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Next year's EPA Congress is in Warsaw, Poland, with the theme **'Towards New Models, Goals and Challenges.'**

"Environment and biology are not separate"

Opening ceremony delivers unifying message

One of the opening ceremony's highlights was a lecture by President Silvana Galderisi in which she highlighted the importance of promoting a unified identity of psychiatry in response to the obstacles and contradictions faced by professionals. "We're faced with different models [of psychiatry] and different challenges," she told delegates.

Summarising conflicting viewpoints on the field, she cited a *New York Times* article which argues that neuroscience has failed to live up to its promise¹. She quoted: "We have little to show for it on the treatment front. With few exceptions, every major class of psychotropic drugs basically targets

the same receptors and neurotransmitters in the brain as in their precursors which were developed during the '50s and '60s.'" Then quoting a *Lancet* article², she said: "[Psychiatry] is too remote from the rest of medicine, it is viewed negatively by other medical professionals, and it's time for the specialty to realign itself as a key biomedical specialty at the heart of mental health."

Psychiatry is a complex discipline, Professor Galderisi stressed. The way forward, she said, is not to choose one model over another – instead, we should recognise that it is an overarching discipline that sits in the middle of natural sciences, social sciences and human sciences. "There is no choice

to be made, there is no alignment to be done. Environment and biology are not separate."

The opening ceremony concluded with a musical programme developed by Local Organising Committee Chair Philippe Courtet, together with Patrice Boyer who also performed several pieces on piano. He was joined by Christophe Guiot and others of the Paris National Opera Orchestra, performing works by Strauss, Wagner, and Bizet including his famous opera *Carmen*.

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Identifying good practice for mental health care of the forcibly displaced

Dr Domenico Giacco (Queen Mary University of London, UK) will present new evidence on forcibly displaced people during today's session on the response of large health organisations – EPA, the World Psychiatric Association (WPA) and the World Health Organisation (WHO) – to the mental health consequences that such populations find themselves facing.

Forcibly displaced people are not the 'burden' on society they are often reported to be, Dr Giacco told *EPA Congress News*, and they often show incredible mental resilience.

He explained that a new review by the WHO of current research

into the mental health of forcibly displaced people in the WHO European region, including refugees and asylum seekers, showed that rates of mental illness do not significantly differ from those of the adopted country as a whole – apart from a higher rate of PTSD in newly resettled refugees.

The team of researchers reviewed 69 academic papers in which refugees, asylum seekers and irregular migrants in at least one of the WHO European Region formed part or all of the population studies.

Dr Giacco said: "It seems counterintuitive, but in our review we found in general that the rates of psychotic, mood and substance use disorders in these groups appear similar to those found in host countries. An exception is PTSD, which is more common in refugees and asylum seekers."

The prevalence of depression in refugees at more than five years of resettlement is higher than in the corresponding host country population, he added. "This has been linked to adverse post migratory socioeconomic conditions. A study in Sweden also found a higher incidence of psychotic disorders in refugees compared with the host country population and non-refugee migrants."

Risk factors for developing mental disorders are encountered by refugees, asylum seekers and irregular migrants before, during and after migration. Before migration, they may be exposed to persecution, traumatic conflict experiences and economic hardship, explained Dr Giacco.

During migration they can experience physical harm and separation from family members, he noted. After migration, poor socioeconomic conditions, including social isolation and unemployment, are the main factors associated with poor mental health outcomes for refugees. Asylum seekers and irregular migrants can also face uncertainty about



"Migrants are incredibly resilient... They can be an asset."

Domenico Giacco

asylum applications and detention.

"These migrants are incredibly resilient," said Dr Giacco. "They might have been exposed to potentially traumatic events or hardship – but they still made it to Europe. They can be an asset. We need to put out a positive message about their qualities."

"However, if these people don't get access to appropriate support in their adopted country after they resettle than they are more at risk of developing mental health problems associated with social isolation, language difficulties and unemployment – such as depression. This is not inevitable though and many of these problems can be prevented."

Barriers to preventing post migration mental health problems include language problems, lack of knowledge about access to healthcare entitlements, distrust of professionals and authorities, lack of education, housing and employment opportunities.

In order to support policymakers in strengthening or introducing specific policies regarding mental

health care for these migrant groups and to facilitate good practice, various policy recommendations were made by the WHO authors. These included promoting the social integration of these groups to help to prevent the occurrence of new mental disorders and to improve the outcomes of pre-existing ones; and mapping of existing outreach services and establishing them where required to facilitate access to mental health care.

Other recommendations included ensuring strong links between different services, as well as uncomplicated administrative procedures for appropriate referrals and pathways. In addition, providing information on health-care entitlements and available services, both to people from these groups and to professionals was deemed important. Providing training to professionals was cited as a means of increasing awareness of the barriers these groups face and to ensure skills in engaging and working with them; and creating methods to overcome language barriers.

Dr Giacco said: "To implement these policy options, resources are required for outreach services, information services, training of professionals, interpretation programmes and initiatives for social integration. Coordination and organisational flexibility are required to integrate physical and mental health care and to facilitate appropriate referrals and care pathways."

He concluded: "Around 77 million international migrants are estimated to live in the WHO European Region. Among them, the proportion of those migrating because of violation of their human rights, persecution and conflict is increasing. In 2015, 1.2 million first-time asylum applications were made in the EU member states alone. Organising and delivering good quality mental health care and prevention strategies for these individuals is increasingly a priority."

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Publishing and Production
MediFore Limited

EPA President
Silvana Galderisi

EPA Local Organising Committee Chair
Philippe Courtet

Editor-in-Chief
Rysia Burmicz

Editors
Tatum Anderson
Jo Waters
Sophie Goodchild

Design
Peter Williams

Industry Liaison Manager
Lorraine Tighe

Head Office
MediFore Limited
51 Fox Hill,
London SE19 2XE, UK
Tel: +44 (0) 208 771 8046
Mary.Kennedy@MediFore.co.uk

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State of the art: Planning ahead for acute mental health crises Hermes Tuesday 13:15

Planning ahead for acute mental health crises

Claire Henderson (Institute of Psychiatry, King's College London, UK) has researched means of improving freedom of self-determination and freedom from unnecessary restriction of care for individuals accessing psychiatric care services within the UK over the past two decades. Central to this aim is the involvement of health service users in the development of their care and crisis plans, which allow them to formulate and document care preferences while they are well, for adoption under the possible eventuality that they encounter a mental health crisis where decision-making capacity is affected. Professor Henderson will discuss methodologies under investigation looking to improve crisis planning, as well as issues surrounding their implementation, during her State of the Art lecture this afternoon.

The need for improvement in the way that crisis planning is carried out stems from increased rates of compulsory admissions to psychiatric hospitals in the decades since the 1990s¹. It is thought that better empowerment of service users in the decision-making process may be a means of more successfully delivering early intervention, reducing rates of compulsory admissions and hence reducing cost of care².

Joint crisis planning (JCP) was developed with this in mind, as a shared decision-making process between the service user and care staff. JCP represents the middle path between the paternalism of routine care

plans produced without any involvement of the service user, and the advance directives determined solely by the service user. JCP consists in a dialogue between care provider teams and service users, alongside a JCP facilitator, who is not part of the care team and who ensures that clinicians' views are taken into consideration in the service user's final decisions about their crisis care preferences.²

Shared decision-making acknowledges the expertise of service user and clinician, and that the most effective decisions will be generated from joint working. Charles

"If you don't incorporate people's preferences, you are more likely to get a bad outcome and reduce quality."

