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Welcome to the Conference

Mark Agius, Rashid Zaman, Peter Jones & Shahid Zaman

Welcome to Luton and Cambridge International Conference on Mental Health 2005. This conference has several themes which will give a broad perspective on issues involving the field of mental health, recognising that whilst cutting edge developments are necessary, we should not lose the sight of the sufferers of mental illness.

We are fortunate to have several international and British speakers of international repute, including Professor Norman Sartorius, of WHO, and Professor Sir David Goldberg.

The Luton Mental Health Conferences began five years ago as a regional conference to help launch Mental Health Reforms in the Eastern Region of England. Two years ago, the conference had an international flavour with the visit of Croatian Psychiatrists to the Luton Early Intervention Service. In the following year, the conference became truly international, with the participation of psychiatrists from Germany, the Netherlands, Croatia, Slovenia, Malta, Bulgaria, and Bosnia, as well as a number of key psychiatrists from the United Kingdom. At the end of that conference, a group was formed to establish cooperation between the psychiatrists of all the countries present. The formation of this 'Luton Group' was announced in the Correspondence section of the British Journal of Psychiatry in July this year.

This year, we have expanded further afield, with the attendance of psychiatrists from Belgium, Bosnia, Bulgaria, Croatia, Italy, Malta, Romania, Russia, Slovakia, Slovenia, Switzerland and Turkey.

The conference is organised by the Bedfordshire Centre for Mental Health Research in association with the University of Cambridge. We believe the conference leads to many areas of co-operation, including exchange visits, the development of new projects, joint grant applications to the European Union, as well as joint research projects. We also believe that the exchange of ideas and cooperation will lead to benefits for all involved and, most importantly, of likely benefit to our patients, be they residing in Ljubljana, Luton, Sarajevo or Zagreb.

Indeed as a direct result of this cooperation, several innovative projects have occurred, including:

- a first episode ward has been set up at Vrapce Hospital, Zagreb;
- a clinic for prodromes of psychosis exists in Ljubljana;
- a new day hospital is being inaugurated in Slovakia;
- an NGO offering family groups for families of patients with schizophrenia has been set up in Croatia.

We further believe that the conference helps to stimulate research and development and form closer links between NHS organisations (such as BLPT) and the University of Cambridge, as well as other academic and non-academic institutions, nationally and internationally. Indeed the conference has the strong support of the Department of Health, UK.

CONFERENCE ABSTRACTS

Stigma and Mental Illness

Professor N. Sartorius
Switzerland / World Health Organisation

The main obstacles to the provision of mental health care are the stigma attached to mental illness and all that is related to it – the persons who have the illness, their families, institutions in which treatment is provided, psychotropic medications, mental health service staff – and burn-out, that is increasingly reported as a major problem affecting people with the illness, their families and mental health staff.

Dealing with these two problems – stigmatisation and burn-out – can no longer be conceived as being the responsibility of the mental health services alone. Other stakeholders have to be involved – including, in particular, people with mental illness and their carers, as well as community leaders.

The recently conducted programmes against stigma and discrimination because of mental illness (and in particular the WPA Global Programme in this area) have also indicated other requirements that should be met if stigma is to be fought with success. An outline of these will be presented.

Mental Health: a carer's perspective

Catherine Gonzi
Malta

I am the relative of someone who suffered from mental illness. I feel that it is important that the patient should receive an accurate diagnosis of his illness as soon as possible. It is the right of every patient to know the diagnosis of his or her illness. Carers should know what they are dealing with when caring for a family member who is experiencing mental illness unless there are other mitigating circumstances.

In order to provide the necessary information to the patient and carers, there is a need for more patient and family education about the illness that the person is experiencing and about the pharmacological and psychological interventions available. Only then can the patient and family begin to adopt a positive attitude towards the illness. In our case, we realised that no one was to blame for the illness and we could then empathise with our relative's feelings and moods, and more importantly we could identify early signs of relapse.

The public needs to be educated in issues connected with mental health. Mental Health Awareness Campaigns

are a must and need to be ongoing, targeting all sectors of society—the police, managers at work-places, priests, teachers and students, doctors, nurses, politicians and civil servants. In this way, not only can we provide environments which are healthy but we could also fight stigma and discrimination.

I encourage patients, families and carers to attend self-help groups in order to increase their knowledge of caring and handling the illness better. These groups also help the patients and their relatives to gain information about the range of treatment options available and they give hope to persons experiencing mental illness, and their families.

I am involved with non-governmental organisations which want to make a difference in the area of mental health. These have a critical role to play in the planning and delivery of mental health services and in empowering civil society to be proactive. Therefore these services need to be adequately funded.

Inpatient treatment in a psychiatric hospital is important but lengths of stay should be kept to what is essential in order to avoid institutionalisation. Specialised community services especially for severe mental health problems should be accessible 24 hours a day, 7-days a week. Aftercare services should focus on Recovery thus helping patients to return to their previous social relationships with their family and friends and where possible to their chosen occupation or education.

I am committed to carry on championing mental health as a priority in the Maltese social agenda.

Starting an NGO

EN Gruber, M Kajević, J Anđelić, V Cerančević, S Martić-Biočina, Elza, S Franić
Croatia

Starting an NGO can be a lengthy, time consuming process. In our country, NGOs are filling the gap between society, government and hospitals. It is always hard to manage this gap in service provision if you are small and the gap is to big, because founding an NGO can be difficult. The great achievement is to overcome the difficulties.

The problems that we have encountered and the solutions which we have found will be described in this presentation.

We will also describe research and audits which we have carried out together with the other NGOs which have been developed in Croatia, which validate our approach.

The Interface between Primary Care and Community Mental Health Services: different developments in different countries

Professor Sir David Goldberg
UK

In most countries there has been a dramatic reduction in psychiatric beds, necessitating new thinking about the way in which care is divided between primary care and specialist care. In countries in which mental health care is either funded by central government or by universal insurance payments, an increasing burden falls upon primary care. In many developing countries, primary care provides the main source of mental health care. This lecture describes various developments of collaboration across the world.

In the UK, various patterns of closer working have been described, but these are troubled times for the NHS. With increasing demands being made on community mental health services, and in-patient units in our big cities becoming more over-crowded and disturbed, the pace of change for close collaboration has slowed. The situation in chosen services will be described.

Basic Standards for the Management of Patients with Serious Mental Illness in the Community

Mark Agius [UK], Sanja Martic Biocina [Croatia], Koksal Alptekin [Turkey], Vladimir Rothstein [Russia], Paolo Morselli [Italy] & Albert Persaud [UK-Chairman]

Background
These standards have been written in order to enable GAMIAN-Europe, the International Organisation of Patient Advocacy Groups in Europe, to advocate for a common, effective and safe standard for the management of patients with serious mental illness in the community. It originated from requests from the Gamian-Europe members convention in Tallin, Estonia in 2004 and was agreed by the membership convention in Bucharest, Romania in September 2005.

It is recognised that, whereas there is general agreement that patients with serious mental illness are best managed by a system of community based mental health services, there are enormous differences in Health Care Systems and funding constraints across the various European states. It is also recognised that many states, in different parts of Europe, are attempting to set up community mental health services.

This document is therefore an attempt to inform such developments, so that community mental health services for serious mental illness may be delivered effectively, safely and in a way which is consistent with human dignity and rights to include the individual's cultural, spiritual beliefs and does not discriminate on the grounds of gender, race, ethnicity, or sexual orientation. It should serve as a negotiating basis for patient advocacy groups when dealing on behalf of patients with governments, politicians, practitioners and other bodies such as the European Commission.

The term 'Serious Mental Illness' is used throughout in these standards, with the exception that the term 'Psychosis' or psychotic illness is used when there is only evidence for a given standard.

Standard 1:
Patients with serious mental illness can be usually supported by trained staff in their own or their family's home, provided they are well enough not to provide a major risk to themselves or others.

Standard 2:
The aim of care for patients with serious mental illness should be Recovery, so that the patient can return to their chosen form of work and education. This will ensure that the patient is living in society in such a way that they are able to resume the social relationships with their family and friends that is an essential part of normal living.

Standard 3:
Each patient should have their own care co-ordinator who will ensure that the patient will receive all the care that they require. The care co-ordinator could be a nurse, a social worker, a psychologist, or an occupational therapist, who will carry out a full assessment of the needs of the patient and his family. This needs assessment will include their physical, psychological, social, spiritual/religious and cultural needs, and a full assessment of the risks which the patient might be exposed to. This includes risks (safety) to the patient and to others, and especially risks of self-harm, suicide or abuse.

Standard 4:
The care-coordinator will draw up a care-plan for each patient, which will detail all the care that the patient will receive, and who will provide the care.
The plan will be agreed collaboratively with the patient and the family based on the patient's needs. The plan will be reviewed at a formal meeting of those concerned. Such a meeting will be held every six months or more frequently if necessary.
All parties will be given a copy of the care plan.

Standard 5:
Carers of patients will have their own needs assessed by the care co-ordinator, and a plan to address these needs will be developed.

Standard 6:
Medication of patients will follow the guidance laid down in internationally accepted guidelines of good practice. Appropriate psychological interventions should be available to the patient as part of the care package.

Standard 7:
Serious Mental Illness can affect the family in a variety of ways. Thus it is the patient's right, if they choose, that their family should receive a full explanation of the illness, the medication and the care-plan, unless, in exceptional

circumstances, the patient requests specifically that the family should not be involved.

Standard 8:
All patients and their families should be shown how to identify early signs of relapse. They should have devised a plan for relapse prevention with the Care Co-ordinator, and they should be told of appropriate contacts, for example, telephone numbers in order to call for help. Psycho-social education for patients and families should be available as part of a community mental health service.

Standard 9:
Some patients with serious mental illness may also use illicit drugs which add to their problems. Special services should be developed to assist patients who suffer from a number of problems.

Standard 10:
Patients with first psychotic episodes should be identified early and treated particularly intensively in both the wards and the Community Follow-up

Standard 11:
Each community service should be able to deal with the number of clients residing in a particular community. There should be sufficient care coordinators employed in a particular service to deal with the number of seriously mentally ill patients in the community, or 'catchment area' which it serves.

Standard 12:
Psychiatric wards, including long-stay wards, should never be closed until an appropriate community service provision has been established to provide continuing care for patients who are to be discharged into the community.

Standard 13:
Each Community Team/Centre/Service should be staffed by nurses, social workers, occupational therapists, psychologists and doctors, including consultant psychiatrists, who have been appropriately trained to work in the community. The training should be based on best evidence to deliver best practice.

Standard 14:
To enable Community Mental Health Services to concentrate on working with more demanding cases, there should be a continual educational program to enable Primary Care doctors and nurses to identify and treat common mental health problems such as depression, postnatal depression and anxiety in Primary Care. Primary Care and Community Mental Health Services should work together collaboratively. They should develop joint protocols for referral, assessment, and treatment.

