, in the past, from Columbia University."

Professor Zalsman continued: "First of all, we teach people about the manual of the specific ratings scales, such as the PANSS [Positive and Negative Syndrome Scale] rating scales for schizophrenia, or the Hamilton Rating Scale for Depression, and we introduce the tool to them."

Discussing the problems encountered in this area, he said: "Most of the people working in clinical trials have been doing it for many years, but not in the exact way they should. It's very important to make sure that all of them will do it exactly in the way it should be done; for example, time frames, which is a very common area for mistakes – some people interview the patient for the past week and the others for the past month.

"Of course, it's carrying out the same clinical trials in different locations in the world, which is usually what happens, that ruins the study, and they didn't even know that they were doing it."

> *"The outcome measure is the rating scale and the decision that is made by the FDA [US Food and Drug Administration] or the pharmaceutical companies or academia whether to use this specific drug for a specific culture or specific population is based on this specific rating scale."*
>
> *Gil Zalsman (Tel Aviv University, Israel)*

Returning to how he educates clinicians, Professor Zalsman added: "So, first I introduce the tool, telling them about the time frame, telling them about the way to ask the questions. We usually show them an interview and then look at reliability together, and try to convince them that we all should do it exactly the same way. This way, we are raising the inter-rater reliability of a tool which is very valid, but each person is using in a different way."

There are many other factors related to the application of rating scales that can undermine a study, as Professor Zalsman explained: "Another point is inter-cultural reliability and validity, which raises many questions. For example, in the PANSS rating scale, which is the most used rating scale for schizophrenia research, is totally different in India than in the US. The everyday life of the Indian patient is totally different from everyday life of patients from Florida, and we need adapt it to the specific culture."

"Another point is the language. Actually, most of the studies that are done today by the big pharmaceutical companies in the East, such as Asia or India, use English because, if you try to translate the rating scale into the specific dialect, its almost impossible. In India itself, there are more than 1000 different dialects and about 100 languages, and for someone in the north of India or in the south of India to do the same rating scale, the only way to do it the same way is to do it in English. So, we use British English in the whole of India, which is the second language of most of the districts in India."

Commenting on the knock-on effect of inconsistent scale application, he added: "These issues are very important when you come to analyse the rating scales of the results, and it's a must because, actually, the outcome measure is the rating scale and the decision that is made by the FDA [US Food and Drug Administration] or the pharmaceutical companies or academia whether to use this specific drug for a specific culture or specific population is based on this specific rating scale."

Gil Zalsman

This also raises the question of how well a drug or therapy's performance can be assessed further down the line, such as in a meta-analysis. Does Professor Zalsman agree that this is an issue? "That's right, it's exactly the point," he replied. "And if you compare psychiatry to other scenes of medicine, they have very accurate scales and measurements. They collect blood pressure or cholesterol levels. It's very clear to measure and it's the same thing in India, China and America.

"But when you come to psychiatry, all your knowledge is based on what the patient is reporting to you and, you know, basing this on rating scales is very tricky. When you ask patients about hallucinations or about delusions it's very, very different from culture to culture, from patient to patient and, of course, between rater and another rater.

"So our main job is to keep them honest, to make sure these multicentre, huge studies will give accurate results and that the decisions that will be made afterwards will be to the benefit of the patients, and also to the benefit of the pharmaceutical companies."

Professor Zalsman will co-chair the session 'The maintenance of reliability in psychiatric clinical trials: what are the challenges and solutions?' on Tuesday 6 March, 13:15–14:45, Hall D.

Asenapine – from pharmacology to clinical effect

Date: Sunday 4th March 2012
Time: 13:15 – 14:45
Room: Forum Hall/Hall B
Chairman: Michael Bauer

Programme

13:15 – 13:20	Chairman's welcome and introduction	
13:20 – 13:40	Beyond symptomatic remission in bipolar disorder	**Michael Bauer** *Germany*
13:40 – 14:00	The pharmacology of antipsychotics – is it related to the clinical effect?	**Steven Potkin** *USA*
14:00 – 14:20	Pharmacology of asenapine, an untypical antipsychotic	**Frank Tarazi** *USA*
14:20 – 14:40	Effective remission with asenapine for patients with bipolar I disorder	**Andrea Fagiolini** *Italy*
14:40 – 14:45	Panel discussion	**Led by Chairman**

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EECP Pro & Con Debate: Early intervention in psychiatry Hall J Monday 5 March **15:00–16:30**

Continued from page 16

explained. "Tony and he have debated in the *British Medical Journal* about this, and really his argument is that we can actually prevent the worsening of mental illness, with secondary prevention as the key.