Claire Henderson

et al (1999)³ set out that in shared decision-making: both the physician and patient are involved in the treatment decision-making process; that they share information with each other; that they both take steps to participate in the decision-making process by expressing treatment preferences; and that a treatment decision is made and both the physician and patient agree on the treatment to implement.³

In contrast to JCP, crisis care plans under routine clinical care in the UK have been found to be generic (not patient-specific) in nature in 85% of cases – a lack of detail that suggests improvements could be



made in implementation of such protocols.²

In 2004, Professor Henderson and colleagues found evidence of JCP reducing compulsory admission and treatment in mental health services, in a randomised controlled pilot study of 160 participants recruited between 2000 and 2001 from eight community mental health teams from Southern England.⁴

However, these findings have more recently been contradicted in the larger CRIMSON (CRisis plan IMPact: Subjective and Objective coercion and

eNgageMENT) study, which compared the effectiveness of additional JCP against treatment as usual alone for people with severe mental illness. No significant effect was associated with the addition of JCP, upon either compulsory admissions or total societal cost per participant over 18 months of follow-up.⁵

The reasons for the differences in outcome of these two studies could involve their timing and location: "Various things have changed in the interim," Professor Henderson told EPA Congress News ahead

of her lecture. "The first trial was me as a PhD student recruiting teams that were interested in the intervention. Overall, they may have had a more positive attitude in the implementation of the intervention."

"When we got to the second trial, at least in the London site there were fewer beds available so choices about going into hospital earlier or later may have been more difficult [to implement] – quite a number of people preferred to be admitted earlier so that they didn't have to be invol-

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Planning ahead for acute mental health crises

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untarily admitted. Also, we use home treatment teams now in all of those sites, so people are more likely to be admitted at an earlier stage in the illness. There weren't any during the first study."

Barriers to implementation of shared decision-making have been fully discussed with respect to these trials in Farrelly et al (2015)⁶. This qualitative study identified, on the part of clinicians, four barriers to participation in the JCP process: (1) ambivalence about care planning; (2) perceptions that it was not necessary given that routine care planning already existed; (3) concerns regarding service users' choices; and (4) perceived limited availability of service users' choices. These barriers led to a lack of constructive engagement in the process, and an undermining of both the service user's experience and subsequent implementation of the plan

(the formulation of a plan not necessary leading to adherence to it).⁶

"There were struggles implementing the plan the way we wanted to," summarised Professor Henderson, who noted in addition that because the JCP facilitator was not a local staff member, they tended not to be well-received by clinical teams.

"Part of the problem may be that, because people are likely to be detained under a section, there is an assumption that all choice then disappears. Obviously choices are limited when you have particular pathways that have to be followed, and people are going to be detained, but within those limitations there are still choices that people can make. That needs to be emphasised

and respected."

On the perspectives of the service user, Professor Henderson noted that both CRIMSON and the pilot trial found therapeutic relationships to be improved with JCP⁵: "It is more likely that people will be more satisfied

"Because people are likely to be detained under a section, there is an assumption that all choice then disappears."

Claire Henderson

if there has been sharing of the decision-making process – if there is information exchange about the patient's values and preferences and using those to reach a decision, as well as information about treatment choices.

"If you don't incorporate people's preferences, you are more likely to get a bad outcome and reduce quality; you may be trying to do something that the person doesn't want. They may not engage in that treatment either, as opposed to if they have really thought about the pros and cons of each and how they align with their personal preferences."

An important finding that emerged from an economic analysis of CRIMSON was that JCP was cost-effective for Black British and Afro-Caribbean participants, as part of a sub-group analysis by ethnicity. This is significant, said Professor Henderson, because pathways in care tend to be different for Black British and Afro-Caribbean people, who are also more likely to be subject to coercion. "Those results are worth paying attention to."

"In terms of policy, we should be thinking about

how we can reduce coercion in general and in particular in Black and Afro-Caribbean groups. The evidence from CRIMSON suggests that JCP may be the way forward."

Professor Henderson delivers her State of the Art lecture at 13:15 in Hermes.

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European addiction reward prize

European addiction reward prize

Each year the *European Federation of Addiction Societies* (EUFAS) and *European Addiction Research* (EAR) jointly present the European Addiction Research Award, recognising scientific excellence in clinical research in the addictions field in Europe. Yesterday at EPA 2018, Prof. Falk Kiefer, Editor-in-chief of *European Addiction Research*, and Prof. Anthoni Gual, Past-president of EUFAS, awarded the prize to Wim van

den Brink. Following the prize-giving ceremony Professor van den Brink delivered his State of the Art lecture on novel developments in the search of more personalised treatment strategies for individuals suffering from addictive disorders. Professor Wim van den Brink is Professor of Psychiatry and Addiction at the Academic Medical Center, University of Amsterdam. He is also Director of the Amsterdam Institute for Addiction Research.



Falk Kiefer

Anthoni Gual

Wim van den Brink

Karl Mann

We need to shift toward secondary prevention of substance misuse

Geert Dom, medical director of the Psychiatric Center, Multiversum, Boechout, Belgium, EPA-board member and President of the European Federation of Addiction Societies (EUFAS), answered key questions on targeted approaches to reducing substance misuse in conversation with *EPA Congress News*. This is ahead of his presentation at this morning's ECP Training Workshop, which tackles the theme of prevention in a number of psychiatric areas.

How big a problem is substance misuse in Europe?

Substance use disorders are unfortunately highly prevalent in the European population. Recent data indicate that the number of affected individuals is increasing, most notably for alcohol use disorders (AUDs). From 2005 to 2011 for example, the number of people suffering from alcohol dependence increased from 7.2 million to 14.6 million within the EU. Both on a EU and global level, alcohol use disorders are showing an increase in overall prevalence. There are multiple reasons for this. Availability, changes in demography, changes in social and legal regulation, socio-economic variables, all these factors have been proven to mediate alcohol consumption (and subsequent risk on disorders) within a population.

Can you talk about primary prevention schemes and what has been found to be most successful?

Traditionally (primary) prevention (and funding for research) is in most countries very poor, with only a fraction of the health budget used for implementing prevention activities. As to the use of psychoactive substances, most prevention efforts have been developed within the context of schools or within industry. The focus in the latter is the safety within the work-related environment and limiting substance use-related accidents and loss of working capacities (e.g. due to frequent sick-leave).

Could you talk about the newer, promising approach of identifying individuals or sub-groups of individuals who are at high risk of addictions?

Secondary prevention, i.e. targeting populations at risk is in my view the most promising area of prevention. As regards to substance use, a lot of research is going on exploring risk factors for initiation of substance

making and difficulties in delaying rewards. Although the genetic underpinnings of addictions are extremely complex (as with any other psychiatric disorder), more and more research points to a role of genetic factors that can be identified.

What specific interventions have been tried in these groups and how effective are they?



use, risk of progression towards harmful use (e.g. binge drinking), and risk factors mediating the risk on developing substance use disorders (addiction). These developments follow an overall trend towards developing precision medicine in psychiatry. Risk factors can be identified on different levels, including social: e.g. quality of parental supervision and peer influences.

Personality, including several personality profiles or coping styles (i.e. hopelessness, anxiety-sensitivity, impulsivity and sensation seeking) are associated with an increased risk of earlier initiation of substance use and later substance use problems. Different cognitive measures can be used to evaluate risk of progression towards problematic substance use. Typically, these are cognitive measures that relate to risky decision-

One of the more interesting examples of intervention is the 'Preventure' program developed by Professor Patricia Conrod in Canada and piloted within Canada, the UK, the Netherlands and Australia. Within this program, school children at risk (identified by high scores on personality scales), are offered a training program specifically adapted to their specific personality style. This intervention is offered within the school context. By targeting specific vulnerabilities, the aim is to prevent development of substance use problems, i.e. delaying age of initiation, decreasing risk of transgressions towards problematic use.

Could you describe in detail some of the findings of the longitudinal studies?

Findings of the Preventure program

as documented by longitudinal follow-up, are very positive with a delay in use and decrease of substance problems found at two to three years follow-up. Psychiatric symptoms (internalising and externalising symptoms) also decreased in response to the interventions.

What are the advantages of these types of approaches over the primary approaches in prevention?

Are they more cost effective?

Taken together, these types of secondary interventions are in my view more promising than the primary approaches. Indeed, one of the big problems in addiction is that only a small percentage of people who use substances develop problems, and so identifying those individuals at risk and targeting intervention on their needs might prove to be a more efficient way to reduce the risk of addiction. Whether this would prove also to be cost effective is a matter for future studies.

What is your take home message?

The topic of this workshop on prevention is very important. Indeed, in line with developments in other fields of medicine, focus is (and should even more) be shifted towards prevention and specifically secondary prevention.

