



GAMIAN-Europe NEWSLETTER

Year 10, no 29, summer 2008

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Dear readers!

We wish that our newsletter serve as a vehicle of ideas, opinions, and information within all people concerned with mental health issues. Its success depends on your involvement. You can make it a very alive document! Please send us news, facts and events in a field of mental health, that took place in your country; your ideas and suggestions; and everything related to the advocacy in mental illness.

We rely on you!



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*Dolores Gauci**Dear Members*

This address deals with two matters which are very different but equally important. The first part looks at how the Board has been implementing the business plan whilst the other is the upcoming elections for a new board which will lead our Organisation.

One of the priority areas in our Business Plan has been to build partnerships with organisations working in patient advocacy, such as European Patient Forum, in the brain field such as the European Brain Council and in the field of mental health such as the World Federation for Mental Health (through the Leadership Advocacy Summits) and EUFAMI as well as the health care industry, such as Lilly, Pfizer, Astra Zeneca, GSK and Lundbeck. We have chosen to do this by working together on a number of common initiatives which we continue to inform you about through our newsletter and the website.

One of the common issue which GAMIAN-Europe shares with EUFAMI and Pfizer is the importance of physical wellbeing in mental health in view of the fact that physical health is often ignored in people with a diagnosis of mental illness such as schizophrenia and bipolar disorder. In November 2006 you recall that a meeting had been held in Barcelona specifically on the theme of Physical Wellbeing in Mental Health: Time for Action. The meeting agreed that it was time

for psychiatrists, healthcare providers, people with mental illness, their families, friends and carers, advocacy groups and politicians to get together to address how to ensure that when managing mental illness psychiatrists are also to ensure the person's overall health in order to maintain a high level of best physical health. This is a basic human right. The three organisations continued to work on this issue during 2007 and in November held Advocacy Media Training for a number of members from both organisations in Frankfurt. An Advocacy Media Tool Kit was also produced. For the training, patients, carers, psychiatrists, the press and industry participated.

From the two events it became clear that there was also a need for patients to be informed in order to be able to take control of their physical health and know what is required from their psychiatrist. Together with leading physicians and others across a variety of health specialties we went on to develop user-friendly guides for both patients and carers. These guides can be found on our website. I encourage you to make use of them and also to disseminate the guides not only amongst patient organisations in your own country but also amongst the psychiatric community as well as the press.

Now to the second matter. The Board is in its final quarter of its term of office. As laid down in our Statutes, elections for the Board of Directors take place every two years. Therefore, at this year's General Assembly which will take place in Israel on Friday 19th September elections will take place for a new board. According to our Statute the procedure for electing the Directors must begin 8 weeks before the General Assembly.

Over the years members have asked what capabilities a member on the board needs to have.

The Board needs to bring together a number of skills in order to be able to function. Board members therefore need to be elected for what they can contribute to the Board. A first requirement is the ability to understand and speak English in view of the fact that the working language of our Organisation tends to be in this language. There is no need to emphasize that being a patient brings extremely important, relevant experience which the board needs. There are also other important and relevant experiences and skills which are required for the board to function well and achieve the mission of GAMIAN Europe. Board members need to be able and willing to give time to the Organisation as well as be prepared to take an active part in its running. They need to have drive and passion and also a consistency of purpose. Being a non-profit Organisation means that Board members give of their time and expertise voluntarily and they do not get paid for the work that they do. They will however get re-reimbursed for expenses which they carry out whilst carry out GAMIAN-Europe work.

Amongst our membership there are persons who are willing and able to actively contribute to the development and strengthening of GAMIAN-Europe. I augur that they will come forward to ensure that the mission of our organisation is achieved. I take this opportunity to thank you for your support and contribution and to encourage you to nominate a person from your organisation who you think has the skills and is able to contribute to the development of GAMIAN-Europe.

Until we meet again in Jerusalem, Israel.

Dolores Gauci



Editor's comment:

We are trying to start a new rubric now: "Mental Health Care in Different Countries". Please send your articles, describing how psychiatric care system works in your own country. It is so interesting to know and so important to compare!

PSYCHIATRY IN ITALY TODAY



Paola Pivano – D.I.A.PSI. Piemonte (Italy)

In 2008 Italian psychiatry celebrates two anniversaries of international importance.

The first anniversary: thirty years ago the Law no.180, known also as "the Basaglia law", was approved. It gradually closed mental hospitals, created wards in general hospitals with no more than 15 beds for acute cases, reduced compulsory medical treatment and established the Mental Health Departments with territorial and home help services. Thanks to this law, Italy was the first country in the world to be free of specialist hospitals for the mentally ill.