Standard 15:
In order to empower patients, Self Help Groups, Non-Governmental Organisations (NGOs), Advocacy Groups and patients who have first hand knowledge and understanding of their illness, should be seen as part of the mainstream of mental health care, both in the planning, the delivery and evaluation of services.

Standard 16:
Legislation should exist in each country to enable treatment of acute mental health problems as rapidly, effectively, and humanely as possible, by providing effective and easy access to services at primary, community, and in-patient levels.

And finally:
This document has proposed standards in Community Mental Health Services for patients with serious mental illness, which GAMIAN-Europe and all patient advocacy groups should promote, develop and share. The evidence for the standards, in terms of controlled trials and consensus views, is well documented. Importantly, the standards are linked with the statements of the new WHO Declaration for Mental Health for Europe and the European Commission Green Paper: Improving the Mental Health of the Population. Towards a Strategy on Mental Health for the European Union.

There are some important caveats to this document. It is true that many countries, particularly in the Balkans and the Mediterranean, are beginning to develop community services for patients with serious mental illness. The standards will clearly need to be developed in each country over a period of years, depending on the resources available with regards to training, manpower, and finance. There is need for further study in each country as the model of community care is adapted to local circumstances and cultures.

Finally, it is worth concluding with the words of the WHO Declaration regarding the empowerment of patient groups, such as those in GAMIAN-Europe.

'*We are strongly committed to the empowerment of users and carers and their inclusion in mental health service planning and delivery. We believe the following actions are necessary:*

Stimulate the creation and development of local and national non-governmental and service user run organisations representing people with mental health problems, their carers and the communities they live in.

Set standards for representation of users and their carers on committees and groups responsible for planning, delivery, review and inspection.

Introduce legal rights to independent advocacy for persons subject to involuntary care.

A full set of these Standards with references and titles are available on request from Albert Persaud, Gamian – Europe Board Member.
albert.persaud@dh.gsi.gov.uk

Changes in the Mental Health Care System in Slovakia in 1995-2005

Eva Pálová
Slovakia

Since the political change in Czechoslovakia in 1989 and the separation of Slovakia in 1993, the health care system in Slovakia has been changed a great deal. The system of mental health care is one of the departments which is exposed to even more turbulent changes.

Before 1989 psychiatry was characterised by stigmatisation, non-attractiveness, and overlooked as a branch of medicine with a restricted array of therapeutic approaches. But not

everything that was done was totally wrong – standard psychiatric care has been based on current knowledge and kept on a very good level, mostly due to the personal effort of psychiatrists (to compensate for the negative attitude towards psychiatry in society). Moreover, psychiatry in Slovakia has not been proved to be abused or misused by political power.

There has been significant improvement in the quality of mental health care during the last ten years. The total number of psychiatrists has increased but the number of outpatients has increased as well – there are 28 outpatients per psychiatrist per day (12 minutes per patient), whilst there is steady increase in number of first examinations. The average lenght of in-patient treatment has been shortened (from 31.1 to 18-21 days in 2003) and the quality of care provided has improved significantly. The number of beds for long-term treatment has decreased substantially – from 6.1 in 1975 to 1.8 in 2001 per 10,000 inhabitants. However, day-care hospitals are underfinanced and are not able to carry on their traditionally high quality of therapy. Psychologists and social workers have been exluded from standard psychiatric care as they are not covered by the health care system anymore.

There is a lack of facilities for the treatment of substance abuse, children and adolescents, and geriatric psychiatry exists only officially – on paper.

Governmental support is just proclaimed. The Ministry of Health usually does not consult on their decisions with representatives of psychiatry (and if they do so, they do not accept the comments) - they did not react to the audit that was completed by WHO in in 2003.

However, there are also positive trends – we have managed to involve the media in a mostly positive way (education of journalists) that has reflected better societal acceptance and slightly decreased stigma of psychiatry. The whole variety of treatment (pharmacological and psycho-therapeutic) is now available. Possibilities for international cooperation and participation in international activities and programs has also increased.

We hope that there is still a better future for psychiatry in Slovakia and that we will be able to increase the quality and availability of psychiatric health care.

The Ljubljana Prodrome Project: a pilot study of symptom dimensions or syndromes in the prodrome, acute psychosis and residual psychosis

Marjeta Blinc-Pesek, Mark Agius, Bojana Avgustin, Nada Perovsek Solinc & Marga Kucmur

The inception of this project is described: a Microsoft Excel database of 49 patients who first presented with prodromes of psychotic illness.
The database records the symptomatology, treatment and key statistical data for these patients.
The data is recorded in three stages: during the prodrome; at 'conversion' [when the symptoms first are observed to develop into acute psychosis, dated at the first visit once this has happened]; and later, once the patient has stabilised.

The medication policy was to treat prodromal patients with whatever medication was appropriate for the presenting symptoms [i.e. antidepressants for depression] and to start anti-psychotic medication as soon as possible, once an acute psychotic episode had commenced.
Psychological treatment was offered as necessary. All the doctors concerned were able to deliver either CBT or psycho-dynamic counselling.

The rating scale measure used was a modified version of the full version of CAARMS. The modification was that, since the patients were being rated retrospectively, the symptoms were rated using the following scale: 0 (no symptoms); 1 (mild to moderate symptoms); 2 (moderate to severe symptoms).
The data was recorded numerically on an excel database.

It is presupposed that the onset of psychosis is a dynamic process, and that prodromal symptoms gradually escalate in intensity to develop into a full psychotic episode. We used Swaran Singh's Model of onset of psychosis [NOS] in order to demonstrate this.
We accept McGorry's model of early psychosis as a series of overlapping syndromes.

What we have been able to do is to demonstrate the structure of the prodrome [which may contain individual symptoms, and sometimes particular syndromes, such as 'negative symptoms', even at that stage, and then again the series of syndromes which develop with the onset of full psychosis]. Finally, we have also demonstrated a final 'cross section' of symptoms which are residual symptoms after the patient has been stabilised on medication.

We are not aware of any study which presents three cross-sections (Prodrome, Acute Psychosis, and Residual Symptoms). The closest study to this is Hafner's ABC study.
The present study is a pilot using 21 patients from our database

Findings:
In the Prodrome, we noted the importance of somatic symptoms as being part of the prodrome. We noted the importance of basic symptoms [Bonn Scale] such as 'delusional mood, poor concentration, derealisation and

perplexity' in the prodrome.
We found that depression and anxiety syndromes are common in the prodrome.
We found that paranoid symptoms and positive symptoms, such as hallucinations, are actually unusual in the prodromal patients whom we studied.
We found that negative symptoms/ syndromes [e.g. patient withdrawal, loss of role function] tend to occur in the prodrome. Where positive or paranoid symptoms tend to occur, we suspect that these patients were seen later in the prodrome.
We noted that disorganisation syndrome symptoms [thought disorder] are rare in the prodrome.
Conversion was deemed to occur on the first occasion that the patient was seen when the illness escalated to the point of acute psychosis.
All syndromes, including positive, paranoid and disorganisation symptoms were present at this stage.
The negative syndrome, as well as the depression and anxiety syndrome were also present.
Of note was that the full estimation of positive symptoms included many forms of hallucinations, such as somatic, visual, tactile and olfactory, rather than auditory hallucinations alone.
In most cases, it appears that our medication policy was effective in curing positive, paranoid and disorganisation syndromes of psychosis.
What was left behind were some negative symptoms / syndrome and depression and anxiety syndromes. How these results fit in with what is known about the development of psychosis is discussed.

Provisional Findings of the LEO CAT Trial: a cluster randomised trial of an early detection team in psychosis

Dr Paddy Power
UK

The LEO CAT trial is evaluating the impact of a new Early Detection & Crisis Assessment Team (LEOCAT) on the Duration of Untreated Psychosis, pathways to care and engagement in treatment for young people (aged 16 - 35) presenting with first episode psychosis to mental health services in Lambeth (population 270,000). LEOCAT is the gateway into a larger Early Intervention Service, the Lambeth Early Onset (LEO) service which provides follow-up for two years. The LEOCAT trial involves a cluster randomisation of the 59 GP practices in Lambeth (only the intervention GPs received training in early detection and their patients the services of LEOCAT initially).

During the 2 years of the study, 391 patients were referred to Lambeth's mental health services with query first episode psychosis. Of these, 194 met the criteria for first presentation of first episode psychosis and 153 consented to the study. The provisional findings are presented on the characteristics of the 150 patients whose baselines were completed. This has significant implications for the way early detection strategies are targeted.

Cannabis and Other Substance Misuse in First Episode Psychosis: causes, effects and mediators of outcome

PB Jones, J Barnett, U Werners, K Hill, S Secher, G Murray, Edward Bullmore and the CAMEO Team

Co-morbidity between psychotic disorder and substance misuse is a major clinical problem. Cannabis use may play a part in the cause of psychosis and certainly complicates its management, being associated with poor outcome. We have investigated the prevalence of substance misuse in a geographically defined early intervention service, CAMEO, and have investigated whether a cognitive endophenotype may be different in those people dependent upon or who use cannabis heavily and those who do not.

Of 110 consecutive referrals with a first episode psychosis were dependent upon or had used cannabis heavily. A high prevalence of alcohol and amphetamine use were also seen.

The age at onset of drug use was alarmingly young, showing a marked increase around puberty, and likely coincident with a move to secondary schools. This indicates a target for primary prevention.

Investigation of neuropsychological test profiles concentrating particularly on attention, frontal executive and memory functions, showed no differences between those who used cannabis heavily and those who did not. This pattern was seen for other substances despite statistical power adequate to show differences between disease groups and controls. This indicates that psychosis associated with cannabis (and other drug) use may not be a different entity or phenocopy at least with respect to a putative cognitive endophenotype. Cannabis and other drugs clearly have effects on cognition but when associated with psychosis may have led to a final common cognitive pathway that does not differ from others with a psychosis phenotype. Pharmacogenetic interactions are most likely important .

Clapham Junction: British carts in Maltese ruts? Whither Maltese mental health community care?

Dr Charles Pace
Malta

A British archaeologist gave the name ‘Clapham Junction’ to a spaghetti junction of mysterious, prehistoric, so called ‘cart ruts’ in Malta. Should Maltese community mental health services aspire for a British label and import British models? Should a process of model selection and adaptation to context first take place? How is a model to adopt chosen, and how is the adaptation process to be tackled?

Such a process of adoption has inevitably taken place in Malta, but this

paper attempts to apply Active Remodelling for Congruence (ARC) as a systematic methodology to rationalise the adaptation and remodelling process, in the hope of making it more successful.

In ARC, congruence on the *services* level is sought with four other levels, each of which has therefore been first appraised. The Maltese *country context* takes account of cultural expectations, comparative welfare and the progress of public policy and management. The *user* world looks at local user needs and their living setting. Prevailing and desirable *values* are identified and applied. Recommendations for service are made that are congruent also with the *organisation* level, or available management capability and resources.