A more individualised approach identifying and targeting individuals at risk will help to reduce risk of both the start and the deterioration of substance use disorders. Importantly, these early interventions might have effects on multiple domains. Indeed, comorbidity between psychiatric symptoms and substance use problems is highly prevalent in adolescent individuals. Significantly, the latest results of programs such as Preventure indicate these interventions can also be used to reduce the risk of substance use problems in youngsters who have already developed psychiatric symptoms such as anxiety/depression or externalising patterns (i.e. ADHD and conduct disorder).

Professor Dom speaks during the ECP Training Workshop, 'Prevention of mental health disorders', taking place in Clio between 8:00 and 9:30 today.

Continuous exercise training in schizophrenia

Continuous exercise training (CET) improves fitness and quality of life for patients with acute schizophrenia, according to the findings of research presented yesterday morning at a session on exercise interventions as a tool for promoting recovery in the disease.

However, the Aerobic Exercise Interventions as Feasible and Effective Interventions for Schizophrenia study¹ did not demonstrate any significant improvement in cognition, or result in weight loss, explained Berend Malchow (Ludwig-Maximilians-University of Munich, Germany) to delegates: "I think [CET] should be implemented in every department or ward – you just need to lower expectations and don't expect (the patients) to lose weight."

In this study, investigators recruited stable outpatients with schizophrenia (n=43/41), with a ten year or longer history of the disease. They were enrolled into three half-hourly group sessions every week for 12 weeks of either CET on an exercise bicycle ergometer (n=21/20), or table soccer (n=22/21). For both groups, twice-weekly thirty minute computer-based cognitive remediation training (COGPACK) was added from week six.

A sports scientist was also

recruited to encourage patients to attend the exercise sessions, and calling them if they did not turn up.

The control group (n=20/19) of unfit but healthy people was age and gender matched with the

"[CET] should be implemented in every department or ward."

Berend Malchow

schizophrenia patients. They took part in CET and the cognitive training but not the football sessions.

The motivation for both patients and the control group for joining the trial was to lose weight, according to Dr Malchow who described participants as 'couch potatoes' who did not engage in any sports or physical activity.

Fitness levels were measured during the trial using a series of measurements including oxygen uptake and physical work capacity (PWC). Brain scans were conducted of the hippocampus and dorsolateral prefrontal cortex (DLPC) using magnetic resonance spectroscopy (MRS).

Results from the German study showed that the fitness of the endurance training group improved overall, said Dr Malchow. After three months, patients had exceeded

the baseline fitness levels of the control group in some instances.

Improvement in GAF (Global Assessment of Functioning) was observed in the endurance training group, with a 10 point score increase from baseline to three months (p=0.001). Social adjustment scales (SAS-II) also improved for household activities (p=0.003) such as food shopping. These benefits were not observed in the table soccer group.

Dr Malchow said: "They got better on household activities like going to the grocery store, went out a lot more and got more fit in their daily routine. Patients also said they felt better."

"They got better on household activities like going to the grocery store."

Berend Malchow

The improvement in cognition in the endurance training group was not as much as researchers had expected, Dr Malchow explained during the presentation. In addition, brain scan results showed no carry over effects on grey matter after cessation of endurance training and table football. "You have to do

exercise for the rest of your life if you want to benefit [from exercise] otherwise the benefits will not be lasting," said Dr Malchow.

There were significant alterations in mean fractional anisotropy (FA) at baseline but no effect of aerobic exercise after three months for schizophrenia patients. No changes in N-acetyl-aspartate (NAA) and glutamate-glutamine (Glx) levels were observed after exercise, although there was a positive correlation between the endurance capacity of patients and NAA concentration for the left and right hippocampus.

None of the patients lost weight, an issue which Dr Malchow attributed to the fact that 90-minute weekly aerobic exercise sessions are not enough on their own. People also would need to change their diet, he said.

Discussing the study findings, Dr Malchow concluded: "[These results show] you can do exercise interventions with schizophrenia patients.

"The daily living gets a lot easier so I think this is a benefit. It can very boring though to be in a small room three times a week so find something (exercise) the patient likes."

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Focus on resilience rather than risk

During yesterday morning's session on the theme of resilience in mood and psychotic disorders, Andrew McIntosh (University of Edinburgh, UK) talked about brain mechanisms of resilience to stressful life events, psychological distress and depression. He introduced two different models of resilience: one being the mirror image of distress; the other being a residual measure of distress, taking into account population norms of distress for a particular level of exposure to stress.

"Resilience research is less worked out in many ways than depression or psychosis research," he began. "We have very good tools for measuring whether somebody is depressed or not, with reliable measures of how you do that over time that are shown to be stable across populations and within samples. We haven't worked out a lot of the same facts out for resilience yet."

Defining resilience, he continued: "Some people, when faced with the same adversity, seem to cope or adjust to it more successfully than other people. When we compare, for a measured degree of risk of vulnerability, the differences between people who do or do not respond well to adversity, we refer to those differences as resilience and we assume that the brain changes that are associated with those changes might be causally linked to that process."

Professor McIntosh talked about the genetic and imaging associations with distress and depression. "Genetic factors in particular are important here," he said, "Because unlike neuroimaging, where we don't know whether we are looking at the cause or the effect, with genetic

factors we should always be looking at factors causally associated with the trait of interest."

He discussed the UK Biobank, and a sample therein on broad depression that formed the basis of determining genetic associations of depression heritability from genome wide association study (GWAS). Work from UK Biobank and the Psychiatric Genomics Consortium identified enrichment of such genes associated with depression in the anterior cingulate cortex, putamen, accumbens and hippocampus. Neuronal cells, but not oligodendrocytes or microglia, were found to be enriched. Pathway enrichment was identified at excitatory synapses, post-synaptically, and within neuronal spines and dendrites. Similar findings were identified in GWAS of neuroticism, the personality trait Professor McIntosh noted as most strongly associated with depression.

Brain morphological associations of depression and distress were determined from large-scale study by the ENIGMA Consortium, and these included decreased hippocampal volume and decreased surface area and volume of the anterior cingulate cortex, relative to controls. Analysis of around 4,000 images from the UK Biobank identified lower white matter integrity over the whole brain, and specifically less anisotropic white matter diffusion in thalamic tracts to the prefrontal cortex, correlated with distress at the time of imaging assessment.

Professor McIntosh then addressed how

"People who had higher resilience had greater volume of the accumbens, and greater volume of the thalamus."

Andrew McIntosh

genetic liability relates to measures of vulnerability and resilience. Residual measures of distress, which adjust for underlying differences in population norms, were determined using data from the Generation Scotland Expert Working Group for Psychiatric Disorders, which includes around 24,000 individuals. "We administered a measure of resilience, the Brief Resilience Scale, which is a six-item scale that measures how people perceive they bounce back from adversity. We were interested in the differences between resilience and neuroticism, with neuroticism a measure of depression risk, and resilience a measure of how quickly one bounces back from adversity. We wondered if those two things are simply the same trait, by a different name."

Professor McIntosh and colleagues profiled every individual with complete data (n=10,000), using a polygenic risk score for depression. With the most recent results from the Psychiatric Genomics Consortium, using structural equation modelling they then assessed whether there were separate contributions by neuroticism and resilience to depression, or whether the best model was a single trait of which both neuroticism and resilience were measures. "We found that genetic liability to depression was associated independently both to neuroticism and resilience. Those two traits together mediated about 50% of the risk for depression, in these studies. Genetic factors seemed to account for about 14% of the overall variation in resilience, and the nuclear family seemed to account for another 5%."

Data from UK Biobank was also used to investigate the genetic and imaging associations of trait resilience and coping. Regression analysis was carried out looking at psychological distress versus stressful life events in individuals, relative to population means. This was used to infer how resilient an individual is. "We found that people who had higher resilience had greater volume of the accumbens, and greater volume of the thalamus. There was also greater anisotropy of the thalamic radiations."

