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A naturalistic study of outcomes in a general psychiatry day hospital
A report from a new general psychiatric day hospital in Canton Fribourg.

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Mit dem Rollstuhl ans Ende der Welt. Meine Reise durch Indien

Das Buch ist kein herkömmlicher Reiseführer. Es möchte den Leser – ob mit oder ohne Beeinträchtigung – dazu ermutigen, doch das Unkonventionelle, ja das scheinbar Unmögliche zu wagen.

Walter Beutler

Verlag Johannes Petri
This issue leads off with an interesting review on functional neurological disorders by Christian Greiner et al., outlining current clinical practice and potential treatments. Functional disorders are common in neurology and general medical practice, and physicians are often uncertain how to approach patients with these problems. The situation is confounded by the fact that even naming the condition is a challenge. Some of the innovative hypotheses are based on data generated by neuroimaging studies examining brain activity in order to explore the neural basis of functional neurological disorders. The challenge will be to integrate and understand these neurobiological data in a psychodynamic model. Among the many useful steps in management, physiotherapy has long been considered to be an important component of treatment. Pharmacological therapies are used frequently, presumably targeting underlying depressive or anxiety symptoms. Neuromodulation by means of noninvasive brain stimulation methods has been proposed and is currently evaluated. Psychological treatment is commonly used. Psychotherapy, such as a psychoanalytic approach, aimed at a better understanding of the patient’s emotional life has been found helpful. A big challenge is to explain their symptoms to the patients. Given the highly complex aspects of psychosomatic disorders, there is a strong need to develop interdisciplinarity between neurologists and psychiatrists for optimising patients’ care and defining appropriate treatment strategies. The review “The Istanbul Protocol (Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment)” by Thomas Wenzel et al. is a timely reminder that torture is common in some countries. Torture remains a key theme in healthcare and a number of publications confirm its relevance also in regard to mental health. Posttraumatic stress disorder, chronic pain and depressive disorders are the most common sequelae. Medical ethical and legal aspects are discussed and the importance of rehabilitation programmes is stressed. Anik Debrot et al. present a field study of outcomes in a general psychiatry day hospital in the canton of Fribourg. The effectiveness of partial hospitalisation or day hospital care is a subject of considerable current relevance, especially at a time of increasing pressure on allocation of health resources. This study, the first in Switzerland, presents a comprehensive picture of a day hospital. It is based on an analysis of a large representative sample of the treated population and the data were gathered over more than 3 years. Several questions were addressed, such as evaluation of different treatment outcome indicators and treatment improvement predictors. Obviously, in a highly diverse population, with heterogeneous diagnoses, illness severity and comorbidities, outcomes will be variable. Nevertheless, some interesting trends emerge. Overall, patients had a significant improvement in their functioning level during the stay. Patients with a substance-related disorder benefited less from the treatment, whereas patients with an affective disorder benefited more. Importantly, longer treatment and more frequent attendance at the day hospital predicted a better outcome. It is worth mentioning that this was not a randomised controlled study comparing the effectiveness of a day hospital with outpatient or inpatient services. Future studies in this important area of mental health treatment options are clearly needed. The interview of Niklas Baer by Karl Studer emphasises the importance of work rehabilitation for mentally ill patients. Dr Baer describes how a partnership-based collaboration between patients, psychiatrists, employers and insurers can improve work rehabilitation. During a study trip through Australia, New Zealand and Hong Kong, Hanspeter Walti visited various institutions and organisations. His travel report summarises the impressions gained and observations on “International strategies and concepts for the early detection of mental disorders and suicide prevention”, pointing out the particular characteristics of the individual countries.
Functional neurological disorders: a treatment-focused review

Christian Greiner, Armin Schnider, Béatrice Leemann
Division of Neurorehabilitation, University Hospitals of Geneva (HUG), Switzerland

Introduction

Patients with medically unexplained symptoms present in all medical and surgical settings, acute and chronic, with protean symptomatic manifestations. Whether they present with globus pharyngeus to the otorhinolaryngologist, inflammatory bowel disease to the gastroenterologist, chronic pelvic pain to the gynaecologist or chronic fatigue to the rheumatologist, they occupy more than 30% of all generalists’ and specialists’ practice [1]. In the field of neurology, these patients can present a wide range of symptoms such as paresis, paralysis, abasia, astasia, paraesthesia, anaesthesia, aphony, dyskinesia, akinesia, dystonia, tremor, ataxia, vesico-sphincteric symptoms, blindness, amnesia, or seizures [2].

Even naming these conditions is a challenge, and a wide variety of terminology has been used over time, across countries and between health professionals. In a recent survey, patients found the word “functional” to be less offensive than “hysterical”, “psychosomatic”, “medically unexplained”, “stress related”, “depression related”, or “symptoms all in the mind” [3], and we will use the term “functional neurological disorders” in this review in accordance with trends in current diagnostic nomenclature (see below).

UK neurologists have described these patients as “the most difficult to help”, and they came bottom of a recent US neurologists’ inquiry of “most likeable conditions” as a consequence of persistent uncertainties about aetiology [4]. That this condition is currently still very poorly understood is all the more surprising given the fact that these disorders provided major building blocks for both the theoretical basis and clinical semiology of the foundation of modern neurology and psychiatry in the late 19th century. Nonetheless, the last decade has seen a substantial increase in research into many aspects of these disorders.

