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Contents lists available at ScienceDirect

European Psychiatry

journal homepage: <http://www.europsy-journal.com>

26th European Congress of Psychiatry

Ask the Experts

Ask the Experts I

ATE0001

Person-centered psychiatry

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Most of our current, supposedly humanitarian or dialogic therapeutic practices are based on the ideal of establishing some form of consensus between patients and carers. Yet consensus is a woolly kind of dialogic value. While it looks for agreement and harmony, it implicitly holds that some values are better than others and builds on the metaphysical belief that conflict of values is just a stage on the way to sharing universal values. In this vein, conflicts of values are signs of imperfection, rather a constitutive part of human life. This unrealistic idea promotes pseudo-dialogic practices that downplay the person’s subjectivity and surreptitiously endorse one-sided values. Examples of this are social rehabilitation (which endorses prevailing social values), or potentially intolerant techniques to enhance compliance (which endorse the distinction illness/health based on the clinician’s values)—both taking for granted that “good” values are on the side of the clinician. Coexistence with mental sufferers and with the values each of them embodies is better practice. This practice is produced in dialogue, which is contact across a distance. It aims to acknowledge, understand, and respect different ways of life, enlighten our ethical conflicts, honor conflicting values—and ultimately negotiate reciprocal recognition.

Person-centered practice is much more than assessing operationalized symptoms and eliminating them, or reducing their intensity through some kind of therapeutic technique. Rather, it is a *quest for meaning and reciprocal recognition*. It seeks for meaning, order, and value within and throughout ordinary experience and the patient’s everyday life. It is a meeting of forms of life—the patient’s and the clinician’s—each with its system of relevance and meaning structure, stemming from different and sometimes conflicting values. It is the occasion to initiate a shared project of reciprocal understanding between the vulnerable person and the mental health carer.

Disclosure of interest.— The author declares that he has no competing interest.

<https://doi.org/10.1016/j.eurpsy.2017.12.010>
0924-9338/

Further reading

G. Stanghellini, M. Mancini (2017) The therapeutic interview in mental health. Cambridge University Press.

ATE0002

Why eating disorders being in adolescence

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Over 30 years ago it was found that involving the family reduced relapse following inpatient treatment in adolescents with a short duration of illness (less than 3 years). This has been replicated, and has since been used as a standalone treatment, with various family permutations (separated parent/individual, multifamily therapy). The treatment is cost effective. For example the length of inpatient stay can be reduced if family therapy is added. Furthermore elements of the intervention have been delivered in self-help forms, sharing skills and information for carers. However 20–30% of cases fail to respond. In particular those who have been ill for over 3 years do not benefit. Non responders may be identified early in the course of treatment. Therefore work to develop new interventions to manage this group of patients is in progress.

Both family therapy and guided CBT are of benefit for binge eating disorder and bulimia nervosa but the evidence base is smaller. In this lecture I will review past evidence and consider new approaches.

Disclosure of interest.— The author declares that he has no competing interest.

Ask the Experts II

ATE0003

Dealing with migrants’ mental health needs

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The discussions in this “Meet the expert session” will mainly focus on the following topics: Terminology (migration, migrants, forced displacement, refugees, asylum seekers, IDPs and etc.); Current dimensions of forced displacement and migration; Historical perspective on migration; Mental health consequences; Role of psychiatrists and mental health workers.

Disclosure of interest.– The author declares that he has no competing interest.

ATE0004

The WPA program for strengthening the contribution of psychiatrists in situations of conflict and emergency

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The WPA Action Plan 2017–2020 sets out a collaborative strategy for expanding the contribution of psychiatry to improved mental health for people across the globe. It is based on consultation within the WPA and with potential partner organisations including EPA as well as the work that has preceded it. It builds on the capacity of organised psychiatry to promote mental health and improve equitable access and quality of mental health care. In doing so, the plan provides a targeted strategy for reaching people—particularly young people—who face adversity and disadvantage.