He concluded: "Actually measuring it accurately and reliably is challenging. One can look at very simple tests of the mirror image of psychological distress, or perhaps an even broader psychiatric phenotype that captures many outcomes simultaneously. The advantage of adjusting for base-levels [of distress] is that one gets to the nub of whether someone is different from where you would expect them to be from the population average, for that level of stress or exposure to risk. The disadvantage is that one is dealing with a very small number of studies, so if one conceptualises resilience as the mirror image of distress or depression, one can effectively bring in a much larger literature."



Debate: Disclosing a mental disorder Athena Tuesday 10:00

To reveal or not reveal?

Today's debate will pitch two researchers against each other over the potential advantages and disadvantages of disclosure by individuals with psychiatric problems.

Against the motion is Saeed Farooq, Senior Clinical Director at Keele University and Visiting Professor at Chester University (UK) with expertise in disclosure of psychiatric disorders¹.

In favour of the proposition is Sara Evans-Lacko, Associate Professorial Research Fellow at the London School of Economics and Political Science (UK).

Sara Evans-Lacko: In favour of disclosure

Professor Evans-Lacko focuses her research on improving access to care and support, especially for young people with mental health problems, with the goal of improving long-term outcomes related to health, employment and relationships. "A key to improving access to care and support is reducing stigma," she told *EPA Congress News*. "I have done a lot of work around understanding the consequences of stigma and discrimination and how we can reduce stigma and its harmful effects."

She placed disclosure as one of the most important ways to help reduce stigma and discrimination for people with psychiatric problems. Indeed, she has analysed Time to Change, England's largest ever campaign against mental health discrimination².

Disclosure has a greater social advantage than might be assumed, she said: "The more people start talking about the issue, the more it is normalised and, the more people can come out and feel open in talking about mental health problems," she said. "I think this is really connected to the stigma."

"We can see the consequences of this from other

social movements where people came out about, for example, their HIV status. From the LGBT movement, there has been a huge impact in terms of celebrities coming out about their own status and garnering support and acceptance for the cause."

Interestingly, her work on the evaluation of the Time to Change campaign revealed that those most resistant to improving attitudes were health professionals². "There was an overall reduction in reported experiences of discrimination from people using psychiatric services, but it was difficult to change the reactions from health-care professionals," she said. "Some of this is because of therapeutic pessimism – health professionals don't see people when they are fully recovered. Thus, healthcare professionals remain an important target group given that they have an important role in treatment. They have a lot of contact with people with mental illness."

Professor Evans-Lacko noted that the decision

to share mental health issues is a personal one, but creating a positive environment should one wish to do so is important: "People have so much stress about disclosing and

starting that conversation. I don't think that people should have to tell their whole story in every detail to everyone. But I think that they will feel that they can tell their story if there is an open environment where they are able to share those details."

Hence, a social movement that creates a more positive and accepting environment around mental health problems is needed, she stressed. When one is surrounded by avoidance and shame about mental health issues, she explained, it can create a pervasive negative attitude that is self-reinforcing: "Having everything closed off leads to a more negative cycle."

"The more people try to be open about the stories, the more normal people realise these issues are and it creates a virtuous circle," she said. "The public begins to realise that mental health problems and recovery are common and the circle can go into reverse."

"The more people try to be open about the stories, the more normal people realise these issues are, and it creates a virtuous circle."

Sara Evans-Lacko

"They will feel that they can tell their story if there is an open environment where they are able to share those details."

Sara Evans-Lacko



Saeed Farooq: Against disclosure

Professor Farooq explained that his arguments focus on disclosure within the context of mental health professionals approaching the discussion of diagnoses with patients. "My first objection is, in terms of psychiatry, that 'disclosing' means I as a psychiatrist control the information and disclose it, which is not correct," he said.

"You have to have shared decision-making, which means you sit with the person and share and understand how much the person knows, and you share the information in a mutual respectful way."

Critically, he will also object to the way in which mental health professionals are expected to carry out these interactions: "There is no training for psychiatrists on how to talk about a condition, like schizophrenia, which will be life-changing for a young person."

While there is general guidance on communicating with people suffering from mental illness (e.g. psycho-education), he noted, there is no guidance or literature, or aids or interventions, for mental health professionals on the subject of talking to people about their psychiatric diagnoses.

This needs addressing, stated Professor Farooq, noting the three aspects of talking to a person about their diagnosis, namely, "What to tell, when to tell, and how to tell."

"Even in the most severe cases of schizophrenia, a psychiatrist has no guidance on telling the person what the condition is, how is going to affect them, what is the likely outcome and how it is going to affect their life, because they are going to have to make important decisions."

Indeed, Professor Farooq

"There is good evidence...that shows that sometimes disclosing diagnosis is doing more harm than good."

Saeed Farooq

"In terms of psychiatry, 'disclosing' means I as a psychiatrist control the information and disclose it, which is not correct."

Saeed Farooq

has analysed available literature on this topic, showing that in schizophrenia there is no study at all on any training intervention¹. he said. "We have published a Cochrane systematic review and showed there is practically no evidence to guide clinicians on how to talk about these psychiatric diagnoses in general, but particularly about schizophrenia."

"In contrast, there are number of studies and few systematic reviews on interventions to disclose the diagnosis of cancer and other life changing conditions such as multiple sclerosis."

Issues of disclosure also include medical professionals, and barriers to accessing mental health treatment have recently been

discussed^{3,4}. The issue is how to do so without causing harm, explained Professor Farooq: "You cannot argue that you cannot disclose. But continuing the way it is at the moment – where we don't know what, we don't know when, and we don't know how – is harmful."

He believes that developing a consensus on how to talk about psychiatric diagnosis is essential. "I'm going to raise this as a responsibility for august organisations like EPA, to deal with this matter as urgently as possible," he concluded.

"We must develop some guidelines because until we have them, there is good evidence in the litera-

ture that shows that sometimes disclosing diagnosis is doing more harm than good."

The debate 'Disclosing a mental disorder: Do the advantages outweigh the disadvantages?' takes place in Athena between 10:00 and 11:30 today.

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The hunt for a biomarker of lithium response in bipolar disorder

The European Network on Biomarker of Lithium Response (R-LiNK)

Franc Bellivier, Professor of Adult Psychiatry at University Denis Diderot (Paris, France) will tell the Congress about R-LiNK¹, an ambitious new collaboration to find a much-needed biomarker for lithium response.

Lithium is the main treatment for preventing relapse in bipolar disorders, but clinical response is variable and clinicians cannot accurately predict who will benefit without a lengthy trial, Professor Bellivier told *EPA Congress News*.

"It is difficult for clinicians to reliably predict which patients will respond, without recourse to a lengthy treatment trial of at least 18 to 24 months," said Professor Bellivier. The challenge is to improve this. The identification of biomarkers capable of predicting response to lithium is highly desirable to enable personalisation of treatment, to define criteria for patient stratification, and to refine the eligibility criteria for a trial of treatment. This would improve long-term management and prognosis of those with bipolar disorder I, noted Professor Bellivier, and is likely to reduce the risk of suicidal behaviours.

"Biomarkers that predict lithium response are currently lacking, but neuroimaging, genomic and post-genomic studies have produced tentative but promising results for future use in clinical practice," he said.

Professor Bellivier outlined some of the key ambitions of the R-LiNK collaboration, a H2020 funded project: to identify the eligible criteria for long-term treatment with lithium in bipolar disorders in terms of response, safety and tolerability, transferable to clinical practice to improve relapse, prevention, acceptability and to avoid useless lengthy trials.

It is a €7 million collaboration between 20 partners, including three small and medium-sized enterprises in eight countries (Denmark, UK, France, Norway, Sweden, Germany, Italy and Spain), running between 2018 and 2022.

Outlining some of the many approaches that are being explored, Professor Bellivier continued: "First of all, we know that lithium is a multi-tar-

get product. There is a biological 'storm' in the body after the drug is initiated. We don't know which parts of the biological signals are related to the therapeutic effect of the drug.

"To find out if there may be any predictive biomarkers of long-term response, we are taking blood samples and carrying out MRI scans before and after starting lithium and following the patients for two years to assess the level of response prospectively."

Neuroimaging biomarkers, as well as molecular signatures of lithium in the blood (via mRNA and miRNA, epigenetic marks and proteomic profiling), will be measured before and after lithium initiation, to test their predictive value at two years.

