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World Psychiatric Association
Institutional Program on Psychiatry for the Person (IPPP)

London Conference on Person-centered Integrative Diagnosis and Psychiatry for the Person

Novartis Foundation, Portland Place, London, October 26-28, 2007

Conference Report

Introduction

The London Conference on Person-centered Integrative Diagnosis and Psychiatry for the Person was co-organized by the WPA Institutional Program on Psychiatry for the Person (IPPP) and the England National Institute of Mental Health, Department of Health, United Kingdom. The Conference Chairs were Profs. Juan E. Mezzich, Bill Fulford and Ihsan Salloum.

The London Conference was opened by Prof. Juan E. Mezzich (WPA President) and Sheila Hollins (Royal College of Psychiatrists President on behalf of the UK Department of Health). The Conference General Rapporteurs were Profs. Vladimir Gasca and Claudio Banzato.

The main body of the Conference Report includes summaries of each session, including key points of the presentation and its ensuing discussion. Appendix A displays the Conference Program and Appendix B the List of Conference Participants.

First Day (October 26, 2007)

First IPPP Progress Report Session

1- IPPP Conceptual Bases Component.

George Christodoulou, Bill Fulford.

The approach to psychiatric diagnosis must be more humanistic, more comprehensive, more holistic and more person-centered. The physician should be more of a "person". This initiative is also consistent with ancient traditions of our discipline and with our aspirations for the future of our field. The need to incorporate rather than neglect technological advances in the field of medicine was pointed out by the presenters. Patients should be the main decision makers in health care. The ethical principles or framework should be taken into very close consideration. The term "Person" was deemed an appropriate term to use for the development of the conference and the IPPP philosophy. Some members warned that any new philosophy should take into consideration the limitations of time constrain imposed by current clinical practice. The challenges between the theoretical and practical aspects of the model should be properly addressed. Human rights should be taken into consideration in our model.

One of the key issues is to avoid depersonalizing the clinician. The focus on the person and his/her issues should be the initial point, followed by the "people" in general and then consideration of modern practice limitations. Attention to the person must not diminishes attention to the community. Interpersonal relationships between the patient and the physician are been neglected often in general medical practice but also in psychiatry care.

The patient needs to be empowered without forgetting the environment. Clinicians, patients and families should be working on a collaborative manner.

2- IPPP Clinical Diagnosis Component
I. Salloum, J Mezzich

First, we need to consider that an adequate diagnosis model is important for achieving a psychiatry for the person. Diagnosis has had traditionally a purely nosological meaning (identifying disorders) but it can also refer to "understanding of the person". Let us remember that diagnosis is a *process.* There has been a long collaboration between WHO and WPA in the field of diagnosis and many meetings have been held internationally to discuss the basis of what this group is now working on. The development of IGDA and GLADP represent the results of previous efforts in the advance of psychiatric diagnosis. GLADP has been well accepted in Latin America. We hope to have the IPPP model and guide ready around 2010.

Reference was made to a significant event that took place during a WPA Conference in Dresden in June 2007. Service user groups that had usually protested against psychiatry decided to partake in the discussions with WPA. This represented a historical moment for the engagement of all stakeholders in the mental health field. There is a plan to continue this dialogue.

The discussion reviewed also in general terms the place of categories, dimensions and narratives, as well as multilevel schemas. The group agreed that there is a need for a classification system that works in the "real world." To serve the patients' needs is the reality test for diagnostic tools.

There are several editorials and other papers published regarding the above topics. They were included in the packages submitted to each participant.

3- Clinical Care Component
R. Montenegro, A. Tassman

Two major general educational curricula have been developed by WPA in past years, one for the training of psychiatrists and another for medical students. There is the plan of updating them and upgrading them with the IPPP approach.

Core competencies must be defined in accordance with a person-centered approach, and a comprehensive approach of the patient's life needs to be considered. Clinicians should be trained according to the integrative diagnostic model.

Interdisciplinary work is very important. We need to foster communication among members of all areas involved in the delivery of care. The philosophy of PID is not only to promote a humanistic approach but also to improve the dialogue between humanism and science.

The group raised concerns on how to organize the work (the specific steps) to approach the above goals. Training programs nowadays tend to promote an education that is "disease-based" and the IPPP initiative needs to address this issue fully.

There is a need to build in critical thinking in our curricula.

We should try to anticipate and to limit negative consequences of the system we are developing.

Second IPPP Progress Report Session

1- IPPP Public health component

H. Herrman, M. Amering

Integrating mental health into public health is a main task of WPA and classification plays a vital place in this effort.

Health policies in the 21st century should be designed with the question in mind: what makes people healthy? Mental health in public health comprises treatment, prevention, rehabilitation and health promotion. One main effort is to strengthen what we already have available.

Several definitions of mental health and poor mental health and their relationship with the environment were discussed by the group.

Current projects/concerns of the public health component include: Chart of person-centeredness of services; promote the person's involvement as user and citizen in creating policy; address the guidelines for nonconsensual treatment situations; and define the role of IPPP in understanding population and personal approaches to promoting mental health.

The recovery model can be very helpful to the development of IPPP. The cultural and international perspective in this component is also of the utmost importance. We can learn from positive approaches in all countries whatever the level of professional resources available.

The cultural and international perspective in this component is of the utmost importance.