In this paper, the process as applicable to Malta is outlined as a case study illustrating its use. In so doing, it encourages others to use a similar template as basis for reflection and dialogue aiming at guiding the adaptive transfer of good practice and service models from one country to the other, in ways to facilitate the identification and compilation of lessons to be learnt for other contexts. Listeners are invited to make similar attempts to describe policy transference practice, achieved, desired or just appraised. An attempt is encouraged to compile similar experiences and aspirations, while developing a common basic language and framework, particularly in the fields of systems to assure (a) dependable and holistic community care and (b) early intervention in psychosis.

The Croatian Mental Health Registers: psychiatrist observations

Ninoslav Mimica
Croatia

The beginnings of psychiatric epidemiology in Croatia have their roots in the Royal Institute for mentally ill in Stenjevec / Kraljevski zemaljski zavod za umobolne u Stenjevcu / (today's Psychiatric Hospital, Vrapce, in Zagreb), which from its early days, paid special care to medical statistics e.g. psychiatric epidemiology. In more than 126 years of continuous work of this biggest psychiatric institution in Croatia, numerous publications dealing with epidemiology of psychoses were published. The first epidemiological report of committed suicide in Croatian psychiatric patients was published in 1908 by Zirovcic. After that, in 1930, Geratovic on the islands of Krk and Kuljzenko in the northern part of the Adriatic Littoral studied the schizophrenic patients, and found out that there was a high concentration of schizophrenia. Big epidemiological studies of psychoses, including schizophrenia, started relatively early in Croatia e.g. in the early 1960s. At that time, Croatia was a non-developed country, and these studies were made in collaboration with and with financial support from the USA. Since 1961, the Croatian Psychoses Registry (CPR), founded by Professor Kulcar, has been run by the Chronic Disease Epidemiology Service in the Croatian

National Institute of Public Health (population about 4 million). It is a case-name register designed for following-up the republic's schizophrenia patients treated in psychiatric institutions. The CPR has so far used diagnostic criteria from ICD-7, ICD-8, ICD-9, and ICD-10. Special attention was paid to the epidemiology of schizophrenia in Istria and the Croatian Littoral, because it was previously supposed that the prevalence of functional psychoses in these regions was higher than in other parts of Croatia. This has been confirmed by these studies, because the rates for schizophrenia were shown to be 5.9 per 1,000 in the study area, and 3.3 per 1,000 in the control area of Croatia. But after that, on the basis of CPR data from 1971 until the present time, we established that the incidence for schizophrenia for Istria and Croatian Littoral was not greater than in other parts of Croatia, and even that it was somewhat lower. Therefore, we consider today that a previously registered greater prevalence of schizophrenia in Istria and Croatian Littoral was a result of economic migration and a negative selection in the domiciliary population.

In 1972, from the base population of 10,569 schizophrenic patients recorded in CPR, a representative sample of 402 patients (207 males and 195 females) was formed for further long-term field-clinical-epidemiological follow-up. The patients were followed up until 1995. Recently, several papers regarding comparison of paranoid type vs. catatonic type of schizophrenia were published. The aetiology of schizophrenia (genetic and viral) was tested through the CPR. In future, possible new distinct subtypes of disorders (PTSD with psychotic features) should be observed with the CPR.

The Croatian Committed Suicides Registry (CCSR), which was set up at the Croatian National Institute of Public Health in 1986, keeps a record of any resident in Croatia who has committed suicide. CCSR, linked with CPR, provides data about the natural course and prognosis of schizophrenia, its subtypes, and other psychoses.

In conclusion, it should be stressed that the Croatian Mental Health Registers are most precious instruments for psychiatric clinical-epidemiological research, and should be used more often.

The Magnitude of Mental Disorders in Croatia

V Hrabak-Zerjavic & M Silobrcic-Radic
Croatia

Relatively high prevalence, frequently chronic course, onset at adolescence and early adulthood, as well as reduced quality of life, mental disorders pose a public health priority worldwide. The purpose of this paper is to present trends in mental disorders in Croatia. Epidemiological analysis has been based on the Croatian National Institute of Public Health data (Hospital Discharges Database and Primary Health Service Database). The presentation shows absolute figures, percentage proportions, crude, and specific rates per 100,000.

In 2004 in Croatia, ranking seventh with 7.0% among the causes of hospitalisation, was the mental disorder group (41,214 cases). However, by number of hospitalisations at active working age (20-59 years), mental disorders rose to the second place with 13.0% (27,449 cases). For years, the mental disorder group has topped the scale of hospital care day total in Croatia. Nearly every fourth day of hospital care (1,616,513 bed days) in Croatia in 2004 was spent on providing care to the mental disorder patients. On the criterion of duration of hospital treatment in Croatia, schizophrenia was the leading individual diagnosis. Alcoholism (21.0 %), schizophrenia (20.4%), depressive disorders (10.8%) and reactions to severe stress, including PTSD (7.9%), accounted for two thirds of all causes of hospitalisation from the mental disorder group in 2004. Schizophrenia clearly led this group with a hospital care day portion of 38.4% (620,650 bed days). For 1995, the reported mental disorder hospitalisation rate was 632.2, and with slight oscillations, it grew continually until 2004 (928.8). The largest number of hospitalisations for alcoholism was recorded in 1996 (a rate of 212.3); in 2004, the rate was 194.6. In 1995, the schizophrenia rate was 144.2 with a peak in 2000 and 2004 (189.2). The depressive disorder hospitalisation rate reached a low in 1995 (54.6), but since then has been rising with oscillations, being 100.2 in 2004. With the introduction of ICD10 in 1995, recorded for the first time was the reaction to severe stress, with the hospitalisation rate being 34.3 and rising until 1998 (92.3), since when it has been displaying a declining trend (73.2 in 2004).

By the number of diagnoses recorded in Croatia's Primary Care Service in 2003, mental disorders ranked tenth with 4.0% (334,128 diagnoses; rate 7,529). Neuroses, stress-related affective disorders and somatoform disorders, accounting for 58.0% of the total diagnosed mental disorders, were the leading diagnostic subgroup.

Mental disorders according to the regular health statistics data present one of the leading public health problems in Croatia, especially in the scope of hospital care day and hospitalisations at active working age, highlighting schizophrenia, alcoholism, depressive disorders and reaction to severe stress as leading diagnoses.

Croatian Mental Disorders Registries

M Silobrcic Radic & V Hrabak-Zerjavic
Croatia

Croatian Psychoses Registry

Taking note of the public health importance of mental diseases, the Croatian National Institute of Public Health set up the Croatian Psychoses Registry back in 1961. It started operation by taking a census of all patients found in psychiatric hospitals and psychiatric wards in the republic on 31st December. The Registry is a special health statistical instrument for long-term patient monitoring, also having the characteristics of a population registry. It monitors data on the

schizophrenic patients permanently residing in Croatia who have received treatment at psychiatric hospitals and psychiatric wards. A psychiatric form, completed at hospital discharge and on the census day (31 December annually), is the source of information in monitoring the patients. For every individual patient, the course of treatment, institution, length of hospitalisation, underlying and secondary psychiatric diagnosis, somatic diagnosis, cause of death in the case of death in the hospital, and possibly committed suicide, can be monitored. Aggregate data is analysed on patient and case levels by selected characteristics (age, sex, community/ county of birth/residence, treating institution) within individual subgroups, so-called contingents.

The presentation covers the Psychoses Registry data for the period 1962-2001, showing absolute figures and age-standardised rates per 1,000 population older than 15 years.

The greatest number of incident schizophrenic patients was recorded in 1962. Although a portion of these had been hospitalised earlier, they were not registered until the establishment of the Registry. In the subsequent period, the age-standardised rate of hospital incidence of schizophrenia did not exhibit any major change, accounting on average for 0.26/1,000 population above 15 years old. Although slightly higher incidence rates were reported for males, there were no significant differences in disease development by sex. Most often, schizophrenic patients had their first hospitalisation at the age 20-29 years. On the other hand, the highest hospital incidence rates in the past few years were recorded at the age of 25-39 years. Evident in the observation period (1962-64/1998-2001) was an increase in the average of admitted (1,687/4,792) and discharged schizophrenic patients (1,671/4,921), as well as in the average number of admissions (2,071/7,735) and discharges (2,006/7,797). There have also been increases in the ratio of admissions to admitted patients and in the ratio of discharges to discharged patients (1.2/1.6). Though more frequent, hospitalisations are mainly shorter. Whereas the number of hospitalised schizophrenic total rose by 59% (3,813/6,070), the number of total hospitalisations grew by 98% (4,245/8,399). One may notice a fall in the average number of year-long treated patients (1,805/844), as well as in the ratio of treatment days for these patients to the total days of treatment for schizophrenia (76.9%/44.3%). Whereas in the 1962-64 period the revolving door/ hospitalisation patients had an average hospital stay of 100.8 days annually, in the period 1998-2000 this became 74 days. Practically every indicator exhibited either a stagnating or declining trend from 1990-95, reflecting the war operations in Croatia.

Croatian Committed Suicides Registry

Suicides, which are an indicator of mental health risk, are one of the leading causes of deaths from injuries in Croatia.

The Croatian Committed Suicides Registry was set up at the Croatian National Institute of Public Health in 1986. It keeps a record of any resident in Croatia who has committed suicide. For this it uses two sources of information: the statistical death report, and the death certificate. Aggregate data is analysed by age, sex, community/county of birth and residence, methods of committing

suicide, and possible psychiatric diagnosis.
Suicide trends are shown for the period 1985-2004. Registry data are completed for the year 1985 by routine mortality statistics, and presented by absolute figures, percentage proportions, crude, specific and age-standardised rates per 100,000.

Suicides are the leading causes of death from injuries in Croatia 2004, with a proportion of 30.4%. Both the number of suicides committed and the rate per 100,000 oscillate. In 1985, there were 1,050 suicides (rate 21.9). The registered suicide rate reached a peak in 1987 (1,153; rate 24.1) and 1992 (1,156; rate 24.2). Suicide lows were recorded in 1995 (930; rate 19.4) and in the period 2000-2004 (871; rate 19.6 in 2004). Male suicides outnumbered that for females, ranging in proportion from 2.2-3.5:1. While the age-standardised suicide rate until 1997 oscillates, from 1998 on it shows a steady decline. In both sexes, the suicide mortality rate grows significantly with age. For ages 15-19 years, an increase in the number of suicides committed was recorded (rate 5.8 in 1985; rate 13.5 in 1996). However, in the period 2000-2004, a declining trend was present in this age group (rate 8.0 in 2003; rate 5.4 in 2004). In both sexes, suicide by hanging was the most common method of death. The number of suicides by using firearms rose significantly during the war and post-war years, particularly among males (in 1992 and 1995 this was about 26%). In recent years, however, this method of suicide recorded a declining trend (17.0% in 2004). There are significant differences between suicide rates in Croatia by counties. Northern and north-western counties have the highest suicide rates, and southern counties have the lowest.

In Croatia, mental disorders and suicide is one of the public health priorities for which continuous medical prevention programs with interdisciplinary cooperation need to be run.