"There was some research in which people said that if you decrease the duration of untreated psychosis – so decrease the time for these people to receive care – you will alter the outcome of the illness itself. The illness will be less chronic, people are able to access help better and you are actually changing long-term outcomes for what is essentially one of the most disabling diseases in the world. The WHO [World Health Organization] has put schizophrenia within the top 10 of diseases in terms of disability for the young."

Dr Jauhar continued: "So Patrick McGorry's argument has been that if you get in there early, you can alter the course and prognosis of the illness itself. They make a distinction between early intervention – so that's before someone develops their first psychotic episode – and a first psychotic episode service, but the argument here is in first episode disease."

One of the patterns of developing schizophrenia is progressive brain changes, thus the eventual aim of early intervention would surely be to be able to prevent those happening or getting worse? "You're right," Dr Jauhar said. "There's different lines of converging evidence. We now know it's a neurodevelopmental disorder, and Steve Lawrie and the Edinburgh group have just done the meta-analysis showing progressive brain changes.[1]

"People's argument would be: Yes, aim for the prevention of worsening of the illness, as opposed to anything else. A lot of people within the movement for early intervention are saying that the focus should be not just on medication but also psychosocial interventions as well; so, interventions that help people have contact with services."

Moving on to what Dr Morgan will discuss in his presentation, Dr Jauhar said: "He has been very measured in his abstract, and argues really that it is about service provision. The service provision model means that people will concord with treatments, and they'll have a better relationship with services. That's based on evidence that the first episode of what ends up becoming schizophrenia can be very traumatic for the person, the individual. A significant number people may be detained against their will, and also be lost to follow-up for services.

"The service model that they try and provide involves going out to people's homes, offering assertive outreach, having increased numbers of case workers for a patient population. So they're exceptionally well-staffed compared to generic teams, and that's the main cut-and-thrust of it. They're saying can we change the outcome of the illness itself and they're also saying can we change how people access services and access care, for what is, in essence, a lifetime illness."

A lot of research is focused on people being at-risk of illness. Are we potentially in danger of over-treating people who may not progress? "Well, that'll be two arguments, because that's the argument for early intervention versus first episode intervention," Dr Jauhar responded. "It's legitimate to bring that into it, and the point is exactly one that people have made about DSM-V [the fifth edition of Diagnostic and Statistical Manual of Mental Disorders, which will be published in May 2013].

"They're trying to give a new diagnosis called the At-Risk Mental State, except there will be a lot of people who have an at-risk mental state who don't develop the illness. The relative risk compared to the general population might be, for example, 10; so they might be 10 times more at risk than someone in the general population. But, of the people with an at-risk mental state, about 20–30% will actually develop the illness.

"So if you were to overtreat, for example with antipsychotic medication, which has got a number of different side effects throughout the life course, obviously that would be detrimental, and that's been one of the main arguments against DSM-V. There's been a lot of controversy in Australia with that, with Patrick McGorry and the work that's done, because hundreds of millions of Australian dollars have been put into services for early psychosis prevention and intervention."

However, it's not just the EECP Pro and Con Debate that is taking place at EPA 2012. There are a multitude of sessions covering a wide range of topics from across the field of psychiatry. Is there anything in particular that Dr Jauhar is looking forward to attending? He said: "Obviously I enjoy the primary debates, but what's really good fun is when you have the early career psychiatrists part, when they get to chat to someone. A couple of my colleagues are going to be interviewing Robin Murray [Professor Sir Robin Murray, Professor of Psychiatric Research at the Institute of Psychiatry, King's College London] and going through his life story. People can get to ask questions of someone they would never had had access to before, and that's very interesting."

> *"If you look at it historically, psychiatry moved from the asylum to community care and then it's supposed to have evolved since then. But you're actually not providing a better service over the lifetime of these people…you're actually forgetting some of the people with the greatest need."*
>
> *Sameer Jauhar (Glasgow, UK)*

> *"Some research [indicated] that if you decrease the duration of untreated psychosis…you will alter the outcome of the illness itself. The illness will be less chronic, people are able to access help better and you are actually changing long-term outcomes for what is essentially one of the most disabling diseases in the world."*
>
> *Sameer Jauhar (Glasgow, UK)*

Dr Jauhar will be chairing the EECP Pro & Con Debate: Early intervention in psychiatry: a valuable waste of resources? on Monday 5 March at 15:00–16:30, Hall J.

