



## Inside today

### Page 4

E-mental health:  
Views from Asia

### Page 6

Humanitarian  
psychiatry today

### Page 8

Network analysis  
connects the dots



### Page 10

Is polypharmacy  
ever warranted?

### Page 12

EPA launches online  
CBT course

### Page 13

How to implement  
early intervention

### Page 17

A look forward to  
Warsaw 2019



# Welcome!

**M**ental Health - Integrate, Innovate, Individualise - is the theme of the 26th Congress of the European

Psychiatric Association (EPA), the largest international association of psychiatrists in Europe, which will take place on 3-6 March 2018 at the prestigious Nice Acropolis Convention Centre located in the city of Nice, the dynamic, cosmopolitan, unofficial capital of the Côte d'Azur.

The theme of the Congress is aimed at highlighting the importance of new models in mental health research and care.

**Integrate** emphasises the need to include mental health in both health and social policies; promote the integration of different approaches to mental health care and research; integrate research and mental health services focusing on different life epochs.

**Innovate** emphasises the importance of identifying priorities for mental health care and research; disseminating and promoting translation into standard practices of new successful prevention and intervention programs; developing e-mental health programs to improve service delivery and communication with users, and overcome spatial and linguistic barriers.

**Individualise** emphasises the current view of mental health care and research as person-centred by matching therapeutic interventions with individual's characteristics, values



Silvana Galderisi

and preferences.

A special focus of the Congress will be the integration of new technologies and research findings into person-centred approaches to prevention, care and training, at a time in which difficult challenges, such as displacement, war, terrorism and economic constraints, require new answers.

The Congress will bring together

expert clinicians, researchers and leaders of stakeholder organisations in the field of mental health, offering an outstanding set of Plenary and State of the Art Lectures, Educational Courses, Debates, Symposia, Workshops, informal meetings with experts and sessions designed by and for early career psychiatrists.

**Silvana Galderisi** EPA President



## Live: EPA Forum

# A focus on person-centred care in psychiatry

## Perspectives from the EPA Forum

Yesterday's EPA Forum drew together key stakeholders to discuss three elements of person-centred care, namely: measuring quality and outcome of person-centred mental healthcare; challenges in the implementation of patient-centred research and care; and the role of the EPA and National Psychiatric Associations (NPAs).

"The Forum's purpose is to bring together, with the NPAs, EPA individual members, as well as other Congress participants and other European organisations, policymakers, and key stakeholders in the field of mental health and mental health care," said Silvana Galderisi, introducing the proceedings.

On the choice of the theme of

person-centred mental health care, and in particular outcomes that matter to patients and their carers, she continued: "We firmly believe that psychiatry is increasingly moving in this direction. This is an important direction – the direction we need to take."

"Person-centred care means that people's values and preferences are known to clinicians and practitioners. Once expressed, they guide all aspects of healthcare and support realistic health and life goals."

### The importance of patient-reported indicators of health system performance

Linking together the work of EPA and the Organisation for Economic Cooperation and Development (OECD), Niek Klazinga spoke on behalf of the latter to describe the OECD's work on assessing the performance of healthcare system and the extent to which they contribute to value.

Discussing how the OECD broadly assesses mental health, Dr Klazinga noted that suicide rates have classically been used as a general marker – adding that mortality gap data within specific diagnoses are useful to characterise differences in average life expectancy in, say, schizophrenia, versus the population as a whole, in different countries. "The [schizophrenia] mortality gap is actually bigger than the socioeconomic gap," he said. "There is a lot of political interest in people with high and low income and their life expectancies. But here, these differences are bigger."

Professor Klazinga went on to note the limited availability of clinical registries in mental healthcare compared to some other clinical fields. He reported that last year the OECD mandated for looking more in-depth in person-, patient- or user-reported clinical measures. "This fits into a broader story of trying to

*"This is an important direction – the direction we need to take."*

Silvana Galderisi

assess what actually constitutes value," he said. "We are moving from statistics about death, diseases and measures of disability – towards statistics on wellbeing, and trying to measure things that actually matter to patients."

Professor

Klazinga discussed the formulation and validation of patient-reported outcome measures (PROMs) and patient reported experience measures (PREMs), and means of integrating them into electronic healthcare records. He outlined the principles to be explored at EPA 2018 that will harness PROMs and PREMs to achieve person-centred care.

Value for patients is delivered, he said, by involving them in the development of these measures, and ensuring that these measures, such as PROMs and PREMs are actually used in practice. "When you look at the OECD, it is not just mortality-based data that tell you something about the function of the mental healthcare system," he concluded.

### Stakeholder voices: The point of view of the users

Discussion from main stakeholders juxtaposed viewpoints of professionals, users, and families of men-

quality in terms of patients' expectations: "Easy access to care means that you have so-called accessible places to go when you are mentally ill. You don't want a complicated organisation where you need to get a referral from your healthcare centre to see a specialist – whether that is a mental health nurse or a psychiatrist. In Finland there is a good example of this: the Open Dialogue method.

"The more the patient learns about his or her condition, the better placed he or she will be to take control of it. Psycho-education should be an integral part of an overall treatment plan. It may also help the patient to keep taking their medication. It is very important to answer patients' questions on what to expect in the future regarding all aspects of life. Each patient will need to work together with psychiatrists and healthcare teams to determine what combination works best for him or her. Also, it is very important for patients to get honest information on the side-effects of medications, as well as information on mental health services, self-help groups and other services, and information on self-management tools."

She stressed the importance of self-help groups in offering a voice to people to discuss medication side-effects and self-doubt. This has the effect of reassuring them, and improves adherence. "The only real experts in living with mental health disorders are those who are really doing so. They are experts by experience, and this has nothing to do with the special expertise of doctors. Most support groups are full of people who can share how they have managed to cope and move on with their lives."

Ms Kärkkäinen highlighted the importance of holistic care, noting that as much as people with physical conditions are more likely to suffer also from mental illness, people with mental health conditions are less likely to receive physical healthcare. She defined a safe place for

*"The [schizophrenia] mortality gap is actually bigger than the socioeconomic gap."*

Niek Klazinga

tal healthcare service users.

Speaking on behalf of the Global Alliance of Mental Illness Advocacy Networks (GAMIAN) was its European President Hilka Kärkkäinen. Quality of care, she explained, often means different things to the doctor and to the patient.

She detailed the meaning of

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*"Patients want to be equal partners. They want to be heard, not to be told."*

Hilkka Kärkkäinen

patients to make treatment options as possibly being a small and secure care home (rather than a psychiatric ward), or a psychiatric department within a common hospital. Admittance can be frightening, she explained.

Speaking of the relationship between doctor and patient, she went on: "Patients want to be equal partners. They want to be heard, not to be told. They must feel that the illness can happen to anyone. Mental health patients often feel worthless, and they have lost their zest for life. It is important to give them hope."

She concluded: "Quality of care has not improved [worldwide] to the same extent as that for physical

conditions. The rate of improvement is slow compared to general medical conditions.

"Patients' quality of outcomes should be an essential part of measuring quality of care. The field of mental health quality improvement needs the involvement of patients."

#### **Stakeholder voices: The point of view of the families**

Martine Frager-Berlet, Vice-President of the European Federation of Associations of Families of People with Mental Illness (EUFAMI), spoke about the significance of the family behind each person suffering from mental illness.

EUFAMI was involved in a survey, Caring for Carers, assessing the experiencing of family caregivers caring for a relative with severe mental illness from an international perspective, which highlighted the central role that they play.

"What is person-centred mental healthcare? It is about focussing care on the needs of the person, rather than the needs of the service," she said. "Mental healthcare workers have to be flexible to meet the needs of patients, and to make our system suit them, rather than the

other way around."

Ms Frager-Berlet highlighted the important role that the family plays – often giving up work in order to care for their family member suffering from mental illness, as well as informing professional teams about life events, risks of relapse and of the impact of care upon the condition of the person in question. She noted a general reporting from families regarding a lack of accessibility of services.