Disease Biomarkers in CSF of First-onset Schizophrenia: evidence for a common final disease pathway of this etiologically heterogeneous disorder

Sabine Bahn
Cambridge, UK

At present, little is known about the basic mechanisms that underlie the schizophrenia disease process. This lack of knowledge is most likely due to the fact that, until recently, large-scale expression profiling studies were technologically impossible. Thus, most researchers employed a “candidate gene/protein” approach. With recent technological advances in genomics, proteomics and metabolomics, the time is now right to understand the fundamental processes of psychiatric conditions and to translate this improved knowledge into new (pre-symptomatic) diagnostic, therapeutic and preventative regimes.

The combined application of advanced computing and bioscience technologies

with functional genomics studies offers unprecedented powerful approaches to explore the molecular "fingerprints" of medical conditions from early onset through their progressive stages, exploring alterations at the gene, protein, lipid and metabolite level. This in turn should reflect and reveal dynamic changes of interlinked pathways in the normal and atypical brain.

I will present results from our biomarker discovery studies. To date we have identified a number of highly significant peptides and metabolites that distinguish first-onset paranoid schizophrenia patients from healthy controls. Furthermore, we found that some of these changes "normalize" after short-term treatment with antipsychotic medication implying that they may represent early readouts of drug efficacy.

T Cell Responses: developing the field of immunopsychiatry

RM Craddock, DA Rider, EJ Jackson, MT Wayland & S Bahn
Cambridge, UK

Despite advancing our understanding of schizophrenia, current research models have yet failed to provide us with a concrete basis on which to build hypotheses. The very nature of this disorder however, makes it difficult to find suitable research tools and accessible tissues for experimentation, especially as it has remained unclear whether pathological differences in schizophrenia could be detected outside the brain. We have therefore sought to develop a new model in which to investigate schizophrenia, improving upon current methods to minimise post mortem and drug effect, whilst remaining physiologically relevant.

In the present study, peripheral blood T cells were utilised to perform dynamic investigations into cell function using *in vitro* stimulation. T cell receptor signalling can be simulated using immobilised anti-CD3, ultimately resulting in the production of cytokines and entry into cell cycle. This model therefore not only allows for biomarker discovery, but also for dynamic investigations into cell function which may underpin the pathology of this disorder. Schizophrenia patients were found to have significantly lower proliferative responses to *in vitro* stimulation, compared to healthy controls and an initial proteomic screening study showed numerous significant differences in T cell responses and PLSDA analysis of these results demonstrated complete separation of patients from controls. Furthermore, transcriptional investigations using Code link gene array chips identified a number of significant changes. These surprisingly clear differences, detectable in peripheral cells validate the importance of this novel model as a research tool and may lead us to understanding the cellular mechanisms underlying disorders such as schizophrenia.

This work is funded by The Stanley Medical Research Institute.

Transcranial Magnetic Stimulation (TMS)

Rashid Zaman
UK

The idea of using electromagnetic fields to alter neural function is not new. In fact, it was as early as the 1900s that Psychiatrists, Adrian Pollacsek and Berthold Beer (working not far from Sigmund Freud in Vienna), filed a patent to treat depression and neuroses with an electromagnetic device.

However, the modern era for Transcranial Magnetic Stimulation (TMS) really began in 1985 when Barker and his colleagues, from the University of Sheffield (UK), reported the first successful triggering of brain cells using TMS.

The principle behind TMS is relatively simple. As an electrical current suddenly passes through a wire coil, it momentarily generates a magnetic field, which unlike a direct electrical current penetrates the skull easily and painlessly. Once inside the skull the magnetic field induces electric current, which fires off neurons in the targeted region of the brain. Although TMS only affects neurons relatively close to the surface of the cerebral cortex, some of its effects are thought involve deeper structures due transynaptic transmission.

In the early 1990s came the development of a more powerful and refined method over the single pulse TMS, and was described as repetitive transcranial magnetic stimulation (rTMS). The frequency range of rTMS machines ranged from 1Hz to as high as 50Hz. With the use of rTMS over other cortical regions (apart from the motor cortex) and the resultant effects on mood and behaviour, the researchers began to investigate a number of psychiatric and neuropsychiatric disorders as well as exploring its therapeutic potential.

In this relatively short talk, I shall go briefly into the history and principles behind single pulse TMS and rTMS. I will describe various TMS coils, their usage, and some the important parameters used in field of TMS and rTMS.

I will also briefly describe some of the early (relatively) therapeutic studies of rTMS in the field of neuropsychiatry and indeed the state of current research in this field.

I will end the talk with some of the findings from our own published studies: investigation with TMS of the cortico-spinal system in patients with chronic fatigue syndrome.

Functional Neuroimaging

Dr Paul Fletcher
Cambridge, UK

The introduction and development of functional neuroimaging has had a big impact upon the study of the human brain, both normal and abnormal. It allows us to make experimental manipulations in healthy individuals and the measure the outcome of these manipulations in terms of changing levels of activity in different brain regions. This has presented us with a number of novel possibilities in exploring human higher cognitive functions using objective, precise, quantifiable variables. This has been especially exciting for psychiatry since it brings into the realm of neuroscience a number of areas that had not previously been considered tractable to rigorous manipulation and experimentation – pain, pleasure, reward, regret, deception, and consciousness itself: all areas that are of interest to the psychiatrist. However, it has also led to a number of unrealistic expectations and set in train a number of experimental endeavours that require careful scrutiny. In light of this, I would like to present a simple view of functional neuroimaging: how it works and what it can and cannot tell us. I would like to establish that the functional neuroimaging output is not, qualitatively, different to any other outcome variable and that, in this regard, it is not freed from the constraints that govern good experimental design in other fields using less complex techniques.

Notwithstanding this caution, there appear to be instances where functional neuroimaging has proven more sensitive than other measures and may even give us information that is inaccessible to the subjects themselves. Furthermore, functional neuroimaging information can, under certain circumstances, be predictive of later behaviour. I would like to consider these aspects of the techniques and to provide practical examples of each.

Prodromal Interventions in Psychosis: Ethical & Clinical Challenges

Dr Swaran Preet Singh
UK

Prodromal intervention in psychosis is a highly contentious and challenging area with concerns about stigma and inappropriate treatment of false positive cases weighed against the possibility of preventing a potentially devastating mental illness.

The talk will focus on recent research and clinical evidence on the identification of the true prodrome, the rationale for intervening in the prodrome and the pros and cons of different treatment strategies.

Establishing Coordinated Community Care in Bulgaria

Dr Svetlozar Vassilev
Bulgaria

This presentation delineates a methodology for the implementation of community-based programs in Bulgaria. The characteristics of the cultural and social context, such as the domination of the institutional model, splitting between academic and clinical tradition, and the high degree of stigmatisation, are clarified and discussed.

Integrated interventions on a political, academic and clinical level are utilised as a systemic methodology for the implementation of reform. The approach is illustrated by a description of a specific regional project.

The crucial importance of systemic interventions on all three levels is commented on through the prism of experiences over the last 16 years.

Outcome Measures of Schizophrenia

Professor Köksal Alptekin
Turkey

The aim of this presentation is to discuss the role of quality of life, disability and cognitive functions as outcome measures in evaluating the prognosis of schizophrenia. In recent years, there has been increased interest in the concept of "Quality of Life" and “Disability”, in part because of the interest in this concept of the World Health Organisation (WHO).

Quality of life refers to the individual’s perception of the quality of his or her own health in his or her cultural and moral systems, not the views of others, their family members, medical workers, or government. Disability is restrictions, due to impairments, on many domains of daily life such as hygiene, self-management, vocational and leisure activities, family and social relationships.

Schizophrenia, having a chronic disabling feature, takes attention according to the negative effects on the patient’s quality of life and disability, which both may be related to cognitive dysfunction. Therefore, improvement of positive and negative symptoms in schizophrenia is not enough to assess treatment effect. Biological and psychosocial treatments need to be effective in improving poor quality of life, disability and cognitive impairments, along with positive and negative symptoms in schizophrenia.

Traditional Chinese Medicine and Psychiatry

Shun Au
UK

The rise and popularity of the Traditional Chinese Medicines (TCM), especially acupuncture, outside China for the last two decades have been a worldwide phenomenon. Although people use it for a wide range of conditions, mental health has been a major area for its use in the West.

This talk charts its rise in the west, outlines briefly the theory and treatment modes of TCM, and looks at the evidence in the mental health field. It concludes by offering some insights into potential areas for service development and research in the western context.

Factors important for Compliance among Croatian Patients who are suffering from Schizophrenia: how to improve psychiatric services in Croatia

Sanja Martic Biocina & Vesna Baric
Croatia

In our paper we analysed the results of a questionnaire on compliance and insight into the disease among chronic schizophrenic patients and their carers in Croatia. We interviewed thirty female patients and fifteen carers.

We have found that patients in general have poor knowledge about the illness, symptoms and side effects of medicine. This finding is similar to that obtained in other studies. Patients often stop taking medication, which results in an exacerbation of the disease [on average 10 hospitalisations within 12 years of disease]. They do this mainly in order to check whether they have been cured or not, or because of the side effects of medication. Two thirds of patients were diagnosed within one year of the onset of the disease, and one third were diagnosed between one and five years of the onset.

The most useful information which they get about the illness and about medication is from the psychiatrists and from the directions on the medicine box. Information from other medical staff was considered by the patients to be on a par with that of other non-professional people e.g. friends and family. Over 70% of patients did not have access to educational material such as leaflets, and only 3% used the internet. Both groups were completely dissatisfied with the role of the media.
The presence of stigma was denied by the group of patients but reported by the carers, in that 40% still conceal the illness of the family member from others.

As a result of the questionnaire, we noted some good points about the care of patients, and suggest some new ideas on how to improve psychiatric services in Croatia.

The Trieste Experience

Dr Barbara Bavdaž
Italy / UK

In the early 1970s, I joined as a medical student the team of Professor Franco Basaglia in the Psychiatric Hospital of Trieste. Trieste later became a pilot site for mental health policies and experiences in the world. I definitively decided to work in the local Centres of Mental Health after my degree in 1978. Since then I have been specifically involved in a project on women and mental health, working within the team involved with prisoners and with refugees. I worked with learning disabilities teams in multidisciplinary settings, and have been for some time also called to improve and review the cooperation between the GPs and our teams.

I used to share our practice and policies, within the international association Alpe-Adria, with colleagues from Austria, Slovenia, Croatia and some other counties in Northern Italy.

I am currently working as a Consultant in BLPT, and find this experience really challenging.

My presentation is mostly about the evolution of the deinstitutionalisation in Trieste. I will try to describe that experience from its first beginning and explain how it then developed in the organisation into a very accurate, effective and efficient network of Centres of Mental Health. Trieste is still one of the most advanced realities in the world, particularly regarding the social and working rehabilitation of people with psychotic problems. Recently, some other important goals have been achieved as regards suicide, starting a project which is involving the Department of Mental Health, the City Council and a private firm.

