ΕΛΛΗΝΙΚΗ ΨΥΧΙΑΤΡΙΚΗ ΕΤΑΙΡΕΙΑ

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HELLENIC PSYCHIATRIC ASSOCIATION (UK DIVISION)

HELLENIC (UK) PSYCHIATRIC BULLETIN

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Front cover and layout of Hellenic (UK) Psychiatric Bulletin and HPA-UK Psychiatric Bulletin logos were designed by Konstantinos Ioannidis.

The Hellenic Psychiatric Association (HPA) was founded in 1986 in Athens. HPA's mission is to promote the discipline of Psychiatry in Greece, to open lines of communication and encourage collaboration not only within psychiatry, but also with other medical, or psychiatry-related specialties. Among HPA's scopes is to promote and enhance excellence in psychiatric clinical practice in Greece, to assist in the prevention of mental illness, to protect the rights of the mentally ill and to promote education and research.

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Please think of the environment before you print this issue.

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Editor's note

Anastasios Dimopoulos, *Editor, Hellenic (UK) Psychiatric Bulletin*

Dear friends and colleagues,

It has been a while since our last edition. As you have already been alerted, Dr Filippidou had to reduce temporarily her involvement as an editor of the newsletter. I joined the effort as a co-editor at a time of personal change myself that also had an impact to the timescale of this edition. I do apologize for the late circulation of the bulletin. We are already in the process of securing material for the next edition and we hope that we will be able to re-establish a biannual edition with the first one around July 2018 and the second one before Christmas 2018.

Our first article is by Dr Filippidou that offers her reflection on the term "meta-community health care" as it was proposed in a comment authored by Prof Bouras, Prof Ikkos and Prof Craig and published in Lancet Psychiatry. Times are changing and existing models of care in community often fail to meet the growing demands of the population for mental health services. Dr Filippidou succinctly summarizes the challenges in front of us and offers a roadmap for the future of community mental health care.

In this issue, we have the honour to host a feature article by Dr Athanassios Kanellopoulos, a Child and Adolescent Psychiatrist, member of the Hellenic Society of Child and Adolescent Psychiatry. Dr Kanellopoulos discusses the impact of forced immigration on the mental health of children and adolescents and outlies what local societies and professional organizations have to do to alleviate the trauma caused by it. The data provided are scary suggesting an impact that often extends to more than one generation involved. The call for action as it was conceived by the European Society of Child and Adolescent Psychiatry (ESCAP) may appear idealistic in its proclaimed targets, but in reality is the only way to prevent catastrophic outcomes from the experience of forced immigration.

This issue closes with my brief commentary on the activities of the psychiatric section of the Royal Society of Medicine. Two events organized by the RSM are brought to your attention, indicating the interdisciplinary approach that the society follows. The first conference engaged in a dialogue between evolutionary theories and psychiatry. It took place on 13/03/2018, unfortunately before the coming out of this edition. It was a very well organized and stimulating day that made evident how using evolutionary theories and research can enrich our understanding of mental disorders. The next one is a highly expected appointment, with an impressive panel of speakers that will take place on 08/05/2018 with the title "In Kraepelin's shadow; Historical and philosophical foundations of contemporary biological psychiatry". Will be a pleasure to see you there.

CHAIR'S Message

Professor Eleni Palazidou, *Chair, Hellenic Psychiatric Association, UK Division*

Dear all,

I hope you had a good Xmas break and, very belatedly, wish you a Very Happy New Year! I'll restrain myself from going into a political tirade as I did in the last issue of the Bulletin! Suffice to say, that things have gone from bad to worse in the Eastern Mediterranean and Greece and Cyprus are facing continued and worrying external and internal threats. Time will show what impact this is having on people's collective mental wellbeing, on top of the ongoing stress of the relentless economic austerity.

Our role as a small group of mental health professionals, in the UK, is limited. All we can do is declare our solidarity with our colleagues in Greece and Cyprus. We can also keep bringing Psychiatry to Society through our open to the public meetings at the Hellenic Centre.

There has been some delay in producing the winter issue of the Bulletin for unavoidable, practical reasons and we apologize for this. You may note a change in the editorship of this issue of the Bulletin. Our talented editor, Maria Filippidou has temporarily taken the back seat, for family reasons and we are grateful to the equally talented and enthusiastic Tassos Dimopoulos, who has taken the lead in producing the current issue of the Bulletin. I am delighted to announce that it was agreed that the two will work together in the future as co- editors.