This intent is translated into action through a strategic framework based on three dimensions: (1) Strengthening the contribution of psychiatrists to reducing distress, illness and suicidal behaviour among young people under extreme stress including those affected by conflict and emergencies; and people living with long-standing mental illnesses and their caregivers. (2) Enabling activities—supporting psychiatrists to promote mental health and improve care capacity. These activities include: service development; awareness raising and advocacy; education, publications and research; all conceived as gender- and culturally-sensitive. (3) Partnerships and collaboration—expanding the reach and effectiveness of partnerships with both service providers and service beneficiaries.

Disclosure of interest.– The author declares that he has no competing interest.

Ask the Experts III

ATE0005

Caring for people with intellectual disabilities

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Intellectual Disability (ID) has a prevalence of up to 3% in the general population. The prevalence of mental disorders in people with ID is high compared with people without ID for example, Schizophrenia prevalence rate is 3%. In addition, the rates of physical disorders for example, diabetes and epilepsy is higher too that can lead to great health inequalities when compared with the general population.

Assessing mental disorders in people with ID can be challenging because of communication difficulties, the co-existence of neurodevelopmental disorders or other neurological disorders. An understanding of the presentation of mental disorders in people with ID is essential to making accurate diagnoses and offering treatment.

The purpose of the Ask-the-Expert session is to assist colleagues with limited experience in working with people with ID to manage the complexities involved in assessing and managing mental disorders in this group of people. Participants are encouraged to present relevant cases in the session to the panel who will seek to provide more insights in to assessing and managing mental disorders in ID.
Disclosure of interest.– The authors declare that they has no competing interest.

ATE0006

Planning ahead for acute mental health crises: Methods and outcomes

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The term ‘advance statements’ covers a range of interventions which vary with respect to their basis in legislation and the manner in which health professionals are involved in their creation. Advance directives lie at one end of this range because their content is determined solely by the patient. They have not been shown to have an effect on rates of involuntary hospitalisation. The most likely reason for this is that they are enacted only when the holder is deemed to have lost capacity to make treatment decisions.

Routine care plans lie at the other, paternalistic, end of the crisis planning spectrum, as they may be produced without any patient/consumer involvement, although by consensus this is not seen as good practice. Joint crisis plans (JCP) lie toward the centre of this spectrum, as an application of shared decision making. To achieve this, JCPs require an external facilitator, namely an independent third party, to complete the crisis plan. The facilitator, a mental health professional independent of the treatment team, aims to engage the service user and treating mental health professionals in writing the JCP.

The results of a randomized controlled trial of JCPs for people with psychotic or bipolar illness showed reduced use of involuntary hospitalization associated with their use and reported positive views of the plans by service users and mental health professionals, when compared with routine care plans. The larger CRIMSON multi-site trial found a positive effect on service user-rated therapeutic relationships, but no reduction in compulsory admission rate. There was clear evidence that the JCP process had not been fully imple-

mented by many members of staff, because of attitudinal barriers to sharing clinical decision making powers with patients. Increasingly such implementation barriers are being recognised as critical brake on healthcare improvement. Implementation science may therefore be of use for translating the findings of the first trial into routine patient benefit

Disclosure of interest.– I was the PI for the first trial of Joint Crisis Plans and a coapplicant on the CRIMSON trial

ATE0007

Changes in the classification of sexuality, sexual health, and gender identity for ICD-11

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In forthcoming Eleventh Revision of WHO's International Classification of Diseases and Related Health Problems (ICD-11), there have been substantial changes related to the classification of conditions

related to sexuality and gender identity previously conceptualized as mental disorders. Changes have implemented based on advances in research and clinical practice, and major shifts in social attitudes and in relevant policies, laws, and human rights standards. Gender identity disorders in ICD-10 have been reconceptualized as 'gender incongruence', and moved to out of the classification of mental disorders to a new chapter on Conditions Related to Sexual Health. All categories specifically related to sexual orientation have been deleted. The proposed classification of paraphilic disorders distinguishes between conditions that are relevant to public health and clinical psychopathology and those that merely reflect private behaviour. Yet, some areas of controversy remain. This Ask the Experts session will provide an opportunity to discuss the main changes, the rationale and evidence considered, and important differences from ICD-10 and DSM-5, as well as to consider the clinical, legal and policy implications of these changes in Europe and around the world.

Disclosure of interest.– The author declares that he has no competing interest.