Psychiatry, human rights and social development: progress on the WPA Action Plan 2017-2020

Activities are underway on several fronts to bring the WPA Action Plan 2017-2020 to fruition. While human rights and social development are front and centre in our activities, this is also a period of change and institutional strengthening for WPA. The WPA website is revamped to suit contemporary uses, communications with Member Societies and other components of WPA are modernized, public service materials more readily accessed, and the early career psychiatrists in our ranks are making good use of the leadership opportunities offered to them[1,2]. The management of WPA Congresses has changed to serve a diverse and growing membership across the world regions. The signature change is the annual convening of the World Congress of Psychiatry, bringing world psychiatry to each region in turn.

At the same time, we are making progress with significant initiatives to advance a range of strategic mental health and professional objectives, as anticipated in the plan and described in previous reports[3-5]. One of these objectives is successfully positioning psychiatry as a partner in improving mental health for young women and men in adversity. Our aim is twofold. We wish first to engage with groups previously in limited contact with psychiatry, and second to provide opportunities for those psychiatrists interested to participate in this community-oriented work. Evidence and experience from post-disaster and emergency settings provide a framework for action with the young people. We continue this work in partnership with citiesRISE and thereby link psychiatry more fully to social development – to achieving the UN Sustainable Development Goals – and to the sources of support for that work[5,6].

The work is proceeding on establishing a service user and family carer advisory group to the President[4], extending WPA's sustained interest in best practices in working with service users and family carers. The Lancet-WPA Commission on depression[7] continues its work. I am indebted to Prof. Mario Maj, who has agreed to chair one of the four writing groups. Following review and discussion of a preliminary document at its third meeting in mid 2019, the Commission is formulating recommendations to be published and disseminated in coming months.

In another initiative, the Executive Committee has approved plans, supported by the Standing Committee on Ethics and Review, to establish a taskforce on minimizing coercion in mental health care. The WPA is working with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) on this topic, leading to a joint project linked to the activities of the taskforce. This joint initiative emerged from a desire on both sides to test and demonstrate a stronger role for psychiatry in implementing the positive provisions of the United Nations Convention on the Rights of People with Disabilities (CRPD).

While continuing to advance the importance of the range of matters associated with implementing the CRPD, by concentrating on minimizing coercion we have decided to tackle an issue that is most acutely associated with violations of human rights[8]. We also understand that this is a problem manifest in various ways in countries across the world, and recognize efforts to redress these[9]. We believe that there is a paucity of practical and demonstrable approaches, methods and standards that apply to coercion. While recognizing the diversity of views on the subject among mental health professionals, civil society groups and those responsible for public safety, the WPA and the RANZCP see an important need for a clear framework on minimizing coercion and for support for that framework to be built.

The taskforce will conduct its work in two phases. In Phase 1 (Research, development and publication), it will produce a discussion paper on the current situation relating to coercion in mental health care and strategies to reduce and minimize it. The paper will consider how best to discern and support the contribution of psychiatrists and other mental health professionals to implementing the provisions of the CRPD. This will include improved practice, conditions, care and links with community supports in institutional and other settings for people with early-onset and long-standing mental illnesses and disabilities, and their carers. The WPA will send the paper to its Member Societies to request comments and also collect and develop examples of how the recommendations can be adopted in each country.

In Phase 2 of its work, the taskforce will advise on the development of the joint project (Practical resources and implementation). The project will build on the recommendations of the discussion paper to develop practical resources and tools for psychiatrists, and conduct a pilot field work study of these resources in one or more countries.

Through the two phases of work, we are seeking not only to raise the profile and importance of the subject of minimizing coercion, but also to demonstrate, test and validate approaches that can be adopted by mental health professionals and their organizations. Ultimately, we want to build a movement for positive change that achieves enduring benefits for individuals and their families who are receiving mental health care and may be vulnerable to coercion.

To achieve truly global influence, it is very important to invite participation from diverse nations. We will encourage the engagement of people with lived experience of coercion in mental health care, and their family carers, so that the work of the taskforce is informed by perspectives from civil society as well as those of mental health professionals.