Caring for Carers evidenced that around 90% of families wanted more opportunities to meet and share knowledge and experience with professional carers, other family members and peer groups. "Carers don't feel involved in impor-

tant decisions," noted Ms Frager-Berlet. "Those decisions have a very big impact on them, as families. Only 1 in 3 are satisfied with their involvement in important decisions in treatment and care planning. Less than 4 in 10 carers feel that medical staff take them seriously."

She also highlighted the mental health consequences of care for caregivers, with issues such as lack of sleep, stress and severe depression, as well as physical health problems, being prominent.

Wide availability of mobile services was noted by families as one potential way of avoiding crises. In addition, better mental health education of primary carers (such as general practitioners, nurses and childcarers) was cited as important. Emotional support, respite care, and financial support, were also noted.

Outcomes that family carers cited as important, she said, included goals such as: the patient no longer denying their illness; their compliance in the long term with medication; that they have regular activity, independent housing, and happy relationships; and that they are able to ask for help. "We call that 'recovery'", she concluded.

*"What is person-centred mental healthcare? It is about focussing care on the needs of the person, rather than the needs of the service."*

Martine Frager-Berlet



# E-mental health

## International perspectives

An international joint symposium taking place this morning brings together perspectives from different continents on the topic of e-mental health. Representing the Asian Federation of Psychiatric Associations is Afzal Javed (Coventry and Warwickshire Partnership NHS Trust, UK), who spoke to *EPA Congress News* ahead of the meeting about the potential benefits of e-mental health and the challenges in its implementation across a diversity of economic and social backdrops.

E-mental health is assuming an important position in Asian countries, said Dr Javed, despite technological limitations of less economically developed nations and regions meaning that the pace of its development is slower than in Europe. Speaking about its major applications, he said: "Some countries have started e-mental health programmes with consultations and assessments over the phone, using Skype and other media.

"One of the objectives in the action plan of the Asian Federation is to start some pilot projects in developing countries with the support of developed countries, to see how we can set up e-mental health services in those countries."

In Pakistan, for example, an e-clinic has been established, with World Health Organisation support, with the objective of linking remoter rural areas of the country to university hospitals or large psychiatric centres, removing geographical barriers to care. "The results so far from that pilot are very encouraging," noted Dr Javed. "And in India, there have been a number of similar projects that are underway."

Asked what such

has been the experience so far of people using these services, Dr Javed spoke about the particularities of remote care, and the pressures this can put on culturally established modes of dealing with mental health issues: "In many parts of Asian countries, and especially in the low-income countries, it is still considered that face to face contact with a health professional is most rewarding. Second, when it comes to using these gadgets, people may have reservations about describing and explaining their feelings.

"Third, unlike many of the European countries, in many Asian countries patients are usually accompanied by a number of family members who really speak on behalf of the patient and may be able to give collateral history. All of these issues are barriers. But in practice, using these tools actually

helps us to overcome them."

Moreover, these barriers must be overcome in order to address the overarching issue of access to care, one of the most important challenges in Asian countries: "We do not have enough infrastructure, enough mental health professionals, or mental health units. It seems very promising that, if you use e-mental health, at least you can improve access to care."

Looking back to his own medical training in Pakistan, at a time when psychiatry was emerging as a specialty in the country, Dr Javed spoke more generally on the growing shift in attitudes towards mental health that have followed: "There have been massive changes. There are more than 120 medical schools in Pakistan, and today it is mandated by law that there is a faculty member in behavioural sciences — these are the psychiatrists. So there are more people becoming interested in psychiatry, there are more jobs available, and there is more awareness and acknowledgment.

"Social media and the internet have also made people more aware about the impact of mental health problems. The general population is gaining more access about how to reach this profession.

"The third thing that is very encouraging (although we are still not up to the mark) is that the other medical specialties have started realising the importance of mental health. Referrals from physicians in other specialties are increasing, because the new generation of specialists

are looking more at the impact of mental health." This change is also reflected in a shift away from large psychiatric hospitals to smaller units within district general hospitals, he added.

Bringing e-mental health into broad use means introducing its concepts to the medical training curriculum, continued Dr Javed. This, he said, should take place not only in psychiatric training, because it is crucial that all healthcare professionals have a more positive attitude about tackling mental health issues.

"We should also encourage collaboration and linking of low – and high-income countries for these projects. For example, the Royal Australian College are very keen to develop and help countries in the Western Pacific as well as in other parts of the Asian region. If we could implement these, it would increase recognition and help us in terms of implementation."

As WPA President-elect, Dr Javed is developing an action plan prioritising the planning of safe and accessible services, especially for low-income countries. "One of the salient features of the action plan is to formulate policies in terms of convincing governments and states about the access to care for the mentally ill," he said. "At the moment I am collecting data from almost all countries in all continents on available facilities, what needs to be done, and how we can convince policymakers to include this in their actions.

At our WPA meetings we plan to initiate some discussion sections on access to care and improving the image of psychiatry. We would really like the active contribution of the EPA, because it is a well-established mental health organisation, full of resources, full of ideas."

**'Mental health in different continents: Challenges and Opportunities' presents perspectives from Asia, Africa and Latin America, today from 8:00 to 9:30 in Euterpe.**



*"Social media and the internet have made people more aware about the impact of mental health problems."*

Afzal Javed

**Attention-deficit hyperactivity disorder and suicide** Thalie Monday 10:00

# ADHD, NSSI and suicide

## What role do comorbidities play?

**D**uring tomorrow's session discussing the relationship between ADHD and suicide, Judit Balazs (Institute of Psychology, Eötvös Loránd University, Budapest, Hungary; Vadaskert Child and Adolescent Psychiatry Hospital, Budapest, Hungary) looks at the role of comorbidity in ADHD and suicide as well as non-suicidal self injury (NSSI).

An increasing volume of literature has been dedicated to NSSI over the last decade. Dr Balazs herself is part of the European Evidence-Based Suicide Prevention Program [EESPP] Group by the Expert Platform on Mental Health, Focus on Depression, who recently published a position paper<sup>1</sup>. She has also recently co-authored on ADHD and suicide<sup>2</sup>, as well as on suicidal behaviours in young migrants<sup>3</sup>, and in adolescent clinical populations<sup>4</sup>.

Dr Balazs began her career by interviewing patients who had recently attempted suicide, who were taken to the central hospital in Budapest. She found that suicide was associated with psychiatric disorders in 88% of cases, with an additional 6% suffering from sub-threshold psychiatric disorder.<sup>5,6</sup>

"As a clinician, I treat a lot of patients with ADHD," she told *EPA Congress News*. "It is one of the most common psychiatric disorders in the clinic among young children, and in adolescence untreated ADHD cases are very often comorbid with behaviour, mood, anxiety and/or substance use disorder."

ADHD and suicide are bound together by impulsivity, she went on to say. Investigations of their relation in a sample of patients under the age of 12 and in adolescence identified not a direct link between the two phenomena, but that comorbid disorders fully mediated their association. Interestingly, different disorders were found to mediate under the age of 12 (these were mainly anxiety disorders) compared to adolescence (mainly mood disorders and substance use disorder).<sup>7</sup>

It was this work that led to investigation of non-suicidal self injury (NSSI), which became an individual diagnosis for the first time in DSM-5 under the section 'Conditions for Further Study', said Dr Balazs. "Over these past 20 years we have the impression that we see more and more youth with this problem in clinical practice. The prevalence of NSSI is lower among adults, but the question is: why? Is prevalence of NSSI really increasing among adolescents nowadays? Do those adolescents who have NSSI now, not reach adulthood? Or maybe it is not reported by adults?" Longitudinal studies will address these questions, she noted, yet the issue must still be



*"Maybe the non-suicidal aspect should not be highlighted if NSSI is on the suicidal spectrum."*

Judit Balazs

ameliorated in the meantime.