I close with my best wishes to all for a successful and happy 2018!

Eleni Palazidou

A COMMENT ON META-COMMUNITY MENTAL HEALTH CARE

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The August issue of the Lancet Psychiatry hosted a comment by three prominent psychiatrists of the United Kingdom, Professors Bouras, Ikkos and Craig. The term "meta-community mental health care" was coined, describing an ambitious conceptual framework of particular interest. This gives hope to the perceived quiescence in the advancement of community mental health care in recent years.

One cannot ignore the weight of the authors' views, given their extensive experience in mental health care. Professor Bouras has been a pioneer in the closure of asylums and establishment of the first community centres in the United Kingdom in the 70's. He recently published a book on his successful career journey, narrating some fascinating stories on this experience (Bouras, 2017). Professor Ikkos has had many important clinical and academic achievements and contributions to psychiatry. He has had pivotal roles like serving as president of the RSM sections of psychiatry and pain medicine and as Hon. Treasurer of the Royal College of Psychiatrists. He has been a leader in Medical Education for decades, having trained hundreds of young psychiatrists. Professor Tom Craig, a Professor in Community and Social psychiatry has played a remarkable role in the development of community mental health service models. He has also contributed to the establishment of the Sainsbury Centre for Mental Health, a charity now known as Centre for Mental Health.

As a young consultant and having trained in the UK, I was never truly familiar with the function of asylums. It is often thought that psychiatrists who trained in the new millennium not only haven't worked in a psychiatric hospital, but we haven't even seen one (Leff, 2001). Not unexpectedly, this mostly sounds and feels like a positive attribution considering the remarkable shift that took place for patients and their wellbeing from the 70's onwards. Nonetheless there is at the same time always a sense that I have missed a significant experience. Had I been there, it would have shaped my development as a mental health professional very differently. Perhaps even young colleagues who have worked in the community (including myself) would have been in a better position to evaluate issues that have not allowed community care to fully satisfy our patients' needs.

When I initially read the proposition of the conceptual framework of meta-community mental health care, it clearly felt a natural result of years of experience of professionals who have seen asylums, fought for their closure and significantly contributed to the development of the mental health care in the community. Their ideas are a direct result of cultivated thought, integrated knowledge of the history of psychiatry through

many years of experience and effective use of theoretical frameworks.

The model has five principles: learning from community mental health care, identification of restrictions in the community, advocacy of pluralism, delivery of information and care in diverse locations and emphasis on flexibility, innovation and environmental sustainability (Bouras et al, 2017).

The need for community care to evolve is not only the result of it peaking following its revolutionary approach at this time. It is also the result of a society that continuously changes and has seen war, movement of populations, discrimination and trauma. Attitudes towards mental health at a governmental and personal level have also seen changes to a smaller scale. Nevertheless those changes haven't exactly followed the degree of societal change and they haven't satisfied the societal needs. This is for example reflected in the function of prisons, which struggle to contain people with mental illnesses and where mentally ill people (particularly young people) spend nights in police cells instead of psychiatric wards. Also, in cases of chronic severe mental illness, often with co morbidity, community mental health care sometimes fails to contain them to the desired degree. Prevention of crisis in chronic illness and the impact on long-term recovery, have not been adequate.

Those frustrations in the system that are often unfairly attributed to the function of Community Mental Health Teams (CMHTs) are closely related to the closure of wards and the reduction of available beds. The lack of cost effectiveness from the continuous closure of beds has been recorded (Ewbank et al, 2017). Psychiatric beds reduced from 150000 in the 1950's to 47000 in 1996 and 34000 in 2006 (Cooper, 2010). According to a King's Fund briefing, the overnight mental health and learning disability beds show the biggest reduction amongst hospital beds, reaching 72.1% and 96.4% respectively between 1987/88 and 2016/17 (Ewbank et al, 2017).

I am certainly not one of those who believe that community mental health care has failed the patients who were discharged from the asylums. This has in any case been supported by evidence; homelessness was not increased after the asylum closures (Craig & Timms, 1992) in contrast to what a large number of people and the media believe. Additionally, the patients' quality of life significantly increased (Leff & Trieman, 2000). I think though that the balance between contemporary inpatient and community care was probably lost at some point, psychiatric wards were demonised and this black and white rhetoric of inpatient vs community care was unhelpful (Thornicroft & Tansella, 2002).