The aim of this paper is to provide a treatment-focused review of ongoing developments in functional neurological disorders.

Methods

A MEDLINE/PubMed and google.scholar literature search was conducted, focusing on treatment studies on functional neurological disorders from 2000 to 2016. The search included articles with the following words in title or abstract: “functional”, “conversion”, “psychogenic”, “somatoform”, “hysteric”, which were combined with the subsequent terms: “treatment”, “management”, “physical”, “physiotherapy”, “psychological”, “psychotherapy”, “pharmacological”, “medication”, “drugs”. Titles and abstracts were reviewed to identify potentially relevant articles of which there were 51; the full articles were then retrieved and reviewed. All results were limited to English-language articles.

Summary

Functional neurological disorders are commonly seen in medical practice. Despite the fact that these conditions are currently poorly understood, the last decade has seen a substantial increase in research into many areas, notably treatment. Thus, there is good evidence supporting physical treatment with emphasis on specific elements. Psychological treatments, for a long time viewed as the mainstay of therapy for these disorders, showed remarkably low levels of evidence until better conducted studies were published recently, with interesting new trends such as interdisciplinarity or self-help. Pharmacological treatments lack clear confirmation of efficacy. Evidence for neuromodulatory treatments is at an embryonic stage, but there have been some encouraging results.

Key words: functional neurological disorder; treatment, physical; psychological; pharmacological; neuromodulation
being listed among somatoform disorders in the former and among dissociative disorders in the latter. The latest version of DSM-5 removed the diagnostic requirement for a “recent psychological stressor”, as well as the need to exclude feigning, and replaced them with the need for positive physical signs to support the diagnosis [7].

The ICD 11th revision is due in 2017, and in its current beta draft, functional disorders are for the first time a separate category within the neurological section [8].

Functional neurological symptom disorder (conversion disorder), DSM-5 [5]

A. One or more symptoms of altered motor or sensory function.
B. Clinical findings provide evidence of incompatibility between the symptom and recognised neurological or medical conditions.
C. The symptom or deficit is not better explained by another medical or mental disorder.
D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Functional clinical manifestations of the nervous system, ICD 11 Beta draft [6]

Functional paralysis or weakness:
Motor weakness of a limb or body part in which there is positive evidence of either internal inconsistency (e.g., the presence of Hoover’s sign or Hip Abductor sign) or incoherence with other causes of limb or body part weakness.

People with functional neurological disorders present some commonly noted clinical features, such as sudden onset of symptoms, often precipitated by a physical event (e.g., injury or illness), rapid progression, severity increasing with attention and decreasing with distraction, and shifting symptomatology [4]. Two broad entities were classically depicted, functional movement disorders (in decreasing order of prevalence: tremor, dystonia, gait disorder, parkinsonism and myoclonus) and nonepileptic seizures, but these are increasingly considered to overlap and respond to the same treatments [9–11]. It is also increasingly usual to distinguish between negative/loss of function symptoms (e.g., paresis, sensory losses or blindness) and positive/productive symptoms (e.g., functional movement disorders and nonepileptic seizures).

Clinical manoeuvres such as Hoover’s sign (fig. 1) gained some empirical credibility in distinguishing functional from organic motor symptoms, and it is more and more often recommended to emphasise positive signs in the diagnosis [12]. The gold standard for diagnosis of nonepileptic seizure remains video-electroencephalogram [4]. In terms of illness representation, people with functional neurological disorders have been found to have illness beliefs similar to those of their counterparts with the corresponding organic disease, except that, paradoxically, they tend to be less likely to attribute their symptoms to stress than patients with organic disease [13].

Epidemiology
The prevalence of functional neurological disorder is notably difficult to establish because of case definition issues. Nevertheless, lower estimates of community prevalence extracted from a population-based case register are at around 50/100 000 [4]. One of the largest multicentre prospective cohort studies of neurology outpatients to date found that up to 30% had neurological symptoms that were either “not at all” or only “somewhat” explained by neurological disease, with a diagnosis of “conversion disorder” in 5.6% of cases [14].

Prognosis is often poor, with long-lasting symptoms in approximately half of the patients leading to distress, disability, social isolation and early work retirement, to a greater extent than in patients with organic disease [8]. For example, functional neurological disorders cause impairments of quality of life that are worse than those experienced by patients with Parkinson’s disease [15]. In the UK, estimates of yearly costs associated with patients with “medically unexplained symptoms” are slightly higher than the annual costs associated with dementia patients [16]. Psychiatric comorbidities such as depression and anxiety are frequent, and there is good evidence that averse childhood experience is more common in patients with functional neurological disorders than in controls, although not psychiatric controls. The frequency of recent life events around the time of onset is also somewhat increased, but results between studies are incongruent [4].