2- UK Department of Health Guidance and Links to IPPP

B. Fulford

The main aims of the guidance are to identify a *Shared Vision* of good practice; to raise awareness of the wide variety of different approaches to diagnosis; and to be able to build a mutual understanding of these different approaches in order to get the involvement of users, providers and carers to reach the best way to understand the needs and strengths of individual service users. This approach is being implemented in England, WHO and ICD, DSM and of course WPA-IPPP.

In summary, we have to keep in mind the following: values for psychiatric diagnosis; diversity of values; practical tools; use in policy training and research; the *Shared Vision*, evidence-based and value-based practices as they relate to the shared vision, and evidence-based medicine. It is important to point out that the field of psychiatry is a pioneer in these initiatives.

We need to take a close look to the possible contributions of value-based practices to the assessment of health status (including positive aspects).

3- UK Department of Health Guidance and IPPP User and Carer Perspectives.

J. Wallcraft, L. Duhig, L. Bryant

The person-centered view includes positive aspects of health as key components. The current classifications only emphasize the negative aspects of the person without considering the positive aspects of health. The paradigm of psychiatric diagnosis needs to be replaced, otherwise clinicians will go back to make the same mistakes we do nowadays.

One of the goals of the new model should be to decrease the stigma and the pejorative connotations about patients that are drawn from current systems.

The hierarchy to consider in this model is important, this is in reference to the terms: value, evidence and expertise.

What to do with a diagnosis? which ones to include? What to do ultimately with them? More important than the values themselves, the process is crucial; we reach a diagnosis if the diagnosis works for the patient. The domains to consider for a model can be very complex.

First Session in Designing Person-Centered Integrative Diagnosis (PID)

1- Principles of diagnosis in psychiatry and general medicine

I. Salloum, M. von Cranach

It is important that each of us think of how do we react to the concept of diagnosis. Diagnosing is not only identifying but also understanding. Health is not the absence of disease. The definition of diagnosis continues to evolve, now is a partnership approach, the process has become more important.

The three areas to consider are: domains, evaluators/partners and measures.

How to structure the model? Structures, validating criteria, evaluations.

A very important principle of diagnosis to consider is that of empathy which allows us to understand the patient. That understanding is the basis of the therapeutic process. Two approaches are in play: the disease-based and the person-based.

What are the advantages of this new model? How can we convince our colleagues of this need?

The advances in genetics and mental illness make the need for comprehensive diagnostic models even more important. The models implemented or created in other specialties due to the advances in genetics can be of help to this psychiatry model.

The diagnosis that we are proposing is "information building", which means we get all the data relevant to the patient in order to understand him or her. This information including nosological diagnosis will help in the implementation of the care plan. Once again, the limitations of current policies and allocation of resources including *time* are to be carefully considered.

Some argued that there is a concept of dualism in Jaspers' tradition that in a way by the mere fact of being just dualistic limits the approach to diagnosis. Others stressed that we need to use the positive aspect of Jaspers' approach in order to help us understand what we are trying to accomplish in this new model, without blindly following it.

One of the problems that we might be facing is that we have not being able to integrate the psychodynamic with the biological aspects of mental illness, which has been posited as the reality of psychiatry in the United States.
The attitude of the clinician is very important, even more than the allocation of resources.

2- Critical evaluation of current diagnostic systems

C. Banzato, B. Fulford

Most diagnostic categories have not been validated. The current classifications contain problems in the taxonomy of disorders and in the diagnostic core itself.

Naturalistic versus pragmatic framework for the design of classification was discussed.

Diagnosis should have precedence over classification.

The advances in information technology have made patients aware of classification systems and they report to clinicians according to what they have read.

The person-centered approach must be a very scientific one not a loose, disjointed one.

There has been a discussion on the issue of *power* in developing diagnostic systems. The group stressed that it should not be the psychiatrist competing with the psychologist, or about which organization takes over the best system first, but rather that the patient and his or her wellbeing should matters most.

However, the role of the user should not limit the impetus of the professionals working for better mental health.

We need to understand that all systems are tentative and temporary, that is their nature.

3- Desirable goals and perspectives for PID
J. Mezzich, J. Marsh, R. Cloninger.

The concept of *of, for, by* and *with* the person was explained.

The strategy of PID includes the following features:

Humanism is the core of psychiatry, science is the tool.
The framework is bio-psycho-social-cultural
It utilizes all pertinent descriptive tools and Structures
It includes, in partnership, all key evaluators: patients, clinicians, family, etc.

The timelines for the development were outlined starting with the design of the theoretical model being conducted as we speak, and expecting completion of the guide or manual around 2010, and implementation and training in the years that follow.

Second Session in Designing Person-Centered Integrative Diagnosis (PID)

1- Principal content domains of a PID model
T. Sensky, M.Botbol, G. Christodoulou

The concept of personhood by Eric Cassell explains the interactions of body, self, person and the experiences that fall under each of those conceptualizations.

Sense of *Coherence* by A. Antonovsky is composed of three facets: comprehensibility, manageability, meaningfulness. People who posses these three are usually healthy and cope better. Coping is also a multilevel experience.

Spirituality is a crucial domain but there is a great deal of variety within this concept. An issue is what to do with the non-believers?

Listening in the dyad patient-clinician plays a crucial role in the therapeutic alliance.
The list of variables to look at for the PID includes personhood, personal illness models, sense of coherence, coping, finding meaning, spirituality, personal growth, suffering, and personal narrative. Other members point out that quality of life, functioning, resources and disability should be also considered. Sense of coherence includes resilience but it also could be considered separately.