References

1. Olabi B, Ellison-Wright I, McIntosh AM, et al. Are there progressive brain changes in schizophrenia? A meta-analysis of structural magnetic resonance imaging studies. Biol Psychiatry 2011; 70(1): 88–96.

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New horizons in neuropsychopharmacology Hall B Monday 5 March **10:00–11:30**

Interview **Hans-Ulrich Wittchen**

One of the key remaining barriers to understanding the development and prognosis of mental health disorders, and to unlocking the full potential of treatments, has been our relatively incomplete picture of the size and scope of the true burden of mental illness.

However, the field of psychiatry will take a step closer to fulfilling this much-needed goal on Monday, when Hans-Ulrich Wittchen (Technische Universität Dresden, Germany) will offer insights to and discuss the implications of the size and burden of mental health disorders in Europe, as part of a joint symposium with the European College of Neuropsychopharmacology (ECNP).

Professor Wittchen is Chairman and Director of the Institute of Clinical Psychology and Psychotherapy and Center of Clinical Epidemiology and Logitudinal Studies (CELOS) at Dresden Technical University, and has published over 500 peer-reviewed articles, as well as authored a number of textbooks. Alongside being a member of many leading international groups, Professor Wittchen is an editor, or on the editorial board, of many peer-reviewed journals, such as Addiction, Drug and Alcohol Dependence, and Psychological Medicine. His research interests include the diagnostic classification of mental disorders, diagnostic assessment instruments in psychopathology, clinical epidemiology and behavioural medicine.

He spoke to *EPA Congress News* about the difficulties that have hampered so many previous investigations into the size and burden of mental health disorders, the insights that the present findings will offer, and the need for action to improve treatment rates and outcomes in mental illness.

Thank you for speaking to us today. Perhaps we could begin by discussing some of the issues in estimating the true size and burden of mental health disorders, and why previous attempts have not been successful?

In the past, most of the studies and documents that tried to demonstrate the true size and burden of mental disorders were actually of quite restricted utility, for three simple reasons.

The first reason was that past documents actually covered only a very restrictive range of what mental disorders are. They were focused on anxiety and depression and maybe some of the addictions, but they rarely covered the full spectrum of over 500 forms of mental disorders. So, when looking at the true size, actually it was quite restricted and only focused on a few groups of mental disorders, and not the whole spectrum.

The second reason why their utility was so limited was that most of these studies only described mental disorders for adult ages – between ages 18 and 65 – and thus excluded children, adolescents and the elderly population. So both in terms of the numbers of people affected, as well as the question as

New horizons in neuropsychopharmacology Hall B Monday 5 March **10:00–11:30**

to what degree a mental disorder is already a problem in children, adolescents or the elderly, plus whether the challenges in these age groups are the same or they are particularly different in some respect, has never been properly addressed.

The third reason is, in the past, most of these estimations of the size and burden did not really use state-of-the-art diagnostic criteria. So they could be better labelled as demonstrating mental health problems, rather than the presence of thresholds of mental disorders in terms of real diseases that are in need of intervention and treatment.

How is the data you will be presenting on Monday different?

What I'm going to present at this meeting is, for the first time ever, the calculation of a more comprehensive spectrum of mental disorders across all age groups based on the clinical criteria of what constitutes a mental disorder. I will be able to describe how many children have attention deficit disorders in childhood, or what proportion of the population suffers from mental retardation, as well as how many people across all age spans have anxiety disorders, and whether anxiety disorders are as frequent in children as they are in adults or in the elderly.

This allows us, for the very first time, also to look into the age and gender-adjusted rates of the burden. The burden is a complex construct and, in this study, what we did is to examine the number of disability days in each year people go through when they have a particular disorder, or combinations thereof.

So, for example, if a depressed person has a depressive episode in a given year, what is the average number of days that person falls completely out of their social roles – they can't go to work anymore, they have to report in sick – and how many days afterwards he returns to the job or his professional duties? How many days does it take until he reaches full productivity again and get back to normal performance, in that respect? So we are able to really describe in much more detail the burden for society in a given country in a given year regarding, for example, depression, anxiety or attention deficit disorders. How many days can children with these disorders not go to school or under-perform in academia, and so on?