Imaging
Over the last decade, neuroimaging studies examining brain activity with different paradigms have started to explore the neural basis of functional neurological (essentially motor) disorders [17, 18]. Summarising the findings is notably difficult, but three of them fit very broadly with current putative models of these disorders. The first of these findings suggests an alteration/down-regulation of networks involved in planning, execution and interpretation or attribution of movement (insula and motor cortex) by dysregulated areas involved in emotional regulation (orbitofrontal cortex), perhaps reproducing a phylogenetic mechanism of deceiving predators by mimicking illness/disability in presence of intense fear [8]. The second implies potential abnormalities in the sense of agency/self-monitoring control of movement. In patients, motor pathways (e.g., M1) seem less coupled with premotor areas and more with default mode network regions (precuneus, ventromedial prefrontal cortex and other midline regions), suggesting a role for internal self-representations in influencing motor activities in these patients [19]. Aberrant functional connectivity between these networks is thus capable of producing movements or perceptual experiences that are not associated with the normal sense of agency and interpreted therefore as involuntary by patients [20]. The third finding involves arousal and memory alterations. Globally, an overly sensitive amygdala, possibly conditioned by previous learning (early life stress events), seems to drive changes in networks mediating perceptual experiences (temporoparietal junction) and movement plans (supplementary motor area, SMA) [4]. Moreover, during stressful tasks, patients with functional neurological disorders show greater dorsolateral prefrontal cortex (DLPFC) and SMA activity, and decreased hippocampal activity. Interestingly, inferences were made in support of some psychodynamic concepts, such as memory repression (greater DLPFC activity inducing lower hippocampal activity), associated with conversion symptoms (greater SMA activity) [20, 21], although evidence is mixed [22].

Treatment
A 2005 Cochrane systematic review of treatment for conversion disorders identified 260 references, including over 100 case reports, and described a “Prévert’s catalogue” of treatment regimens as different as spa treatment, hypnosis, abreaction/cathartic therapy, family therapy, psychodynamic therapy, cognitive behavioural therapy, surgery, drugs, electroconvulsive therapy, transcranial magnetic stimulation, physiotherapy, inpatient psychiatric care and packages of different interventions. The authors found it impossible to draw any conclusions about their potential benefits or harms, and urged researchers to aim toward more reliable evidence [23]. This was of particular importance because patients with functional disorders are notably susceptible to unethical health practices, especially via the web [24].

One of the major barriers to treatment is the lack of a defined treatment provider and treatment transition strategies.

Indeed, evidence for effective treatment regimens in functional neurological disorders has grown up in recent years. A large number of new studies have reported marked short-term improvements, mostly in the region of a 60–70% symptom reduction [25], regularly with a class 2 level of evidence. Whatever physical, psychological, neuromodulatory or combination treatments are nowadays proposed to these patients, effective communication with them and their relatives, and providing a shared rational model of the functional symptoms, are now cornerstones of experts’ recommendations [16], given that diagnostic acceptance is a well-documented prognostic factor [26]. One of the major barriers to treatment that remains and that will be difficult to resolve with evidence-based medicine is the lack of a defined treatment provider and treatment transition strategies. The neurologist is often the health professional who makes the
There is increasing sound evidence for the use of physiotherapy for functional neurological (movement) disorders.

In contrast to the classical view that physical methods help by providing a “face-saving way out” for patients, new evidence showed that elements of physiotherapy matter. Three points are of particular relevance and are outlined in the 2015 expert consensus recommendations [29].

1. As a rule of thumb, physiotherapy with patients suffering from functional movement disorders draws attention away from the disabled body part. This approach contrasts with physiotherapy of neurological conditions such as stroke, spinal injury or multiple sclerosis, which relies on focused attention on the poorly functioning body part [31]. The challenge here is for the physiotherapist to demonstrate normal movement in the context of a meaningful activity such as walking. Distractions are preferably motor-oriented (finger tapping) rather than cognitively oriented (conversation, music, arithmetic) because they seem more effective.

2. A second element is the strong educational framework given with physical therapy, centered not only on patients’ representations, but also on recognizing inconsistencies between their presentation and the work with the physiotherapist [33]. Useful ingredients are, for example: acknowledgement that symptoms are real and not imagined, and that they are relatively common in the general population; explanations that these symptoms can improve and are often reversible (by showing the patient clinical signs of reversibility such as Hoover’s sign, hip abductor sign, or entrainment of tremor); and introduction of the role of the physiotherapist in helping the patients “regain control” over their “nervous system” and voluntary movements.

3. The third element is goal-directed physical rehabilitation that focuses on function and automatic movement (e.g., walking) rather than impairment (e.g., weakness) by creating an expectation of improvement (e.g., by daily or weekly objectives recorded in a rehabilitation diary or workbook) and developing a self-management and relapse prevention plan.

The only randomized controlled trial to date on these questions, by Jordbru et al., investigated a 3-week inpatient rehabilitation programme based on adapted physical activity with a strong educational frame of reference [30]. It showed effectiveness on two scales assessing physical and cognitive disability, and functional mobility, respectively; treated patients kept their gains during a 1-year follow-up. Contrary to the previous opinion that recovery would be less likely more than 2 years after disease onset [34], patients with a disease duration as long as 4 years responded well.