The second anniversary is just the opposite to the Basaglia law. Seventy years ago Lucio Bini and Ugo Carletti tested electroshock for the first time in Rome. It was deemed a step forward as to the previous so-

called somatic treatment, but was initially overused causing considerable damage, also thanks to the mistaken opinion that it might have been useful for psychotic patients. But in the seventies, after deeper and more accurate studies, the usefulness of electroshock was, however, reassessed and proved to be clinically very suitable in treating acute depression. Nowadays, it is applied when strictly necessary and under general anaesthetic, without pain for patients, with reduced anxious reaction and positive outcome.

At the beginning of the sixties the newly discovered psychotropic drugs greatly reduced the harmful effects of the so-called "desperate treatments" and psychiatry entered a new era. It was now possible to imagine the reorganization of the mental healthcare from a new point of view. Since the adoption of psychotropic drugs greatly reduced patients' terrible anxiety mental hospitals were gradually able to

open the doors and allow patients to leave and be treated in the community.

All around the world laws began to change little by little, encouraging psychiatry in the community, also thanks to psychoanalysis and other psychodynamic approaches.

Meanwhile, the theoretical basis and violent methods of traditional psychiatry were strongly criticized, both from a philosophical and a political point of view. The peculiar and varied movement called "antipsychiatry" was born. And in Italy, for reasons which still have to be clarified, it was much more politically influential than in many other countries. Basaglia's success in the seventies, when he revolutionized the Trieste psychiatric care

by organizing services in the community and closing the local mental hospital, allowed all mental hospitals to close overnight. And all this while Italy was facing a serious political emergency: the kidnapping and assassination of the then Prime Minister Aldo Moro. However no substantial alternatives were offered, since the Law no.180 was an outline law leaving application to the Regions. While some Regions, mainly in the North of Italy, put it into practice, others did not, the consequence of which meant that families were loaded with great responsibilities and difficulties that they were not in a position to face.

All the 76 operative mental hospitals in 1978 were closed, and





in 2007 less than two thousand chronic cases were living in the remaining facilities. Recent epidemiologic studies show that the law reduced the availability of beds for emergency admissions in state medical institutions. It follows that today Italy, compared

to the European average, has fewer beds for emergency admissions and that private facilities have more beds than state ones. The situation is particularly serious in the South of Italy.

Nowadays psychiatry has all the means necessary to adapt

services and treatment to specific situations and to patients' needs. Therefore, it is to be hoped that the two anniversaries, the Law no. 180, ethically exemplary but only partly applied, and the introduction of the electroshock in psychiatric clinical medicine

will be an occasion to reflect seriously on the evolution of Italian psychiatry. Moreover, it is an opportunity to find new paths through which to overcome ideological contrasts and to focus the medical action on the difficulties and sufferings of the mentally ill.

AWARE'S NEW DEPRESSION AWARENESS PROGRAMME IN IRELAND

PROJECTS REALISED BY GE MEMBER ORGANISATIONS



Fran Gleeson Executive Officer – South East



To coincide with its annual Depression Awareness Week Nationwide (DAWN) held last January, Ireland's national depression support organisation Aware, announced details of its new depression awareness and education programme called Beyond the Blues.

Aware devised this programme in response to an Irish Government health policy framework document, A Vision for Change, which highlighted a preference for community-centred mental health care.

Beyond the Blues is a comprehensive awareness training package which encompasses many different aspects of depression/mood disorder. Depression affects many people in a variety of different ways. While an individual may be experiencing the acute symptoms of depression, relatives may be struggling to understand; employers/

course coordinators may be bereft of knowledge but wish to help and support.

This programme is designed to assist in the wide variety of settings touched by depression/mood disorder, and so aims to provide vital information on depression/mood disorder to a wide variety of individuals and groups/organisations. Aware believes that it will be of benefit to those who work in community settings, especially 'gatekeepers' such as teachers, police, community, youth and family support workers as well as mental health professionals

The package contains 5 modules as outlined below which are delivered in a very flexible manner:

Module 1 Depression & Stigma: a better understanding

This provides a basic introduction to depression/mood disorder, and dispels some commonly held myths about the illness.

Module 2 Working with Depression & Mood Disorders

This module is designed for those working with people who experience depression/mood disorders but have no training in the area of mental health.

Module 3 Relatives' support

This is aimed at family, friends and carers of people with

depression/mood disorder.

Module 4 Pre Discharge

This module caters for people who have been hospitalised due to their illness and are about to leave hospital and return home.

Module 5 Living with depression & elation

- 1) Stress management & Relaxation



- 2) Moods, Foods & Exercise
- 3) Communication
- 4) Positive Esteem
- 5) Personal Responsibility & Dysfunctional Thinking

This module is intended for use by people who directly experience depression/mood disorder. It is divided into 5 separate sessions and aims to help people develop skills to manage their illness and to identify methods of staying well.

Programme Format

The workshops for each module last from between one and three hours depending on the module. Material is presented in the form of mini lectures, group activity, worksheets and discussion. The programme is accessed by contacting Aware to register for scheduled workshops, or alternatively the pro-

gramme can be delivered by arrangement to specific interested groups, either in stand-alone modules or in its entirety.