The above list may need some simplifications and clarifications. Some argue that following the above list will help the clinician and the patient to identify areas of strength.

Previously PID has contemplated in its development that the important domains to consider are: Illness, disabilities, resources and quality of life.

An integration of the two above sets of suggestions should be helpful.

What dimensions should be considered as the psychological basis of mental disorders?

Conflict between objectivity and subjectivity in psychodynamics, and between classification systems and clinical diversity were explored. Holistic subjectivity is a difficult goal to reach but it may be very valuable.

Are narratives the only way to address the person part of the diagnosis? What about categorization and multiaxiality? Are we merely extending the multiaxial classification by adding narratives?

Narratives involve input from the clinician, the patient and the encounter itself.

Second Day October 27, 2007

Second Session in Designing Person-Centered Integrative Diagnosis (PID) (Continuation)

2- Broad methods for a PID model
R. Cloninger

The structure of PID may contain (using an approach to personality disorders) 3 learning systems: Habits, Propositions, Narrative perspectives. 5 layers of personality: sexual, material, emotional, intellectual, spiritual. 3 levels of self-awareness: egocentric, allocentric, holistic.

We need to pay attention to three character dimensions: self-transcendence, cooperation, self-directedness.

An important reference to look at is the organization of a government: executive, legislative and judicial.
The PID model should be based on human relationships.

It is possible to consider the levels of personality disorders.

The group discussed the need for schemes in classification. Also the concept of *self* is important.

3- General classification and diagnosis of psychopathology, including possible use of dimensions and narratives.
I. Salloum, C. Banzato, M. Abou-Saleh

Psychopathology within PID will possibly use the best classification of diseases, expectedly ICD-11.

Enhancing the clinical relevance of diagnostic models is a key factor.

Comorbidity and multimorbidity should be considered as well, for example their causative relationships.

The Chinese classification has seven axes, the last one is used to describe the relationships among other axes.

How can biological variables truly inform a valid psychiatric nosology? There isn't a single reliable biological marker that can be used at this time for diagnosis. There are several publications that address tentatively the biological measures (including images) for bipolar disorder, schizophrenia.

There is a modular approach to classification that contains six modules. Endophenotypes may be helpful. Biological markers have limited value as diagnostic criteria.

The group asserted that the new model needs to articulate science and humanism at all levels.

Some participants argued that historically classification systems have failed to prove their validity, but we continue to think that we can cluster psychiatric disorders in a "natural" way that in reality may not exist.

A clarification was suggested that clinical validity and utility are somewhat different concepts.

Third Session in Designing Person-Centered Integrative Diagnosis (PID)

1- Classification and diagnosis of psychopathology in primary care and general health.
R. Jenkins, W. Van Staden, L. Gask

Location of disease is a high order classificatory determinant for most ICD chapters. For mental disorders, the mind is seemingly taken as such location, but is the mind such to qualify as a location, for the question remains: where is the mind?

To locate disease is to "zoom in". For mental disorders, zooming in on a proper location would suggest a proposal such as "Disorders of Higher Brain Functions"

Crucially, PID needs to "zoom out" (holistically) as well, not only for psychiatric disorders but parallel to any diagnosis. The challenge is to zoom-out in a classification system, if attainable at all. A parallel (zooming out) chapter in ICD may be on "Person Centred Health Diagnosis" in which is captured personal health dimensions and contextual-environmental health dimensions. The personal health dimensions may include the experience of heath status; individual resources, functioning and limitations; substance use choices; personal identity and social preferences; and personality patterns. Contextual-environmental health

dimensions may include adverse life events; social circumstances; occupational and economic circumstances; and environmental living conditions.

In primary care people presents with an undifferentiated mix of physical, social and psychological problems.

A model for primary care should contain meaningful and simple categories and use a dimensional assessment of severity.

The fact that the group meeting this time in London has limited representation from important parts of the world is a concern.

Most people in the real world are treated in primary care and this should be a main focus of attention of any model.

The challenge of time available in some settings (developing countries) posits a major factor to consider.

A system with tiers that is able to address the realities of current practices is important.

The model offered by IGDA has in a way addressed this issue and we can look at it for PID.

2- Disabilities and functioning
L. Salvador, V. Gasca, R. Williams

Apart from WHO/DSM models there are other disability models such as the system based on Activities of Daily Living (ADL). This approach, which is focused mostly in the assessment of mobility and self care, had a great impact on the development of dependency assessment in Europe and it underscores those domains of disability impaired in mental disorders. It is necessary to make an effort to transfer the knowledge base on disability from the mental health sector to the general health sector and, at the same time, to adapt the psychiatric formulation of disability to general health care. A special focus should be provided to the formulation of MH related disability in primary care, where the needs and efficiency of assessment are different from the specialized MH sector.

Disability/functioning as part of the IPPP model. Patient's input needed to design a comprehensive diagnostic model: disability/functioning should be incorporated into this model. Develop a WPA framework and operational terms. Selection of instruments (GAF /WHODAS-II). The psychometric properties of any disability measure should be tested in mental health.

3- Positive health
R. Cloninger, M. Amering, H. Herrman

How do we measure wellbeing?
Definition of mental health by WHO.
QOL measures are complementary.
WHOQOL is available in a short version and a comprehensive one.

The recovery model is somehow similar to what QOL and Wellbeing address. Some diagnosis imply that you are not working in the same way that other people do and that is a problem with current diagnostic systems.