An influential study at the Mayo Clinic investigated a short-term (5 day) physical rehabilitation protocol consisting of a twice daily step-by-step strategy establishing elementary movement in the affected body part and then building on this, coupled with distracting motor tasks (e.g., finger tapping, balloon bouncing). This study showed that approximately 70% of the patients were rated by themselves and a neurologist as “markedly improved”, “nearly completely normal” or “in remission” [35].

A retrospective study of 60 patients, conducted in 2013 at the Maudsley Hospital, London, investigated a twice weekly, essentially physiotherapeutic intervention. This included exercises targeting posture with balance and strength, combined with techniques employing...
distraction from the affected limb and assistance for the patient in recognising inconsistencies between presentation and work with the therapist. There was a “marked improvement” in 69% of the patients immediately after treatment with lasting effect at 25 months [33].

More recently, two studies using the physiotherapeutic guidelines issued in the 2015 recommendations have shown positive results. The first, conducted by one of the leading experts involved in the 2015 recommendations, investigated a prospective, brief (5-day) physiotherapeutic programme, and showed again that beneficial outcomes are possible even with patients for whom previous evidence suggested poor prognosis (symptoms for more than 2 years, loss of role, e.g., unemployment or divorce, receipt of disability-related financial benefits) [32]. The second study, published in 2016, was a case series of 35 patients, which again showed positive results, with substantial gains for patients with both acute and chronic presentation, even if the former gained significantly more points on average [31].

Finally, there is certainly a role for other physical therapies apart from work with a physiotherapist. Non-specific, graded exercise is more and more considered to be a part of general rehabilitation programmes that address reduced exercise tolerance, chronic pain, fatigue, and anxiety and depressive traits [26]. Dallochio et al. observed that a group exercise programme of low to mild intensity could improve functional movement disorders and general well-being in a group of mildly to moderately affected patients [36]. The challenge with these nonspecific group exercises is to have the right exercise intensity to prevent exacerbation of symptoms and build up adherence to the programme [27].

Psychological treatment

Despite the belief, common since the early 20th century, that psychological therapies are the mainstay of treatment of functional neurological disorders, there are very few appropriately powered studies in this area. The 2005 Cochrane systematic review investigating psychosocial interventions for conversion disorder found no convincing support for any treatment, with only slight experimental evidence for two therapies, namely hypnosis and paradoxical intention therapy (symptom prescription where patients are instructed to deliberately increase symptomatic behaviour) [23]. A more recent 2014 Cochrane systematic review on psychological treatment for nonepileptic seizures highlighted that there is little evidence to inform physicians and health practitioners regarding existing psychotherapeutic treatments and how effective they are [37]. Recent randomised controlled trials provided class 2 evidence for psychological treatments of patients suffering from functional neurological disorders, but essentially in the short-term and mostly for nonepileptic seizures, with much less information on functional movement disorders [38–41]. In this domain lessons have yet to be learned from the treatment of similar conditions, especially somatoform disorders (most subjects with a functional neurological disorder fulfil criteria for a somatoform disorder [40]), where the evidence for psychological treatment is wider and more sound [42].

Cognitive behavioural therapy (CBT) is the most studied psychotherapeutic modality in functional neurological disorders. It is a form of psychotherapy that can be administered in a limited time-frame to help patients become aware of their dysfunctional thoughts and maximise function by practicing new ways to think about their symptoms and learning new ways to respond to these symptoms. Most of the literature on the use of CBT in functional neurological disorders involves nonepileptic seizures [43]. The rationale is that functional neurological disorders represent dissociative responses to arousal, occurring when the person is faced with fearful or intolerable circumstances [38]. Two pilot clinical trials had promising results. The first, in 2010, showed a reduction in seizures in patients with nonepileptic seizures as compared with a treatment-as-usual control group, but the benefit was not maintained at 6-month follow-up [38]. The second trial, in 2014, demonstrated that manualised psychotherapy for patients with nonepileptic seizures reduced seizures and other somatic symptoms, improved psychiatric symptoms including depression and anxiety, and improved quality of life and overall functioning [39].

Psychodynamic psychotherapy is a modernised form of psychoanalytic cure aimed at reshaping personality structure. It is based on the articulation between early life experiences, parenting dynamics, negative emotions, current life experiences and enduring personality traits. It showed promising benefits in a 2006 single-blind clinical trial investigating brief (12-week) psychodynamic psychotherapy in 10 patients, with improvement in movements, and depression, anxiety and global functioning scales [44]. However, a 2014 randomised controlled trial developed to build on the results of this previous study found no specific benefit in the brief psychodynamic psychotherapy group, as opposed to the active control group with neurological observation and support [40].

Adaptations of the previous models to overcome limitations such as shortage of qualified therapists, low...
cost-effectiveness and unwillingness of patients to be face-to-face with a therapist, led to investigations on group therapy and self-help methods. In their pilot study, Conwill et al. found preliminary evidence to support the feasibility of CBT-based group therapy, which needs further studies [41]. Bullock et al. adapted and assessed the acceptability of group therapy in patients with nonepileptic seizures by using Linehan’s manualised dialectical-behaviour therapy (initially created for borderline personality disorder but now a transdiagnostic treatment offered in a wide range of acute and outpatient psychiatric settings); this will be followed by effectiveness studies [45]. Chen et al. found that group psychoeducation in patients with nonepileptic seizures, administered early and by the same team who diagnosed and communicated the affection, induced significant functional improvement [46]. Finally, Sharpe et al. sought to provide a self-help form of therapy (bibliotherapy) built on the effectiveness of guided self-help in depression; findings were positive in the short term, but the benefit had vanished at a 6-month follow-up [47].