Preliminary studies investigating whether lithium response in bipolar disorders is associated with DNA meth-

ylation signatures are already underway, confirmed Professor Bellivier. He said rapidly developing advances in neuroimaging and molecular technologies mean that psychiatrists and researchers now have the tools to detect such biological signals.

Trial participants will also wear a data collection device similar to a wristwatch to record their circadian rhythms. Abnormal circadian rhythm is a core feature of bipolar disorder and lithium can influence it too. "We're interested in finding out whether this might be a predic-

tor of response to lithium. Our ambition is to record circadian rhythm before and after lithium initiation to see if there is a signal," said Professor Bellivier.

A collaboration with the Monsenso company will also organise the collection of data using a smartphone-based app to monitor symptoms and adherence during the follow-up period. Other tests include neuroimaging techniques to see if lithium causes anatomical changes to the brain and whether these changes are a predictor of response. Tests will be carried out before initiating treatment and 12 weeks later.

Another approach being investigated, 7Li MRI, is capable of characterising brain lithium distribution in specific regions of the brain 12 weeks after its initiation. "We are trying to find a pattern associated with a response," explained Professor Bellivier.

He said research carried out by Dr David Cousins from Newcastle University (UK) on brain lithium concentrations in bipolar disorders patients using 7Li MRI studies were a very important innovation. Dr Cousins will be speaking on this topic in more detail during the session.

Professor Bellivier concluded: "This sort of large scale study would have been very difficult to set up before the European Union started to support large consortia; in terms of scientific co-operation this is quite unique.

"We hope to identify predictive biomarkers of long-term response to lithium and contribute to the development of predictive and personalised approach."

"This sort of large scale study would have been very difficult to set up before the EU started to support large consortia."

Frank Bellivier



The symposium, 'Molecular and brain imaging biomarkers of response to lithium treatment' takes place in Athena from 8:00 until 9:30 this morning.

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Plenary: Schizophrenia is a myth with a strong genetic component Athena Tuesday 11:45

Schizophrenia, a term of the past?

Sir Robin M Murray, Professor of Psychiatric Research at the Institute of Psychiatry, Psychology and Neuroscience of King's College London, UK, will use cutting-edge research to broach controversial ideas regarding the appropriateness of 'schizophrenia' as a category during his Plenary lecture today. As he explained to *EPA Congress News* ahead of the meeting, "Probably half the delegates in the room will agree, and half won't."

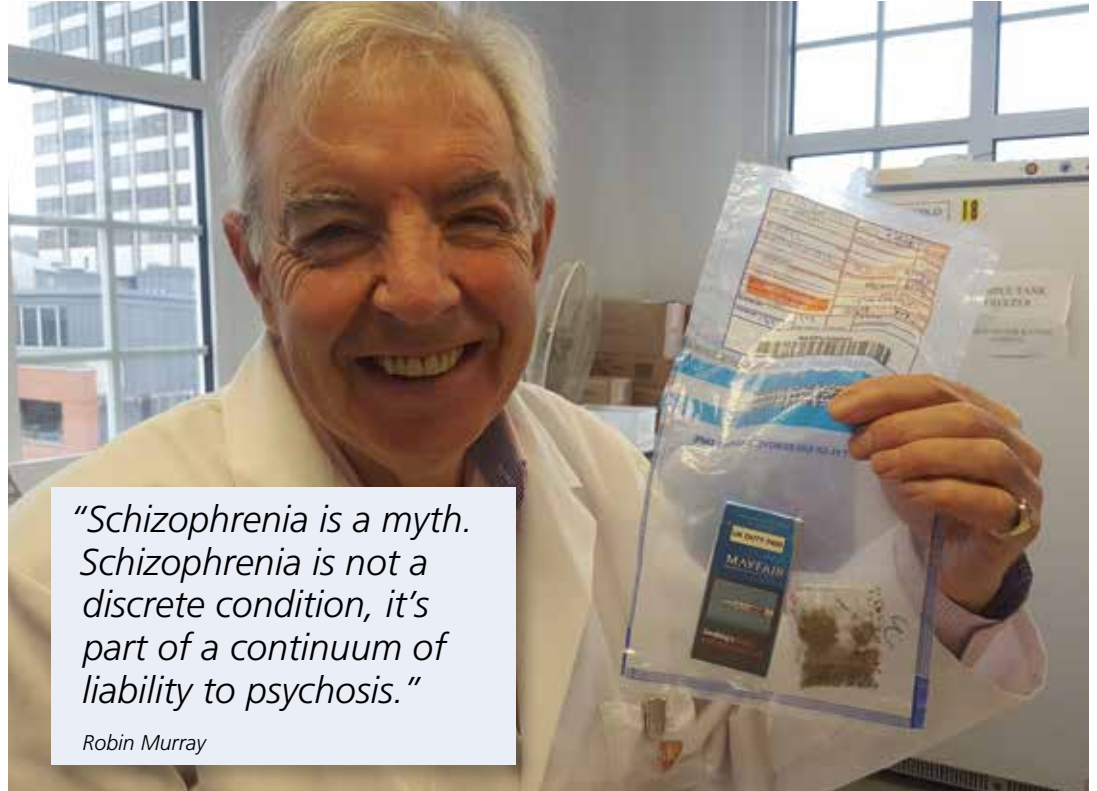
'Schizophrenia', he believes, is not a useful term: "I would hope that this will cause people to think and stop using the term schizophrenia. We should just say that somebody has a liability to psychosis or they are having a severe psychosis."

A psychiatrist with a long and distinguished career looking into the causes of psychosis and improving its treatment, Prof Sir Murray noted two important pieces of research over the last few years that have overturned the traditional idea of schizophrenia as a discrete disease^{1,2}. "We used to think that 98% of the population have no genetic predisposition to schizophrenia and 1-2% carried a major gene that caused people to get the illness. Thus, people were split into two. You either had the gene or you didn't have it," he told *EPA Congress News*. "Now we know that this is not true at all."

The first piece of research, from the Psychiatric Genomics Consortium¹ has looked at the genetic makeup of people with schizophrenia and compared them with the wider population. "We have learned that there are hundreds of little genes that contribute to schizophrenia. And that it's not just people with schizophrenia who have an excess of them. People with bipolar disorder or severe depression carry a lot of the same susceptibility genes too."

In other words, the lines have been blurred between a number of conditions: "It's not that genes predisposes people to schizophrenia alone, they predispose to bipolar disorder and depression as well."

And importantly, a paper recently published in *JAMA Psychiatry*²



"Schizophrenia is a myth. Schizophrenia is not a discrete condition, it's part of a continuum of liability to psychosis."

Robin Murray

has raised the idea that dopamine is a key factor in psychosis within a range of conditions. "We have known for a long time that one of the major abnormalities in schizophrenia is excess synthesis and release of striatal dopamine," said Sir Robin. "Now we find that people with bipolar disorder have too much striatal dopamine as well."

This explains why patients with either mania or schizophrenia respond to antipsychotic drugs that block dopamine. As well as genetics, levels of striatal dopamine can also be influenced by adversity. "People who are abused as children, or people who are subject to a lot of stress – this increases the striatal dopamine they produce," explained Prof Sir Murray, "Because a big factor that drives the likelihood of psychosis is environmental factors associated with adverse life events and stress."

"So two major factors – genetic disposition and adversity – don't just cause schizophrenia, they increase the risk of a whole range of psychiatric disorders – anxiety, depression, bipolar disorder and schizophrenia," he explained.

"Schizophrenia is a myth. Schizophrenia is not a discrete condition, it's part of a continuum of liability to psychosis."

Prof Sir Murray argues that if psychiatrists are prepared to jettison the term 'schizophrenia', there must be an overhaul in approaches to both treatment and prevention. "We should begin to think about a public health approach to preventing psychosis," he said. "I think we need to do the same as has been attempted for disorders such as obesity and diabetes – in these disorders, physicians don't just focus on those already obese or diabetic. Rather, they attempt to persuade the general population to eat more sensibly and do more exercise and thus reduce the risk factors."