In conjunction with the launch of Beyond the Blues Aware has also expanded its information service with the inclusion of two new leaflets.

The first, entitled *Continuing Your Recovery from Depression: A Guide to Staying Well* is aimed at people who are recovering from depression, and it offers reassurance that recovery can take time but that it is possible. The idea of 'Staying Well' also applies to those who experience recurring bouts of depression or indeed bipolar disorder.

The second leaflet, *Aware Support Groups: Supporting You through Depression* details what a person accessing Aware's support groups can expect. It emphasises that the organisa-



tion's research shows that its support groups play an important role in relapse prevention, and are effective in helping the person with experience of mood disorder recover from their illness and manage its disruptive effects.

Both of these leaflets are freely available by download from Aware's national website www.aware.ie or South East regional website www.aware-southeast.com

Tel. +353 53 918 4525
aware.se@o2.ie

“ATHENS SIBLINGS”

Spyros Zorbas, "Athens Siblings"

"Athens Siblings" for mentally challenged people is an initiative to bring together as many siblings as possible with a view to get acquainted, to share news and feelings so as to make their development as smooth as possible. The purpose of the meetings apart from exchanging experiences is to expose their problems free of "taboo" labels, as they have so far been treated by the Greek society. They exchange friendly opinions and practical advice in a pleasant and welcoming environment.

The siblings have a lot of issues to work out with regard to themselves; the extent of help they are able to offer to their beloved ones, the way they are going to live their lives, the way to discuss the issues that concern them in a comprehensible and not emotionally charged way, to name but a few. Above all, they should be able to lead a worthy life free of burdens that they cannot shoulder.

Once this is achieved or after they reach a maturity level that allows them to venture out-

side, they then have the option to seek informative networks, solutions and good practices for their beloved ones. We should also bear in mind that the siblings are likely to spend most of their time together, since at some point their parents will not be able to support them any longer.

The meetings held in cafés in Athens turn out very well and it is a pleasure for the participants to get make new acquaintances. What we experience in this community is very usual and such a network can be of multiple benefits. For further information you can call us at 0030 6946.00.35.22 or visit our web page www.athenssiblings.com We look forward to meet siblings of persons with mental illness in Europe.

We have a lot to share! In order to exchange ideas, tell us If you know any other groups like us or just say a simple «hi!» please send your e-mails at athenssiblings@gmail.com. (Address: Zorbas Spyros, Kanari 6, 106-71, Athens Greece)



USERS BECOME TEACHERS



*Vladimir Rotstein, Marianna Bogdan,
"Public Initiatives on Psychiatry"*

*For many years "Public Initiatives on Psychiatry"
continue the project
"Psychoeducation: step by step".*



The sense of this project is the following. We realized very well that there could not be any partnership between professionals and users unless the latter are absolutely ignorant. That is why we've established three-month courses for patients and their relatives on a permanent basis. During 12 weekly seminars, listeners obtain basic information about the main mental disorders, their treatment possibilities, as well as social and legal problems arising because of mental illness. In total, 100 people had received education by the beginning of 2008. As a result, we could observe a significant transition not only in their relationships with professionals, but also within their families.

Unfortunately, our capabilities were restricted because all teachers worked as volunteers, and there were only 4 of us working in this program. Taking into consideration that there are about 200,000 families of mentally ill persons in Moscow, the total amount of educated people is "a drop in the ocean". However, without financial support, we were unable to widen the scope of our activity.

Luckily, representatives of a Russian charity foundation "Quality of Life" found out about us and offered their support. Due to it, it became real to make our dream true and to start a new project.

We decided to establish education courses for mental health users in 8 Moscow out-patient clinics. There are around 20 of them in the whole of Moscow, however, in the first year it was impossible to embark on all of them. The first challenge was the apparent shortage of teachers. Our experience showed that the courses become much more effective when users themselves provide information to listeners. Especially, it concerns a "social part" of the program (relationship with professionals, positive thinking, friendly environment within the family, adequate attitude to the ill family member).

So it was decided to start the project with the new 3-month educational course for future teachers, and to recruit them from the graduates of our former seminars. We counted about 15 people in advance, but to our surprise, more than 30 of them expressed willingness to participate and came to the first seminar.

The second stage of the project presumes that all our new postgraduates will start the educational programs themselves throughout Moscow. Each of them will be able to provide them in different Moscow regions, close to their residency. It is very important in such a huge megacity. They will work in close cooperation with professionals who will be responsible for the medical part of the program. In fact, both parts (social and medical) will be overlapped.

We strongly hope that the project will be successful, and the network of educational programs realized by psychiatric users will widen and spread more and more over the city (may be later – through the other regions of Russia).