One of the most curious aspects of the NSSI puzzle is in fact its name, noted Dr Balazs, because the relation of NSSI to suicide is at present poorly characterised: "There are shared comorbid conditions in NSSI and suicide, such as borderline personality disorder, depression, anxiety, alcohol dependence and ADHD. But there are things that seem to be different between suicide and NSSI cases, such as the frequency and methods of self-injuring and specific comorbid and personality disorders. Is NSSI a good name? Maybe the non-suicidal aspect should not be highlighted if NSSI is on the suicidal spectrum."

Individuals with ADHD and NSSI share the characteristic of poor response inhibition, which is associated with impulsivity. Dr Balazs has investigated the mediators of this association, as well as looking at gender differences in ADHD and NSSI<sup>8</sup>. "We involved in this study adolescents who were hospitalised in our psychiatric clinic. Altogether we involved more than 200 inpatients, boys and girls equally, ending up with 52 adolescents who fulfilled the criteria of ADHD according to the DSM. We even enrolled a further 77 patients with sub-threshold ADHD,

which is another issue we focused on.

"We found that more than two-thirds of the 52 adolescents with ADHD had NSSI. This is alarming. What is more alarming that in the group of patients with ADHD and NSSI were significantly more girls than boys.

"It is very interesting that most researches focus on boys with ADHD, while in youth the prevalence is higher among boys. But there is thinking now that ADHD is under-diagnosed in girls. Attention problems seem to be more important in girls. We have known for a while that among adults the prevalence seems to be more equal. Our current adolescent data shows very clearly that we have to screen and focus on girls with ADHD as well because this risky behaviour, as NSSI, is significantly higher among girls."

"We also found that the connection between ADHD and NSSI is fully mediated, as it is with suicide, with comorbid symptoms and conditions. Affective disorders (mood disorders, and suicidal behaviour) mediated this connection, and psychotic disorder. For girls, alcohol abuse and dependence was an additional mediator."

These findings imply that screening of NSSI is important in ADHD, because NSSI can increase the risk of future suicide.

They are also interesting in the context of

*Continued on page 6*



**Attention-deficit hyperactivity disorder and suicide** Thalie Monday 10:00

# ADHD, NSSI and suicide

*Continued from page 5*

changing concepts around NSSIs and externalising disorders – Dr Balazs was recently the senior author of a systematic review paper noting that the topic of NSSI and internalising disorders has historically been more extensively studied<sup>9</sup>: “It was previously thought that externalising disorders are comorbid with other externalising disorders, and internalising with internalising. It was not so clear before that ADHD could be comorbid with depression. But it is very logical, and we now see it. From adolescence, people often don’t come to the clinic with ADHD, they come because they are depressed and stressed and have other problems. People with ADHD are frustrated at school or work, they have low self-esteem, problems with teachers, colleagues, bosses, parents, husbands, wives. So depression is often comorbid, as well as anxiety and other things.

“It is true that depression is the most common risk factor among psychiatric disorders for suicide. But it took a time for all of us to turn from this internalising/externalising. We have to

perceive systematically what we see in clinical practice, and to focus on externalising psychopathology as well.”

One limitation of the NSSI-ADHD study was in its population being exclusively recruited in the in-patient setting, where general psychiatric condition is poorer. Indeed, Dr Balazs hopes to extend this work in the near future to investigate the relationship between ADHD, and sub-threshold ADHD, and NSSI in a population without severe psychiatric comorbidity.

Dr Balazs was, however, cautioning about the risks of such investigations of sub-threshold traits within the healthy population. “We have to be very careful because we don’t want to medicalise more people,” she said. “But on the other hand, it is an important issue that even sub-threshold psychopathology increases the risk for full psychopathologies and increases the risk of suicide.”

**Dr Balazs speaks during ‘Attention-Deficit Hyperactivity Disorder and Suicide’ between 10:00 and 11:30 tomorrow in Thalie.**

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**Presidential Symposium: Vulnerable people in humanitarian emergencies** Apollon Sunday 10:00

# A respectful partnership

## The role of psychiatry in humanitarian settings

Last year saw the publication of the World Psychiatric Association’s (WPA) Action Plan for 2017-2020, the continuation of WPA’s contribution to supporting the profession of psychiatry, developing programs that focus on critical mental health topics and people living in adversity, and attracting new investment to support this work.<sup>1</sup>

WPA President Helen Herrman will contribute to today’s session on vulnerable people in humanitarian emergencies with a discussion of a program, initiated as part of the latest WPA Action Plan, to strengthen the contribution and availability of psychiatrists in national and international responses to conflict and humanitarian emergencies. The program is being initiated in Latin America with support of the mental health platform citiesRISE<sup>2</sup> and the Juan Jose Lopez-Ibor Foundation and engagement of local partners.

There is scope to extend this work over time, with the possibility of regional and national associations becoming involved in other regions including Europe alongside government and community partners. Falling under the definition of humanitarian emergency is not only conflict and natural disaster, but adverse living states (such as major city slums) and displaced communities.

“This initiative is based on the idea that psychiatry is a partner in emergency responses,” Professor Herrman told *EPA Congress News*. “It is a necessary but not sufficient response to mental health needs for psychiatrists to become involved. An appropriate response at population and individual levels to the mental health needs of people living in adversity is much enhanced when the expertise and experience of psychiatrists is included, when there is respectful partnership, and

when there is consideration of human rights in the community involved.”

Professor Herrman will focus on elements of specific clinical care as well as the capacity to train and collaborate successfully with others under such circumstances.

There are many groups doing important work in this area, explained Professor Herrman. The World Health Organisation (WHO), United Nations Children’s Fund (UNICEF), and major non-government organisations have worked together to create guidelines about responding to needs for psychosocial support in emergencies, detailing the determinants of mental health such as community stability, employment and housing. Extensive work is underway for example through Médecins Sans Frontières (MSF), the International Medical Corps (IMC) and the American Psychiatric Association.

“We are not coming into vacuum,” noted Professor Herrman. “WHO worked with WPA some years ago to conduct a combined training course for psychiatrists, to equip them to work with other groups in the emergency response in its various phases, from preparedness to aftermath.

“The disaster experience has also been used as an opportunity to ‘build back better’. In some countries such as Sri Lanka, and in Aceh in Indonesia, for example, responses to the 2004 [earthquake and tsunami] disaster has brought community mental health services where there were few services before.”

The backbone of much of the response to disasters such as the 2004 Indian Ocean earthquake and tsunami has been formed by either lay or nonspecialist health workers, under the supervision and training of mental health specialists including psychiatrists. Tools are

**Presidential Symposium: Vulnerable people in humanitarian emergencies** Apollon Sunday 10:00

being developed by organisations such as WHO and IMC for training community groups and primary healthcare workers. Low intensity psychological interventions are also emerging, from WHO and others, targeting emotional distress and the strengthening of community connections.

On the topic of evidence linking practice and research, Professor Herrman noted work by Tol et al

*"The most important safeguard for mental health is community connection of various kinds."*

Helen Herrman

(2011), which reviewed evidence from implementation studies of mental health and psychosocial interventions in humanitarian settings. The investigators found evidence in support of strengthening community and family support and specialised services (such as narrative exposure therapy and meditation-relaxation treatment) under different circumstances. However, research and evidence was found to focus on infrequently-implemented interventions, with commonly-used interventions undergoing little rigorous scrutiny.<sup>3</sup>

"We have an important gap in our knowledge base. The research is practically and ethically difficult in the circumstances. But it is also important to pursue."

Cultural sensitivity is increasingly

recognised as critical to the success of foreign intervention, said Professor Herrmann. "Harm can also be done. When aid groups arrive they have been described as the second tsunami, almost compounding the problems of people as much as relieving them."

Hence, sensitivity to difference, both cultural and inter-individual, is crucial. For example, stress and disturbance following humanitarian emergency recede at different rates for individuals affected. Mood and anxiety disorders might be a longstanding risk for some. Primary care workers need tools to deal with the consequences they may be less familiar with such as substance abuse, sleeplessness, or even bedwetting. Pre-existing mental health conditions are another particular

challenge under conditions of intensified stress and interrupted medical supplies.