Preventing psychosis means trying to reducing exposure to a range of risk factors from reducing obstetric complications to tackling child abuse to social fragmentation in inner cities said Prof Sir Murray. He added: "We should be less hostile to migrants – migrants have very high rates of psychosis because they're discriminated against. And, most importantly, we must try to

decrease the consumption of high-potency cannabis. In some parts of Europe this accounts for more than 20% of cases of psychosis."

It's a tall order, he admitted, but one that at the very least recognises how much higher mental health should be on the political agenda. In the clinic, schizophrenia should become a term of the past, he concluded: "I don't think it is useful for psychiatrists to use the term schizophrenia with their patients. It conveys a sense of stigma and hopelessness. People think schizophrenia always deteriorates which is not true at all. There are many people who get such a diagnosis who recover and are able to live a useful life."

Prof Sir Murray delivers 'Schizophrenia is a myth with a strong genetic component' in Athena between 11:45 and 12:30 today.

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In-between cultures

Reaching out to women of Turkish heritage in Berlin

Chair of the EPA Section of Cultural Psychiatry and Professor for Intercultural Psychiatry, Meryam Schouler-Ocak (Psychiatric University Clinic of Charité at St. Hedwig Hospital, Berlin, Germany) spoke to *EPA Congress News* about suicide attempt rates and intervention effects in women of Turkish origin in Berlin, ahead of this afternoon's session focussed on suicidal behaviour in the vulnerable migrant populations.

Professor Schouler-Ocak has previous published on the suicidal behaviour of ethnic minorities and immigrants within Europe¹. In Germany, Switzerland and the Netherlands,

"Females of Turkish origin underlined...missing information about the healthcare services, too few programs in Turkish, and the stigmatisation of psychiatric patients."

Meryam Schouler-Ocak

she told *EPA Congress News*, young women of Turkish descent have elevated rates of suicidal ideation, suicide attempts, and completed suicide.

In an analysis of mortality registration data from 1980 to 1997, Razum and Zeeb (2004) found an almost two-fold increased risk of suicide in girls and young women of Turkish origin compared to Germans aged ten to 17 years, despite an overall lower rate of suicide among people of Turkish origin than Germans².

In Berlin, more than 230,000 of the population have a Turkish migratory background, noted Professor Schouler-Ocak, such that Turkish immigrants and their descendants are one of the largest immigrant groups in Berlin, as well as in Germany as a whole.

Professor Schouler-Ocak was

part of a team of psychiatrists and psychologists at Charité – University Medicine Berlin that developed and evaluate a multi-modal intervention study aimed to improve care-seeking behaviour of women of Turkish origin in suicidal crises.

The study suggested a particularly high suicide rate among second generation 18-24 year olds, with a positive trend identified following the population-based intervention program.^{3,4}

Professor Schouler-Ocak noted that two central, cultural-specific themes emerge from studies exploring the reasons for attempted suicide: namely, the impact of family and community, and the impact of German society. These themes

emerged from a focus group she and colleagues conducted in suicidality among women of Turkish descent in Germany: "Participants stated that family and community pressures as well as discrimination and lack of acceptance cause social isolation. Fear of stigmatisation and dishonouring themselves or their family, as well as shame and self-stigma decrease the likelihood of reaching out for help."⁵

Other studies have identified relationship problems as the most frequent reason for attempted suicide,

and in women specifically, domestic violence.^{6,7}

"In our study, the feeling of being 'in-between two cultures' that was described by second generation women specifically illustrates the effect that the two central themes have on suicidal behaviours," continued Professor Schouler-Ocak. "The two central themes also suggest that social and societal factors have a significant impact on suicidal behaviour and help-seeking⁵."

Immigrants are very heterogeneous groups, she stressed, with different values, traditions and explanatory models of illnesses or diseases. Thus, to reach these groups, unique strategies must be developed based on targeted research.

"The cooperation with members of the community and training of key persons are crucial. There is an urgent need for many other interventions, such as the training in cross-cultural competency of professionals in the field of education, prevention and mental health care. Also, cultural competence training of key persons like teachers and social worker, qualifying GPs in dealing with culture-specific issues should be added to the intervention strategies.

"In focus groups, females of Turkish origin underlined as barriers, for example, missing information about the healthcare services, too few programs in Turkish, and the stigmatisation of psychiatric patients." Confidentiality was also an issue, she added, with women wishing to stay anonymous, hiding their help-seeking behaviour, mistrusting German healthcare services, and not accepting help due to the thinking that problems should be resolved within the family.⁵

"There is a great need for cultural sensitivity and culturally competent treatment concepts in mental health care services for immigrants," concluded Professor Schouler-Ocak. "For especially vulnerable, high-risk groups like our target group of Turkish women, special services may be helpful."

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Suicidal behaviour in the vulnerable populations: Focus on migrants Euterpe Tuesday 13:15

Advocacy and community engagement key in reducing suicide among UK South Asians



During this afternoon's focus on suicidal behaviour in vulnerable migrant populations, Dinesh Bhugra (Institute of Psychiatry, London, UK) will discuss explanatory factors of attempted suicide among South Asians in the UK, as well as research needs and the active role that psychiatrists must play in advocating for better resources in general for vulnerable people of ethnic minority communities.

Differences as well as similarities exist in suicide rates among South Asians and the total UK population. Rates of deliberate self-harm are higher among South Asian people, with South Asian women reportedly at particular risk for attempted suicide between the ages of 18 and 24¹. Recently, a study in self-poisoning (the commonest form of self-harm presentation to UK hospitals) found gender and ethnicity to play a role, with an increasing rate in women of Black African or Afro-Caribbean heritage².

Exploring these in the context of culture conflict as a central theme in the South Asian community, Professor Bhugra said: "South Asian

women were much more likely to have experienced domestic violence and domestic alcohol abuse. There is conflict in the sense that their parents are expecting them to behave in a certain way, whereas they want to be like their British counterparts.³

"It is also culture conflict with the larger society. You may have been born in the UK but for whatever reason the larger society sees you as an outsider. That stress might contribute further to feeling rejected, hurt and isolated."

The experience of one's own inherited culture and religion responds to the local environment, and this can affect first, second and third generation immigrants differently. There is evidence that Asian people in general who attempt or complete suicide are more likely to be suffering from stress, while less likely to have been diagnosed as mentally ill. Nation of origin, religion and religious attitudes also influences suicide rates.^{4,5}

"There is also no doubt that there is a lot of stigma against people with mental illness within the

"It is important that clinicians work with religious healers to engage patients."

Dinesh Bhugra

South Asian community so people will not seek help. Linked within that is that, quite often, particularly with Punjabi women, they would present with physical symptoms to their GP rather than psychiatric ones. Whether the GP picks that up or not is one more complicating factor.

"Another factor is what people's explanatory models are, and the stigma related to that. Quite often in depression, Punjabi women see it as part of life's ups and downs to sometimes feel low and lose your appetite. But they would also see it as a religious thing, preferring to go to the mosque or temple or Sikh temple to talk to religious leaders rather than doctors.

"When a South Asian person in the UK says that their voices are a result of something they did in their previous birth, it is important that clinicians work with religious heal-

ers to engage patients. While that may be the patients explanation, we can manage it with whatever intervention."

Services in the UK also tend not to be competently equipped for the requirements of ethnic minority communities, from basic linguistic needs to cultural sensitivity to dietary or religious needs. "One of the things we need to be doing as doctors is advocating for our patients – talking to policy-makers, stakeholders, and funders, to say that we need resources for training, for providing services that are culturally sensitive," said Professor Bhugra.

Guidance on mental health and mental health care in migrants was recently published by the World Psychiatric Association⁶. "The basic aim is to provide accessible and affordable services," said Professor Bhugra. "There are three things you need no matter where you are in the world: early diagnosis, affordable and accessible intervention, and recovery.

"Most people can live with their symptoms as long as they have social support: a job, a house, some money. Medication, for example, is one way to get to that."

The session 'Suicidal behaviour in the vulnerable populations: focus on migrants' takes place in Euterpe between 13:15 and 14:45 today.