PID must focus on positive aspects of life goals and learning. It also needs to look at protective factors, insight and judgment. Importance of self-awareness for the sense of happiness. Resources initially external need to be internalized for the sense of recovery and healing.

A key point is the fact that we do not ask enough about our patients' functioning and goals.

The concepts of humble spirituality and hope were discussed. These concepts are important not only for the patient but also for the clinicians.

Fourth Session in Designing Person-Centered Integrative Diagnosis (PID) and Links to the DH Guidance.

1- Descriptive tools

J. Saavedra, D. Lecic-Tosevski, T. Thorton

The current systems have many problems with their categorical formulations. We believe that categorical and dimensional approaches can complement each other. The principles of psychiatry for the person are being implemented at the National Mental Health Institute in Serbia.

The tools to use in PID must address the reality of the community, they have to be efficient.

IGDA's idiographic formulation has been tested in Peru by Dr. Saavedra, it has provided very helpful information to the clinicians, with reasonable applicability and time use.

Is the idiographic formulation and narratives the same? Some argue that not and that PID should go for narratives and forget the idiographic part. How idiographic formulation proves its validity, is it impossible?

Others point out that both idiographic and narrative parts are helpful. Idiographic formulation would help to establish the connection between the clinician and the patient. A compromise between the two approaches could be sought. The group remembers the contrast between the lengthy process of a narrative and the time constrains of current practices.

We have to remember the issue of subjectivity in the narrative process.

2- Structural Schemas (unilevel and multilevel)

K. Schaffner, L. Kuey

Reductionistic unilevel approaches if looked at closely are in reality multilevel. The approach for PID must be multilevel. Prototypes are not sufficient in the psychiatric field, but can be very helpful. In addition to the biopsychosocial model, we should look at the McHugh & Slavney's multi-perspective approach, which includes: disease, dimension, behavior and life story.

The IGDA model is also very valuable as it goes beyond previous models. It takes into consideration not only illness but also positive health and individuality.

It is important to keep in mind the need for research oriented PID. PID needs to have treatment specificity and clinical validity.

The work of this group must be modest, honest and respectful of the clinical truth.

The social aspect of the diagnosis is usually not well developed and PID should be pioneer in this effort.

3- Evaluators and their interactions
J. Wallcraft, M. Amering

Clinicians, patients, family, carers and other participants. Interactions and Consensus.

Involvement is empowering to a certain point, but it becomes disempowering when it's not acted on. If there is no commitment behind it, it will not work. That is the case of the minority black community in many countries that is constantly offered improvements that never take place and remain beautifully only on paper.

The new system should foster involvement, empowerment and independence.

"Trialogue", an exercise in communication among consumers, carers and mental health professionals go beyond role stereotypes.

Parallel Session Diagnosis Group I Psychopathology and General Health Classification

Participants: Claudio Banzato, Michel Botbol, Vladimir Gasca, Juan Mezzich, Javier Saavedra and Kenneth Schaffner.

It was agreed that a need-based approach should be pursued and that the diagnostic model envisaged should be tiered (that is, with several levels).

The goal is to simplify and at the same time to broaden the diagnosis.

Both domains of ill and positive health should be assessed in standardized and personalized ways.
It was suggested that in addition to the key structures and descriptors of each domain, variables that cut across psychopathology such as suffering and disability should be included in the diagnostic model.

Another suggestion was the use of prototypes along with diagnostic criteria. A few critical prototypes (about 10-15) would be selected for use in primary care for instance and general practice. For more specialized care and research several other prototypes (clustered within a hierarchy) could be provided. In regard to prototypes, Dr. Schaffner mentioned the recent book by Dominic Murphy "Psychiatry in the Scientific Image" (The MIT Press, 2006).

Perhaps prototypes would be better accepted by the users than diagnostic labels and somehow easier to be articulated with narratives. Of course these points should be empirically assessed.

Finally, it was pointed out that the (refined version of the) questions used in the Peruvian epidemiological study by Saavedra for evaluating IGDA's personalized diagnosis would be helpful to flesh out the diagnostic practice recommended.

Parallel Session Diagnosis Group II Positive Health

The focus of this small group included positive health and disabilities. The task of the group was to address the question of how to assess positive health and disabilities.

The process of this small group included two meetings and feedback from a plenary session.

Positive Health, as opposed to Ill Health, is the other major component of the emerging PID dyadic model. The aim of this component is to characterize, as broadly as possible, positive health aspects relevant to the activities of the clinician with emphasis on recovery and health restoration.

The following measurable Domains of Positive Health were considered.

I. Quality of Life (QOL): This includes domains of physical, cognitive, emotional, intellectual, environmental, spiritual well being.

Measurements: There are a number of widely used and easily administered instruments that could be used to measure domains of QOL, including the World Health Organization (WHO) QOL instruments, or Mezzich et al's Multicultural Quality of Life Index.

Since these instruments are intended to facilitate assessments in clinical settings, ease of administration, in addition to psychometric validity, is a key consideration in selecting a scale.

II. Positive Emotions, Character Development, and Strength and Virtues: These include characteristics related to the Person seeking care and encompass key areas of positive health and bases of well being.

It was emphasized that factors that reduce symptoms are not necessarily the same as factors promoting health. The importance of this point should be underscored, so that factors promoting well being are not confused with factors that usually lead to symptoms reductions, although some overlap may exist.