> *"What I'm going to present at this meeting is, for the first time ever, the calculation of a more comprehensive spectrum of mental disorders across all age groups based on the clinical criteria of what constitutes a mental disorder."*
>
> *Hans-Ulrich Wittchen (Technische Universität Dresden, Germany)*

One thing that struck me when you were talking about assessing the true burden of mental health in children is I imagine that, without this data, you can't really plan for the future, because it offers an indication of what the coming adult population's burden will be. Is that the case?

Absolutely right. This is a very important thought, actually. What we learned in the past was basically that the onset for many severe mental disorders does not happen, in most cases, in adulthood but actually has a history beforehand. And the reason why the previous studies were unable to do this has to do a little bit with their methodology. For example, if you assess mental disorders in children or adolescents, you use slightly different instruments from those in adults. And again in the elderly, you have to use slightly different instruments from the other groups.

In the past, when previous reports were prepared, they were methodologically unable to aggregate this information from children, from the elderly and from adults because the research done in this field was fragmented. It was done either in adults or in children, either in the elderly or in adults, but never in all age groups, trying to account for the methodological differences. That's what we did in this report. We accounted for this and we looked into the lifelong expression of mental disorders in people in Europe.

One of the key debates at EPA 2012 is that of early intervention. Obviously, your data has implications for such approaches. Where do you stand on a debate like that? Is early intervention the inevitable next step?

Well, the core message here is really that intervention in general in the field of mental health is unusually deficient. What I mean by this is that, unlike let's say other prevalent disorders like diabetes, heart disease, or whatever you might look at in the somatic disease fields, the proportion of people with mental disorders receiving any professional help and intervention is miserably low: only one-third of all people with mental disorders has ever received any type of professional intervention in their life.

> *"Unlike let's say other prevalent disorders like diabetes, heart disease, or whatever you might look at in the somatic disease fields, the proportion of people with mental disorders receiving any professional help and intervention is miserably low."*
>
> *Hans-Ulrich Wittchen (Technische Universität Dresden, Germany)*

In addition, if they receive an intervention, what is unique to mental disorders is that usually years go by, several years, until the disorder actually receives professional attention. Finally, the most depressing is, if an intervention is launched in a person, in few cases is this intervention according to the state-of-the-art treatments established in our system.

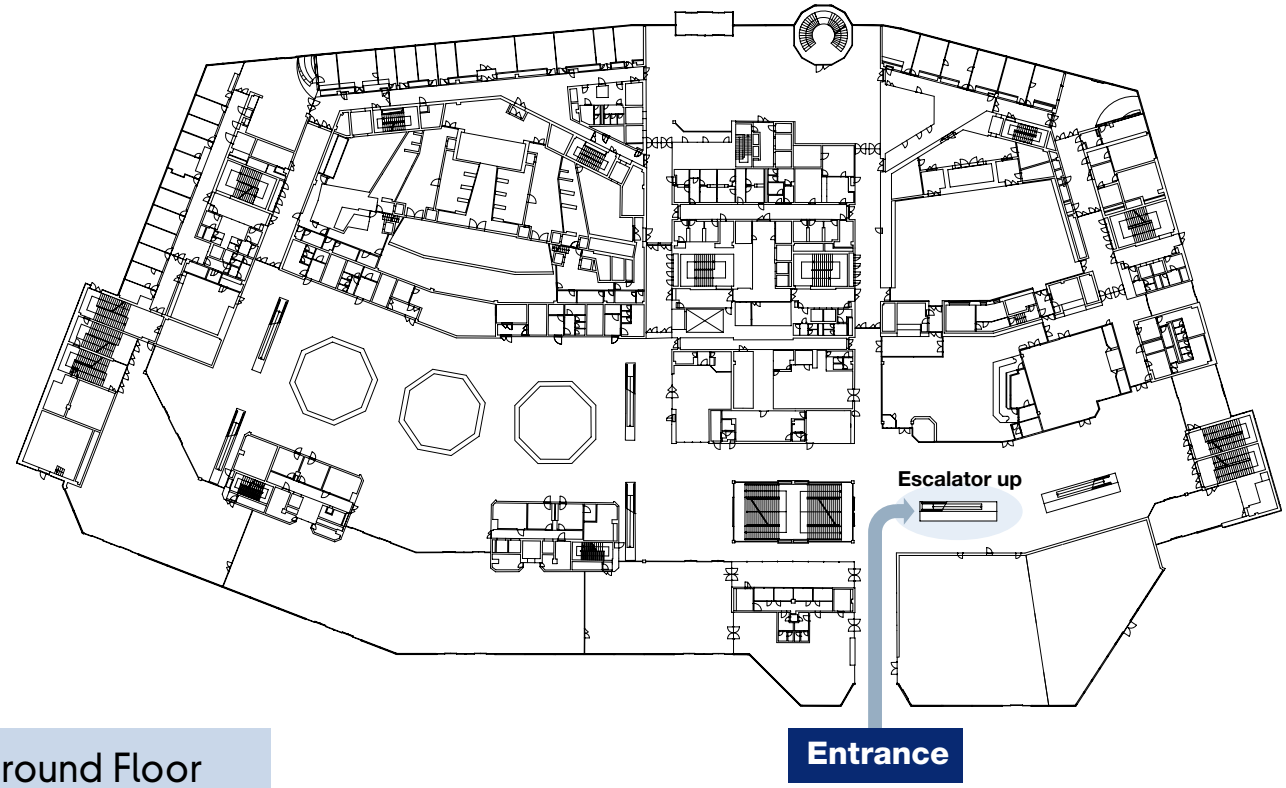
So we have a very deficient treatment system, and that applies to most countries in Europe. Only few do a little bit better, but overall it's a very disappointing and depressing picture that, since the years 2000 and 2005, when we've looked into this, there is only the slight indication of a change except for depression. For most other mental disorders, treatment and intervention rates remain miserably low.