Returning to the particular issue of cross-cultural collaboration, Professor Herrman stressed: "The evidence tells us that the most important safeguard for mental health is community connection of various kinds. This lies behind the role of everybody concerned in psychosocial support. It can range from how food is distributed, and how housing is allocated, to ensure that vulnerable groups (including women and girls) are first in line rather than last in line. The same goes for employment, schooling and other needs.

"So the role of the psychiatrist will be indirect in many of these matters. It is important to keep in mind that psychiatrists are not imposing themselves on people, or expecting everybody to talk about their problems. This kind of intervention is no longer regarded as helpful and may even be harmful. Psychiatrists can help make sure that people are aware of what to expect in terms of their reactions, where they can get assistance, and to know that that can be helpful. They are needed for the care of people with complex conditions and for the training and support of primary care and community workers"

Recent humanitarian emergencies have seen the collaborative response of a number of non-governmental organisations including the International Red Cross, MSF, and the IMC. Still, there never is enough capacity, explained Professor Herrman, and coordination is critical. "Preparedness is important. Coordinating groups meet regularly during an emergency. Some of the aid groups may not include mental health in their work, though IMC and MSF do. And major aid groups tell us that it's often hard to find psychiatrists who are available and culturally attuned when they are needed."

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# A network theory of mental disorders

**D**enny Borsboom (University of Amsterdam, the Netherlands) delivers a plenary lecture this morning on a conceptualisation of mental disorders as an emergent property of direct interactions between symptoms. The theory integrates the biological, psychological and societal mechanisms causally related to symptoms and, importantly, models a feedback mechanism describing how psychiatric disorders become self-sustaining.<sup>1,2</sup>

In an interview with *EPA Congress News*, Dr Borsboom discusses the concept and its implications for the way in which diagnosis and treatment is represented and understood – which could be beneficial not just for clinicians, but for patients too.

## How have you applied network theory to integrate the factors involved in mental disorders?

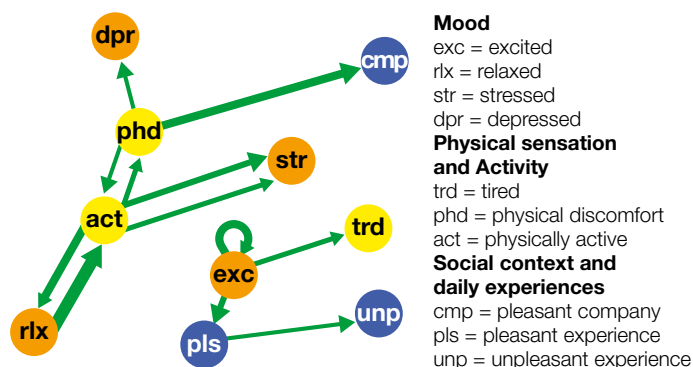
In the network theory, psychiatric disorders arise from causal and homeostatic relations between symptoms that often engage in feedback loops (e.g. worry → insomnia → concentration problems → feelings of worthlessness → worry). If the causal effects that symptoms have on each other are sufficiently strong, the symptom network can sustain its own activation.

Simulations show that this can happen when the level of connectivity crosses a certain threshold relative to the external stressors that impinge on the network (e.g. losing one's job, feelings of worthlessness, or chronic pain, insomnia). In such cases, the network can get 'stuck' in the disorder state, so that even if the external stressors wane, the disorder remains.

Psychiatric disorders, as we currently recognise them, are then to be seen as sets of symptoms that have particularly strong causal rela-

tions between each other. That is, the reason that paranoia and delusions are in the same disorder, while paranoia and low self-esteem are not, is that in the symptom network at large paranoia is closer to delusions (i.e. the causal interaction is more direct) than to self-esteem.

**Is network analysis, therefore, a formalised version of what a psychiatrist might do in successfully treating a patient, by evaluating the corpus of autobiographical history, personality traits, etc.**



**Figure 1. Predictive relations between a number variables. Green arrows indicate that an increase in the source node predicts an increase in the target node at the next time point. Red arrows indicate that an increase in the source node predicts a decrease in the target node (these effects are statistically controlled for all of the other nodes). In this example, increase in exercise (exc) predicts a decrease in tiredness (trd) but an increase in pleasant experience (pls). Such graphs can help in the selection of interventions, and may in time also be used to monitor the effect of interventions in real time.**

## that might be feeding into the patient's psychiatric condition?

Yes. The network approach aims to uncover the causal and homeostatic relations between symptoms and other variables that are responsible for the onset and maintenance of disorder states. In our view, such network models match the 'natural' way of thinking about patients – as already exhibited by many practicing psychiatrists and clinical psychologists – much closer than more traditional models, in which the correlation between variables is explained by an untraceable and often somewhat mysterious 'latent disorder'.

Many of the interactions between symptoms rest on prosaic processes that are often quite well understood in terms of the underlying biology and psychology, and that could become the renewed focus of scientific research. This means that network models have the potential to greatly improve the 'interface' between clinical practice and scientific research because they can better align the conceptions of mental disorder used in science and in clinical practice.

## Could you relate your work in network analysis to other innovative frameworks such as the Research Domain Criteria (RDoC)? how could these potentially fit together?

RDoC identifies basic components involved in mental disorders (e.g. memory, attention, sleep) and details the psychological and biological underpinnings of such components. This is highly useful work. What RDoC still misses, in my view, is an assessment of how the different components in the system are linked, both causally and homeostatically, and how variation in their functioning plays out dynamically over time.

I do hope RDoC will move in this direction in the next few years, as it has great potential to link different sources of scientific knowledge to each other. RDoC has proved effective in getting scientists from different fields to engage with the project.

I suspect that networks could also be used to connect RDoC to the more traditional disorders as documented on DSM and ICD.



After all, the basic components in RDoC must somehow give rise to the statistical grouping of symptoms that these diagnostic manuals partly rest on. My guess would be that the missing link between RDoC and DSM could therefore very well be a network model.

**In the network analysis conceptualisation of a given disorder, is there the possibility to encode within it the disorder's time course**

**(e.g. prodromal phase and schizophrenia; or early and latter stages of bipolar disorder)?**

In view of the time course of disorders and the timescales at which causal processes play out, the network structures that are currently reported and that typically extracted from statistical analyses (i.e. so-called pairwise Markov random fields) are still simplistic.

Many disorders are characterised by interactions at different time-

scales (e.g. insomnia/fatigue builds up over days, while fear/avoidance plays out over minutes). What is more, these time scales often also interact with each other. For instance, fatigue as built up over a number of days can increase the strength of instantaneous interactions like fear/avoidance.

There is a lot of work waiting to be done in figuring out how to analyse such systems. However, I think we can learn a lot from other

fields where researchers have been accustomed to thinking about interactions on different time scales, like climate science and ecology.

**How can network analysis data be applied in the psychiatric setting to understand disorders as a whole, and the individual patient?**

I hope that the network analyses will bring us a bit closer to unravelling the causal architecture of mental disorders. Ideally, we would develop a detailed understanding of the way symptoms and other problems influence each other: on which time scale and through which mechanisms. This may lead to novel approaches to treatment that will hopefully be more effective

*"Such network models match the 'natural' way of thinking about patients."*

Denny Borsboom

than current interventions.

For individual patients, there is the additional benefit that network models naturally incorporate person-specific factors. Thus, it should be much easier to tailor interventions to the individual's situation. I have also come to suspect that the network representation itself has a certain amount of empowerment. When patients see the causal graph with all their problems in it, that may help them understand more about these problems and how they interact. That in itself can demystify these problems and make them a bit more manageable.

**Dr Borsboom delivers 'An innovative conceptualisation of mental disorders: the Network Approach' in Apollon between 11:45 and 12:30 today.**

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# Debate: Is antipsychotic polypharmacy better than monotherapy?

Today at EPA Congress delegates will hear arguments in favour of and against antipsychotic polypharmacy. Polypharmacy is a clinical issue characterised by highly heterogeneous data<sup>1</sup>, as well as being associated with greater illness acuity, severity and chronicity<sup>2,3</sup>.