Elements of positive health would include assessment of character traits such as self – directiveness and cooperativeness, responsibility, resilience, resourcefulness, emotionality, other strengths and virtues such as moderation, courage, hope, love, and awareness of life narrative.

Measurements of these domains do exist, however the selection of the most appropriate measurements for these domains remains to be defined.

III. Resiliency was also highlighted as an important component of positive health. The concept of resiliency was considered to be very relevant to hardiness, recovery, and health restoration and merited separate emphasis, although it overlaps with point II above.

IV. Functioning and Disabilities were also included as key domains to be assessed as part of this PID component.

Measurements would include WHO instruments measuring functioning (deficit, restriction, etc; HOODAS –WHOCALL)

Other domains of Positive Health and Disabilities were mentioned which included experience of health status, individual resources, limitation, personality patterns, social activities,

aspiration, and contextual/ environmental factors. The definition of the relationship of domains with each other was also considered to be relevant.

Positive Health Small Group Participants:

(1,2) R. Cloninger (USA) (Chair) clon@tci.wustl.edu
(1,2) I. Salloum (USA) (Secretary) isalloum@med.miami.edu
(1,2) L. Salvador-Carulla (Spain) luis.salvador@telefonica.net
(1,2) L. Küey (Turkey) kueyl@superonline.com
(1) W. van Staden (South Africa) cwvanstaden@icon.co.za,
(1) M. Amering (Austria) michaela.amering@meduniwien.ac.at
(1) V. Gasca (USA) vigasca@aol.com, gascav@nychhc.org
(1) H. Herrman (Australia) H.Herrman@unimelb.edu.au
(1) R. Montenegro (Argentina) rogermontenegro@wpanet.org, rogermontenegro@contener.org
(1) L. Duhig (UK) lu.duhig@dh.gsi.gov.uk
(1) P. Kinderman (UK)

(1,2): Attended both Small Group meetings
(1) Attended 1st session of Small Group Meetings

Parallel Session Clinical Care Group Curriculum Development

Participants in the discussion were Roger Montenegro, Linda Gask, Mohammed Abou-Saleh, Peter Kinderman and Tom Sensky.

This discussion group followed an earlier discussion on 27.10.07 involved the same participants, plus Jan Wallcraft, Rachel Jenkins, Richard Williams and Ken Schaffner. The points below reflect the thinking developed in this first group discussion.

Overarching principles

1. The curriculum should be expressed in terms of competencies rather than learning objectives, reflecting current trends in curriculum development in the UK, the USA and elsewhere.
2. There should be a single curriculum. The needs of different users of the curriculum (e.g. mental health professionals, medical students, primary care professionals) should be accommodated by making the curriculum modular, rather than by devising separate curricula for each group (to ensure that the curriculum itself is integrated rather than fragmented).

3. Initial work will focus on key competencies required by psychiatrists and other mental health professionals, and by medical students. Subsequently, attention will be focussed on the learning needs of primary care clinicians and others.

4. The group acknowledged that it will be important to consider how the curriculum should be implemented optimally. It is likely to be more difficult to introduce the curriculum in settings which already have well-established curricula than in settings where training in mental health care is in the process of being established. Some of the settings or cultures into which we would wish to introduce person-centered integrative diagnosis (PID) might possibly be frankly hostile.

5. In developing the curriculum, it will be important to think globally, and to take advantage wherever possible of existing resources

Key Topics (not in any specific order)

1. Focus on values and value-based practice

2. Partnerships
    - Users
    - Carers/advocates/families
    - Other professions
    - Institutions
    - Society
3. Power relations

4. Social Inclusion
    - Social
    - Economic
    - Personal

5. Cultural inclusion ("the Whole Person in context")

6. Focus on the patient's narrative

7. Person-centered practice (rather than diagnosis-centered)

8. Recovery-focused (rather than symptom-focused or cure-focused)

9. Shared understanding

10. Interactive/collaborative formulation

11. Application of critical thinking skills

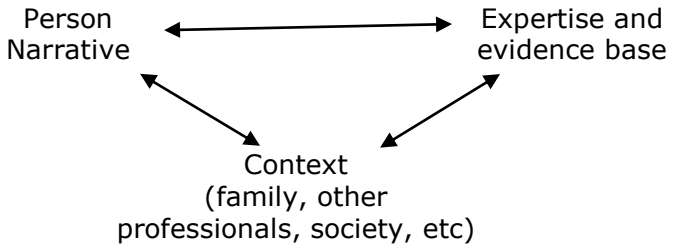
12. Development of appropriate interpersonal skills to support the processes

13. Tolerating and sharing uncertainty (involves confidence and appropriate assertiveness)

14. Appropriate and flexible use of leadership and advocacy

15. Knowledge
    - Evidence base of patient centred care
    - Evidence base of the domains incorporated into PID (including 'gold standards' where these are available)
    - Acknowledgement of the contribution to PID of the expertise of all those involved (including specialist knowledge of different professional disciplines)

16. Integration



17. Zooming in – zooming out
    - Whole Person ⟷ (Individual) problems
    - Need to keep asking at every step – "Why are we (considering) doing this?

Parallel Session Public Health Group

Regarding the current projects of the IPPP Public Health Component

1. Working towards a "Chart" of person-centeredness of services (e.g. cultural sensitivity; complaints procedure).

2. Promote the Person's Involvement as User & Citizen in creating policy and planning and delivering services (professionals' and systems' skills as well as communication and practical circumstances including money).