Achieving tangible results from the project will rely on maintaining a clear vision of what is feasible and will have the most impact over time. We envisage that the work will represent a transformative step for mental health care in three ways: a) by establishing a strong commitment to and

leadership for a significant improvement in practice on the subject; b) through supporting and building a network of practitioners and those with lived experience of mental ill health and their supporters, in effect a movement for better practice to minimize coercion; c) by developing new materials, testing them and learning from their use in a way that strengthens knowledge on human rights and mental health more broadly, of which minimizing coercion is a central element.

Ultimately, the impact we seek is that an understanding of ways to minimize coercion is developed by mental health professionals internationally, in collaboration with civil society, and that better practices are adopted. As a result, the dangers of coercive practices will also be minimized, and the supports available to people experiencing mental health problems and their families will increase significantly over time.

There are people and groups across countries working actively to promote these and other initiatives that contribute to the common goal of the advancement of psychiatry and mental health for all people. All of us in the WPA leadership welcome comments and engagement from readers and colleagues.

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Evidence and perspectives in eating disorders: a paradigm for a multidisciplinary approach

The WPA Section on Eating Disorders is primarily concerned with the prevention of these disorders, the assessment of their psychopathology and psychiatric and physical comorbidities, the identification of pathways to specialist care, the organization of integrated multidisciplinary approaches to their management, and the promotion of information on evidence-based treatments and strategies to support caregivers and to facilitate treatment adherence and effectiveness.

Eating disorders are complex mental diseases growing on a psychopathological core, i.e. the overconcern with body weight and shape in determining self-esteem, as recently confirmed through network analyses[1]. This psychopathological core also includes maladaptive perfectionism, impulsive traits, dysfunctional emotion regulation strategies, and social cognitive deficits, which lead to a number of abnormal behaviors ranging from extreme diet restriction to uncontrolled overeating with or without purging, vomiting and laxative or diuretic misuse, as well as excessive exercising.

Anorexia nervosa, bulimia nervosa and binge eating disorder are the most well-known eating disorders, although other disorders have been included in the DSM-5. Eating disorder types differ in terms of lifetime prevalence and age at onset, but the peak age at onset of both threshold and subthreshold anorexia and bulimia nervosa occurs during adolescence. In this period, eating disorders are recognized as being the third most common chronic illness[2]. Moreover, they often co-occur with other psychiatric disorders, particularly anxiety and depression, over the lifespan. Hence, they have a considerable impact on personal, family, working and social life. On the other hand, treatment may promote recovery in 40-50% of adult people and higher percentages of adolescents[3].

Eating disorders are marked by a high rate of physical comorbidity[4], with anorexia nervosa reaching the highest mortality rate of all mental disorders. This highlights the need for multiple levels of treatment, including outpatient facilities as well as rehabilitation and hospital units, depending on the severity of the clinical picture. In addition, a multidisciplinary approach, which includes access to physical, nutritional, psychological and psychiatric interventions, is recommended in order to achieve full recovery[5]. Psychiatrists with adequate training and expertise are in the best position to build links with general practice, medical/emergency wards, mental health settings and specialist services. They play a key role in coordinating other clinicians in both diagnosis and treatment processes.

Unfortunately, the current access rate to specialized services is unsatisfactory. Possible reasons for this are the complexity of the pathways to care and the patients' ambivalence towards change or denial of their illness, but also some deficiencies in the transition between adolescent and adult mental health care. The relevance of this issue is higher in eating disorders than in other mental diseases, as there is evidence that early intervention, i.e. in the first three years, yields more favorable outcomes[6].

Trained mental health professionals are essential in addressing these problems through the promotion of educational programs for health care practitioners, which may facilitate knowledge and identification of the disorders, and through support to patients in their therapeutic engagement. For the latter purpose, offering shared decision-making and creating supportive environments may be particularly effective. The application of evidence-based treatments for these disorders is a critical area that needs to be pursued[7], but therapeutic alliance has been identified as a non-specific therapeutic factor that significantly contributes to promoting recovery[8].