The use of polypharmacy is widespread, despite guidelines recommending against it and poor understanding of the reasons for its use. The trends of anti-psychotic polypharmacy have remained fairly stable over the last decade, but vary quite strongly across regions and settings, according to a 2012 meta-analysis<sup>4</sup>.

Chris Correll (The Zucker Hillside Hospital; Hofstra Northwell School of Medicine; and Feinstein Institute for Medical Research; NY, USA) will be defending the appropriateness of polypharmacy under certain clinical circumstances, while Stefan Leucht (TU-München, Germany) argues against the proposition.

## The case against polypharmacy

"Antipsychotic combinations are quite irrational," said Professor Leucht to *EPA Congress News*. "All antipsychotics are dopamine antagonists. The combination, therefore, doesn't make any sense."

While different antipsychotics are known to exhibit different degrees of promiscuous binding, explained Professor Leucht, the dopaminergic mechanism remains the principle mechanism of action.

Moreover, binding profiles for specific drugs are not completely elucidated: "We don't really know what the effects are on the various receptors for a single antipsychotic compound, and what this means. So if you combine two, we know even less."

"There is very little

*"All antipsychotics are dopamine antagonists. The combination, therefore, doesn't make any sense."*

Stefan Leucht

evidence supporting this strategy. In a 2017 systematic review and meta-analysis of antipsychotic augmentation versus monotherapy in schizophrenia<sup>5</sup>, we saw some effects when we included all randomised trials, but when we only included double-blind trials, the effect disappeared.

"Then there are more pragmatic reasons, like, the side-effect burden increases, and there is a risk of drug-drug interactions. It is very difficult to be compliant with a regimen of several drugs, in particular for people with schizophrenia who may have cognitive problems."

A recent review on the safety and tolerability of antipsychotic polypharmacy noted its association with

increased global side effect burden, rates of Parkinsonian side effects, anticholinergic use, hyperprolactinemia, sexual dysfunction, hypersalivation, sedation or somnolence, cognitive impairment

and diabetes.<sup>6</sup>

What should the psychiatrist do, then, when the initial antipsychotic drug attempt does not work? "If you try one drug in the therapeutic range and it doesn't work, then you have several options. Either you switch the antipsychotic, or you increase the dose or use an

augmentation strategy (adding another compound, such as an antidepressant), or you add another antipsychotic or you use clozapine. Among all these strategies,

the clozapine approach is the most evidence-based one. But one problem with clozapine is that it has many side effects. For this reason you can only use it after you have tried two other antipsychotics.

"After clozapine, the evidence is not very strong. We have very few strategies for specific symptoms. For example, if patients have persistent negative symptoms, then the prescription of antidepressants has some evidence of efficacy.<sup>7</sup>

Two major reasons seem to dictate the pursuit of polypharmacy, continued Professor Leucht: "The bad one is that people think, 'I have tried this combination very often, I

have a very good experience with it, and I believe in it.' This is not an evidence-based approach. The other reason is when patients are resistant, we need to do something. I definitely agree on this, but it is important to always follow-up after a few weeks whether a combination works, and if it does not work, we should stop the combination."

Turning to possible alternatives to polypharmacy, Professor Leucht discussed adjunctive non-pharmacological treatment strategies, including cognitive behavioural therapy (CBT), perhaps the best evidenced strategy for the treatment of resistant positive symptoms at present.

Non-invasive brain stimulation methods present another alternative. Transcranial magnetic stimulation (TMS) is less well-established than electroconvulsive therapy (ECT), he said, and as such is not a standard treatment. "TMS could be worthwhile trying, because it is not harmful. But there is evidence for ECT from at least one well-conducted randomised trial, in which patients who did not respond to clozapine were treated with ECT, showing that it is effective. In very treatment-resistant patients ECT should be considered."

He concluded: "My credo is, if we try to combination of antipsychotics, one thing is that we should



*"The side-effect burden increases, and there is a risk of drug-drug interactions."*

Stefan Leucht



at least apply more or less rational strategies. For example, all the antipsychotics are dopamine blockers, but some of them block dopamine only very little. For example, clozapine blocks dopamine receptors by about 40%, while we usually say that 65% is necessary for antipsychotic effect. So adding a selective dopaminergic antipsychotic to clozapine, in this example, makes pragmatic sense. We don't have good evidence that this works, but it is well-reasoned.

"Then again it is very important that if they try a combination, that doctors then check whether this has worked after two to three weeks. If it did not work, stop it again and try something else. Do not keep adding a third, a fourth, a fifth drug."

### The case for polypharmacy

"Combining medications for chronic disorders has been a problem in many areas of medicine," Professor Correll said to *EPA Congress News*, "Because it can be difficult to sufficiently cover all of the different aspects and dimensions of a complex disorder, such

as schizophrenia."

Professor Correll noted that guidelines indicate antipsychotic monotherapy to be the evidence-based practice. "Clinicians seem to combine antipsychotics in

*"One of the major problems with antipsychotic polypharmacy is that it is used before or instead of initiating clozapine."*

Chris Correll

patients where antipsychotic monotherapy yields insufficient response across one or multiple dimensions of the illness that are clinically

relevant," he continued.

"However, some of the insufficient response may also be due to insufficient adherence to antipsychotic medication, which is not improved by making a medication regime even more complex."

He noted that improvements in symptoms that can be observed in the transition from one antipsychotic to another (while both agents are in the patient's system) may be due to expectation biases or other unrelated factors. Therefore, he advised, clinicians should always attempt to complete the intended switch before concluding that only the combined use of the two antipsychotics can yield the desired or enhanced efficacy.

Moreover, while there may be subgroups of patients who may do better on specific combinations of two antipsychotics, efforts to identify which patients would benefit from specific combinations relative to adequately dosed and adhered-to antipsychotic monotherapy have not so far been convincing.

"One of the major problems with antipsychotic polypharmacy is that it is

used before or instead of initiating clozapine, which is the agent with the best evidence for benefiting treatment-resistant patients," said Dr Correll. "While in meta-analyses antipsychotic polypharmacy does not seem to be superior to monotherapy, in high quality and blinded studies there may be a subgroup of patients who may benefit from two antipsychotics more than from one."

Such patients may be too sick or unwilling to participate in randomised controlled trials, he added, noting that partial evidence supporting this comes from studies that have randomised patients who are on two antipsychotics to either stay on two or go to one antipsychotic. But there is a risk in doing so: "Such trials have shown that while maybe two-thirds of patients can safely be moved to antipsychotic monotherapy with some associated benefits in tolerability, a subgroup of maybe one-third deteriorates during the switching process to monotherapy."

He added: "Although the combined use of two antipsychotics may lead to drug-drug interactions and increased risk for adverse effects, data are less convincing in this regard and some combinations, such as combining a partial dopamine D2 agonist with a full D2 antagonist may actually improve certain side effects."

*"In high quality and blinded studies there may be a subgroup of patients who may benefit from two antipsychotics more than from one."*

Chris Correll

Summarising his thoughts, Dr Correll said that antipsychotic polypharmacy should only be applied only where absolutely necessary, but avoided where possible. "Antipsychotic polypharmacy should only be used when adequate monotherapy options have been exhausted, and ideally – or especially – only after clozapine has been tried and was either refused or itself only partially effective."

"Future research in the minority of patients failing to remain stable after the attempt to switch them from two antipsychotics to one antipsychotic may provide leads to identifying such subgroups and medication combinations. However, worsening by chance or due to expectation biases in view of knowing that one antipsychotic will be removed need to be considered and ruled out too."

**The debate 'Antipsychotic treatment: polypharmacy is better than monotherapy' takes place in Athena from 15:00 to 16:30 today.**

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**EPA launches cognitive behavioural therapy massive online open course**

# Interview: Stirling Moorey

## MOOC lecturer in cognitive behavioural therapy

**E**PA's massive online open course (MOOC) launches on April 9. The MOOC delivers training to a wide group of people via the internet, with interaction and exchange complementing a series of lectures.

