

The future of academic psychiatry in Europe

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Academic psychiatry is going through a difficult period in Europe. Models of mental healthcare have changed dramatically in the last few decades and academic centres are often conforming reluctantly to this change or even trying to withstand it rather than being proactive and leading the process. Furthermore, only a minority of big or well organised university psychiatric departments are currently able to compete successfully with other academic centres for the meagre funds available for research, and at the same time to respond effectively to the persistent demand to be as 'productive' as non-academic hospitals or mental health services in terms of numbers of patients seen and treated in ordinary clinical practice. In several European countries, psychiatry has become less attractive to medical students and junior doctors than it was in the past, and recruitment of smart young researchers in academic departments has become increasingly difficult. In addition, the current confusion about the identity of psychiatry is generating uncertainty and controversies about the content of psychiatric education and training, which in some countries is being regarded as obsolete. Finally, the need to interact with an increasingly broad range of counterparts – including other mental health professionals, administrators at a variety of levels, families and their organisations, magistrates and journalists – has caught some academics unprepared. These new challenges in clinical practice, teaching and research need to be approached in a thoughtful and comprehensive way. The role and aims of academic psychiatry need to be re-defined so that it can resume the initiative and lead further developments in the field rather than being overwhelmed by them.

Concerning clinical practice, the move from hospital-based to community-based mental healthcare is now occurring, although at a different pace, throughout Europe. However, the call for 'balanced' mental healthcare, that is, the provision of modern hospital care as well as a range of services in the community, is to some extent redefining the target (Thorncroft & Tansella, 2002). On the other hand, the experience of those European countries in which the development of community psychiatry has been most rapid is emphasising the need to reaffirm that the main mandate of mental health services remains the timely and proper diagnosis and management of the whole range of mental disorders. Promotion of mental health in the community is a complex task, which has to be approached by concrete, evidence-based programmes, and cannot be the pretext for an aimless and disorganised political activism, distracting psychiatrists from their clinical duties. Academic centres can contribute decisively to the development of balanced mental healthcare and mental health promotion programmes in their countries,

upholding those models and interventions that have been proved to be effective by systematic research.

The organisation of psychiatric education and training very much depends on the range of mental health services available to an individual academic centre. It is clear that psychiatry cannot be taught only in hospital wards, and that the most severe mental disorders cannot be the only or the predominant subject of psychiatric teaching. Medical students and especially residents should rotate in hospital wards as well as in out-patient clinics, special units (e.g. substance use or eating disorder clinics) and community services (e.g. early-intervention centres, rehabilitation units, day care centres, hostels and residential homes). They should be exposed to the whole range of mental disorders, with a special focus on those that are most prevalent in the community. The role of psychiatrists as partners of colleagues in other medical and surgical disciplines in managing the emotional problems of patients with severe or chronic physical illness should be at the forefront of teaching (as well as of clinical practice). The emphasis on psychiatry as a medical discipline, which has much to offer to other medical and surgical specialties, as well as to the general population, can do much to improve the image of our profession among medical students and make it more attractive.

On the other hand, the attitudes required of community psychiatry should be a special focus of postgraduate training: residents should learn to recognise in themselves and their colleagues any stigmatising tendencies towards patients and families; they should be trained to work effectively in multi-disciplinary teams and to manage group dynamics; they should become familiar with the legal aspects of psychiatric practice in the community (Martindale, 2005). They should be alerted to the risk of professional isolation run by psychiatrists working in mental health centres, which may contribute to the neglect of physical health in patients with severe mental disorders, now emerging as a major public health and ethical problem (Maj, 2007).

On the research side, the increasing shortage of funds should encourage the development of networks of academic centres, joining their forces in applying to national and European funding bodies for studies of clear public health relevance. Crucial for the success of an application are the way the objectives of a proposed study are formulated and the way the needs that the study is going to address are specified. We psychiatrists are probably not fully aware that our research projects often appear to funding bodies as abstract, redundant and inconsequential. In the current competitive environment, there is no place any more for projects proposed only because a research group has to publish something from time to time. Drug companies have been very successful in recent years in putting together national

and international networks of academic centres and in keeping them active, although the outcome of these endeavours has not always been worthwhile. A similar effort should be made in all those research fields which are consistently regarded as promising by academic centres at the national or international level. These networks could also be used for exchange programmes involving residents and researchers.

Finally, the specific skills needed to interact effectively with families, administrators, journalists and the legal system should become a formal component of postgraduate training and continuing medical education. Academic psychiatrists tend to be seen by such counterparts as a competent and reliable source of information, but their performance when they are asked to provide an expert opinion or advice is not

always brilliant, which contributes to the deterioration of the image of our profession. We should learn from our own mistakes and train ourselves and our young colleagues in the art of being convincing and effective partners and communicators.

References

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THEMATIC PAPERS – INTRODUCTION

Ethno-psychopharmacology

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How we judge in what way, with what potential side-effects, our patients respond to medications designed to help them recover from their psychiatric disorders is informed by experience, scientific knowledge and guesswork. The rapid movement of populations around the world, usually voluntary but sometimes driven by other motives or exigencies, means that many psychiatrists are increasingly frequently faced with providing treatment for individuals who come from cultures about which they know little. Determining the characteristics of the illness itself can prove challenging in such circumstances, as this can be influenced by cultural differences in, for example, the degree of somatisation of symptoms. In this issue, we link three papers, each of which provides a different viewpoint on the way in which the effectiveness of pharmacological treatment for psychiatric problems could be influenced by the ethnic background of the patient.

There are several factors that must be taken into consideration in making decisions about medication that depend on the ethnic origins of the patient. Perhaps the one that is attracting most attention at present concerns their genotype. We have known for decades that certain enzymes involved in drug metabolism vary in their efficiency, systematically by ethnic origin. Every medical student knows that a high proportion of people from the Far East cannot metabolise alcohol efficiently and that they have unpleasant side-effects from the consumption of alcohol – a reaction that greatly reduces the risk of alcoholism. In recent years we have discovered not only the genetic basis of the difference in enzymatic activity with respect to alcohol metabolism but also critical enzymatic systems that play a role in the metabolism of lipophilic drugs, which cannot be easily eliminated

from the body by means of excretion. They are usually biotransformed to more hydrophilic compounds, which are easily removed by the renal system.

Many drugs we use in psychiatric practice are metabolised by the cytochrome P450 (CYP) system. The CYP system consists of a number of different enzymes and the classification of these involves the following nomenclature: the CYP{number}{letter}{number}*{number} groups. The first number refers to a group of compounds that have high (> 40%) protein sequence homology. There is then a letter which refers to subfamilies that have greater than 55% homology. The second number refers to members of subfamilies that are encoded by a particular gene. Finally, there is a number following the * which represents specific alleles of that gene. The cytochrome P450 system differs in its genetic profile by ethnic group, and hence the efficiency of its component enzymes in terms of drug metabolism.

The P450 system is involved in the metabolism of many lipophilic drugs, but from the perspective of psychiatrists the most intensively studied have been the selective serotonin reuptake inhibitors (SSRIs), which serve both as substrates and as inhibitors of these enzymes. For example, both paroxetine and fluoxetine are potent inhibitors of CYP2D6 and therefore they have the potential to increase the plasma concentrations of antipsychotic medications metabolised by this enzyme. Polymorphisms of CYP2D6 can either greatly increase the rate of drug elimination or decrease drug metabolism, and the proportions of populations that fall into one or other of these categories varies considerably with ethnicity. Do we need to genotype our patients before prescribing medications, such as the SSRIs, that interact with this enzymatic system? Should we be purchasing the