At the end I will briefly compare some aspects that characterise the Services of Mental Health in Trieste and in Bedfordshire.

Innovative Communication Tools in the Management of Bipolar Disorders

Dr Mara Baretto
Belgium

Bipolar Disorder may sometimes be misdiagnosed as Unipolar Depression when the exploration of symptoms is not adequate enough. Bipolar Disorder involves, for many patients, social dysfunction as well as occupational impairment in fields such as work, spare-time activities and family life. Improving the quality of clinical assessments remains a challenge towards a more

exact diagnosis and a more accurate follow-up.

The COPE-Bipolar program (Clinical Outcome and Psycho Education in Bipolar Disorders) consists of a Psycho Education Program for bipolar patients and their families and a computerised tool for Clinical Outcome Measures (COPE-Bipolar.COM). It was developed in the Department of Psychiatry of Erasme Hospital in Brussels, Belgium.

The Psycho Education Program permits not only a personal approach between caregivers and patients but also a family approach between caregivers and patients' relatives. Working sessions are interactive, focusing on shared experiences and knowledge about the disease.

COPE-Bipolar.COM is a software composed of the following modules: Demographic Data, the MINI International Neuropsychiatric Interview, Current and Previous Psychotropic Treatment, Side Effects, Somatic Comorbidity, Family History of Psychiatric Disorders, Severity Scales, Quality of Life and Functioning and New Mood Episode. COPE-Bipolar.COM is used to perform baseline and outcome structured interviews. Acquired data have, in consequence, a highly organised structure and are gathered as well as automatically exported to an Excel data sheet and then analysed by using the SPSS statistical software.

The COPE-Bipolar.COM is a quality management program that offers an integrative approach and potential research implications. It is intended to be used by caregivers within networks of reference centres involved in the management and treatment of Bipolar Disorders.

Croatian Observations on PTSD with Psychotic Symptoms in War Veterans

N Mimica & S Ivezic
Croatia

Aim
To investigate the prevalence rate of co-morbid psychiatric disorders in post-traumatic stress disorder [PTSD] and to explore psychotic symptoms in patients with combat-related current PTSD.

Method
The sample included Croatian war veterans [N=41] who were hospitalised at the University Department of Psychiatry of the Vrapce Psychiatric Hospital during the 1995-1996 period, who fulfilled the DSM-IV criteria for current and chronic PTSD.

The Schedule for Affective Disorder and Schizophrenia [SADS-L] was applied for the assessment of current and lifetime psychiatric disorders. Only three subjects had a pre-war Axis I psychiatric disorder. One third of the patients met the criteria for personality disorder.

Findings
After severe combat trauma, the majority of PTSD patients [33/41] had at least one comorbid psychiatric diagnosis on Axis I. In those with personality disorders the most frequent was alcohol dependence, whereas in those without

personality disorders it was major depressive disorder. Psychotic symptoms occurred in 8 / 41 PTSD patients. None of them had a primary psychotic disorder or a personality disorder. In all the patients, psychotic symptoms were different from flashbacks. They were symbolically related to the trauma and resistant to antipsychotic treatment. Psychotic symptoms were associated with depression in 5 / 8 patients with psychotic symptoms.

Conclusion
Severe and prolonged combat trauma may be followed by the co-occurrence of PTSD and psychotic symptoms, forming the atypical clinical picture of PTSD.

Extreme Stress Vulnerability – A Basis For Psychiatric Genetic Research

Lilijana Oruč & Lejla Kapur
Bosnia and Herzegovina

The war period in Bosnia and Herzegovina (1992-1995) was characterised by the continuous exposure of the civilian population to numerous extreme life events that led to an increase of psychological and psychiatric disturbances.
Molecular psychiatric genetics studies in Sarajevo were initiated after 1997 followed by family and population based genetic studies of bipolar mood disorders type 1 and schizophrenia. In light of the stress vulnerability model, the Bosnia & Herzegovina population represents a unique pool for psychiatric genetic research. In that respect, the options for comparative molecular genetic study designs of PTSD followed by psychotic features in Bosnia & Herzegovina will be discussed.

Results of an Ovid / Medline Search on PTSD with Psychotic Symptoms

Dr Mark Agius
Bedfordshire, UK

The object of this brief presentation is to show what is already known regarding the link between PTSD and Psychosis.

A number of papers will be quoted which show that PTSD has been reported from various conflicts.

Potential Questions for further research are raised.

The reasons why this issue is relevant to contemporary British Psychiatry are given.

Development of Community Care In Slovenia

Vesna Svab
Slovenia

This lecture will describe the beginnings of the development of community care for serious mental illness in Slovenia, a central European country which has recently joined the European Union. It is particularly appropriate that this subject should be addressed by the conference, as there are a number of Slovenian mental health staff who are presently attached to the Bedfordshire and Luton Community Trust in order to gain experience in community care.

POSTER PRESENTATIONS

Promoting Early Intervention in Psychosis through Experience-Focused Case Formulations: a report from Bulgaria. Rumiana Dinolova and Toma Tomov

Abnormal frontal activations related to decision-making in current and former amphetamine and opiate dependent individuals. Ersche KD[1,2], Fletcher PC[1,2], Lewis SJ[2], Clark L[2,3], Stocks-Gee G[4], London M[5], Deakin JB[1,2], Robbins TW[2,3] & Sahakian BJ[1,2]

[1] University of Cambridge, Department of Psychiatry, Addenbrooke's Hospital, Cambridge
[2] Behavioural and Clinical Neuroscience Institute, University of Cambridge, Cambridge
[3] University of Cambridge, Department of Experimental Psychology, Cambridge
[4] University of Cambridge, Wolfson Brain Imaging Centre, Cambridge
[5] Brookfields Hospital, Cambridge Drug & Alcohol Service, Cambridge

Quality of Life and Need at First Presentation of Psychotic Illness: how do they relate Tto depressive symptoms? O Gallagher, U Verners, C Hill, R Brassil, M Painter, E Bullmore & P Jones

After the Tsunami: Setting up a Community-Based Mental Health Service. Dr Ian Soosay

Self-explanation strategies in children with learning difficulties. Research Paper submitted to: British Journal of Special Education (2005). Q. Almeqdad

POSTER PRESENTATIONS

Posttraumatic Stress Disorder and Psychotic Symptoms. Narcisa Pojskić & Lilijana Oruč

Survey of the Prevalence of Depression and Anxiety During the IInd Days of Mental Health in Eastern Slovakia in 2004. Eva Palova, Dagmar Breznoscakova, Milana Kovanicova, Katarina Kubasovska, Pavol Leto & Peter Nawka

Increased Th_1 Th_2 and Th_3 Immune Reactivity in Patients with Acute Exacerbation of Schizophrenia and Chronic Schizophrenia. B Avguštin, B Wraber, M Blinc-Pesek

Th_1, Th_2 and Th_3 Immune Reactivity in Patients with First Episode Psychosis. B Avguštin & B Wraber

The Urgent Psychiatry Outpatients' Department (UPOD). Lea Žmuc Veranič & Peter Pregelj

Changes in the Mental Health Care System In Slovakia in 1995-2005. Eva Pálová

Monozygocity and dizygocity: the effect of twinhood on inheritance of schizophrenia. Use of a conditional probability model, with reference to doctor-lay person communication techniques. C McLernon & R Zaman

Omega-3 fatty acid supplementation in three patients with schizophrenia: a longitudinal study. C McLernon C, S Shah & R Zaman

Getting It Right: Clinical Audit Processes within a Trust's Clinical Governance Structure. Mandy Quarmby, Maggie Nicholls & Seema Jassi

Report on Clozapine Monitoring in Weller Wing, Bedford Hospital. Dr SN Ashraf & Dr BS Mani

Occupational Therapy Referral Pathway for Acute Psychiatric Inpatients in Weller Wing, Bedford. Dr P Rajamani, Tina Browning, Dr R Zaman & Dr Gayatri

CONFERENCE SPEAKERS

Dr Mark Agius MD
Dr Mark Agius completed his MD in Malta. He has since worked in Bedfordshire, England, for many years, first as a GP and then in Psychiatry. He has been actively involved in the development of community mental health services in Bedfordshire, and in the Eastern Region of the UK.
His main interests include the development of the interface between primary and secondary care in mental health and the development of early intervention services for young psychotic patients. He has published widely and lectured in several countries on both these areas.
He is an Associate Specialist for the Early Intervention in Psychosis team in Luton, Bedfordshire, and is a Senior Research Fellow with the recently formed Bedfordshire Centre for Mental Health Research in association with the University of Cambridge, specialising in early intervention service audit and studies on first episode psychosis. He is an Honorary Research Associate in the Department of Psychiatry, University of Cambridge.

Qais Almeqdad BA, MA, MPhil
Qais is a PhD candidate at the Faculty of Education, Homerton College, University of Cambridge.

Professor Koksal Alptekin MD
Köksal Alptekin MD is Professor of Psychiatry at the University of Dokuz Eylul, School of Medicine. He earned his medical degree from Eagen University, School of Medicine, and completed his postgraduate training in Psychiatry at the Department of Psychiatry at the University of Dokuz Eylul. He also trained in Psychoanalytic Oriented Group Psychotherapy and Psychodrama in Izmir. He took an important role in medical education at Dokuz Eylül University based on active learning. His research interests include quality of life, disability and cognitive functions in schizophrenia, and he has also been involved in studies on brain imaging and cognitive functions of patients with Obsessive Compulsive Disorder. He is the organising president of the Schizophrenia Solidarity Association of Izmir and organising member of the Halime Odağ Psychoanalysis and Psychotherapy Foundation. Besides some national awards, he is a member of editorial boards for several Turkish Journals and a past president of the Schizophrenia Section of the Turkish Psychiatric Association. He is a reviewer for Acta Psychiatrica Scandinavica, Psychiatry Research: Neuroimaging, Clinical Neuropharmacology, Progress in Neuropsychopharmacology and Biological Psychiatry, and Annals of General Psychiatry.

Dr SN Ashraf
Dr Ashraf is doing a clinical attachment in Psychiatry at Bedfordshire and Luton Partnership Trust.

Shun Au
Shun Au read psychology at City University, London, and linguistics and business administration at Cambridge University.
Shun spent seven years working as a senior manager in the NHS prior to setting up TCM HealthCare. He has a strong interest in developing evidence based complementary medicine. He has been part of a research consortium

conducting a pilot RCT on acupuncture and depression, working with a medical school and two NHS Trusts in London.
He has been invited to speak at a range of international health conferences, which include: a key note speech at the Inaugural International Asian Health Conference, Asian health and well-being – now & into the future, at the University of Auckland (New Zealand, November 2004); a symposium at the World Psychiatry Congress (Cairo, September 2005); the Pan Asian International Conference (Shanghai, November 2005). He has several publications on complementary therapies and mental health.
He is currently working on a survey on complementary therapies commissioned by the Department of Health.