We argue in the presentation that the combination of low treatment rates, delayed treatment, and inappropriate treatment actually is a characteristic of the field of mental health treatment and intervention, and that we must act to change the situation. Because the reason for not providing treatment and intervention in time means that there is an increased risk of comorbidity of a number of severe complications like suicide, increasing suicide attempts, increasing rates of dropping out of your profession, your job, and, ultimately, being unemployed.

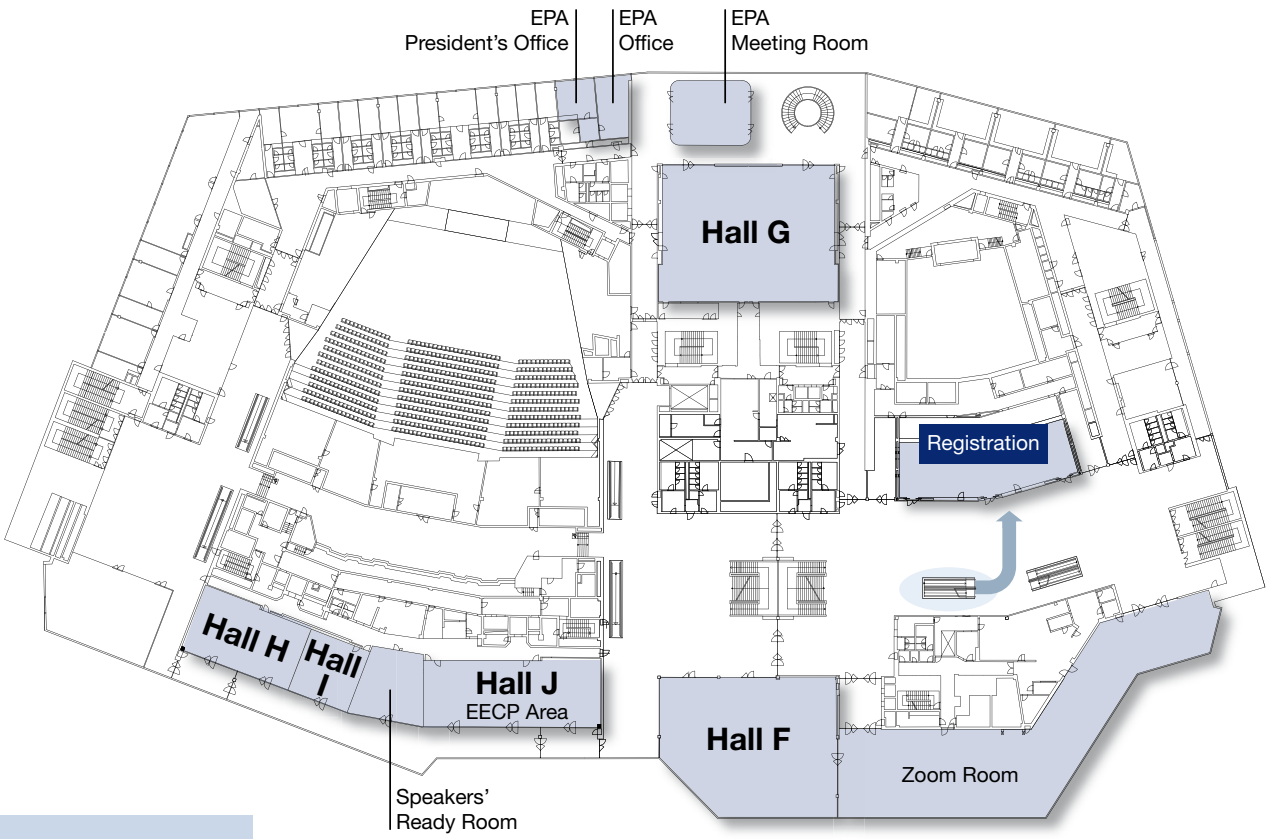
Professor Wittchen will give the presentation 'Size and burden of mental disorders in Europe: Update, insights and implications' as part of the New horizons in neuropsychopharmacology: Updates on two key ECNP initiatives – Joint Symposium with ECNP, Monday 5 March 10:00–11:30 in Hall B. In addition, he will give the talk 'Size, burden and treatment of mental disorders in Europe from a German perspective' during the Mental Health Care across Europe – Part II session on Monday 5 March, 17:00–18:30, Hall C.