This gigantic change has subsequently and gradually had a direct impact on CMHTs as they struggle to contain crises for which they were not designed. Their caseloads are also often very large, hence the elaborate personalised management patients need cannot take place. This domino effect has had its impact on all types of psychiatric services, from the liaison and crisis teams that are often to their knees, to community, inpatient and specialised care teams. I believe that the meta-community mental health care approach would bring some relief to the system in its current form. At the same time, significant recovery work could be done for those groups of patients.

The closure of beds however has not been the only scourge of our time. Integration in multiple levels of care (i.e. primary with secondary health care, health care with social care, psychiatry with other medical specialities, integration amongst psychiatric teams, integration of information as well as of personalised patient needs with available resources and evidence base) is vital and has been deficient for a very long time. Bouras et al refer to the challenge of working at a service user level but with the support of evidence base. To that I would add the challenge of integration on all the aforementioned levels. It is elegantly referred to as the "pluralistic approach", which is nothing less than the essential co-existence of different facets of care. Continuity in the patient's journey is so much desired.

Finally, flexibility and innovation are smartly being suggested because nothing can grow without embracing change and we have to be in a position to use technology in our favour. The key point is that the invitation for the development of the meta-community mental health care is a realistic one. With focused and methodical planning, it could give solutions to multiple issues that patient care is facing at the moment and I will be looking forward to further developments on this front.

REFERENCES

1) Bouras, N., Ikkos, G., & Craig, T. (2017). Meta-community mental health care: towards a new concept. *The Lancet Psychiatry*, *4*(8), 581-582. DOI: 10.1016/S2215-0366(17)30108-6

2) 2) Bouras, N., 2017, Reflections on the Challenges of Psychiatry in the UK and Beyond: A Psychiatrist's Chronicle from Deinstitutionalisation to Community Care, Pavilion Publishing and Media Ltd.

3) Cooper, B., 2010, British psychiatry and its discontents, *J R Soc Med.* 1; 103(10): 397–402.

4) Craig, T. & Timms, P. W., 1992, Out of the wards and onto the streets? Deinstitutionalization and homelessness in Britain, *Journal of Mental Health*, 1(3):265-275

5) Ewbank, L., Thompson, J., McKenna, H., 2017 NHS Hospital bed numbers: Past, present, future, The Kings Fund, https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers

6) Leff, J. & Trieman, N., 2000, Long-stay patients discharged from psychiatric hospitals. Social and clinical outcomes after five years in the community. The TAPS Project 46, *The British Journal of Psychiatry*, 176 (3) 217-223; **DOI:** 10.1192/bjp.176.3.217

7) Leff, J., 2001, Why is care in the community perceived as a failure? *The British Journal of Psychiatry*, 179 (5) 381-383; **DOI:** 10.1192/bjp.179.5.381

8) Thornicroft, G. & Tansella, M., 2002, Balancing community-basedand hospital-based mental health care, *World Psychiatry*, 1(2): 84–90

Feature article:

Mental Health of Child & Adolescent refugees. Is it too late for an international call for action?