Dr Bojana Avgustin MD, MSc, PhD
A resident in psychiatry and working as a young researcher in the Ljubljana University Psychiatric Hospital, Bojana's research interests are in the field of psycho-neuroimmunology & psychosis. Her clinical work includes early interventions in psychosis, psychoeducation for patients with psychosis and their families and group therapy for patients with psychosis.

Dr Sabine Bahn MD, PhD, MRCPsych
Sabine Bahn is a principle investigator at the Institute of Biotechnology and the Babraham Institute of the University of Cambridge. She is also a senior Research Associate and Honorary Consultant in Psychiatry at the Department of Psychiatry, University of Cambridge, and a Visiting Research Fellow at the Human Genome Mapping Project Resource Centre.
She graduated from medical school [Albert-Ludwigs-Universitat], 'sehr gut', in 1995, and received a doctorate in medicine from the same university, 'summa cum laude', in 1994. She became a Doctor of Philosophy while working at the Cambridge MRC laboratory of molecular biology in 1997, and a member of the Royal College of Psychiatrists in 2000. She has received many scholarships and awards, both at Cambridge and Freiburg, and is currently a Research Fellow at Clare Hall, Cambridge. She has completed the Cambridge Specialist Registrar rotation, which has included clinical lectureship posts and work with CAMEO, the Cambridge Early Intervention Service.
She has trained in cognitive analytic therapy, interpersonal therapy and family therapy. She has 26 publications and holds 7 patents listed on her CV.

Dr Mara Barreto
Dr Mara Barreto earned her medical degree in 1996 at Buenos Aires University, Argentina, where she has been board certified in psychiatry since 2001. She worked in different in-patient and ambulatory care units focusing primarily on mood disorders. Dr Mara Barreto has also worked as Assistant Professor of Psychopharmacology at the School of Medicine of Buenos Aires University and Maimonides University, Buenos Aires, Argentina. She was also Chair Professor of Psychopathology at the Focus Counselling Institute of Buenos Aires, Argentina.
Dr Mara Baretto started working in November 2003 as a clinical researcher at the Department of Psychiatry of the Erasme Hospital, dependent from the Free University of Brussels. She has actively worked in the development of the COPE Bipolar Program, created in the Department of Psychiatry of Erasme Hospital, under the supervision of Dr Daniel Souery. The COPE Bipolar Program is a quality management program intended to be used within networks of reference centres involved

in the management and treatment of Bipolar Disorders.

Dr Marjeta Blinc-Pesek MD, MSc
Born in 1964, Marjeta Blinc-Pesek graduated from the University of Ljubljana Medical School in 1990. She commenced her psychiatric training at the Ljubljana University Psychiatric Hospital in June 1992. Since 1999, she has run a ward which offers treatment and care to mostly young patients with psychotic disorders.
She started working with groups during her psychiatric training, providing group work for in-patients with residual or chronic psychosis. In 1996 she commenced a group for parents of young persons with psychosis and a group for young patients with psychosis in an out-patient setting. Most recently, in 2000, she passed the introductory course in Group Analytic Psychotherapy and, in 2002, completed her MSc thesis on familial schizophrenia. This year she founded ISPS Slovenia.

Simon Bound
Simon Bound is a STR (Support, Time & Revovery) worker with the CMHT in Bedford. Prior to this, he was a support worker at Progress House which helps rehabilitate people who have suffered from ill health. He prepared this conference poster in response to a course he attended on the subject of the recovery approach in mental health whilst working at Progress House, which works to these principles. It was aimed at celebrating the success of the team.
He was diagnosed with a serious mental illness before coming to work with the NHS and found that the ethos of the course and its NHS patron reaffirmed his hope that the service provision can work effectively with people on their path to recovery.

Dr Rachel Craddock BSc [Hons] MSc PhD
Rachel Craddock undertook a first degree in biomedical science, specialising in haematology before obtaining a masters degree in immunology and infection from Birmingham University, where she won the prize for top student. She completed her PhD in the Department of Immunology and Infection, in collaboration with the Department of Rheumatology, also at the University of Birmingham, investigating delayed apoptosis in chronic inflammatory disorders, providing her with a strong background in cell signalling and function.
She currently works for Sabine Bahn at the Institute of Biotechnology, funded by the Stanley Medical Research Institute, where she has used her background in immunology and cell signalling to develop a functional cellular model for the investigation of complex neuropsychiatric disorders such as schizophrenia. This model will not only answer questions regarding inherent cell dysfunction, such as gene transcription, protein synthesis and trafficking, and cell signalling, but also allow the identification of biomarkers which can be developed into diagnostic aids. This model is unique in that it allows for functional investigations and can help to address the problems associated with drug treatment and post mortem effect. This model can also be applied to an array of psychiatric disorders.

Ms Karen Ersche Dip. Psych., MSc
Karen is a final year PhD student with the Department of Psychiatry at the University of Cambridge.

Dr Paul Fletcher
Paul Fletcher trained in medicine at St. Bartholomew's hospital medical school

and thereafter in psychiatry at the Royal Free hospital. He began functional neuroimaging research in 1992 at the Hammersmith Hospital, initially carrying out positron emission tomographic studies on healthy volunteer and schizophrenic populations. His work focussed primarily upon characterising patterns of prefrontal cortex activity in association with long-term memory. In 1995, under a Wellcome Mental Health Training Fellowship, he worked at the Institute of Neurology developing memory tasks for functional magnetic resonance imaging, continuing to focus upon prefrontal function, an area that was extended upon in a subsequent Wellcome Advanced Training Fellowship based at the Institute for Neuroanatomy, Dusseldorf, and at Cambridge University.

In 2002, he was awarded a Wellcome Trust Senior Research Fellowship to carry out a series of behavioural and functional neuroimaging studies aimed at assessing and refining a neurotransmitter model of schizophrenia. Continuing to use memory tasks, and focussing upon prefrontal contributions to these tasks, his goal is to establish the effects of specific pharmacological manipulations upon psychopathology, task performance and brain activity in healthy subjects and, ultimately, to compare these findings with those from identical tasks run in patients with schizophrenia. In doing so, he is aiming to understand the structural, neurochemical and cognitive bases for the symptoms experienced by psychotic people.

His title at present is Wellcome Trust Senior Research Fellow in Clinical Science at the University of Cambridge.

Dr Olwyn Gallagher MB, BCh, BAO, MRCPsych.

Dr Gallagher trained at the National University of Ireland in Galway. She spent a year at the EPPIC Early Intervention Service in Melbourne, Australia, and subsequently joined the Cambridge Specialist Registrar rotation in psychiatry. She is a member of the Royal College of Psychiatrists. She has worked in Luton, Peterborough, Cambridge and Glasgow. Whilst in Luton , she co-founded LEAP, the Luton Early Intervention in Psychosis Service, and upon moving to Cambridge, she helped found CAMEO, the Cambridge Early Intervention Service, working with Professor PB Jones and Professor Ed Bullmore.

She has recently completed her training and now works as a Consultant in adult psychiatry in Glasgow. She is also an honorary senior lecturer in psychological medicine at the University of Glasgow. She has published a number of papers relating to early intervention , and is a Research Fellow of the Bedfordshire Centre for Mental Health Research in association with the University of Cambridge.

Professor Sir David Goldberg

Sir David Goldberg is Professor Emeritus at the Institute of Psychiatry, and Chairman of the Psychiatry Research Trust. His long-standing interest has been mental disorders in primary care settings, and many of his research projects have been carried out in primary care settings. Before returning to London, he set up collaborative community mental health services with primary care in Manchester and, since his return to London, he has proposed closer collaborative arrangements between primary care and specialist mental health services. He carried out early

collaborative research with health economists on mental health services, and also designed both the General Health Questionnaire and the Clinical Interview Schedule, both of which have been widely used across the world. His recent book with Ian Goodyer provides both an epidemiological and a developmental framework for conceptualising the genesis of common mental disorders.

Catherine Gonzi

Catherine Gonzi has been a driving force as an advocate in the field of mental health in Malta for over twenty years. Ms Gonzi is a founder member and the Vice Chairperson of the Richmond Foundation, an NGO which provides Community Mental Health Services in Malta, and she also holds the position of Hon. President of the Malta Mental Health Association. Ms Gonzi has presented the carer's perspective in issues related to mental health at numerous national and international conferences. Ms Gonzi has often addressed students, employees at their places of work, and the general public, on mental health issues.

Ms Gonzi is the wife of the Prime Minister of Malta, Dr Lawrence Gonzi, who shares her commitment to promote mental health. They were awarded the Gamian Europe Award for the Politician in Europe for their commitment in the field of mental health.

Ms Gonzi raised the issue of mental health amongst the spouses of Heads of Government at the Commonwealth Heads of State Meeting held in Malta in November 2005.

Dr Ema Nicea Gruber MD, MSc

Dr Gruber graduated in medicine in 1998 from the University of Zagreb. Since 2000, she has been undertaking postgraduate education in biology and anthropology at the School of Natural Sciences, University of Zagreb. In 2002, she undertook an MSc in Biology and Anthropology and, since 2004, she has been studying cognitive-behavioural psychotherapy. At present, she works at the neuro-psychiatric hospital in Popovaca, Croatia, and is specialising in psychiatry. She has recently founded the NGO 'Happy Family' to provide group work and psycho-education for patients with serious mental illness and their families. A prolific author, she will shortly have a paper on her work published in the International Journal of Social Psychiatry.

Dr Vlasta Hrabak-Žerjavić MD, MSc

Vlasta Hrabak-Žerjavić is the Head, of the Chronic Disease Epidemiology Service of Croatia. She qualified in 1970 from the University of Zagreb Medical School. In 1975 she achieved a Masters degree, from the same University. In 1985 she became an Epidemiology Specialist. She has attended many courses organised by WHO, as well as a Master class, 'Health Care in Transition —an international Perspective', organised by the Faculty of Medicine, Utrecht University and Netherlands School of Public Health, in 1998.

From 1971-1981, she was MD at the Chronic Disease Service, Institute of Public Health of Croatia. From 1972-1976, she was technical coordinator of a project, Epidemiology of Functional Psychoses—a critical review, conducted by the Institute of Public Health of Croatia, in collaboration with Professor PV Lemkau of Johns Hopkins University in Baltimore. From 1976-1979, she was field director of a project, Use of Computerised Case Registers in the Follow-up Studies PL 480, a project financed by US DHEW NIH.

From 1981-1986, she was Epidemiology Specialist with the Chronic Disease

Service, Institute of Public Health of Croatia. From 1981-1989, she was Coordinator of a five-year national health care measures programs, and an additional one-year implementation program. From 1986-1991, she became Head of the Psychiatric Registration Unit of the Chronic Disease Service, Institute of Public Health of Croatia. From 1991 to 2000, she was Head of the Chronic Disease Epidemiology Department, Croatian National Institute of Public Health (former IPHC), and from 1991, she was a part-time associate in under and postgraduate training courses at the Zagreb University Medical School.