THE MOOD DISORDERS SOCIETY OF CANADA



William Ashdown - Vice President Mood Disorders Society of Canada

Ever since the first settlement of Canada, mental illnesses have been a significant — although usually unrecognized — health problem. Strong evidence suggests that a far higher percentage of people with mood disorders immigrated to Canada than to other regions. So it was no surprise that many of the initial efforts to establish patient and family member organizations originated here.

In 1983, two small mood disorders self-help groups began their work. They were the beginning of what became the Mood Disorders Society of Canada. Founded in 1995, and revamped in 2000, the Society has become the voice of Canadians with mood disorders. We ensure that issues of importance to our members are understood and considered in the creation of government programs and policies related to mental illness, the development of treatment strategies and the setting of research priorities. We provide expert advice from the patient's viewpoint, and a national forum for groups at the provincial and local level. Part of our mandate is to advocate, promoting reduced stigma and discrimination, mental health promotion, disability benefits and a national action

plan on mental illness and health.

Led by our National Director, Philip Upshall, we have had an impact far beyond our size. We are now an influential voice in Canada's mental health community. We were one of the founders of the Canadian Alliance on Mental Illness and Mental Health, the leading coalition on mental illness issues in Canada. After years of intense lobbying, this coalition helped to persuade the Canadian government to create the Mental Health Commission of Canada. It has three initial tasks: a national anti-stigma campaign, developing a national mental health strategy, and creation of a Knowledge Exchange Centre. Philip is an advisor to the Commission. Other Society members serve as Board members and committee members for the Commission.

Additionally, Philip is the organizer for Mental Illness Awareness Week, an annual event that has attracted attention to mental illness issues. He spends considerable time 'on the road', building solid relationships with psychiatrists, researchers activists and politicians across Canada.

As a result of his work, the Society has been busy recently, on a number of major tasks. A project on Patient Wait Time Guarantees for mental health, with a number of key recommendations for improved performance, has been completed. We also hosted a unique conference with the Native Mental Health Association of Canada, bringing Aboriginal and mental health leaders together. The

Society held a national conference on Stigma that assembled the leading health researchers and activists in Canada. One of the areas it focused on was to promote research on effective strategies to reduce stigma and discrimination among health-care providers.

Additionally, we presented to two House of Commons Committees: one on access to medications, where concerns were raised on timeliness, transparency and patient/consumer engagement in the drug approval process, and another, that advises the government on spending priorities. As a partial consequence, the Canadian government has pledged \$110 million on housing for Canada's mentally ill homeless.

My task as Vice-President of our Society is to develop international relations, promote more visibility for patient self-help organizations, and to build more cooperation between our groups and health professionals. Over the course of the year, I have been traveling extensively, speaking at conferences in Pittsburgh, London, Delhi and Cape Town. My goal in much of this has been to build better opportunities for patient organizations to work with the medical professionals who treat us. This is a subject that I wish to address more fully at our upcoming conference.

It has been a very interesting year, and has given me a whole new appreciation for 'jet lag'. Despite that, I am looking forward to the next adventure, visiting Israel for GAMIAN's 11th annual convention.



CARNIVAL CELEBRATION

Andonis Katsamagos, Kraounaki Kyriaki, Secretary of S.O.P.S.I.

As in previous years, the Day Center of Panhellenic Association of Families for Mental Health (S.O.P.S.I.) organized a carnival celebration for 2008.

This celebration took place on February the 28th. Friends of the residents were present as well as the Day Center personnel and

the volunteers. The board of S.O.P.S.I. were represented by Mr Andronikos, Mr Xiromeritis and Mrs Loli.

Everyone was wearing costumes made by the Day Center members and Mrs Vernikou took care of their make-up.

It was a wonderful occasion with a large variety and quantity of food dishes, good cheer, Latin and Greek

dance marked that day.

A big special surprise happened when the President of the Board, Mr Andronikos, appeared dressed up in a "mysterious costume". Everyone was

especially interested in this "mysterious" person and tried through questions to find his identity. Eventually, Mr Andronikos revealed his identity after dancing in Latin rhythm.



THE CARAVAN OF TRUTH – FACE TO FACE CONVERSATIONS

People receiving Mental Health Services talk with the public
A dash against social stigma concerning mental disorders

Petros Andronikos



This Caravan is about several galas in which mentally ill people taking mental health services talk with the public about issues such as: stigma and prejudice against mental health problems, social isolation, interpersonal affairs issues, work and family issues, respect, protection, self assistance and right issues etc. A conversation and a film about mental-social recovery takes place afterwards.

The "Caravan of Truth" has been inspired by the Association of Families and Friends for Mental Health of Serres. The "Caravan" started from Serres and passed from many cities of Northern Greece and Crete. It continues its peregrination, in

cooperation with SOPSI (Pan Hellenic Association of Families with Mental Health), DIPSA-GMPA (Greek Mental Patient Association), POSOPSI (Panhellenic Federation of Associations of Families with Mental Health), EPSE (Hellenic

Psychiatric Association), WARP (World Association Psychological Rea Petros Andronikos bil- itation) and UMHRI (University Mental Health Research Institute) at Athens on March 18, 19, 20 and 21. The aim of this effort is that every city-target of



the Caravan will be a spring-board for a general change, in which mentally ill people and their families together will stand on their right to improve the quality of their lives.