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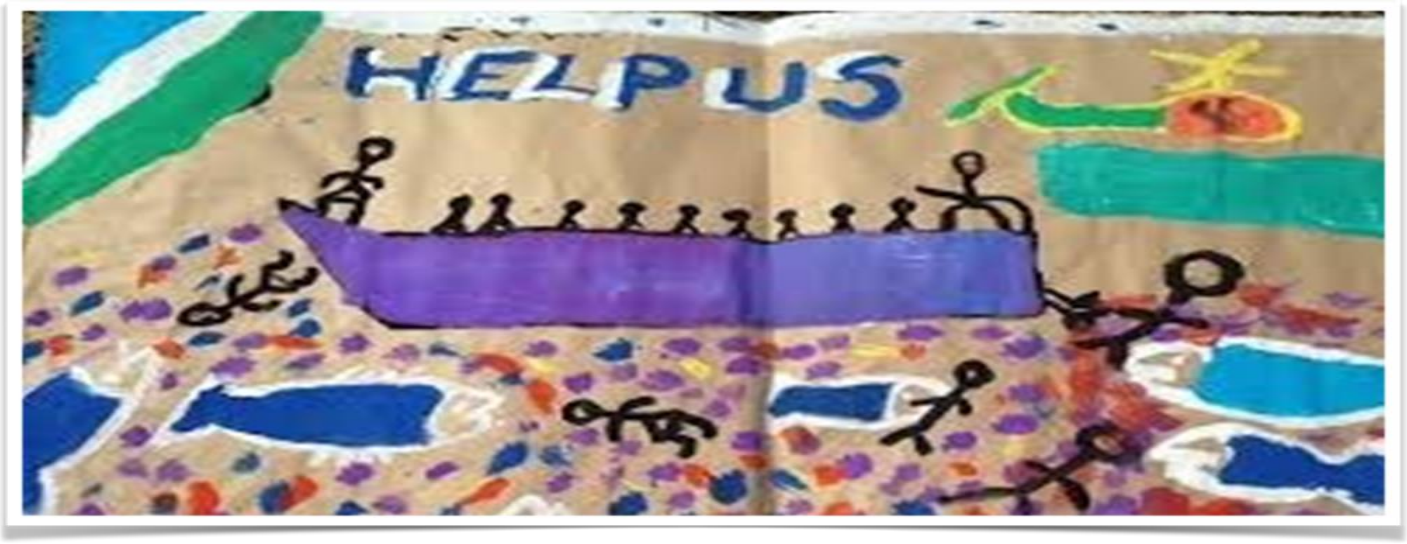
The number of refugees coming to Europe has reached staggering proportions in some countries. In the EU-28 (total population: 508 million inhabitants), first-time asylum applicants in 2015 were 1,255,688, 29% of whom were minors (19 % < age 14; 10 % between 14 and 17years). Germany alone lodged 160.000 asylum applications in the first 6 months of 2015,(UNHCR 2015), reaching 315.000 by the end of October (BBC 2015). In fact, more than 1 million refugees came to Europe in 2015, a vast majority by sea crossing over to Greece and Italy.

The Syrian civil war, which began in March 2011, has subsequently displaced nearly 12 million people, more than 4 million of them beyond Syria's borders. Children under the age of 18 represent about half of the Syrian refugee population, with approximately 40 percent under the age of 12. Syrian refugee children have experienced very high levels of trauma. Research suggests that: 79 % had experienced a death in the family, 60% had seen someone get kicked, shot at, or physically hurt, where 30% had themselves been kicked, shot at, or physically hurt.



Trauma can be described as an event when a person loses the protective barriers that makes them feel safe. With refugees we no longer talk about warning signs for risk of trauma, but actual events in that person's life, the worst nightmares and situations.

The trauma phenomenon caused by fleeing home is extremely complex. When a person is separated from their home and loved ones, they are uprooted and lose their identity. He or she may experience strong anxiety for being persecuted or threatened to be destroyed physically or psychologically (Pakaslahti & Saraneva 2010, 195).

A child is dependent on his or her parents and is mentally not fully developed. In a traumatic event, the child's development is arrested and they lose their childhood. For these reasons refugees and asylum seekers are a particularly vulnerable group for developing mental health disorders. The repercussions of these experiences can influence the mental health even of second or third generation refugees.

The risk factors for a refugee to develop a mental health disorder derive mostly from the traumatic experiences suffered including torture, violence, life threatening flight from home, separation from family, concern for family left behind and disarray in the home country. Mental health problems of refugees can be split in to three separate stages, depending on the status of their journey.

- **Pre-flight** means the time when the person is still living in his or her own country, before the escape journey starts. They may be living in a war zone, conflict area or experiencing a collapse of the social net in their country. During flight is when the refugee is "on the road" and is escaping the home country to seek safety in a new state. Pre-flight experiences depend on their country of origin, exposure to poverty, war, or war-like conditions.
- **The flight** in itself is often traumatic too, since they may experience separation from their parents, forced labor, trafficking, sexual abuse and sexual exploitation.
- **Arriving in the hosting country** they are faced with unsafe or problematic living conditions such as non-access to schooling. They will also likely face several years of insecurity having an uncertain legal and residential status and very often they will be moving in different accommodations. Further risks include parental illness and unemployment, social exclusion and the hostility experienced toward refugees. The initial provision of a safe environment to traumatized young refugees should not be taken for granted. Moreover, even once migrants have settled and formed families, their children, the second-generation migrants, have an increased risk for mental health problems.