3. Addressing the situation of the Person in non-consensual treatment situations (incl. the current concerns regarding the use of Involuntary Outpatient Commitment to ensure resources for care) and the expected outcomes of the London IPPP conference.

I. A working group and format for developing a short checklist of what makes a clinical service (system) person-centered

II. Action plan on citizen and service user involvement in WPA, IPPP et al. and the development (or recommendation of existing) guidelines for service user involvement in services and service systems

III. Agreement regarding addressing the situation of the person in non-consensual treatment situations

IV. Consideration of the role of IPPP in understanding population and personal approaches to promoting mental health

The small group session with Helen Herrman, Michael von Cranach and Michaela Amering resulted in the views that:

re I.
The Shared Vision Model is aiming at coming up with essential guidelines for a person-centered approach. This and the work of the IPPP clinical care component should allow the creation of a checklist or charta of person-centeredness of services.

re II.
The Shared Vision approach is a model consistent with the Public Health Component's aim to promote the Person's Involvement as user & citizen in creating policy and planning and delivering services and a very impressive effort that could serve as a model for other countries. The small group discussion also highlighted the big challenge of involving users and carers in all stages of decision processes and the existing difficulties. Even in the UK, where user and carer involvement is mandatory, the actual processes do not always meet the expectations as was highlighted by Jan Wallcraft in this conference. The presentation of the small group discussion in the plenary resulted in an invitation for the preparation of a

WPA position statement on user and carer involvement. To develop such a statement requires wide consultations and the establishment of a project and a proposal for funding.

Desiderata for WPA include

- a skills base on user and carer involvement in research
- tools to involve users and carers in the diagnostic process
- addressing the situation and human and patients' right status of users and carers in situations of coercive interventions
- addressing conflicting interests of users and carers, e.g. confidentiality issues

re III.
There is agreement regarding addressing the situation of the person in non-consensual treatment situations and the view that as long as there is coercive situations in mental health treatment settings a person-centered approach is also valid in these special situations of reduced rights for the person in treatment.

re IV.
Mental health assessment and promotion need tools and skills that are currently not consistently part of the training of mental health professionals and researchers. Cooperation with the IPPP education component should impact on curricula development in this respect.

Final Plenary Session

The London Conference was regarded as quite successful in that virtually all the agenda topics were adequately covered and the main purpose of substantially advancing the design pf the Person-centered Integrative Diagnostic (PID) Model was achieved.

Some adjustments in the Conference schedule were made to follow discussion's leads. These included rearranging the Parallel Sessions on Diagnosis to attend the main domains (Illness and Positive Health) as emerging organizing principles, and addressing the Shared Vision agenda of the UK's Department of Health in the Parallel Session on Conceptual Components. Topics such as Psychiatrist's Identity in Psychiatry for the Person and Person-centered Guidelines for Clinical Care will be attended in future Conferences.

The next IPPP steps, organized by events, will be the Paris Conference on Psychiatry for the Person on February 6-9, 2008 (where we hope to complete the design of the PID theoretical model) and the Geneva Conference on Person-centered Medicine on May 29-31, 2008 (where we hope to launch an extension of our Initiative towards Medicine for the Person). The last day in each of these events will include a special workmeeting of IPPP workgroup members.

APPENDIX A

CONFERENCE ON INTEGRATIVE DIAGNOSIS AND PSYCHIATRY FOR THE PERSON

Novartis Foundation, Portland Place, London
October 26 – 28, 2007

Organized by:

World Psychiatric Association Institutional Program on Psychiatry for the Person (WPA-IPPP)

National Institute of Mental Health (England) and the Care Services Improvement Partnership, Department of Health, United Kingdom

In collaboration with:

WPA Section on Classification and Diagnostic Assessment

WPA Global Consortium of National Diagnosis and Classification Groups

Conference Objectives:

- To review the progress of the IPPP and the UK DH Guidance on Comprehensive Assessment
- To complete the first draft of the Person-centered Integrative Diagnostic Model and other IPPP major tasks
- To provide input and feedback on the UK DH Guidance and its links to the Person-centered Integrative Diagnostic Model
- To delineate future programmatic steps

Conference Chairs:

Prof. Juan E. Mezzich, WPA President and IPPP Chair
Prof. Bill Fulford, Co-Chair, IPPP Conceptual Component & Lead, DH Guidance
Prof. Ihsan Salloum, Co-Chair, IPPP Diagnosis Component

Logistics: Communication of travel plans, accommodation, meals and other logistic issues. For contacting London: jenny.stuart@keystone-group.co.uk, T: 44-14-5383-5626; for New York: juanmezzich@aol.com, mezzichj@nychhc.org, T. 1-718-334-5094

London Conference Program, specific assignments, and materials
Each group of speakers/leaders for a given topic is expected to prepare a power-point and a long abstract/short paper to be submitted to the e-mails listed above by October 18, which along the final Conference Program and a set of selected editorials and papers will compose the List of Conference Documents. These organized Conference Documents will be distributed electronically before and in paper during the Conference.

