

Section on International Organization Perspectives on Person-centered Medicine

World Federation for Mental Health perspectives on person-centered medicine

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What is the World Federation for Mental Health?

The World Federation for Mental Health was founded in 1948 at the same time as the United Nations and the World Health Organisation. The emphasis was on the preservation of peace and the resolution of conflict. You might think it not very successful overall.

However, the Federation progressed well. With member organisations in over a hundred countries, it is the only organisation concerned with all aspects of mental health. It is in consultative status with the United Nations where its representatives work hard to ensure that mental health is taken fully into account.

In 1992, WFMH founded World Mental Health Day and sets the theme sending out thousands of free packets of information. In the past the Federation placed a mental health employee in the World Bank and invited WHO and ILO to join with it to promote mental health in the workplace. Recently, the Federation has been concerned about the difficulty migrant consumers of mental health services have in crossing cultural barriers and has set up and promoted a transcultural centre and its first conference. Human rights have been a perennial concern.

The Federation has a duty to identify mental health problems and convene appropriate leaders to facilitate solutions while encouraging and monitoring their implementation. This brief history should indicate that the views and opinions of consumers/users are central to the WFMH's concerns.

What is the origin of the present preoccupation with diagnostic labelling?

There is a fear that mental illness is increasingly reduced to issues of diagnosis and medication, driven by commercial and financial considerations, and shortage of trained personnel. In the 1960s, the diagnosis of patients admitted to the State Mental Hospitals in the US showed a preponderance of patients diagnosed as having schizophrenia which was not apparent in the national statistics of other Western countries. Concern in the US led to the formation of the US/UK Diagnostic Project. It was my honour to form part of the team that found serious differences in diagnostic practices between the two sides of the Atlantic [1]. Later, when I succeeded Dr. John Cooper as leader of the UK team, we investigated the large differences in levels of dementia and depression in older people finding similar differences in diagnostic use [2]. These findings and the availability of new medications contributed to the need to improve diagnostic reliability between psychiatrists. The result was the DSM III and IV [3] and ICD 10 with their various rules to encourage diagnostic agreement. It is stated in the introduction to DSM III and to ICD 10 that these classifications are for improving the "reliability of diagnostic judgements" and "in order to improve diagnostic reliability". However, they have become increasingly used by service providers, managed care operators, governments and the law to provide general limits on what might be regarded as illness. This trend has now swung so far that when a colleague of mine, working outside the UK, asked a medical student what he understood by the word

'schizophrenia' he received the answer, "there has to be two or more symptoms from criterion A and one or more disturbances from criterion B ..." and so on. It would seem that diagnosis has become a formula attached to a human being rather than a human being who happens to be suffering from an illness. The need to codify diagnosis has now gone far beyond its original intention, to become a dehumanising label reducing a person's experience of ill health to a code of letters and numbers.

Earlier traditions

The tradition in the UK required the trainee psychiatrist to elicit the history of the illness, the symptoms, the patient's life history including social background and interaction, past history of illness, personality, strengths, needs, quality of life, risk assessment and pathways to recovery. However, financial stringency, shortage of staff and the take over of postgraduate education by government whose concern is with the spiralling costs of health care, threaten this system.

In the early days of the National Health Service in the UK we were taught the order of importance was: the patient, the relatives, the health related workers and the administrators. One's impression now in one's own contact with service provision, is that this order has become reversed.

Dangers of orientating to the person without appropriate provision

At the time of the US/UK Diagnostic Project, psychiatry in the USA was dominated by a very individually orientated approach, a type of psychotherapy based loosely on psychoanalysis. It was very person orientated, on a one to one basis. It was an expensive treatment. The majority of patients however, were 20 not able to pay, and were to be found in mental hospitals receiving minimal treatment from doctors who were often migrants with little English. There is the danger that in highly individualised treatment scarce psychiatric manpower could go to those who can pay while others have a poor service. In practice we would have to be clear how this is to be avoided.

Another principle learnt in the past while examining the practices in a large mental hospital in the UK, was that where the staff have complete power and the patients little or no power and no successful monitoring, the practice drifts inevitably in favour of the convenience of staff and away from the patient. It is the opposite of patient orientated care and yet I suspect it exists in many mental hospitals across the world, and in many nursing homes. It seems to require intense surveillance to prevent it, but such surveillance is expensive.

Many problems are related to the level of resources. It is essential to achieve person orientated care, but the problem is to find the resources which will allow that to be available to all sections of the community and not just to a few. In many countries in the West as much as the lower one-third of the population has inadequate psychiatric care, or for that matter health care in general.

Countries and situations with inadequate services

The remit of the World Federation for Mental Health must embrace mental health in countries in most of which psychiatric care is inadequate and in some where no psychiatrist exists. That is often an excuse for not putting the needs of the patient first, but the resources must come from the funders of care who must be persuaded to embrace the policy.

The Federation is working with its Collaborating Centre in Liverpool to try to bridge this treatment gap by the development of computer assisted technology for making an assessment, diagnosis and suggesting pathways of care. While aimed to bring into care mentally ill people at present deprived, we are conscious that without constant reminders it could become a mechanical process. Consequently, we have given special concern to patient's expressed needs and quality of life [4].

Many problem areas exist where individual orientated care is lacking. The Federation discovered this following the Asian tsunami in 2003, when mental health did not share in the money donated by individuals to humanitarian organisations many of whom do very little for mental health. This has led the Federation to set up a forum to bring together the leaders of mental health and psychosocial support in emergencies to discuss funding, training and procedural issues.

The impact on individuals with mental illness of HIV AIDS and vice versa is being addressed by the Federation's new African Initiative.

One worries about the use of the term 'mental health' suggesting perhaps a public health programme for populations rather than the treatment of individuals. While mental health embraces far more than the treatment of mental illness, one suspects, it has become a euphemism for mental illness and by its use, we subscribed to the stigma still surrounding it.

Are we listening to the consumers of mental health services?

If we are to put the person central to our work we must listen to what the person tells us. Are we listening sufficiently? Do we have an adequate consumer representation? Recently, the Board of Directors of the WFMH approved ten principles for the Federation of which the second is "users/consumers will participate in all the health and social service departments and committees of member countries". Consumers and their families are central to the concerns of WFMH. If we are to put the person back into medicine we must listen to what the person has to tell us about what they want. We may have knowledge of illness but we do not necessarily have knowledge, nor do we necessarily understand what it is that an ill person wants us to do for them. They must guide us in what they want to achieve and be helped to articulate this, and we must surely listen to them.

Finally, we must also remember that patient orientated care is not necessarily in the interests of caregivers and may not appeal to them, so that constant monitoring to ensure its implementation will be vital.

References

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