This pioneer effort targets to change the attitude towards "lunacy" together with the wrong opinion the public has about mental illness. The significant and unique point of this Caravan is the fact that the initiative belongs to the mentally ill people, who stand up for their right to speak publicly and take part in their own individual problem management. This Caravan opens the way to a fruitful and productive dialogue with society through the experience of mental illness.

We believe that this event is the shock against indifference and silence towards mentally ill people.



PSYCHIATRY REMAINS THE «CINDERELLA» SPECIALITY, SAYS BRITISH MEDICAL ASSOCIATION, UK

<http://www.medicalnewstoday.com/articles/108737.php>

Funding for many aspects of NHS mental health care has decreased over the past year with some patient services being adversely affected, according to a survey of doctors published today (Tuesday 27 May, 2008) by the BMA's psychiatry committee.

In a survey (A questionnaire was sent in February 2008 to a sample of 3000 consultants, staff and associate specialists and junior doctors in the UK. There were 217 replies) of UK doctors working in psychiatric services, just over half (52%) the respondents said there had been a decrease in the overall funding for mental health services. The area most affected in the past year has been in-patient care, the survey indicates. Funding for day services, continuing care, and community mental health teams have also seen decreases. Secure and high dependency care and 'access and crisis' services were most likely to have seen increases in funding.

Respondents were most likely to report that in their view the reason for the decrease in funding was mental health not being seen as a priority area. Resources being focused elsewhere in the trust and a decrease in funding at a national level were also blamed.

Dr JS Bamrah, chairman of the BMA's Psychiatry Committee says: «These results show worrying trends. They illustrate the concerns doctors have about funding, management practices and, in some cases, lack of services to patients. We have known for some time that mental health services are often at the bottom of the pile. Despite record spending in the NHS it appears that psychiatry remains a Cinderella specialty.»

Respondents said that cuts in funding have led to a reduction in the number of in-patient beds and some patients being admitted to inappropriate wards, or other services, or being discharged before they have been adequately accessed. Just over half (53%) of doctors reported that low funding levels would result in a delay in accessing psychiatric services. Other adverse impacts included not enough clinical or nursing staff, lack of beds, and delays in implementing patients' care.





MAKING YOUR MIND UP, UK

Article Date: 21 May 2008 <http://www.medicalnewstoday.com/articles/108155.php>

New GMC guidance launched urges doctors to rethink their approach to discussing medical issues with their patients. Doctors should actively engage patients in discussions, allowing them to make decisions based on their individual needs and circumstances. As part of this approach, consent should not be seen as a tick box exercise, but as part of a wider decision making process, in which both parties have an important role to play.



Consent: Patients and doctors making decisions together, which replaces "Seeking patients' consent": the ethical considerations, focuses on the importance of the doctor-patient partnership. It sets out the key principles of good decision making, which apply to all care, from simple treatments for minor conditions to major surgery.

The new guidance will have an impact on all patients, but in particular on those who cannot make decisions for themselves, or where their ability to do so is impaired or fluctuating. This reflects recent legislation which protects those who lack capacity to make particular

decisions but also recognises the need to maximise their ability to make decisions for themselves.

For the first time the GMC provides advice for doctors on how to approach discussions with patients about the risks and possible side effects of treatment. The guidance emphasises that risk should be explained in a way a patient can understand.

The guidance also contains advice on what to do if a patient does not want to know about their condition or the proposed treatment, or asks their doctor or someone else to make the decision for them.

Jane O'Brien, Head of Standards and Ethics

at the GMC said: «We hope that this new guidance will prompt doctors to think about their approach to discussions with patients.

The relationship between a doctor and a patient should be about partnership not paternalism. This means that doctors should work with patients to allow them to make decisions tailored to individual views, needs and circumstances, and respect the choices which they make.»

Neil Hunt, Chief Executive from the Alzheimer's Society said: «A diagnosis of dementia does not mean someone can no longer make decisions for themselves. It is vital people with

dementia and their carers are fully involved in making choices about medical care. We welcome new GMC guidance, which was developed following consultation with Alzheimer's Society and our Living With Dementia programme whose members include people with the condition and their carers.

It is crucial to assume people with dementia have capacity, even though this may fluctuate over time. Written records of patient/doctor discussions and involving close friend or relatives are useful ways of supporting people with dementia and their carers to make decisions for as long as possible.»



WHAT DRIVES REFERRAL FROM PRIMARY CARE PHYSICIANS TO MENTAL HEALTH SPECIALISTS?