DAY ONE: FRIDAY, OCTOBER 26, 2007

9:00 am. – 12:30 pm. MORNING PLENARY

9:00 am. Conference Opening

- Welcome: *JE. Mezzich (WPA), S. Hollins (UK Department of Health and Royal College of Psychiatrists)*
- Introduction: *B. Fulford, I. Salloum.*

9:15 am. First Progress Report Session (a total of 15 min for all presentations and 15 min for discussion per topic; in this and all following sessions, the listed persons for each topic are to interact to coordinate a consensus statement to outline the issues, questions, and options and initiate the discussion rather than to give a formal lecture)

- IPPP Conceptual Bases Component:
  - Progress report (based on introductory paper : *International Psychiatry* editorial)
  - Expected conference outcomes (awareness points and supporting materials)

  G. Christodoulou, B. Fulford
- IPPP Clinical Diagnosis Component:
  - Progress report (based on introductory paper: *Acta Psychiatrica Scandinavica* editorial)
  - Expected conference outcomes (awareness points and supporting materials)

  J.E. Mezzich, I. Salloum
- IPPP Clinical Care Component:
  - Progress report (planned curricula for psychiatrists & other MH professionals and for medical students & general practitioners, based on introductory paper)
  - Expected conference outcomes (awareness points and supporting materials)

  R. Montenegro, A. Tasman

10:45 am. Coffee Break

11:00 am. Second Progress Report Session (15 min total presentation and 15 min discussion per topic; in this and all following sessions, the listed persons for each topic are to interact to coordinate a consensus statement to outline the issues, questions, and options and initiate the discussion rather than to give a formal lecture)

- IPPP Public Health Component:
  - Progress report (based on introductory paper)
  - Expected conference outcomes (awareness points and supporting materials)

  H. Herrman, M. Amering
- UK Department of Health Guidance and Links to IPPP:
  - Progress report (based on key summary to be distributed)
  - Expected conference outcomes (awareness points and supporting materials)

  B. Fulford
- UK Department of Health Guidance and IPPP User and Carer Perspectives
  - Progress report (based on key summary to be distributed)
  - Expected conference outcomes (awareness points and supporting materials)

  L. Duhig (CSIP Carer Lead), L. Bryant (CSIP User Lead), J. Wallcraft (IPPP User Rep.)

12:30 pm. Lunch Break

2:00 – 5:15 pm. AFTERNOON PLENARY (15 min total presentation and 15 min discussion per topic; in this and all following sessions, the listed persons for each topic are to interact to coordinate a consensus statement to outline the issues, questions, and options and initiate the discussion rather than to give a formal lecture)

2:00 – 3:30 pm. First Session on Designing Person-centered Integrative Diagnosis (PID)

- Principles of diagnosis in psychiatry and general medicine:
  - Role of diagnosis in medicine and psychiatry, clinically and in public health
  - Meanings of diagnosis: Identification of disorders and appraisal of health.
  - Concepts of diagnostic validity: Etiopathogenic and clinical validity
  - Domains covered: illnesses, disabilities and other health related problems, positive aspects of health (resilience, resources, protective factors, quality of life)
  - Descriptive tools: Classical and probabilistic categorizations, dimensions and narratives.
  - Diagnostic schemas: Uni-level, multilevel.
  - Evaluators involved: Clinicians, patient, family/careers, other participants.

  I. Salloum, M. von Cranach
- Critical evaluation of current diagnostic systems
  - As classification of disorders
  - As full diagnostic statements

  C. Banzato, B. Fulford
- Desirable goals and perspectives for Person-centered Integrative Diagnosis
  - Bio-psycho-socio-cultural framework
  - Diagnosis of health (ill and positive aspects)
  - Informational basis for prevention, comprehensive treatment, rehabilitation, and health promotion.
  - Collaborative and empowering work with patients.
  - Desirable publication perspectives

  J. Mezzich, R. Cloninger, J. Marsh

3:30 – 3:45 pm. Coffee Break

3:45 – 5:15 pm. Second Session on Designing Person-centered Integrative Diagnosis (PID)

- Principal content domains of a PID model:
  - Illnesses and other health related problems.
  - Positive aspects of health.

  T. Sensky, M. Botbol, G. Christodoulou
- Broad methods for a PID model:
  - Structure: unilevel, multilevel.
  - Descriptive tools (categorizations, dimensions, narratives)
  - Evaluators (clinicians, patient, family/carers)
  - Guidelines or manual for practical implementation

  R. Cloninger, M. Von Cranach, J. Wallcraft, B. Fulford
- General classification and diagnosis of psychopathology, including possible use of dimensions and narratives
  - Broad classes
  - Specific classes
  - Possible use of prototypes
  - Addressing comorbidity

  I.Salloum, C. Banzato, M. Abou-Saleh

7:30 for 8:00 pm. Conference Dinner at the Royal College of Physicians

DAY TWO: SATURDAY, OCTOBER 27, 2007

9:00 am – 12:15 pm. MORNING PLENARY (15 min presentation and 15 min discussion per topic; in this and all following sessions, the listed persons for each topic are to interact to coordinate a consensus statement to outline the issues, questions, and options and initiate the discussion rather than to give a formal lecture)

9:00 – 10:30 am. Third Session on PID Design

- Classification and diagnosis of psychopathology in primary care and general health:
  - Chapters of overall classification of diseases
  - Relationship between mental disorder chapter and other chapters
  - Simplified mental disorder classification for primary care
  - Possible multilevel diagnosis for primary care

  R. Jenkins, W. Van Staden, L. Gask

- Disabilities and functioning:
  - Areas of disabilities/ functioning
  - Use of categories and dimensions
  - Global assessment of disabilities/functioning

  L. Salvador-Carulla, R. Williams, V. Gasca

- Positive health:
  - Resilience,
  - Protective factors
  - Resources
  - Quality of life

  R. Cloninger, M. Amering, H. Herrman

10:30 – 10:45 pm. Coffee Break

10:45 am – 12:15 pm. Fourth Session on PID Design and Links to the DH Guidance

- Descriptive tools
  - Categories
  - Dimensions
  - Narratives

  J. Saavedra, D. Lecic-Tosevski, T. Thornton

- Structural schemas (unilevel and multilevel)
  - Traditional prototypical approaches
  - Uni-levels, multilevel.