The first EPA MOOC, on the topic of cognitive behavioural therapy (CBT), will be taught by Stirling Moorey (South London and Maudsley Hospital UK), who spoke to *EPA Congress News* ahead of the launch. The course's aim, he explained, is to address the interest of psychiatrists to learn psychological therapy techniques (with CBT probably having the most evidence for its effectiveness), in an area that is not routinely part of psychiatric training throughout Europe.

**What is included in the CBT MOOC syllabus?**

The MOOC will primarily look at CBT for anxiety and depression but will also address some aspects of more serious mental illness, such as psychosis.

It is divided into four weeks. The first looks at the history of CBT, the way it grew out of behavioural therapy, its standard approach based on the work of Aaron Beck, which looks at the contents of negative thoughts. We also look at the 'third wave', which is more about the relationships that one has with one's thoughts, decentering from them

and using techniques like meditation. The second week is looking at the cognitive model of anxiety and depression, an overview of treatment for anxiety and depression, and the evidence with respect to this.

The third week is devoted to a single case. This is a patient case of my colleague Suzanne Byrne's (Cognitive Therapy Course Director at King's College London, UK), and we have three role play videos, where I interview her (in the role of the patient) in a therapy session. In the final week, we look at the application of CBT in everyday psychiatric practice.

**How interactive will it be?**

I have recorded a series of 5-10 minute mini-lectures, and put the teaching course together. Each week of the course there are five more of those lectures that people can watch. We have also recordings of me interviewing leaders in the field of CBT.

Shortly after the EPA Congress [April 9], the MOOC will start, and people can do it in real time over those four weeks. They can view the videos any time they want, and they can discuss them in the forum. The MOOC will be launched once again prior to the next EPA Summer School (September 6-9), with another opportunity to do it in this interactive way.

**How have you adapted the course****material to suit the online learner, especially considering possible restrictions in access to supplementary literature?**

A big challenge has been to deliver this to camera, rather than to an audience where you can interact. I do this as an introductory workshop with psychiatrists at the Maudsley Hospital and at the EPA Congress. In those settings, you can tailor what you are saying to the audience and get feedback from them. It is quite a big challenge to semi-script what you are saying, and then say it to camera in 5-10 minute segments, without it seeming artificial.

Because of the uncertainty as to whether people are going to be able to access library references and so on, and also because of issues around copyright, I have ended up writing an accompanying summary of what I am saying in each video, which also adds a bit more. For each individual lecture and chapter, there is a reference list. But where we can we have put in online resources that people can access for free, giving them the opportunity to supplement what is on the MOOC.

**What prompted the creation of the MOOC, and can anyone enrol?**

The MOOC came about because the EPA Secretary for Education Cécile Hanon and others thought it would be helpful for young

psychiatrists to have access to online training.

They chose CBT because there had been an interest expressed by young psychiatrists in getting trained in this. They get quite a lot of training on the biological side of psychiatry, in the prescription of drugs, and so on; but they are often quite interested in learning psychological therapy techniques – and training is patchy across Europe.

While it is produced by the EPA, the platform is a MOOC platform. Because this is 'open', it is available to anyone. But it will be primarily advertised to psychiatrists.

**Who else was involved in the development of the MOOC?**

I am very grateful that they have given me the opportunity to take part in it, as the first MOOC that they have done. This is an innovative thing for the EPA.

The quality of the production has been excellent. I would also like to thank Suzanne Byrne: although I primarily put together the course material, it has been very much a team effort.

Cécile Hanon is also thinking about getting the text, and possibly the audio, translated into different languages. This is going to be an exciting learning opportunity for junior psychiatrists to access teaching from all over Europe and beyond.

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**Setting priorities for mental health research in Europe** Hermes Sunday 10:00



*"Funding is still low compared to the impact of mental disorders in the population."*

*Josep Maria Haro*

## ROAMER

**"We need to continuously push for these goals"**

The research priorities that emerged from ROAMER (Roadmap for Mental Health Research in Europe) were first published in 2015. The project underscores the need for greater funding in neuropsychiatric disorders, currently the third leading cause of disability in Europe, with mental disorders accounting for approximately 20% of the burden of disease in the European region.

ROAMER covered six major domains: infrastructures and capacity building, biomedicine, psychological research and treatments, social and economic issues, public health and well-being. State-of-the-art and strength, weakness and gap analyses were conducted within each of these areas, before future research priorities were established.

The process included participations from a diversity of European expert researchers together with service users, carers, professionals, and policy and funding institutions.<sup>1</sup>

Speaking of the ways in which ROAMER has influenced research in Europe, project coordinator Josep Maria Haro (CIBERSAM, University of Barcelona, Spain) told *EPA Congress News*: "The first priority we had was research into children and adolescents. This was one of the topics in the first European calls, and in that sense we have been successful. There is now a new call for projects on the topic of mental health in the workplace, which was also highlighted by ROAMER as well others trying to push for research in this area.

"We have also influenced other topics that mention mental disorders. There were some in silico models for chronic conditions, and other work on physical and mental comorbidities. So there has been some effect on the European level."

ROAMER has also been influential at the national level, he continued. For example, ROAMER priorities were taken up by the Medical Research Council UK as topics to be funded in the coming years. ROAMER priorities were also actively advocated for in France, with symposia focused specifically on this aim.

The effects of ROAMER, stressed Dr Haro, will only be seen if they are continuously pushed for. In this vein, ROAMER recently characterised national funding allocations for mental health research in a study comparing Finland, France, Spain

has returned.

"There is much to learn, because our treatments are still not completely effective. Despite this, funding is still low compared to the impact of mental disorders in the population."

Dr Haro compared funding in mental health research to that of cancer. In 2014 the UK spent £370m on cancer research, and only £109m on mental health. A report from 2010 placed charitable donations for cancer at £2.75 per £1 of government spending, versus only £0.003 per £1 for mental health<sup>3</sup>. "This is another aspect that we need to be conscious of," said Dr Haro. "The real issue is that we need to continuously push for these goals.

"You need to continuously act to influence policymakers to increase funding for research. While the topics need to be revisited every three or four years, probably the ROAMER project's results will be quite similar over the coming years, because there will be little change in investment and research priorities. The only way to overcome the issues in mental health is to do more research — basic research that can then be translated.

"Another aspect that we discovered during the project is that all this is relatively unknown in the mental health profession, in the sense that there are many who are not so conscious that we need to push for this increase in funding. They see research as being far away from their day-to-day work. This is something we have to illicit at a professional level."

**Dr Haro will discuss ROAMER goals during the session, 'Setting priorities for mental health research in Europe', taking place in Hermes between 10:00 and 11:30 today.**

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*"The only way to overcome the issues in mental health is to do more...basic research that can then be translated."*

*Josep Maria Haro*

# Moving towards psychosis prevention in Europe

This afternoon's workshop will be led by Anita Riecher-Rössler, Professor of Psychiatry and Head of the Centre for Gender Research and Early Detection at the Psychiatric University Clinics in Basel (Switzerland), together with Nadja Maric Bojovic from the University of Belgrade (Serbia).

Professor Riecher-Rössler will be talking about the need for early intervention services for psychosis and their limited availability in European countries. In her opinion, such services should now be implemented everywhere and should not only aim at early detection and treatment of frank psychosis, but also at differential diagnosis and early reliable assessment of the at-risk mental state.

"Indeed, there is now plenty of evidence from research and clinical practice to justify the implementation of early detection and intervention services for psychosis all over Europe with low-threshold access for all patients," she told *EPA Congress News*. "On the one hand, the accurate identification of individuals at risk and prediction of transition to psychosis is now possible. On the other hand, early intervention has shown to be effective not only in preventing transition to psychosis, but also in ameliorating the current suffering of patients."

Attitudes to intervention services have certainly changed, she noted. Professor Riecher-Rössler started the first specialised clinic for the early detection of psychosis in Switzerland in 1999 as well as the FePsy project (Früherkennung von Psychosen – early detection of psychosis), a long-term follow-up study of individuals with a suspected risk for schizophrenic psychoses. "Traditionally, psychiatry (as opposed to other disciplines in medicine) was not so much interested in early detection and prevention," she said. "This has been changing

in the recent two decades, starting with the field of psychosis. It will hopefully also spread to other fields of psychiatry. We can see some-

cation for professionals, patients, their relatives and the public," she said, adding that there is also a distinct lack of policy that will ensure

these elements are put in place and that funding is secured. Psychiatrists and different lobby groups are increasingly interested in this modern approach, she added.