Overall, there is an increase in vulnerability for the development of psychiatric disorders. Almost half of the children displayed symptoms of PTSD (post-traumatic stress disorder). This is an alarming fact since PTSD in childhood or adolescence is not common; its incidence is

approximately 0.4%. Around 14% - 43% of children experience a traumatic event in their childhood, and of these 3% - 15% develop PTSD. For adolescents, that number is 3.7% - 6.3%. It is twice more common in girls than boys (Meltzer et al, 2000 via Chowdhury & Pancha 2011; Pinto & Schub 2015). Presentation of symptoms varies with age. Children aged 5-15 can experience a clinical manifestation in which they mis-sequence the events. In adolescents that number is 3.7% - 6.3%. It is twice more common in girls than boys. (Meltzer et al, 2000 via Chowdhury & Pancha 2011; Pinto & Schub 2015). The commonly observed phenomenon of "omen formation" describes a child's belief that there were warning signs predicting the trauma. They may also compulsively repeat some aspects of trauma, for example increase engagement in "shoot em up" games. Teenagers and adolescents are more likely to incorporate aspects of trauma into their everyday lives. Adolescents are also more likely to exhibit impulsive and aggressive behaviours. (Chowdhury & Pancha 2011).

Children can be affected directly from a personal exposure to trauma, and by adults' reactions. Parents' reactions to events can influence child's capability to recover from the traumatic event (Pinto & Schub 2015). Younger children are usually not able to express their trauma or fear verbally and diagnosing them can be challenging. Children may feel uncomfortable or fearful of upsetting others, or simply unable to verbally express the traumatic experience (Pinto & Schub 2015). Children often complain of stomach aches and headaches instead of verbally expressing the anxiety (Chowdhury & Pancha 2011).

Other mental disorders such as depression, separation anxiety, panic disorder, personality disorders, substance abuse, conduct disorders such as sexually aggressive behaviour, and anxiety are strongly connected to PTSD in children. (Chowdhury & Pancha 2011; Pinto & Schub 2015).

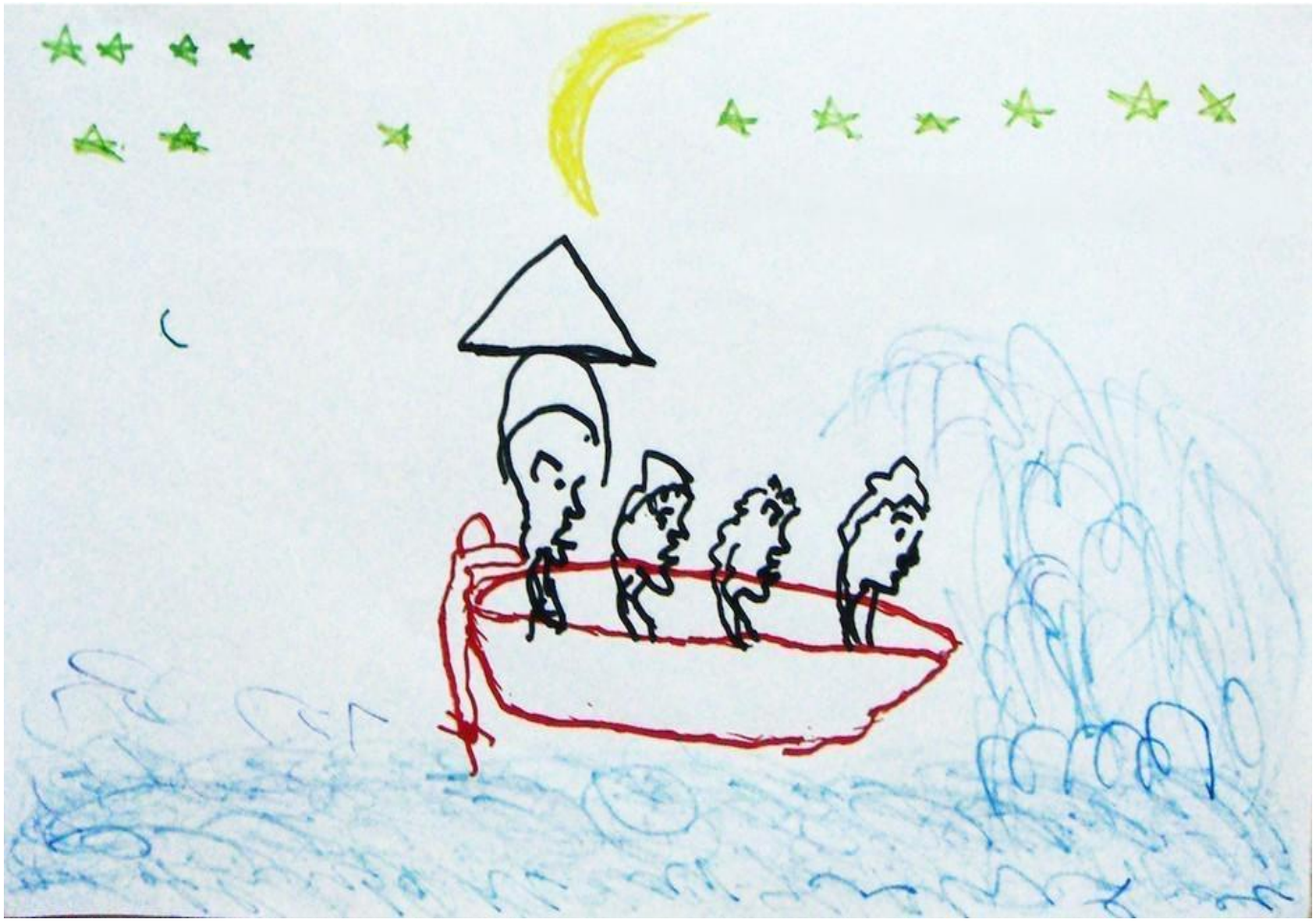
The European Society of Child & Adolescent Psychiatrists (ESCAP) formed a taskforce that issued a position statement for the mental health of child & adolescent refugees. The taskforce was led by Prof. Dimitris Anagnostopoulos, president elect of ESCAP (European Society of Child and Adolescent Psychiatry) and current president of the Hellenic Society of Child & Adolescent Psychiatrists. The taskforce tried to address the main measures that needed to be taken for the mental health of child & adolescent refugees to be safeguarded and summarized them in the following guiding principles:

- Basic health care to be provided to migrants with a joint focus on children's physical and mental health.
- Organizations (including governmental) should be encouraged to engage professionals to work with these populations. Activities of all professionals and organizations working with children in these circumstances must apply the principles of Best Interests as identified in the UN Convention on the Rights of the Child Safeguard children's' right to be heard and to participate in decisions that concern them.

- Hosting countries should try to make the steps leading to a legalization of the residential status and the granting of asylum as transparent as possible.
- Children should not be separated from their families as long as this is consistent with their best interests. The promotion of a healthy adaptation of these young people and their families, lowering the risks involved in the process is crucial.
- Children and youth reaching destination countries should be supported to integrate them and to provide mainstream services as appropriate as the rest of the population.
- A successful educational, cultural, and, if applicable, religious integration is the key cornerstone for future mental health and the prevention of behavioural disorders. Adaptation of a public health approach
- Enhancing cultural competence of professionals and monitoring refugees' access and utilization of services
-Special emphasis toward understanding refugees' experiences and challenges within the new environment
-Fostering resilience among individuals and communities
-Enabling post traumatic growth

(Translation of the ESCAP's Call of Action)

Our attitude toward young refugees and their families will greatly determine the burden of



trauma and attachment disorders as adults. Empathy, secure sheltering, addressing health and educational needs will create a sense of stability and confidence. The main aim is to provide a productive integration in the European society, a heritage of strength and diversity and potentially rebuild and stabilize their native countries for those who want to return. Proactive screening processes should be implemented upon the arrival of the refugee minor, with frequent follow-up in the upcoming months and years and early detection and intervention are crucial in trying to prevent a lifelong mental health illness and helps assimilating the refugees in to the new society. It is never too late for an international call of action.

References

1) Chowdhury, U; Pancha, A. 2011. Post-traumatic stress disorder in children and adolescents. Community Practitioner. December 2011 Volume 84 Number 12

2) Pinto, S; Schub & T. 2015. Post-traumatic stress disorder in children. Quick lesson. Cinahl Information Systems. May 8, 2015.