A current trend in expert opinion emphasises interdisciplinarity between neurologists and psychiatrists [48–53], with opportunities for renewed collaboration around this paradigmatic “neuropsychiatric” disorder between specialties that were separated during much of the 20th century [54]. Joint neurological and psychiatric consultation in an inpatient setting is the cornerstone of this multidisciplinary model, and serves several purposes: better initial contact with psychiatry services by avoiding feelings of rejection and incomprehension by patients when referred to a psychiatrist by their neurologist or general practitioner; a sense of coherence and shared understanding, thus helping medical and paramedical staff (physiotherapists) to work more appropriately with the patient’s representations [51]. The main results that emerged from this trend in the literature were the likely sustained benefits of the interventions (as long as 3 years [51]) in the follow-up studies, and diminished healthcare use during the follow-up period.

A current trend in expert opinion emphasises interdisciplinarity between neurologists and psychiatrists.

A last word on hypnosis, which shares a long and storied history with functional neurological disorders. Notable psychiatric personalities (Charcot, Bernheim, Janet, Freud, Breuer) from the latter 19th century treated these patients with hypnosis, noting similarities between hypnotic response and conversion symptoms. By the end of the 20th century, hypnosis-based interventions had experienced a revival in medical practice, as they appeared to be an effective form of adjunctive treatment in a number of medical situations, such as pain management, smoking cessation, or trauma-related syndromes [2]. Similar alterations of brain function in functional neurological disorders and hypnotic states have been suggested, and this shaped the modern rationale for the effects of hypnosis on these disorders [26]. However, these hypothetical links are not supported by recent brain imaging studies specifically comparing both phenomena in motor paresis [55]. Evidence remains very scarce and mixed: Moene et al. conducted two studies in the early 2000s, observing improvement in an open-label study [2], but no difference in a randomised controlled trial on the additional effect of hypnosis on a comprehensive treatment programme for patients with functional movement disorders [56].

Pharmacological treatment

Evidence concerning pharmacological treatments in functional neurological disorders is scarce. There are no data to support use of drugs that are routinely used for treating nonfunctional movement disorders, such as antiparkinsonian medications. A recent Cochrane review assessing pharmacological interventions for somatoform disorders in adults found only low- or very low-quality evidence for their efficacy, and that solely for two specific classes, namely new-generation antidepressants and natural products [57]. Thus an essential part of the sound medical treatment of functional patients is often removal and avoidance of unnecessary medications [16], such as antiepileptic drugs in patients with exclusively nonepileptic seizures [58].

Nonetheless, psychopharmacological treatments, especially antidepressants, are used frequently in patients with functional neurological disorders, presumably targeting underlying depressive or anxiety symptoms. Voon et al. conducted a widely cited open-label study [59] evaluating antidepressant (citalopram, paroxetine, venlafaxine) treatment outcomes in functional neurological (movement) disorders. They found that patients with chronic primary conversion syndromes (rather than primary somatoform disorders, hypochondriasis or malingering) and recent or current depression or anxiety may respond to antidepressants, which confirmed that the target of antidepressants is the depression and/or anxiety associated with functional movement disorders. A pilot pharmacological randomised controlled trial in nonepileptic seizures, conducted by LaFrance et al.,
reported reduced seizure frequency in a group receiving a selective serotonin-reuptake inhibitor (SSRI: sertraline) compared with a placebo control group. Intriguingly, the findings provided preliminary evidence for a serotoninergic-mediated intervention acting directly on nonepileptic seizures, because the improvement in the SSRI group was not accompanied by a reduction in comorbidities such as depression or anxiety [60].

A 2014 short communication reported that therapeutic sedation had positive results in severely disabled functional neurological patients with spastic paraplegia or fixed dystonia, rehabilitating one of the first modern treatment methods for conversion disorders, which was used massively during the First World War on soldiers who presented these symptoms. Potential mechanisms of the video-recorded propofol-induced sedation protocol are demonstration of reversibility, helping the patient to trust in possible recovery, and cerebral state alteration inducing temporary interruption of altered cognitive, motor and emotional pathways [61].