Between 1993 and 2003, she has been the National Counterpart for the WHO/ EURO 'Smoking Free Europe and European Alcohol Action Plan' for Croatia. She has participated in many other working groups on developing public health in Croatia. She became a 'Primarius' in 1997. Between 2000 and 2003, she became the Head of the Epidemiology Service, Croatian National Institute of Public Health. Between 2001 and 2002, she became Acting Director, Croatian National Institute of Public Health. From 2004, she has been the Head of the Chronic Disease Epidemiology. Service.

She is a member of the Croatian Medical Association—Epidemiology, Public Health and Psychiatric Chapters, a member of the European Committee for Health Promotion Development, a member of the Croatian Atherosclerosis Society and of the Croatian Cardiological Society.

Dr Sladana Ivezic

Dr Sladana Ivezic is an Assistant Professor at the University of Zagreb. She runs the day hospital at the Vrapce Hospital, Zagreb. Together with Professor Urlic, she organises the Annual Conference on Psychotherapy in Psychosis in Dubrovnik. She leads the community mental health centre in Zagreb and is developing programs of training in community psychiatry. She has helped organise the First Croatian Conference on Social Psychiatry in Split, 2004. She represents the Croatian Medical Association in Gamian Europe.

Professor Peter B Jones MSc, PhD, MRCPsych, FRCP, FMedSci

Peter Jones is Professor and Head of the Department of Psychiatry at the University of Cambridge, having been appointed in 2000. Previously, he was Professor of Psychiatry & Community Mental Health in Nottingham and Honorary Consultant Psychiatrist, having moved there from the Institute of Psychiatry in 1995. He is also Special Professor of Epidemiology at the University of Nottingham.

Professor Jones studied neurobiology and medicine in London, and worked in hospital medicine for three years , before moving to the Maudsley Hospital. Alongside clinical psychiatry, he developed an interest in researching the causes of psychosis. He studied epidemiology at the London School of Hygiene & Tropical Medicine, and was appointed Consultant and Senior Lecturer at the Institute of Psychiatry and Maudsley Hospital in 1993.

His clinical work is in general psychiatry, particularly with people with psychosis. His research includes the early life causes of adult mental illness with collaborations with birth cohort samples in Finland and the UK, mental health links across the life course, ethnicity and mental illness, treatment trials in psychosis and the interface between the social and biological understanding of mental health and illness, including G-E interaction. He is co-director, with Ed Bullmore, of the CAMEO Early Intervention Service in Cambridge, and a

non-executive director of Cambridgeshire & Peterborough Mental Health Trust.

Dr BS Mani
Dr Mani is an SHO at Bedfordshire and Luton Partnership Trust.

Dr Sanja Martic-Biocina MD, MSc
Dr Martic-Biocina is a Consultant Psychiatrist in the First Psychotic Episode Ward at the Vrapce Psychiatric Hospital in Zagreb, Croatia. She is also consultant to the first voluntary club for carers of people with serious mental illness in Croatia.
She qualified from the University of Zagreb in 1985, and in 1992 obtained an MSc in Biology and Biomedicine. She is trained in Transactional Analysis, Balint Groups, Family Psychotherapy, Biofeedback and Neurolinguistic Psychotherapy. She trained at the Institute of Psychiatry [London] in family work in schizophrenia. She has published many articles in scientific journals and books.
In 1992, she visited mental health units in Cambridgeshire and Huntingdonshire in the UK, and she has more recently visited the Early Intervention Service in Luton, Bedfordshire. She is an Honorary Research Fellow of the Bedfordshire Centre for Mental Health Research in association with the University of Cambridge.

Dr Conor McLernon BA, MBBChir
Qualifying at Cambridge University, Conor is a pre-registration house officer with Dr Rashid Zaman, Bedford.

Maggie Nicholls
Maggie is the Senior Clinical Audit Facilitator at Bedfordshire and Luton Partnership NHS Trust.

Dr Ninoslav Mimica MD, DSc
Nino Mimica is a consultant at the University Department of Psychiatry, Psychiatric Hospital, Vrapče, Croatia. He studied medicine at the School of Medicine, University of Tuzla, Bosnia & Herzegovina, and the School of Medicine, University of Zagreb, qualifying in 1987. Between 1987 and 1989, he completed postgraduate study on the natural sciences, biology and biological anthropology, at the University of Zagreb. After his internship, he did a residency in psychiatry at the Psychiatric Hospital, Vrapče, the Clinical Hospital, Sestre Milosrdnice, and the Clinical Hospital, Rebro, Zagreb, ending in 1994. He has attended several international conferences and seminars.
From 1996, he was: Consultant Psychiatrist, Psychiatric Ward, General Hospital, Knin, and an Assistant in Psychiatry, School of Medicine, University of Zagreb. From 2003 to the present, he has been a 'higher assistant' at the same university.
In 1994, he received an MSc from the School of Biology, Biological Anthropology, University of Zagreb with the thesis: 'Comparative study of patients with catatonic type of schizophrenia and other schizophrenics in a representative sample of Croatia'. In 2004, he received a DSc from the University of Zagreb with the thesis: 'Study of catatonic and paranoid schizophrenia based on long-term follow-up'. In 2002 and 2004, he received Senior Scientist awards at the 11th and 12th Biennial Winter Workshop on Schizophrenia, Davos, Switzerland.
He is a mentor for medical students for Zagreb University, and he holds several research grants. He has published extensively in the field of functional psychosis.
He is a member of numerous scientific organisations, including: the Croatian

Medical Chamber; Department for Psychiatric Research; Croatian Institute for Brain Research; Centre for Forensic Psychiatry; Croatian Medical Association; Association of European Psychiatrists (AEP); World Federation of Societies of Biological Psychiatry (WFSBP); Croatian Psychiatric Association; Croatian Association for Clinical Psychiatry; Croatian Association for Biological Psychiatry and Psychopharmacology; Croatian Association for Clinical Pharmacology and Therapy; Croatian Association for Neuroscience; Croatian Association for Forensic Psychiatry; Croatian Association of Court Experts; Croatian Association of Experts and Expert Witnesses; Croatian Anthropological Association; Croatian Association for Medical Anthropology; Alzheimer Disease Societies, Croatia; Alzheimer Disease International (ADI).

Dr Lilijana Oruc MD, PhD

Lilijana Oruc is Associate Professor in Psychiatry at the University of Sarajevo. She qualified in medicine at the University of Sarajevo in 1980. She completed her training in neurology and psychiatry in 1985. She completed a master's thesis and subsequently took a PhD at the University of Antwerp, Belgium. From 1993 until 1997, she was the Head and Founder of the Department for Stress Related Disorders at the Psychiatric Clinic of the University Clinical Centre in Sarajevo. She is now Head of Department for Psychiatric Genetics at the Psychiatric Clinic of the University Clinical Centre in Sarajevo.

Dr Charles Pace

Charles Pace joined the University of Malta as lecturer in social policy, having been Principal Psychiatric Social Worker, then Principal Social Worker in Malta's Health and Welfare Departments. His PhD thesis attempted to develop a framework for a methodology in the adaptive transfer of policy and good practice to new contexts, taking as case study the adaptation of UK concepts of mental health community care to Malta's needs and realities. In 2003, he was local organiser and co-chair of 'Psychiatric Care Across Cultures', a conference week that took place in Malta under the auspices of the Transcultural Psychiatry Section of the World Psychiatric Association and the University of Malta.

Dr Eva Pálová MUDr, PhD

Eva Pálová is currently the head of the Ist Department of Psychiatry, University of P.J. Šafárik in Košice. She has an appointment at the Department of Psychiatry of Komenius University in Martin in 2003-2005. She was working as an Assistant Professor at the Department of Psychiatry, University of P.J. Šafárik, Košice, in 1988-2003.

She received her PhD in clinical psychiatry (OCD) from Komenius University in Bratislava in 2000. She passed 1st grade and 2nd grade qualification examinations in psychiatry at the Institute for Postgraduate Education in Bratislava (1985 & 1992 respectively).

She graduated with the degree of MUDr (MD) from the Faculty of Medicine, University of P.J. Šafárik in Košice.

She is actively involved in a range of clinical, administrative and policy related activities and is one of the co-authors of the National Program for Mental Health Care in Slovakia (2004) – writing a chapter on the quality of psychiatric health care. As a chief-psychiatrist in Košice´s region, she is providing consultations to regional council and management on the current development of the mental health care system in the whole region of Košice, focusing on community services.

She has been a vice-president of the Section of Psychiatry of UEMS since April 2005 (representing Slovak Psychiatric Association), a vice-president of Slovak Psychiatric Association (since 2002), and is a past -president of the Slovak Psychopharmacological Society (1997-2002).
She is author and co-author of several chapters and articles mostly in the area of clinical psychiatry and psychopharmacology, and a frequent speaker on a national and international level on various issues of transformation of psychiatry in Slovakia (pros and cons).

Dr Albert Persaud
Albert Persaud has been a distinguished campaigner for better health for people from Black and Minority Ethnic communities for over 25 years. He started in the NHS and worked in a variety of clinical settings, management, research, training and policy development in mental health and public health. He joined the Department of Health's Mental Health Policy Branch four years ago, and is one of the principle architects of Inside / Outside—Improving Mental Health Services for Black and Minority Ethnic people. He led the development of the perinatal section of the Women's Mental Health Strategy and contributed to the development and consultation of the Mental Health Bill.
Albert Persaud was a core member of the group that established the National Institute for Mental Health in England (NIMHE) and currently leads the NIMHE East Midlands program on the Mental Health Act, Traditional Medicines, and International Mental Health, as well as being a strategic advisor on the national anti-stigma campaign.
He is a recent member of the Mental Health Act Commission and has been a Trustee for the Long Term Medical Condition Alliance [LMCA], Acting Vice-Chair of Depression Alliance [DA], a founder member of Primary Care Mental Health Education [PRImhE], and a Board Member of the Global Alliance for Mental Health Advocacy Networks—Europe [Gamian-Europe].

Dr Narcisa Pojskić MD
Narcisa Pojskić graduated from Medical School at the University of Sarajevo in 1987. As a general practitioner, she was involved in different mental health projects in Bosnia and Herzegovina. Since 1996, she has worked at the Psychiatric Clinic, Clinical University Center, Sarajevo, where she specialised in neuropsychiatry in 2000. Currently, she works at the Out-patient Department at the Clinic, as a psychiatrist.
Dr Pojskić completed post-graduate studies at the Medical School, University of Sarajevo. She finished her work for a Masters degree in the field of psychiatric genetics. At the moment, she is working on her Doctoral thesis on Post-traumatic Stress Disorder.
She is engaged in several international projects and clinical studies at the Psychiatric Clinic, Sarajevo. Dr Pojskić is a secretary of the Psychiatric Association of Bosnia and Herzegovina. She has published several articles on a national and international level.