  K. Schaffner, L. Küey

- Evaluators and their interactions
  - Clinicians
  - Patients
  - Family, careers, other participants
  - Interactions and consensus

  J. Wallcraft, M. Amering

12:15 – 1:45 pm. Lunch Break

1:45 – 2:00 pm. Objectives and structure of the small group sessions
JE Mezzich

2:00 – 5:15 pm. First Small Groups Parallel Session (including short coffee break at 4:00 pm.)

Objectives: Preparation of specific draft proposals: Summary of discussions, recommended options or proposals for theoretical models and practical guide or manual.

- **Diagnosis Group I**
  Psychopathology and General Health Classification:
  C. Banzato, R. Jenkins, M. Botbol, M. Abou-Saleh, R Williams, DH Guidance links
- **Diagnosis Group II**
  Disabilities/Functioning and Positive Health
  L. Salvador-Carulla, R. Cloninger, W. Van Staden, I. Salloum, DH Guidance links
- **Diagnosis Group III**
  PID Procedures and links to DH Guidance (structural schemas, descriptive tools and evaluators)
  K. Schaffner, J. Saavedra, L. Küey, T. Thornton, J. Wallcraft, L. Duhig, L. Bryant, V. Gasca, DH Guidance links
- **Conceptual Developments Group**
  Conceptual Bases Monograph, Psychiatrists Role and Identity
  G. Christodoulou, D. Lecic-Tosevski, B. Fulford, DH Guidance links
- **Clinical Care Group**
  Person-centered psychiatry curricula for the training of psychiatrists and mental health professionals, and for the training of medical students and general health practitioners
  R. Montenegro, T. Sensky, A. Tasman, L. Gask, DH Guidance links
- **Public Health Group**
  Person-centered clinical services and health promotion guidelines
  H. Herrman, M. Amering, M. von Cranach, DH Guidance links

Evening free

DAY THREE: SUNDAY, OCTOBER 28, 2007

9:00 – 10:30 am. Second Small Groups Parallel Session

(Continuation of the First Session)

10:30 – 10:45 am. Coffee Break

10:45 am – 1:15 pm. Final Plenary Session

10:45 am – 12:45 pm. Reports and Discussion of Small Group Proposals

12:45 – 1:15 pm. Timeline, Next Steps and Closing
J. Mezzich, I. Salloum, B. Fulford

APPENDIX B

List of London Conference Core Participants

A. International List

Michaela Amering (Austria) michaela.amering@meduniwien.ac.at
Claudio Banzato (Brazil) claudio@lexxa.com.br
Michel Botbol (France) mbotbol@wanadoo.fr, michel.botbol@wanadoo.fr
George Christodoulou (Greece) gchristodoulou@ath.forthnet.gr
Robert Cloninger (USA) clon@tci.wustl.edu, crcloninger44@gmail.com
Michael von Cranach (Germany) m.v.cranach@t-online.de
Vladimir Gasca (USA) vigasca@aol.com, gascav@nychhc.org
Helen Herrman (Australia) H.Herrman@unimelb.edu.au
Levent Küey (Turkey) kueyl@superonline.com
Dusica Lecic-Tosevski (Serbia) dlecic@EUnet.yu
Juan E. Mezzich (USA) juanmezzich@aol.com
Roger Montenegro (Argentina) rogermontenegro@wpanet.org, rogermontenegro@contener.org
Javier Saavedra (Peru) saavedra@terra.com.pe
Ihsan Salloum (USA) isalloum@med.miami.edu
Luis Salvador-Carulla (Spain) luis.salvador@telefonica.net
Kenneth Schaffner (USA) kfs@pitt.edu, kfs12@comcast.net
Werdie van Staden (South Africa) cwvanstaden@icon.co.za,
Allan Tasman (USA) allan.tasman@louisville.edu

B. United Kingdom List

Mohammed Abou-Saleh (UK) mabousal@sgul.ac.uk
Laurie Bryant (UK) laurie.bryant@dh.gsi.gov.uk
L. Duhig (UK) lu.duhig@dh.gsi.gov.uk
Bill Fulford (UK) pwwf@norcam.demon.co.uk
Linda Gask (UK) linda.gask@manchester.ac.uk
Sheila Hollins (UK) shollins@rcpsych.ac.uk
Rachel Jenkins (UK) r.jenkins@iop.kcl.ac.uk
Joan Marsh (UK) JMarsh@wiley.co.uk
Tom Sensky (UK) t.sensky@imperial.ac.uk
Tim Thornton (UK) TThornton1@uclan.ac.uk
Jan Wallcraft (UK) loujan03@yahoo.co.uk, jan@survivor.demon.uk
Richard Williams (UK) rjwwilli@glam.ac.uk
Glenn Roberts (UK) glennroberts@scriptorium42.wanadoo.co.uk
Peter Kinderman (UK) p.kinderman@liverpool.ac.uk
Pat Bracken (UK) Pat.Bracken@mailp.hse.ie
Denise Bobb (UK) denise.bobb@londondevelopmentcentre.org