**Neuromodulation**

Noninvasive brain stimulation methods such as repetitive transcranial magnetic stimulation (rTMS), transcranial direct current stimulation (tDCS) and electroconvulsive therapy (ECT) have been used in past decades to treat various mental disorders, and have been introduced or re-evaluated as potentially helpful in the treatment of functional neurological disorders. As a reminder, the use of electricity or magnetic fields in medical practice has a long history dating back to the 18th century, and is closely linked to discoveries in the nascent neurological fields and paradigmatic shifts away from ancient Galenism [62]. Especially rTMS has been the subject of much recent interest. When applied at suprathereshold motor intensities to the contralateral motor cortex, rTMS can induce movements in the functionally weak, dystonic or tremulous limb [63, 64]. Two recent systematic reviews by Pollak et al. [65] and Schönfeldt-Lecuona et al. [25] provide preliminary evidence that rTMS could be beneficial in the treatment of functional movement disorders, despite heterogeneous protocols and the poor overall quality of examined studies. The mechanism of action of rTMS in functional neurological disorders remains uncertain. One hypothesis is a possible direct effect on neuronal firing rate, but this idea seems at present to be preliminary, because of protocols that are not intense enough to result in these events and because benefits lasted far longer than those seen in some of the better sham-controlled blinded trials of rTMS in Parkinson’s disease or dystonia. Some authors emphasise the crucial influence of patients observing an externally triggered muscle contraction, which is not the case with tDCS and ECT, for which evidence remains anecdotal [25].

Finally, transcutaneous electrical nerve stimulation (TENS) devices, which emit low-voltage current to the skin and are widely used to treat various acute and chronic pain conditions such as musculoskeletal disease, neuropathy, surgery and childbirth, have also been examined. Two open-label studies found benefits on motor symptoms in the short term [66, 67]. The portability and focus of TENS makes it, in any case, a useful tool in the armamentarium of physiotherapists working with patients with functional neurological disorders, especially for those with sensory symptoms such as paraesthesia or allodynia [8].

**Conclusions**

Functional neurological disorders are commonly seen in medical practice, but the field has only recently moved forward to using proper methodologies to explore the question of treatment. Current expert recommendations emphasise physical therapy aimed at drawing attention away from the disabled body part and focusing on automatic movement (e.g., walking) rather than the impairment, within a strong goal-directed framework in order to create an expectation of improvement. Multidisciplinarity between neurologists and psychiatrists is another cornerstone of existing guidelines, with particular emphasis on effective communication to provide a shared rational model of the functional symptoms. Data show promising results, and should encourage neurologists, psychiatrists, physiotherapists and other health practitioners to work together, sometimes in new and original ways, to promote and improve health, prognosis and quality of life of these patients.

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**References**

The full list of references is included in the online article at www.sanp.ch.
Torture and related acts of extreme violence (in the legal formulation “cruel, inhuman or degrading treatment and punishment”) can be seen as a global problem [1] because of their widespread use and because of the severe and long-term impact, especially on mental health, on the victim [2–6], family members as “indirect victims” [7, 8], helpers, therapists [9, 10], and civil society as a whole [11]. International standards, including especially the UN Convention against Torture (CAT), have therefore been established to ban its use, but reports for example by the UN Committee against Torture indicate a persistent or regionally even increased use of torture.

Actions against torture

A number of further strategic action steps have therefore been taken to support the aims of the convention, including

– the creation of the office of the UN Special Rapporteur on Torture;
– the Optional Protocol (OPCAT) that provides for special independent bodies to monitor and help in local implementation;
– and with the UN General Assembly Decision of 4. 12. 2000 as part of Resolution A/RES/55/89, the “Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment” (IP) [12, 13].

Torture is defined by the UNCAT in article 1:

For the purposes of this Convention, the term “torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

Inhuman and degrading treatment (IDT) is equally sanctioned, and characterised by the lack of the intention to achieve aims such as obtaining confessions. A number of standards and declarations including the CAT have underlined the special duty of healthcare professionals, also outlined in the Istanbul Protocol, not only to refrain from any participation in torture but also to document and actively report any act of torture or IDT.

The Istanbul Protocol

The Istanbul Protocol reflects a concerted effort of a large international expert group to establish a binding multipurpose training standard for the documentation, evaluation and investigation of torture. It is supported by key umbrella organisations, including the World Medical Association. The interdisciplinary approach is intended to harmonise the effective collaboration of legal and healthcare experts in the process. Providing expertise in torture cases demands special experience and training. Common medical curricula and everyday work are frequently guided not by forensic but by treatment-oriented principles, and consequently physicians are usually not well trained to produce documentation on reporting or assessment of physical and psychological injuries that stands up as evidence in court, especially in controversial situations.

Principles that guide medical ethics in specific situations might not be common knowledge. Recognition of techniques of torture like falanga and their charac-
teristic sequels [14, 15], as well as their use in different countries, requires specific knowledge.

The IP protocol consists of six parts:

I Relevant international legal standards  
Introduction to the relevant international legal human rights standards

II Relevant ethical codes  
Overview of relevant medical and legal professional standards of ethics

III Legal investigation of torture  
Basic aspects and strategies for independent investigations

IV General considerations for interviews  
This chapter includes also considerations referring to prevention of retraumatisation (secondary victimisation)

V Physical evidence of torture  
Physical medical examination with examples for common sequels and diagnostic steps

VI Psychological evidence of torture  
Psychological impact, as perceived on a symptom and on a diagnostical level

Annexes  
The annexes offer tools including a summary and a map to document physical injuries.