Dr Paddy Power MB, BCh, DCH, MRCPsych, FRANZCP, MD
Dr Paddy Power trained in psychiatry in Ireland and Australia. He joined the Early Psychosis Prevention and Intervention Centre [EPPIC] in Melbourne in 1993 and in 1998 became the Deputy Medical Director of this service [now the Mental Health Services for Kids and Youth-Youth Program]. He is now Lead Consultant Psychiatrist at the Lambeth Early Onset [LEO] Service, South London & Maudsley NHS Trust, and

Honorary Lecturer at GKT & Institute of Psychiatry in London.
Following his move to London in 2000, he established an early intervention in psychosis service [the Lambeth Early Onset Service]. This service now includes a community follow up team, first episode in-patient unit, and an early detection & crisis intervention team. It is also linked to a prodrome research team developed by Professor Phil McGuire, Institute of Psychiatry. Three of these four programs have been established through research and development [R&D] grants that incorporated randomised controlled trials as part of their evaluation.
Dr Power is also the Lambeth R&D Lead, Chair of the London Early Intervention Network, a member of the London Mental Health Research Network Committee and the Department of Health National Early Intervention Taskforce Group.
Dr Power's research interests and publications have included outcome evaluation of early psychosis services in the UK and Australia, which included a randomised controlled trial of an early detection service, treatment adherence and mental health law in psychosis [the subject of his MD thesis], and suicide prevention in psychosis—this included a randomised controlled trial of cognitive oriented therapy for suicidal youth with first episode psychosis.

Mandy Quarmby
Mandy is the Clinical Audit Manager at Bedfordshire and Luton Partnership NHS Trust.

Dr Maja Silobrcic Radic MD
Maja Silobrcic Radic is Head of the Mental Disease and Disorder Prevention Department, Chronic Disease Epidemiology Service, Croatian National Institute of Public Health.
She qualified from the University of Zagreb Medical School in 1985. By 2000, she completed her specialisation in Epidemiology, having carried out postgraduate studies in epidemiology, and participated in various seminars. At present she is doing her PhD Study in Biomedicine and Health Sciences.
In 1996-98, she participated in the genetic-epidemiological study of DNA markers linked with schizophrenia, in Croatia. In 2001, she participated in the WHO project: European Health Interview Survey. From 1986-96, she was an MD in General Practice. From 1996-2000, she was MD with the Chronic Disease Epidemiology Department, Croatian National Institute of Public Health (CNIPH). From 2001 to date, she has been Epidemiology Specialist with the Chronic Disease Epidemiology Department, CNIPH. From 2001-2003, she was Head of the Mental Health Promoting Unit with Case Registries—Chronic Disease Epidemiology Department, CNIPH, and from 2004 to date, she has been Head, of the Mental Disease and Disorder Prevention Department, Chronic Disease Epidemiology Service, CNIPH.
Her areas of interest are the epidemiology of mental and behavioural disorders, mental health promotion and mental disorders prevention programs, epidemiology of self-inflicted violence, risk factors and prevention programs.
She is a member of the Croatian Medical Association, and the Chapter of the Croatian Association of Epidemiologists.

Dr P Rajamani MBBS, MS, MRCPsych
Dr Rajamani is a Staff Grade Psychiatrist in Adult Psychiatry, Biggleswade, BLPT.

Dr Norman Sartorius MD, MA, DPM, PhD, FRCPsych.
Dr Norman Sartorius obtained his MD in

Zagreb (Croatia). He specialised in neurology and psychiatry and subsequently obtained a Masters Degree and a Doctorate in psychology (PhD).
Dr Sartorius joined the World Health Organisation (WHO) in 1967 and soon assumed charge of the programme of epidemiology in social psychiatry. He was also principal investigator of several major international studies on schizophrenia, on depression and on health service delivery. In 1977, he was appointed Director of the Division of Mental Health of WHO, a position which he held until mid-1993. In June 1993, Dr Sartorius was elected President of the World Psychiatric Association (WPA) and served as President-elect and then President until August 1999. In January 1999, Dr Sartorius took up his functions as President of the Association of European Psychiatrists (AEP). Dr Sartorius holds professorial appointments at the Universities of Geneva, Prague, Zagreb and at several other universities in Europe, the USA and China. He is a Senior Associate of the Faculty of the Johns Hopkins School of Public Health in Baltimore.
Dr Sartorius has published more than 300 articles in scientific journals, co-authored several books and edited a number of others.
Dr Sartorius is an Honorary Fellow of the Royal College of Psychiatrists of the United Kingdom of Great Britain and of the Royal Australian and New Zealand College of Psychiatrists, a Corresponding Member of the Spanish Royal Academy of Medicine and of the Medical Academy of Mexico, a Doctor of Medicine, *Honoris Causa,* of the Universities of Umea and of Prague, a Doctor of Science, *Honoris Causa,* of the University of Bath, and a Distinguished Fellow of the American Psychiatric Association. He is an honorary member of numerous professional associations and advisory boards, both national and international. He is also a member of editorial and advisory boards of many scientific journals.
He speaks Croatian, English, French, German, Russian and Spanish.

Dr Swaran P. Singh MB BS, MRCPsych, MD, DM
Swaran P Singh is a Senior Lecturer in mental health and Head of Social and Community Psychiatry Research at St George's Hospital Medical School, London. He runs the newly established ETHOS Early Intervention in Psychosis Service in South West London. His research interests include epidemiology and outcome of first episode psychosis, cultural and ethnic influences in mental health and health service evaluation.

Dr Ian Soosay
A Specialist Registrar and Hon. Lecturer in General Psychiatry, University College, London, Dr Soosay worked for WHO Indonesia from July 2005 to October 2005 as part of the mental health team and was based in Banda Aceh, Indonesia.

Ingrid Steele
Ingrid Steele is Director of Communications and Knowledge Services at the Care Services Improvement Partnership (CSIP) in England. CSIP is a new organisation, which is part of the Department of Health. Our main goal is to support positive changes in services and in the well-being of children and families, with the health and social care needs of older people, people with mental health problems, learning disabilities, physical disabilities and those in the criminal justice system. Ingrid's areas of responsibility include communications,

anti-stigma and discrimination, information and informatics, and knowledge management. The National Institute for Mental Health in England (NIMHE) is a main part of CSIP. Prior to working with CSIP, Ingrid was Director of Programmes and Communications at NIMHE from 2002-2005, where she was responsible for setting up NIMHE's 10+ national work programmes, including a mental health research network and equalities programme. During 2001-2002, Ingrid worked as part of a small team to set up NIMHE as a devolved organisation, including its eight development centres and small central team. Overall, Ingrid has worked in various national, regional and local roles in health and social care in the statutory and voluntary sector for about 10 years. Before joining the NHS, Ingrid worked for several years in marketing and business development in industry, in the car industry, education and nuclear power in France. Her job title is Director of Communications and Knowledge Services.

Dr Vesna Švab MD, PhD

Born in 1959, Ljubljana, Slovenia, Vesna Svab is a psychiatrist at the University Psychiatric Hospital, Assistant Professor at the Medical Faculty, University of Ljubljana, Head of the Clinical Department from 2004 and Founder and President of the Slovene Association for Mental Health (ŠENT) from 1995, conducting publishing, education, research and promotion in public. She completed postgraduate study on mental health in the community in Great Britain in 1992.

She lectures at the Faculties of Medicine, Pedagogy and Law, and on postgraduate courses for psychiatrists and psychologists.

With ŠENT, she has been organising education for patients and relatives of patients with severe mental illness and conducting the experimental education program for the staff working with people with severe mental disorders in the community.

She has organised several conferences. She has lead and participated in several studies on psychosocial rehabilitation and outcome in schizophrenia and other severe mental disorders, especially regarding the effectiveness and quality of work in non-government mental health services.

She is involved in several international projects regarding community care.

Professor Ivan Urlic MD, PhD

Ivan Urlic is a neuro-psychiatrist, psychotherapist and group analyst. He is Associate Professor of Psychiatry and Psychological Medicine, University of Split, and founder member, training analyst and supervisor of IGA Zagreb and IGA Bologna. He is a member of the management committee of the Group Analytic Society in London, and was chairman of E.G.A.T.I.N. His special interest in groups led him to study the application of group analytic principles to groups of war veterans with PTSD and people with psychosis. With regard to his long experience of using the psychodynamic approach with patients who have a psychosis , he co-organises the annual International School of Psychotherapy of Psychoses in the Inter-university Centre in Dubrovnik, Croatia. He is the author of many articles and book chapters in Croatian, English, German and Italian Languages.

Dr Svetlozar Metodiev Vassilev

Svetlozar Metodiev Vassilev graduated in 1994 with the Diploma in Medicine, Medical University, Sofia. In 2000, he received the Diploma in Clinical Psychiatry, Medical University, Sofia. From 2001 he has been undergoing

training in Psycho-analysis at IPA.
From 1994 to1998, he was a psychiatric resident in the Social Psychiatry Department, University Hospital, Sofia. From 1995 to 1998, he was project manager for 'Development of education and care programmes for police officers in Bulgaria' with New Bulgarian University. From 1998 to 2001, he was project manager for the 'Early Detection and Prevention of Psychosis', Mental Health Care Centre, Sofia, Bulgaria. From 1999, he has been Director, Mental Health Care Centre, Sofia, Bulgaria. From 1996 to 1999, he was Honorary Assistant, reading a seminar on Object Relations Theory at New Bulgarian University, Sofia. From 1997 to 1999, he was a lecturer at the Free University, Burgas. From 1999, he has been an Assistant Professor of Psychiatry., New Bulgarian University.
His interests include: community psychiatry—development of care programmes; prodromal and early psychosis; psychic trauma—dimensions, consequences and treatment; psychoanalysis and psychotherapy.
He is affiliated with the International Early Psychosis Association, The Association of Reformers in Psychiatry, the Bulgarian Association of Psychiatry, and the Bulgarian Association for Psychotherapy and Psychological Counselling.

Dr Rashid Zaman BSc(Hons), MB BChir (Cantab), DGM, MRCGP, MRCPsych.
Dr Rashid Zaman works as Consultant Psychiatrist in Bedford (BLPT) and in the Department of Psychiatry, Cambridge University.
He graduated in Medicine from Cambridge University and after General Practice training, received psychiatry training at Charing Cross & St Mary's hospitals, London.
Prior to appointment in Bedford, he worked as lecturer at Imperial College, London.
He has authored Churchill's Pocketbook of Psychiatry and several academic papers in peer reviewed journals.
He has a number of research interests including: Transcranial Magnetic Stimulation, Early Intervention in Psychosis and Biomarkers in Psychiatry.
He is co-director (with Professor Peter Jones) of the Bedfordshire Centre for Mental Health Research in association with University of Cambridge (BCMHR-CU), which also organises annual international conferences on mental health.
His other roles include: clinical tutor, Royal College of Psychiatrists; vice-chair of a Drugs and Therapeutics Committee; a member of a Research Governance Approval Group and the Bedfordshire Local Ethics Committee (LREC); a member of the East Anglian basic & higher training committees, BPPA and South Asian Health Foundation. He is also MB examiner for the University of Cambridge.

Dr Shahid H Zaman PhD, MRCP, MRCPsych
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