3) Salem, B; Flaskerud, J. 2010. CULTURAL COMPETENCE COLUMN. A Closer Look: The Trauma of War and Migration and PTSD. Issues in Mental Health Nursing, 32:184–186, 2010

4) Goosen, S; Stronks, K; Kunst, A. 2013. Frequent relocations between asylum-seeker centres are associated with mental distress in asylum-seeking children: a longitudinal medical record study. International Journal of Epidemiology 2014;43:94–104.

5) Ramel, B; Täljemark, J; Lindgren, A; Johansson, B.A. 2015. Overrepresentation of unaccompanied refugee minors in inpatient psychiatric care. Ramel et al. SpringerPlus (2015) 4:131

6) ESCAP position statement: Mental Health of Child and Adolescent refugees
Dimitris Anagnostopoulos, Johannes Hebebrand, Stephan Eliez, Maeve B Doyle, Henrikje Klasen, Sofie Crommen, Fusun Cetin Cuhadaroglu, Milica Pejovic-Milovancevic, Oscar Herreros, Ruud Minderaa, Andreas Karwautz, Carl Goran Svedin, Jean Philippe Raynaud
https://www.escap.eu/care/position-statement-announcement/position-statement

Royal Society of Medicine – Psychiatry Section Conferences in 2018

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Conferences with topics relevant to the psychiatric discipline are very common and not always inspiring. Proposed knowledge is mostly a repetition of certain trends that don't always promote reflection on the foundations of our discipline, taking them as granted and unshakeable. On the contrary, two forthcoming conferences organized by the Royal Society of Medicine introduce intriguing topics for reflection and further discussion.

The origins of the Royal Society of Medicine date back to 1805 when it was established as "The Medical and Chirurgical Society of London". It took its current form (Royal Society of Medicine) in 1905 and since 1912 has had its facilities at 1 Wimpole Street in the centre of London. The RSM advertises itself as "nowadays one of the country's major providers of postgraduate medical education. Independent and apolitical, the Society promotes an exchange of information and ideas on the science, practice and organisation of medicine". The Royal College of Psychiatrists has a more narrowly defined role aiming first of all at setting standards for the psychiatric discipline. They seem to complement each other well and in fact the two events are organized with the participation of the Royal College Special Interest Group in the History and Philosophy of Psychiatry. Both conferences host internationally known speakers coming from different scientific fields.

The first one is on 13th of March 2018 and is entitled "Psychiatry and evolution: Biological and social perspectives". The second one is on 08th of May 2018 and is titled "In Kraepelin's shadow:

Historical and philosophical foundations of contemporary biological psychiatry".

Topics such as gene and environment interaction, the social body, social learning mechanisms and the influence of evolutionary theory in the understanding of mental distress promise a stimulating day on 13th of March 2018 in the conference co-organised by Drs Christos Sideras, Irene Cormac and Professor George Ikkos. The second conference is possibly on more familiar ground since the title promises a review of the influence of Kraepelin's work in what is our current dominant paradigm of biological psychiatry. It is co-organised by Professors K.W.M. Fulford and Ikkos.

A couple of years ago, in an essay in Volume 5 Number 2 of the Division Newsletter, George Ikkos shared his reflections on one of the late papers of Emil Kraepelin entitled "Patterns of Mental Disorder". Kraepelin's paper is a brilliant summary of his ideas and Ikkos offers a clear read and a balanced account of Kraepelin's contribution to the foundations of the psychiatric discipline, highlighting both strengths and limitations. The May 2018 event will see the participation of eminent figures from the field of psychiatry such as Prof Robin Murray, Prof Norbert Mueller (Munich), Prof Nancy Adreasen (Iowa) and Giovanni Stanghellini (Parma) among others.

Events like this are a breath of fresh air, a good opportunity to get exposed to ideas that may not necessarily reflect mainstream knowledge and an opportunity to network with colleagues that are interested in similar topics. I am looking forward to it and hopefully some bits and pieces of the conferences will find their way in a future edition of the newsletter.

References:

1) https://www.rsm.ac.uk/events/events-listing/2017-2018/sections/psychiatry-section/pyk05-psychiatry-and-evolution-biological-and-social-perspectives.aspx

2) https://www.rsm.ac.uk/events/events-listing/2017-2018/sections/psychiatry-section/pyk06-in-kraepelin%E2%80%99s-shadow-historical-and-philosophical-foundations-of-contemporary-biological-psychiatry.aspx

3) http://psych.gr/documents/DivPub/NewsletterV5N2_2015DivUK.pdf