The interdisciplinary approach of the IP requires that all parts can be read independently of background profession, while chapters II, IV and VI are of special relevance to mental health professionals. Integration of physical and psychological findings can be a challenge that can best be resolved by close collaboration between mental health and other experts. Cognitive or memory impairment from brain or psychological trauma and culture-based factors that can be identified by the psychiatrist or psychologist could, for example, lead to misunderstandings or incomplete history taking for physical examination and in the legal process if not considered. In spite of the fear of stigma, all examinations should therefore include a mental health assessment. In some situations, such as in visits of places of detention with small teams, one mental health professional might have to cover all aspects, so special care has to be taken to update mental health or other specialty-related training.

If used not only for documentation, but also for a full assessment, the IP based report distinguishes between “a) Not consistent, b) Consistent with, c) Highly consistent, d) Typical of, e) Diagnostic of,” (§ 187) to draw conclusions on the degree of certainty regarding causality. A concluding statement should also explain to a court aspects of the findings that might not be obvious to legal professionals. For example, it should draw attention to the fact that a negative finding might not disprove a report of exposure to torture, but could reflect limitations of diagnostic methods, resilience, or the natural course of healing.

The IP is not intended as a complete and comprehensive handbook of state of the art of knowledge on torture or trauma-related disorders, but as a general guideline that must be applied with currently updated knowledge in a respective field. Location-specific factors, including legal processes, or torture techniques must be reflected in materials developed for a country within that framework. The sometimes rapid international development of legal and medical knowledge cannot be reflected in an international standard but must be complemented by updated training materials or by reference to the literature. This is also relevant for the mental health assessment, for example for recent changes in the DSM (Rev. 5) [16] and upcoming definitions in the WHO International Classification of Diseases (Rev. 11).

DSM now emphasises, among other relevant issues, complex symptoms in post-traumatic stress disorder (PTSD), an extended description of trauma related disorders in children, and also culture and disability [17]. It facilitates assessment of these aspects by provision of two standard instruments, i.e., the Cultural Formulation Interview (CFI) and the WHO Disability Schedule (DAS II). Culture-specific “idioms of distress” that might be more relevant than, for example, PTSD as a sequel to traumatic events would be especially important in the assessment of migrants and refugees.

At present, updating the protocol should be only considered with care, as the well-established position of the protocol in many countries and the existing training and implementation programmes would create substantial challenges in the process. Updates are therefore best provided by additional materials summarising present knowledge in a specific field. A specific model for this has been developed as part of the ATIP/ARTIP projects [18].

Mental health aspects

Mental health aspects play a key role in the protocol, not only because they can interfere with a complete and unambivalent reporting of the acts of violence encountered by a survivor. Concentration and memory functions can, as described before, be disturbed during torture and also during examination or court hearings, owing to a number of factors including dissociation, stress-related disorders, brain trauma or other untreated physical or psychological conditions. These psychological sequels are not only common and long-lasting, sometimes requiring long-term treatment, but are also an important part of the evidence.

PTSD is usually seen as the most common specific mental health sequel [19–23]. More nonspecific sequels,

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4 The protocol is freely available on the website of the UN High Commissioner for Human Rights (http://www.ohchr.org/Documents/Publications/trainingRevis.pdf) and in an indexed and annotated German open access version www.v-r.de/_uploads_media/files/9783777000307_frewer_oa_wz_010746.pdf

5 As to October 1, 2016 the list includes but is not limited to the World Medical Association, World Psychiatric Association, World Council of Nurses, and the World Council for Psychotherapy.
such as mood and anxiety disorders, and somatoform pain disorders are also common in survivors of torture and can either reflect culture-based idioms of distress or be added to the cultural patterns [24, 25]. Sequels to blunt brain injury [26, 27] or hunger strike [28] should also be considered in this context. Persecution, war, or stressful life events after torture, such as flight, the insecure fate of family members, or an insecure social situation, can interact with torture related sequels [29, 30].

Specific aspects of the interview underlined in the IP include concepts, such as countertransference, that require further explanation for legal or medical professionals not experienced in mental health terms. The special importance of avoiding secondary victimisation (retraumatisation) through inadequate interviews is again a key factor for both legal and healthcare professionals and is discussed in several parts of the protocol. Investigations in prisons have a special role, but could be seen as an example for other settings, such as evaluation of refugees seeking asylum [31–33] (discussed below), preventive monitoring, or the examination of released prisoners in later assessments.

Torture survivors in Europe

Torture and IDT might be rare in Western European countries and especially in members of the European Union, but a high standard of forensic assessment is required both to ensure effective investigation and prevention of further acts, and to effectively contribute to the distinction between correct and false allegations. Most torture survivors living in Europe have been exposed to torture in other regions, and studies, for example in the US, have demonstrated that they are frequently not recognised in general public healthcare systems [34, 35].

A number of good medical and legal reasons speak for careful screening for exposure to torture and documentation of physical and, especially, psychological sequels in migrants, asylum seekers and refugees [36].

Aims of the documentation of torture in asylum seekers and refugees

Preservation of evidence

Medical or psychological assessment can be difficult, impossible or dangerous for both the victim and the medical expert in many countries where torture is common. Preservation of evidence in advanced models of documentation is therefore of special importance in host countries. It can be essential for the criminal and civil legal case.

