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24th European Congress of Psychiatry

EPA Forum: A common language in European psychiatry – can it be achieved?

EF01

21st century psychiatry: The need for a unitary framework

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While the plurality of approaches is a richness of psychiatry, we need today a unitary framework in which the vast majority of psychiatrists are able to place and recognize themselves. An essential component of this framework should be the awareness that a major outcome of research efforts of the past thirty years is the notion that a simple deterministic etiological model cannot be applied to mental disorders, which instead represent the product of the complex interaction of a multiplicity of vulnerability and protective factors of different nature (biological, intrapsychic, interpersonal, psychosocial). Most current significant etiological research in psychiatry can be accommodated within this framework, thus appearing much less chaotic, inconsistent and fragmentary. This first level of the framework affects in a probabilistic, not a deterministic, way the second one, that of neurobiological, cognitive and psychological intermediate processes. It is unavoidable that different languages be used to describe these processes, but these languages may be translatable into each other to some extent. Furthermore, comprehensive pathogenetic models usually require the integration of different languages. This second level leads, again in a probabilistic way, to the third level, that of symptoms, signs, cognitive dysfunctions and psychopathological dimensions. These are the elements composing the fourth level, the syndromal one. The ICD/DSM formulation of this fourth level is not optimal, but it is the best we have at the moment. Certainly, the fact that two major diagnostic systems exist in psychiatry adds to the confusion and the uncertainty, and should be overcome in the future.

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EF02

Outcomes of promotion, prevention, treatment and care

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The WHO European Mental Health Action Plan encompasses promotion, prevention, treatment and recovery, within the context of a model of mental health that proposes a set of socio-economic and biological determinants that predispose to vulnerabilities and increase the risk of disorders. These determinants also negatively affect access to and quality of care. Such risk factors are shared with common non-communicable disorders, increasing the risk of morbidity and early mortality for people with mental disorders.

Mental health promotion and prevention actions should therefore be addressing determinants such as alcohol and smoking. However, such determinants are not equally distributed in the population, but cluster among vulnerable groups, such as those with a low income, the unemployed and minority groups. These groups overlap with the populations services struggle to reach. In addition, both primary care and specialist mental health services struggle to identify and treat people with co-morbidities. This suggests that connections need to be established between public health, primary care and specialist mental health services.

WHO is focussing on the strengthening of primary care and the interface with mental health services. In particular, there is an urgent need to screen people who present with symptoms of NCDs or mental disorders for common determinants and co-morbidities. Effective health promotion activities need to be offered to populations at risk, in addition to universal health promotion interventions such as taxation or advertising bans. Some examples will be presented.

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EF03

Human rights and mental health care – Can we find a common ground?

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Future of psychiatry is discussed in the context of modern human rights principles, evidence-based policies and sustainable development goals.

After international community agreed on sustainable development goals to be reached by 2030, there is a good opportunity to address mental health as a priority and to substantially invest in promotion of mental health and emotional well-being.

Psychiatry, as an influential specialty, needs to reconsider its strategy in this context, and to rethink strengths and weaknesses of its role and image.

Protection of dignity and human rights of persons with psychosocial disabilities, in the post-CRPD framework, should become

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a priority for psychiatry. Common ground for search of a new consensus between different views on non-consensual treatment in psychiatry could be equilibrium within the principles of "first, do no harm", "right to treatment" and "no hierarchy within human rights". For mental healthcare practice, this would mean that good intentions to provide evidence-based interventions do not justify the use of force and deprivation of liberty which threatens dignity and universal human rights principles.

Psychiatry, while rethinking future directions, should critically reconsider its current focus on neurobiological paradigm and tradition of using force in the name of medicine and social control. These two paradigms, traditionally perceived as strengths of psychiatry and sources of its power, are now too often misused and increasingly discussed as lacking evidence, ignoring human rights and thus threatening image of psychiatry. Instead, psychiatry could consider accepting post-CRPD challenge as a unique opportunity for change, through strengthening strategic alliance with human rights mechanisms, social sciences, general and community medicine, modern public health approach and users' perspective.

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