The aim of today's workshop, concluded Professor Riecher-

Rössler, is to analyse the current status of implementation in different countries around Europe. A number of speakers will present figures from individual countries as well as comparisons between nations: "We will discuss the potential obstacles in different countries and the different ways to overcome them."

"One of the main obstacles certainly is the traditional view of psychiatry as being mainly a discipline for treatment, not for prevention. But with these services we do not only aim at prevention – which would be a worthwhile aim in itself – but also at offering evidence-based help to patients who usually already suffer a lot in the different stages of emerging psychosis."

**The educational workshop 'Implementing early detection and intervention services for psychosis in Europe: obstacles and how to overcome them' takes place in Erato from 17:00 to 18:30.**

*"As regards the area of psychosis, there is enough evidence for establishing early detection and intervention centres now."*

Anita Riecher-Rössler

thing like a paradigm shift here."

Despite these advances, coverage of intervention services is still patchy throughout Europe. Of course, some areas have well-established services that are becoming even more wide-reaching and complex by offering interventions such as vocational, educational and family support, as well as targeting physical health. However, there are marked differences in service availability and structure even within high-income countries, noted Professor Riecher-Rössler.

"There is still a lack of transfer from research to the clinic in most European countries – indeed a lack of broad implementation of early detection/intervention centres, guidelines, training and edu-

*"There is still...a lack of broad implementation of early detection/intervention centres, guidelines, training and education."*

Anita Riecher-Rössler





# The challenge of psychotropics in elderly people

## An urgent need for more data

The treatment of geriatric patients with psychotropics will be the focus of a workshop taking place this afternoon. Professor Gerd Laux, specialist psychiatrist, neurologist and psychologist at the Institute of Psychological Medicine (IPM) in Soyen, and consultant psychiatrist in the Geriatric Hospital of the Kreiskliniken Mühldorf at Haag, Upper Bavaria, Germany, has gained considerable insight into this particular area.

Professor Laux is a member of the EPA Section of Psychopharmacology, which organised the workshop at this year's Congress. Speaking of the motivations for this workshop, he told *EPA Congress News*: "Treatment of geriatric patients with psychotropics is an under-investigated area. There is very limited data available."

Professor Laux will present a study of over 1,080 treatment cases from the last three years. The aim of the analysis was to detect psychiatric illness and psychiatric and physical comorbidities, as well as looking at psychotropic medications prescribed in an effort to assess their adequacy.

Professor Laux said that, of the sample, the average age was around 81 years old, the sample included more women than men, and the average number of oral medications being taken was 11. Those medications included anti-hypertensives, diabetic medication, anticoagulants, Parkinson's medication, sleeping pills and analgesics.

Professor Laux said there is a mismatch between the kinds of mental health services that older people

require compared with what they end up receiving. "Traditionally so far only about 1% of geriatric inpatients receive a consultation with a psychiatrist while about 40% suffer from co-morbid psychiatric illness," he said.

Indeed this has been noted in the 2017-published update of the consensus guidelines for therapeutic drug monitoring in neuropsychopharmacology. Therapeutic drug monitoring, the quantification and interpretation of drug concentrations in blood to optimise pharmacotherapy, considers the interindividual variability of pharmacokinetics and thus enables personalised pharmacotherapy. As such, it was recommended in elderly patients (alongside other key vulnerable groups), due to the progressive impairments of the functional reserve of multiple organs that occurs in ageing. The authors state that elderly patients are frequently hypersensitive to medication, and frailty is a major problem. They are at an increased risk of homeostasis loss after stressful events and a decreased ability to recover a stable situation (e.g. the cholinergic system seems to be supersensitive in aged

*"Study data are scarce and urgently necessary."*

Gerd Laux

subjects, with many psychotropic drugs such as clozapine, tricyclic antidepressants or paroxetine displaying anticholinergic activity).<sup>1</sup>

The authors continue, noting that such increased risk for adverse drug reactions has prompted many authors to develop criteria for identification of potentially inappropriate medication use in elderly patients, while conversely elderly patients are often undersupplied with potentially useful drugs, including antidepressants. A further issue is off-label prescription of psychotropic drugs in the elderly.<sup>1</sup>

And the ageing population will only amplify these issues, said Professor Laux, with increases in the numbers of older people

*"1% of geriatric inpatients receive a consultation with a psychiatrist, while about 40% suffer from co-morbid psychiatric illness."*

Gerd Laux

with dementia, post-stroke depression, and psychiatric alterations due to cancer, diabetes and Parkinson's: "Because of the changes in socio-demographics, severe psychiatric disorders are on the rise," he said. "The treatment of patients, therefore presents challenges.

"Geriatric psychopharmacology is a demanding discipline – because it requires an understanding of pharmacokinetics, side effects and interactions – and that makes profound knowledge essential."

Professor Laux will outline a number of interventions he believes colleagues might find useful. They include recommendations and checklists: "I recom-



mend a register of somatic risk factors, psychotropic monotherapy whenever possible, drug selection according side effects and interaction potential," he said. "Importantly, start low – go slow."

He added: "Psychiatry should get a standard procedure in geriatric medicine." In doing so, detecting psychiatric comorbidity would be more frequently done, and that would eliminate inappropriate medication being given to patients. Instead, he explained, it would encourage prescribing of distinctive psychotropics adequate for geriatric patients.

Importantly, a whole raft of studies must be carried

out to improve the volume of knowledge on geriatrics and mental health, stressed Professor Laux. There should be more research specifically on older patients in ambulatory care, he said, as these individuals are under the care of general practitioners and specialists. In addition, more data needs to be obtained on older people in hospital settings, as well as nursing home settings, to analyse in detail psychiatric diagnoses. There may be also be opportunities for pragmatic trials with different psychotropics using parallel study groups and long-term studies, he said, concluding: "Study data are scarce and urgently necessary."

### Reference

1. Hiemke C et al. Consensus Guidelines for Therapeutic Drug Monitoring in Neuropsychopharmacology: Update 2017. *Pharmacopsychiatry*. 2018 Jan;51(1-02):9-62.

# Unpacking the cogrem puzzle

The latest results determining the effectiveness of cognitive remediation (cogrem) and its clinical implementation in real-world psychiatric services will be the focus of this evening's session, during which Antonio Vita (Professor and Chair of Psychiatry at the University of Brescia, and Director of the Department of Mental Health at the University Hospital Spedali Civili in Brescia, Italy) discusses the implications of cogrem for treatment delivery and functional outcome.

Over the last decade, Professor Vita has studied the effectiveness of various cogrem techniques on the clinical, cognitive and functional outcomes of schizophrenia, and has actively worked to improve cognitive rehabilitation in Italy. Together with colleagues Silvana Galderisi, Paola Rocca, and Alessandro Rossi, he founded the Italian Group for the Study and Treatment of Cognition in Psychiatric Disorder.

Today, Professor Vita will show how the use of psychiatric services compares (both quantitatively and qualitatively) for patients treated with cognitive remediation versus those treated with the usual psychosocial interventions. This study will run over five years.

The results of the first one-year follow-up, which has been already published<sup>1</sup>, indicate that patients who have completed the intervention fair better than those who have not. "There is a comparatively higher reduction in hospitalisations and related costs, and more outpatient service use, with more access to 'advanced

rehabilitation programs', in those who completed a cogrem intervention, at least in the short and medium term," he explained during an interview with *EPA Congress News*.

Prof Vita's most recent

*"There is a comparatively higher reduction of hospitalisations and related costs...in those who completed a cogrem intervention"*

Antonio Vita

research has also investigated the presence of autistic features in patients with schizophrenia, with the aim of identifying possible demographic, clinical, cognitive and functional correlates of schizophrenia with and without autistic traits. "The results could contribute to better characterisation of patients with schizophrenia and help to disentangle the heterogeneity of the disorder," he explained.