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Russia mental health services better for women

The vibrant field of Russian women's mental health will be addressed this afternoon by Natalia Semenova, clinical psychologist at the Moscow Research Institute of Psychiatry, a subsidiary of the Serbsky Federal Research Center for Psychiatry and Narcology. She has been responsible for setting up the Women's Mental Health (WMH) section of the Russian Society of Psychiatrists (RSP), which began in 2015.

Although Dr Semenova is specialised in treating schizophrenia and psychosis, her research has also focused on gendered issues of care, as part of work on quality of life and service evaluation for the mentally ill. In addition, she has introduced women's mental health into the Clinical Psychology, Psychosomatics, and Gender Psychology courses she teaches at Pirogov Russian National Research Medical University and the Russian State University for the Humanities.

It was a meeting with Professor Helen Herrman, President of the World Psychiatric Association (WPA) that inspired Dr Semenova to launch a Section on Women's Mental Health within the RSP: "I am really dissatisfied with the poor representation of Russian women professionals at

international conferences," she told *EPA Congress News*. "And my intention was to put Russia – in terms of women's mental health – on the map."

This led Semenova to bring together some of the most influential thought leaders on women's perspectives in psychiatry and clinical psychology in the country, headed up by Professor Nikolay Neznanov, Chairman of the RSP Board. "We have a broad and diverse group of professionals with a long and impres-

sive list of publications on women's mental health," she explained. "Russian specialists have accumulated a huge amount of material on the biological, social and personality-related factors affecting women's mental health."

In today's session, Dr Semenova will highlight a range of topics covering the work of the Women's Mental Health section of the RSP. She will look at studies and clinical developments as two interconnected sections, including structural com-

ponents of the work and areas of the work overlapping with the key problems of women's mental health, as defined by the EPA.

"What are we discovering, as regards women's mental health within Russian psychiatry, is that we are all aware that some of the topics are not new but the data certainly are, and different professionals have different perspectives," she said.

"It is promising to see both leading experts in the area and first-year research fellows," she said, recalling the first important conference on the topic – the 3rd Dmitrieva Readings – which took place at her research Institute in 2016. This meeting was named after Tatiana Dmitrieva (1951-2010), Professor of Psychiatry and Russia's Minister of Health in 1996/1998. "She voiced her thoughts that the mental health of women handled by different specialties should be made a special area in the context of public health," said Dr Semenova.

Dominant themes at the conference included women's well-being and violence against women; psychosis, stress and psychotrauma in women; gender differences in addiction; and forensic psychiatry – namely, the restriction or deprivation of women's parental rights.

"The Conference seemed to provide impressive evidence that the WMH Section of Russian Society of Psychiatrists is ageing well." But what's crucial now, added Dr Semenova, is to translate much of this work into policy interventions, rather than to accumulate knowledge only: "I'd like to highlight the risks to female patients from a lack of gender-awareness in mental health services. Very few of them have had a women's

mental health strategy."

Dr Semenova cites one particular example: "Traditional health services had no definite policies on offering proactive support to women patients who, for example, disclose abuse (some specific types of women's experiences that may have a particularly damaging effect)," she added. "The time has come to shout about it."

Encouragingly, a growing number of symposia within Russian psychiatry conferences indicates more interest in the nature and determinants of women's mental health, research principles and methods for the study of these issues, and for the design and evaluation of strategies to improve women's health, said Dr Semenova. "Things are changing. The considerable body of research from the last year challenges conventional ideas," she said. "Women's mental health issues are increasingly recognised internationally, and it feels good to be part of it."

In the future, Dr Semenova says it will be vital to build bridges among diverse professional groups. "We would like to outline priority issues in women's mental health and to establish a national women's mental health network among clinics as well as to cultivate a culture of collaborative research participation in academic and community clinics. These activities should be the medium through which the principles of the gender-sensitive care will be disseminated."

'Women's mental health: insights from European countries' takes place in Erato from 13:15 - 14:45 today.



"Traditional health services had no definite policies on offering proactive support to women patients who, for example, disclose abuse. The time has come to shout about it."

Natalia Semenova

Women's mental health: insights from European countries Erato Tuesday 15:00

Women's health today and tomorrow

A panoramic view of women's mental health, going back two generations and forward to the generation of young girls today, will be presented today by Jan Burns, Professor of Clinical Psychology, Head of the School of Psychology, Politics and Sociology at Canterbury Christ Church University. She speaks during a symposium that bring together a number of psychologists and psychiatrists to focus on women's mental health in different European countries.

"I'll be plotting the development of mental health diagnosis and treatment in the context of changing women's lives," Professor Burns told *EPA Congress News*. "I'm weaving it around my grandmother, my mother, myself and my nieces."

Professor Burns is a clinical psychologist with a background in clinical psychology education going back 25 years. Indeed, she was one of the founders of the Psychology of Women and Equality Section within the British Psychological Society.

There has, of course, been a vast change in economic circumstances over the decades, especially in terms of women's expectations around work and engagement in work, explained Professor Burns. "I'll be plotting this development against women's changing mental health."

"Issues of women's place in the family and women's place in the economy are very much intertwined. We've seen women of my grandmother's age routinely getting married at 20 and having two to three children by the age of 22." Today there are less marriages, women tend to wait until age 27 or 28 before they have their first child, and family sizes are smaller, she added.

Transformation can be seen most clearly in the mental health professions: "There are nearing equal numbers of male and female practitioners in psychiatry and in psychology we have seen a swap from males to females in the profession. The presence of the female voice in the profession and how women are seen has changed."

Nevertheless, there has been a marked increase in distress amongst women reported at an earlier age. "If we go back to two generations ago, the average age that women were reporting depression was 45," she explained. "In my grandmother's day the main common disorders were still as they are today – depression and anxiety – but that was commonly referred to as 'nerves'."

This is in stark contrast to today, continued Professor Burns, with mental health reporting having shifting down to much earlier ages including into the early teens. Gender has played



"Issues of women's place in the family and women's place in the economy are very much intertwined."

Jan Burns

a continuing role, with a persistent gap in the reporting of different mental health issues in women and men, boys and girls.

"For adolescent girls, in UK [reporting] has increased recently. In terms of self-harm, hospital admissions are up by two thirds of girls. Girls are reporting depression at age 14 – that's doubled in the last decade to 24.4%. In contrast, reported depression amongst boys is at 9%. Two thirds of all eating disorders are reported by girls. These are shocking statistics. It's quite disturbing."

Traditionally it was postulated that boys and girls have different ways of dealing with mental health issues, with the notion that women talk more openly about it, said Professor Burns. Yet today younger girls are under more stress, she noted, possibly due to a complex combination of expectations and stereotypes. While these are currently being

challenged, gender is difficult to negotiate today: "A young girl of 14 today must develop a pathway where there is an expectation that she does very well at school, is looking to a career and may also want a family. Also, she's dealing with prevailing stereotypes of what femininity is, what she should look like, what she should say and what she should be interested in. I think it's a very fraught time."

Amongst the backdrop of such worrying prevalence rates is a far improved environment for diagnosis and treatment, however. "We are seeing a rise in psychological care and with that a greater acceptance that people have psychological problems. And the stigma around having psychological problems has decreased."

We are finding more people are able to talk about these things and the available treatments has improved."

This change in attitude is reflected in evolving treatment methods.

In 1950, 147,000 people were admitted each year as inpatients into mental health hospitals, with an average length of stay of 863 days. By 2010-2011, inpatient rates fell to 22,700 with an average length of stay of just 61 days.¹ "This shows the impact

Continued on page 16

"We need to look at what is happening in schools and colleges."

Jan Burns

Women's mental health: insights from European countries Erato Tuesday 15:00

Women's health today and tomorrow

Continued from page 15

of better drugs that we have available and the availability of psychological treatment," said Professor Burns.

The UK government has just released a green paper, *Transforming Children And Young People's Mental Health Provision*², which has proposed some important changes to measures for early intervention and prevention for young people, particularly with respect to schools and college involvement and improvement of wait-

ing times. "We are seeing the rates of prevalence within young people rising, so we need to look at what is happening in schools and colleges," stressed Professor Burns.