A Randomized Trial Using Actors Portraying Depressive Symptoms

Richard L. Kravitz, MD, MSPH; Peter Franks, MD; Mitchell Feldman, MD, MPhil; Lisa S. Meredith, PhD; Ladson Hinton, MD; Carol Franz, PhD; Paul Duberstein, PhD; Ronald M. Epstein, MD

Brief psychotherapies are beneficial in depressive disorders, but generalist physicians are not typically trained in their use. Primary care depression guidelines therefore emphasize mental health referral as a valid option for most patients. Although some patients with depression seek mental health specialty care directly, referral is a critically important yet poorly understood mechanism of access.

Referrals may be driven by patient factors, physician factors, the patient-physician interaction, or features of the health care delivery system. Many studies have examined system and patient factors affecting mental health referrals but few have assessed physician factors. Glied reported that family physicians were more likely than internists to diagnose and refer patients with mental health disorders. Alvidrez and Areon found that physicians who were female, considered psychotherapy effective, or frequently employed «psychosocial techniques» were more willing to refer older depressed patients. Williams et al. reported that physicians with greater self-reported knowledge of depression and greater confidence in their ability to treat mental illness were less likely to refer. These studies were limited by incomplete adjustment for patient factors such as condition severity and visit expectations as well as for system factors like availability of specialty mental

health services.

Among 298 visits by SPs with depressive symptoms, 107 (36%) resulted in a suggestion or recommendation for mental health referral: 4% to psychiatrists, 39% to clinical psychologists, 10% to social workers, and 47% to counselors or unspecified mental health providers. The physician or clinic staff helped secure a mental health appointment in 18% of referrals, recommended

a specific person or provided a list of qualified mental health professionals in 34%, told the patient to call their health plan in 20%, and offered no active assistance in 28%.

The probability of referring to a mental health provider in this study was higher for physicians who devoted more time to nonclinical activities, perceived mental health consultation to be more readily available, had less confidence in their ability to manage antidepressants, and had personal life experience with psychotherapy for depression.

Increased knowledge in a particular clinical domain usually increases referrals, possibly





The idea that physicians with academic or administrative responsibilities practice differently than full-time clinicians is consistent with the work of Borowsky et al. who found that mental health referrals are extremely common in academic generalist practices

because more knowledgeable doctors are more attuned to clinical complexities. However, consistent with Williams et al. we found that physicians with greater confidence in their ability to manage antidepressant therapy were substantially less likely to recommend consultation with a mental health provider. Perhaps therapeutic self-efficacy operates differently than diagnostic sophistication, in which recognition of the complexities of a topic might lead to greater appreciation of the value of consultation.

Seventy percent of participating physicians reported that they (or a close friend or rela-

tive) had been treated for depression, and nearly half had direct or vicarious experience with psychotherapy. Physicians reporting such experience were more likely to offer patients a mental health referral.

Taken as a whole, relatively stable physician characteristics (age, gender, race/ethnicity, and primary care specialty) have little influence on mental health referral while more mutable conditions of practice, self-efficacy, and life experiences carry greater weight. Curiously, referral decisions were associated with chart-recorded diagnosis when SPs portrayed major depression but not adjustment

disorder. This suggests that physicians view the basis for referral differently in the 2 conditions, perhaps seeking specific management assistance in major depression and diagnostic validation or general psychosocial support in adjustment disorder.

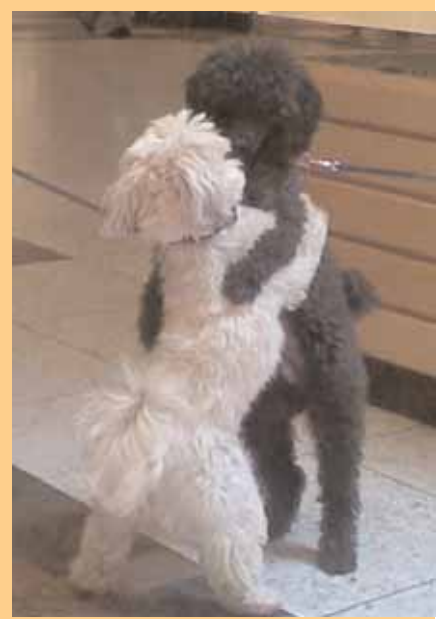
In summary, this study indicates that primary care physicians' perceptions of mental health services availability, personal life experiences, and therapeutic self-confidence are important influences on mental health referral in depression. Further research is needed to determine whether interventions designed to enhance the referral process can lead to better outcomes, especially for patients with more severe depression, in whom the need for combined therapy with medication and psychotherapy might be most compelling.

-Short quotation from http://www.medscape.com/viewarticle/533903_4

At first sight love...



THE LOUNGE





GENE CHIP FOR PERSONALIZED MEDS

Psychiatrists Can Now Predict An Individual Patient's Response To A Drug

http://www.sciencedaily.com/videos/2006/0805-gene_chip_for_personalized_meds.htm

The first in a new generation of gene microarrays, computer chips that chemically or electrically express DNA, can predict how a person's body will metabolize about 25 percent of drugs on the market, including most antipsychotic medications. The chip tests for mutations in genes that break down drugs. Molecular biologists say that slow metabolizers may be susceptible to side effects, while fast metabolizers may not find a drug effective.