Floor Plan

EPA 2012 Floor Plan

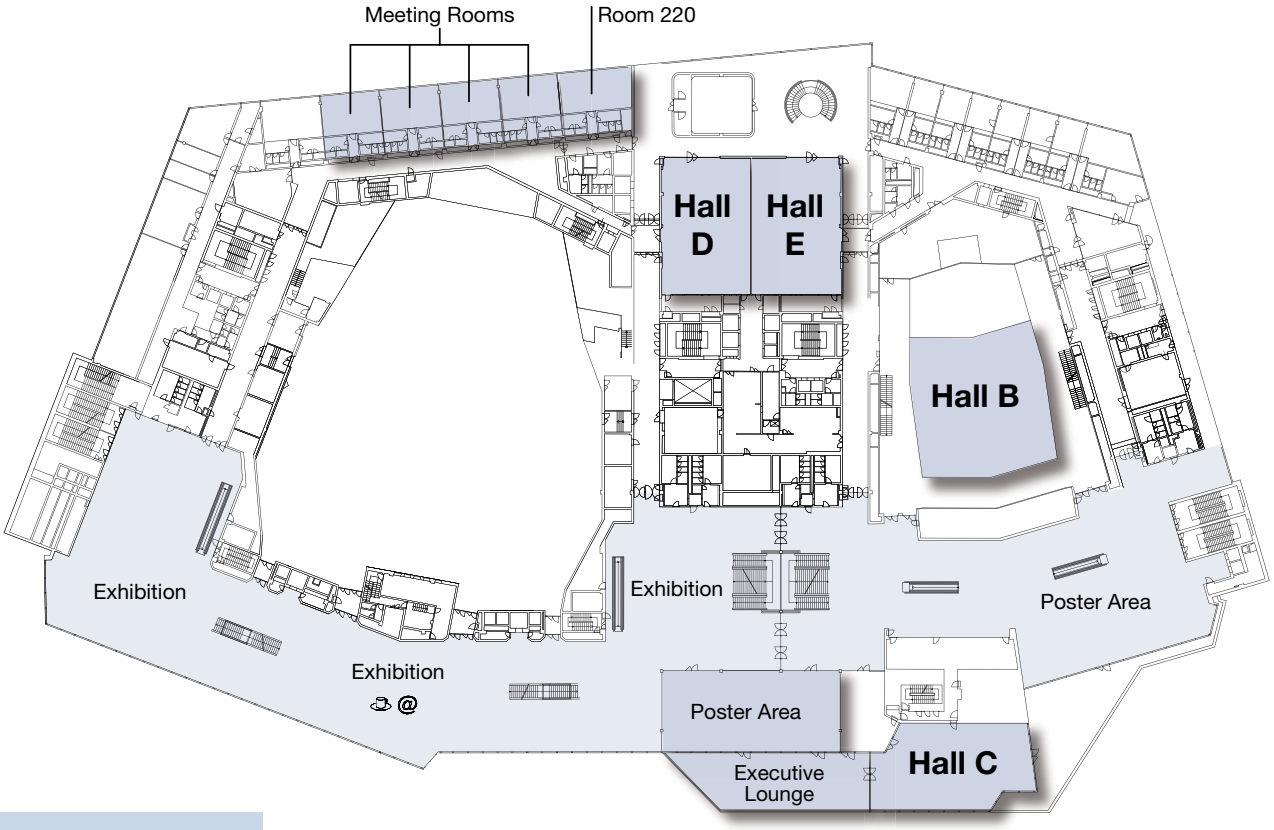


Ground Floor

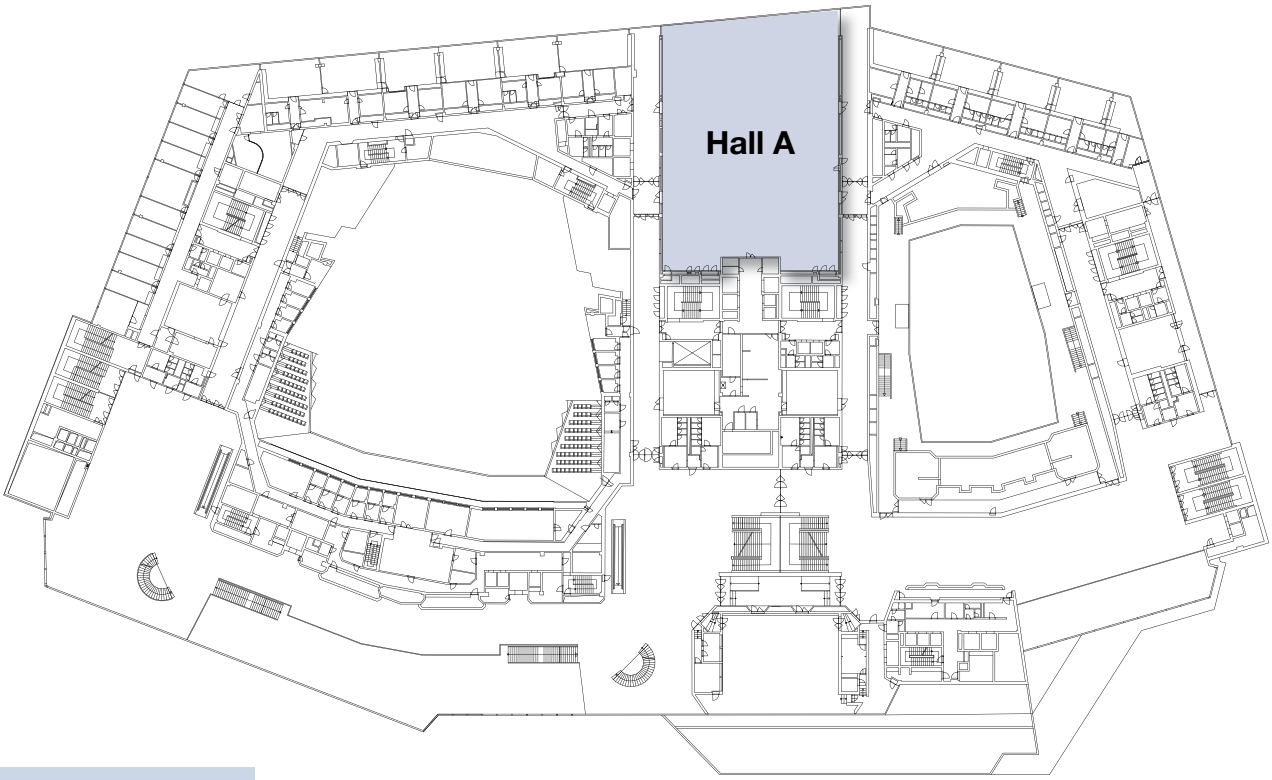


First Floor

Floor Plan



Second Floor



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