Other interventions may also help younger people, suggested Professor Burns. Looking at the impact of social media on younger people, and how to support families is vital. Critically, there must be more focus on building resilience she concluded. "Building resilience in young people means they can manage their own

mental health so they can understand distress, what is causing it, what the signs are and when to seek help."

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From new psychotropic drugs to psychedelic medicine Calliope Tuesday 8:00

MDMA: a tool to dig up the roots of addiction?

Dr Ben Sessa, psychiatrist at Imperial College, London, spoke to EPA Congress News on his presentation during a session that chronicles the recent renaissance in therapeutic interventions involving serotonergic hallucinogens. Dr Sessa will discuss MDMA therapy, which he is investigating as part of the ongoing Bristol-Imperial MDMA in Alcoholism Study (BIMA).¹

Could you begin with your career path: how did you become interested in MDMA as a potential treatment?

I am child and adolescent psychiatrist, who now works in adult addiction psychiatry. My work is heavily influenced by my years working with abused and maltreated children, watching the developmental trajectory from childhood pain into adult mental disorders and addictions. This experience has brought me to the door of MDMA therapy, as the best possible tool to allow a stuck patient to face overwhelming negative memories of childhood trauma.

How are MDMA's receptor binding characteristics related to behaviour?

MDMA works across multiple receptor systems: at 5-HT1a and 5-HT1b it reduces depression and anxiety and provides a positively felt mood. At 5-HT2a it increases the capacity for creativity and free-thinking. The classical psychedelics, e.g. LSD and psilocybin, act primarily at 5-HT2a receptors. MDMA has

a mild 'classical' psychedelic effect, but not nearly as intensely as LSD and psilocybin. This makes it far more tolerable for most people.

At the dopamine and adrenaline receptors it provides mild stimulation – boosting the patient's motivation to engage in therapy. At the alpha 1 and 2 receptors it provides a paradoxical state of relaxation, which takes the edge off the hyper-vigilance – one of the core symptoms of PTSD. At the hypothalamus it induces oxytocin release, which is the hormone secreted from the brains of breastfeeding mothers; it boosts attachment, empathy and bonding.

In totality, the multiple effects above result in MDMA's unique psychological effects. It has this amazing capacity to selectively reduce the fear response, whilst leaving all the other cognitive faculties intact.

How, then, do these drug characteristics augment talking therapy? They make it incredibly useful as an adjunct to trauma-focused therapy.

The bond between patient and therapist is boosted and the patient can address and resolve emotional memories that they have spent their whole life trying to avoid.

Given that trauma underpins almost all cases of addictions, MDMA has a great role to play in allowing a resistant patient to tackle the root problem behind why they are anaesthetising themselves with alcohol and other drugs. Under MDMA they no longer need to avoid their pain; they can face it and resolve it.

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Is there any data at this stage regarding the effectiveness of MDMA and psychotherapy in treating certain conditions, including addiction and PTSD?

Ours is the world's first MDMA for addictions study – so no data there yet.

But the results in from Phase 2 studies of PTSD are very impressive indeed. After a single course of MDMA therapy (in which the patient takes the drug just three times as part of a 16-week course of weekly psychotherapy therapy sessions), 85% of participants with

treatment-resistant PTSD no longer had the diagnosis at the end of the course. The cohort was then followed up for 3.5 years (with no further MDMA sessions and many of them coming off their SSRIs) and the results were totally sustained. These results far exceed the current best treatments for PTSD (a combination of cognitive behavioural therapy (CBT) and SSRIs), which can only provide a 65% symptom reduction.²

So, if results can be replicated (and Phase 3 trials are underway now), MDMA therapy could have profound effects on the way we treat trauma-related disorders in the future. And two sessions of MDMA is, of course, far safer and less toxic than sitting on SSRIs for years.

Tell us about the Bristol-Imperial MDMA in Alcoholism Study (BIMA).¹

I am the principle investigator and one of the therapists on the study. It is an eight-week course of MDMA therapy for people who have undergone a community medical detox for alcohol use disorder. There are two therapists (male and female) who provide weekly therapy sessions, using a therapeutic model based on motivational interviewing. The patients take MDMA just twice during the eight-week course, on weeks three and six. There is close physiological monitoring during the day-long MDMA session. We

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measure their blood pressure and temperature throughout the session, and then they stay overnight in the clinic.

It's an open label proof of concept study. This is typical for a study proposing a totally novel approach. If the study goes well – and we can show that the treatment proposed is safe and tolerated – then we will do a RCT placebo-controlled study in two years' time.

We will see 20 patients over two years. The main outcome measures are safety and tolerability. We are also looking at drinking behaviour and we follow them up for nine months after their

detox and the MDMA course. The sponsor is Imperial College London and the chief investigator is Professor David Nutt.

Could you comment current understanding of safety and tolerability of MDMA. Has there been any shift in negative public perception here too, and what underpins this?

Nothing is 100% safe. And all medical interventions (from sticking

plasters to cancer chemotherapy and cardiac surgery) carry some degree of risk and invasiveness. And clinical MDMA is not ecstasy – our patients are screened, have ECGs, blood tests, are monitored physiologically throughout the sessions and followed up closely afterwards. Risks are reduced to an absolute minimum.

Looking at the data, MDMA is very safe indeed. After 25 years of heavy ecstasy use in the UK (with 750,000 doses consumed every weekend) the rates of morbidity and mortality remain staggeringly low.

MDMA is much safer than alcohol. Most drugs are. Alcohol kills 20,000 people annually in the UK. MDMA kills, at most, five people a year (once other concomitant drugs are taken into consideration). MDMA addiction is virtually unheard of. Recreational MDMA is simply not a public health concern. It is relatively safe – even when used recreationally in the form of ecstasy. And when used in a clinical setting it is even safer. MDMA's harms have been hugely overhyped in the media. The very few cases of harm that occur always make the front page of the newspaper; so, it has a poor media image.

The reason it gets a bad press is because the War on Drugs propagates an inaccurate message about the relative harms and benefits of drugs. Since 1971, successive governments all over the world have conformed to this disinformation about drugs. The results have been horrendous; with too many people dying unnecessarily because of these dangerous and immoral restrictive laws. Drug deaths, harms and even usage have all risen under the current

system of prohibition. Not to mention the growth of the mafia, global criminal networks and destruction to our societies. The drug themselves have not done this. The ludicrous laws have caused this harm. It could be reversed by the actions of brave politicians.

You have compared MDMA to antibiotics as a potentially revolutionary treatment in psychiatry – could it really be that transformative?

"I think so. After 100 years of modern psychiatry we are still failing so many of our patients. Relapse rates for drinking four years after detox (with current best treatments) are up to 90%. This is appalling and desperately needs to be addressed. We are doing no better at curing alcohol addiction than we were in Victorian times! We must have something better to offer our patients than that. MDMA could be transformative.

The analogy to antibiotics is to highlight that at present the way we manage many psychiatric disorders is by papering over the cracks – treating trauma-based disorders merely symptomatically, but never tackling the root cause of the problem: trauma. It's like taking paracetamol or ibuprofen when you have an infection. Sure, those drugs will lower your temperature and make you feel a bit better, but paracetamol and ibuprofen are not antibiotics; they will not kill the microorganisms that are causing the infection.

And when we give SSRIs, hypnotics, mood stabilisers and antipsychotics for people with treatment-resistant PTSD or addictions we are just giving them paracetamols. We mask the surface symptoms, but we are failing to attack the 'bugs' underlying the illness or trauma.

'From New Psychotropic Drugs to Psychedelic Medicine: Risks and Challenges of Research Chemicals in Psychiatry' takes place in Calliope from 8:00 until 9:30 this morning.

References

1. Bristol Imperial MDMA in Alcoholism Study (BIMA). EU Clinical Trials Register. <https://www.clinicaltrialsregister.eu/ctr-search/trial/2016-002547-42/GB> (accessed Feb 2018).
2. Multidisciplinary Association for Psychedelic Studies (MAPS). <http://www.maps.org/research/mdma> (accessed Feb 2018).

"We are doing no better at curing alcohol addiction than we were in Victorian times"

Ben Sessa



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