AUGUSTA, Ga. — It can be a game of Russian roulette. When doctors try out different meds on patients, they don't always know how they'll respond — and the wrong guess can have deadly consequences. Now, there's a new way to tell how people break down certain drugs, paving the way for personalized medicine.

Playing tug of war with her horse, Shilo, is the same kind of struggle 62-year-old Lynne Tollison has always had with doctors. She says, "This is the classic

answer: 'She obviously takes a lot of medication, and her body builds up tolerances,' like I'm a drug addict."

Pain medications haven't worked for Tollison's arthritis, and side effects prevented her from taking a drug for bipolar disorder. "You get to the point where you don't go to a doctor or dentist when you need to go, because what they give you is not going to help, so you don't go!"

But now, a first-of-its kind gene chip test is solving years of medical mystery. It tells

doctors how a person processes about 25 percent of drugs on the market, including most antipsychotic meds.

Psychiatrist Adriana Foster, of the Medical College of Georgia in Augusta, says, "Our slogan is start low and go slow, but patients can't always afford that because they could be terribly depressed and at risk of suicide."

Here's how the test works. First, blood is drawn and DNA is extracted. Then scientists isolate the two genes that break down drugs and look for mutations.

Doctors hope the test will pave the way for a new generation of medicine.

"We have been, you know, waiting for these kind of things for a long time, and now it's here," Zixuan Wang, a microbiologist at Medical College of Georgia, tells DBIS.

For Tollison, who just found out she is a poor metabolizer, it means validation and hopefully finding effective treatments that will allow her to take care of her family. "I have to struggle to keep myself together sometimes, so that would be wonderful," she says.

If a person is a poor metabolizer, they may be susceptible to side effects and will stop taking a much-needed drug because of them. If a person is a fast metabolizer, the drug may not work, and a depressed patient could commit suicide in that time. Right now the gene chip test costs between \$600 and \$1,000, but in the future it could be something insurance would cover. And the researchers say it could ultimately be cost-effective as there would be fewer trial-and-error prescriptions made.

THE SPRING BEGINNING

*The Sun is shining brightly,
The Moon takes dreams away.
The spring is coming quietly
Say to the winter cold farewell!*

*This day we all so happy
To say the words of love!*

*We say — the spring is magic,
And see the sky above!*

*The snow will melt in sun light,
The bad will go away!
And you'll awake in all might
And start to sing all day!*

*Elena Nazarova,
TRD ARSP New Choices, Russia*



T H I R D A N N O U N C E M E N T

ELEVENTH GAMIAN–Europe Annual Convention

18–21 September, 2008**Moriah Gardens Hotel, Jerusalem, Israel****Theme «*The impact of Culture and Ethnicity
on Mental Health*»**

1) ART WORK EXHIBITION

With the occasion of the eleventh annual educational convention GAMIAN-Europe invites your organisation to present a piece of art work (paintings, crafts, hand-made objects, posters) or any item that you consider as being representative for your organization. A short explanation about what makes the piece of art special for your organization should be attached in the object. Art objects' size should not exceed 1mt x1.5mt.

2) TRAVEL AND HOTEL ARRANGEMENTS

GAMIAN-Europe will cover the travel and hotel costs for 3 days for one delegate from each European Organisation that has paid its 2008 membership fee.

Additional delegates will have to pay their own accommodation and travel costs.

Lunches and dinners will be covered by GAMIAN-Europe for all participants.

However, each accompanying person present at the convention will have to pay an additional 50 EUR for meals and tours by nights to Jerusalem and Tel-Aviv (18th and 19th of September).

Please make your travel arrangements now in order to obtain the cheapest price, as this is the only price that will be reimbursed by GAMIAN-Europe.

Every plane ticket that exceeds the value of 550 Euro must obtain the Board's prior approval before the buying is made.

We are giving you an opportunity to compare prices of flights between your travel agent and Diesenhaus Ramat Hasharon. Afterwards you can make your own decision.

Diesenhaus offer special prices for arrivals in cooperation with El-Al and Austrian Airlines.

They can offer competitive prices with other airlines as well.

For further information, please contact at any time Mrs. Sarah Gafni

Direct Tel: **+ 972 3 5400067**

or: + 972 3 5488111

Mobile: **+ 972 52 3315879**

Fax: **+ 972 3 5473531**

E-mail: saraga@d-u.co.il

3) REGISTRATION FORM

The registration form is attached. Please complete it fully in block capital letters or by typing and send the form back to Loredana Tascau and Michal Levy by the 1st of June 2008.

4) REGISTRATION FEE

Each participant shall pay a registration fee of 25 EUR.