Cognitive impairment is a core feature of both disorders, suggesting a possible role for cognitive rehabilitation in the overlapping conditions, Professor Vita said. "Our preliminary results underline that in a subgroup of

schizophrenia patients, the severity of autistic traits seems to predict cognitive rehabilitation efficacy."

Cognitive function in schizophrenia is one of the main elements significantly related to functional outcome, accounting for approximately 25-50% of the variance in real-world functioning, he said. "There is evidence that cogrem is beneficial, but there is still a limited understanding of how the putative active therapy ingredients contribute to changes

in the brain and translate into improved functioning," he explained.

"Cogrem has been shown to improve frontal activity, prevent grey matter decay, improve brain network efficiency and task-related blood flow in fronto-temporal areas. However, we still lack a precise understanding

of how cogrem programmes produce these brain effects, as they are achieved with different programmes, different numbers of sessions, and with or without a therapist."

Cogrem may come into its own when delivered in the context of other psychiatric rehabilitative interventions, but there are still plenty of research gaps, said Professor Vita. "What are the mechanisms of effectiveness of integrated treatment; what is the rationale for choosing an integrated treatment or another; and which are the patient characteristics that could predict integrated treatment effectiveness?" He asked. "There is also a need to conduct more research bridging the gap between clinical practice and basic neuroscience."

The benefits of cogrem seem to be larger in patients in the early phases of schizophrenia or in the prodromal phase of the illness, he added. "Treating cognitive deficits in this population may be a potential tool to prevent or delay the onset of schizophrenia in a primary (in high risk populations) and secondary (in subjects with recent onset disease) prevention framework.

"Evidence emerging from

the research literature indicates that targeting cognitive impairments in the early stages of schizophrenia can result not only in cognitive improvement per se, but in significant functional benefits in such critical domains as social functioning, employment, and role functioning."

Going forward, Professor Vita hopes that future research focuses on the heterogeneity of schizophrenia. "It should shift from 'group efficacy' to 'individual efficacy' of treatments, in the context of precision and individualised medicine," he said. "Issues related to individual predictors of effectiveness and to the interactions between specific pharmacological treatment, particular cogrem techniques, and individual patients' characteristics, should be systematically analysed."

New treatment targets have been proposed for cogrem, too. "On one hand, it has been demonstrated that it could be useful for reducing negative symptoms of schizophrenia, usually poorly modified by pharmacological treatment, and even for moderating aggressive behaviour," noted Professor Vita in his concluding remarks. "On the other hand, new research is being conducted on cogrem effectiveness in other clinical conditions, such as mood disorders, eating disorders or personality disorders."

**'Treating beyond symptoms to improve outcome: cognitive remediation in psychiatry' takes place in Calliope between 17:00 and 18:30 today.**

## Reference

1. Vita A et al: Does cognitive remediation modify the use of psychiatric services and the patterns of care of patients with schizophrenia? *Schizophrenia Res.* 2016 Aug;175(1-3):85-89.





**Warsaw 2019 Congress**

# Warsaw invites next year's delegates

**N**ext year Poland's capital and largest city will welcome the largest international association of psychiatrists in Europe for the 27th European Congress of Psychiatry. It will be the first time Poland has hosted this meeting, which takes place at EXPO XXI Warsaw between 6 and 9 April 2019.

"Warsaw is a unique city because it is located in the centre of Europe, at the junction of the trade roads from the West to the East," said Jerzy Samochowiec, Professor and Head of the Department of Psychiatry at Pomeranian Medical University in Szczecin. Professor Samochowiec is one of the local organising committee chairs, responsible for hosting the congress in the historic capital. With a long pedigree in psychiatry, he has been a member of the board of the EPA since 2015.

"From here it is so near to Russia, Belarus, Ukraine and the Baltic countries, where we have many friends. The long-lasting friendship between people is what holds the neighbouring nations together," he said. "You will be truly fascinated by the history and atmosphere of Warsaw, which combines the influences of Western and Eastern Europe, and where tradition meets modernity."

Psychiatry in Poland has many interesting facets, too, according to Professor Samochowiec: "Transition in psychiatry in our region is promising. Investigations into the impact of social disintegration and growing socio-economic differentiation on mental health disorders in particular reveal that there is less unemployment, homelessness and criminality."

Professor Samochowiec's special areas of research interest include the genetics of addictions, depression, anxiety disorders, ADHD, and the pharmacogenetics of schizophrenia. He is a member of the editorial board of several publications including *Progress in Neuro-Psychopharmacology & Biological*



**Jerzy Samochowiec (seated) with his team at the Department of Psychiatry, Pomeranian Medical University**

*Psychiatry, Psychiatria Polska and Alkohol i Narkomania (Alcohol and Drug Dependence). Throughout his career, he has supervised 17 PhD students and published over 300 papers. Heavily involved with research on the applications of stem cells in psychiatric disorders, his*

*"There are rapid changes happening in world politics as well as societal transitions, including cultural changes. As a result, psychiatry faces many challenges."*

*Jerzy Samochowiec*

department focuses on pharmacotherapy (including new drugs), the evaluation of new psychotropic drugs, and other research efforts. Indeed, at this year's Congress he chairs a symposium dedicated to the impact of biomarkers and epigenetic signatures on psychiatric disorders and treatment response.

The 2019 year's meeting draws on an overarching theme of advancement, led by the guiding

motto 'Psychiatry in transition - towards new models, goals and challenges', continuing to address the interests of psychiatrists in academia, research and practice throughout all stages of career development. The meeting will concentrate upon many of the most recent implementations that have come about as a result of research into psychiatry, explained Professor Samochowiec: "A special focus of the Congress will be the changes occurring in contemporary psychiatry, resulting from advances in research, development of new medication and new treatment methods based on modern technologies, new models of psychiatric care."

"There are rapid changes happening in world politics as well as societal transitions, including cultural changes. As a result, psychiatry faces many challenges and has to formulate new goals, which will be discussed during the Congress."

How psychiatry responds and grows in adaptation to those changes is important: "The European training pathway in psychiatry was discussed in recent years with emphasis on evidence-based

medicine training in psychopharmacology of mental disorders, guidelines for the development of the implementation of community-based mental health systems and suicide prevention programmes."

The organisation of mental health services, as well as traditional approaches to diagnosis, models of care and research paradigm, are in flux. The implementation of community-based mental health systems in many countries, the increasing emphasis on person-centred research and care, the availability of scientific evidence substantiating the biopsychosocial model, the clinical relevance of the diachronic perspective, and the effectiveness of e-mental health interventions represent meaningful examples of the ongoing transition, explained Professor Samochowiec. Such challenges are compounded by global political upheaval and mass displacement characteristic of our time.

"In line with the Congress topics that have been highlighted, we hope to facilitate a fruitful and conclusive discussion on changes to the European psychiatrists' training. This has become a major challenge for our profession," Professor Samochowiec concluded.



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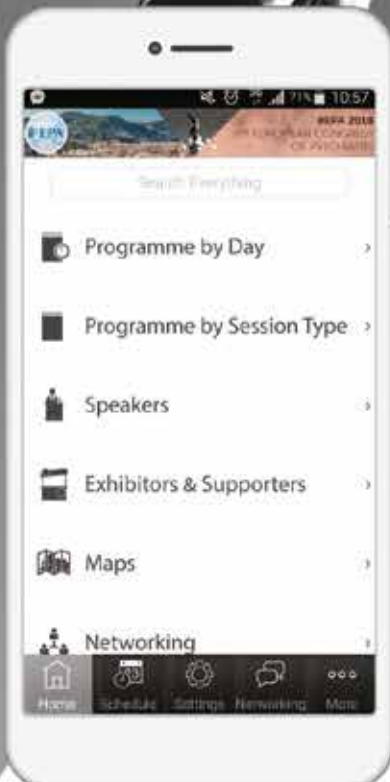
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