For late registrations, after the 1st of June 2008, the registration fee will raise to 70 EUR/participant.

5) PRE-CONVENTION TOUR

This year, GAMIAN-Europe will organize a Pre-Convention tour between 15-18 September 2008.

For registration, please fill in the Pre-convention tour section of the registration form.

The cost of the tour is 200 EUR/participant in double room and 270 EUR/participant if a single room is required. The price covers: 3 nights accommodation at Moriah Gardens Hotel in Jerusalem, all meals, guidance, sites admissions and others.



Please take note that it is essential to register early for the pre-convention tour, as the first bus is for a group of 45 persons only. A second bus will be available only if there are at least 30 more participants registered for the tour.

The tour schedule is as follows:

September 15- Monday, **Arrival to Moriah Gardens Hotel in Jerusalem**

September 16- Tuesday, **North of Israel- Nazareth & Sea of Galilee.**

September 17- Wednesday, **Dead Sea , Masada & Bethlehem**

September 18- Thursday, **Free day in Jerusalem, convention in the evening**

Please consider the deadlines so that we will be able to make arrangements.

Looking forward to seeing you!

With my best personal wishes,

Dolores GAUCI, President.

For more information please contact:

Loredana TASCAU, Information and Communication Officer GAMIAN-Europe

E-mail: gamian-europe@clicknet.ro

Tel: **0040 21 252 08 66**; Fax: **0040 21 252 60 11**

I N F O R M A T I O N S H E E T

Airport

Ben Gurion Airport (Tel Aviv)

Venue

Moriah Gardens Hotel (Previously Kedem Towers Hotel)

Address: **4 Vilnai Street, Jerusalem (P.O.B. 3686 Jerusalem 96100)**

Phone- (abroad)**+972 2 6558888** (in Israel)

02-6558888 Fax: **+972 2 6511092**

Contact Persons

Romania — Ms. Loredana Tascau

Phone: **+40 21 252 60 11**

gamian-europe@clicknet.ro

Israel — Mrs. Michal Levy

Phone: **+ 972-9-742-1401**; Mobile: (abroad)

+972-52-534-7166 (in Israel) **052-534-7166**

michal@netivey-lechet.co.il

Transportation from the airport to the hotel

Distance — 30 minutes

Price — Taxi Special (Private): 200-300 Shekels (around 40-50 Euros). By Taxi "Sherut" (with other travelers) the price is 45-55 Shekels (around 9-10 Euros).

The "Sherut" taxi company is called "Nesher".

Note: it is preferable to pay in Shekels but you may also pay in Euros.

Please show the driver the name and the address of the hotel.

After we have obtained all of the information on the participants' arrival times we will consider the possibility of organizing special buses from the airport.

Transportation from the hotel to the Airport

Busses to the airport: Special busses will be organized for the participants' journey to the airport on Sunday, September 21.

Currency

The name of the Israeli currency is the Shekel.

1 Euro = 5.50 Shekels 1 \$ = 3.50 Shekels (Rates are subject to change)

We suggest that you convert some foreign currency to Shekels to cover expenses.

Languages

The 2 official languages in Israel are Hebrew and Arabic.

Most people, including drivers, speak some English.

Climate and attire

The climate in Israel at the end of the summer just before autumn is typically very pleasant. Mornings and evenings in Jerusalem (and also in the North) tend to be a bit colder than in the center of the country.

We suggest that you bring casual attire suitable for summer and for autumn, a jacket for evenings and formal dress for dinners.

Visas

Participants from the following European countries require visas:

Albania, Belarus, Bosnia Herzegovina, Georgia, Macedonia, Moldova, Serbia, Turkey, Ukraine, Russia.

We will be happy to assist any participants if the need should arise.



Forthcoming events

Fighting Stigma and Discrimination Because of Mental Illness

Cairo, Egypt, June 18-20, 2008

**WPA Thematic Conference on Depression
and Relevant Psychiatric Condition in Primary Care**

Granada, Spain. June 19-21, 2008

14th European Conference on personality

Tartu, Estonia, July 16-20, 2008

XIV World Congress of Psychiatry

Prague, Czech Republic, 20-25 September 2008

XV International Congress of Psychiatry

Buenos Aires, Argentina, September 29-October 2, 2008

**International Pathways of Investigation in Psychiatry: Psychotherapies,
Pharmacotherapies, Combined Treatment**

Rome, Italy, October 16-17, 2008

Third Dual Congress on Psychiatry and Neurosciences

Athens, Greece, October 16-19, 2008

Third International Conference on Schizophrenia

Chennai, India, October 17-19, 2008

Psychiatry for the Person and Social Transition

Belgrade, Serbia, October 19-22, 2008

Support GAMIAN-Europe!

Thank you for your donation. Please contact the secretariat:

gamian-europe@clicknet.ro

or FORTIS Bank S.A. 1040 Brussels, Belgium