Instigation of an investigation

This step can be difficult, as long as no fair process can be expected in the country where torture took place. Newly established tools such as universal jurisdiction might change this situation.

Monitoring by international bodies

Again, monitoring and reporting of human rights violations can be difficult or impossible in countries with ongoing civilian rights violations, though international bodies such as the UN committee on torture require reliable data.

Acknowledgement of suffering

A correct and respectful interview can help the survivor to experience attention to and respect for the suffering encountered.

Protection

Survivors need and are entitled to special protection, including against detention [37–39] and against refoulement.

Preparation and needs assessment for comprehensive rehabilitation

A comprehensive report based on the IP can also identify treatment needs, and offer early intervention and secondary prevention.

Torture survivors and victims of similar acts of criminal violence are entitled by standards like the UN Convention against Torture or the EU reception directives to receive special protection [33] and comprehensive rehabilitation. Therefore, they should be identified at an early stage, though early identification might not be best performed with the IP, but rather with screening tools such as the UNHCR Protect6 or the Refugee Health Screener (RHS-15) [40]. This also should be considered in protection against refoulement, for example in “Dublin III” cases, when a refugee is returned to an EU transit country.

Questions presently under discussion are, for example, application to indirect victims, the impact of impunity, and the specific needs in regard to redress for victim. A recent European Court on Human Rights judgement has granted substantial reparation for psychological suffering to family members of “disappeared” victims as indirect victims, because the state in question had neglected to conduct an investigation to clarify their fate (Cyprus v Turkey [2001] (No. 25781/94).

Rehabilitation of victims is an obligation of all states according to the UN CAT, as are special protection and support for victims of any crime including torture as, for example, outlined by the European Union framework directive for victims of crime7 and the CAT. Special programmes are available in most countries, including Switzerland, to offer such services reflecting the complexity of the trauma and culture-sensitive treatment needs8. Victims should receive support from the respective countries. Comment on specific rehabilitation needs might be part of an IP assessment.

The dissemination, teaching and active embedding of the guidelines of the protocol in everyday practice require active implementation strategies in each coun-

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8 See www.irct.org
10 See www.irct.org
try [41–43]. This includes integration into legal and medical standards and the legal system, and also inclusion in pre- and postgraduate training and curricula. Special programmes such as ARTIP/ATIP® and IPIP® have therefore been developed, many of them supported by the European Union, to support necessary teaching and training activities as well as general implementation.

Disclosure statement
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A report from a new general psychiatric day hospital in Canton Fribourg

A naturalistic study of outcomes in a general psychiatry day hospital

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Summary

Psychiatric day hospitals have potential advantages compared with inpatient and/or outpatient treatment, but results are inconsistent and thus their use is controversial. Moreover, few data are available on the factors influencing the treatment success; this is particularly the case regarding Swiss day hospitals. This paper has three goals; first, to give an insight into the population attending a new general day hospital in Canton Fribourg; second, to assess different treatment outcome indicators, and third, to assess treatment improvement predictors. Results, relying on therapist-assessed data from all day hospital stays gathered over more than 3 years, show that, within a wide diversity, overall patients had a significant improvement in their functioning level during the stay. Moreover, our results indicated that patients with a substance-related disorder benefited less from the treatment, whereas patients with an affective disorder benefited more. Additionally, patients starting with a lower functioning level improved more, whereas patients with a longer disorder history improved less. Suicidality and self-harming behaviour did not affect the outcome. Most importantly for clinical implications, longer treatment and more frequent attendance at the day hospital predicted a better outcome. Results are discussed in the context of the existing literature and their potential utility for further treatment and research.

Key words: general adult psychiatry; day hospital; treatment outcomes

In the last few years, day hospitals have received renewed interest in European mental health services because of their potential advantages compared with inpatient and/or outpatient treatment [1]. However, results are inconsistent and thus their use is controversial. Day hospitals pursue several aims, the most common being a reduction in inpatient treatment, and the promotion of social integration or rehabilitation by keeping patients in contact with real-life conditions [2]. Day hospitals appear to be an adequate alternative to a substantial proportion of inpatient admissions [3], and accumulating evidence shows the advantages of partial hospitalisation. In a recent systematic review, Marshall and colleagues [4] showed that the outcomes are comparable to those of inpatient wards; other studies indicated that they can be even better in terms of social adjustment [5, 6] and treatment satisfaction [7, 8]. Reviews and meta-analyses have shown that treatments in acute day hospitals were effective in reducing symptoms [9] and global levels of psychopathology [7, 8]. Furthermore, the cost-benefit ratio is often better in day hospitals than with inpatient care [7, 10]. The benefits of day hospitalisation compared with an inpatient stay appear to be more salient regarding social functioning [6, 9, 11]. Life quality has been shown to improve to a similar degree as in an inpatient ward [8], even in acutely ill patients [6]. However, these promising advantages are not universal. The models, goals, theoretical orientations, populations and contexts of day hospitals vary greatly. Accordingly, results concerning psychiatric day hospitals are sometimes contradictory [2, 12]. Moreover, data available for Swiss psychiatric day clinics are very limited and concern specific approaches or diagnoses [13, 14]. A few years ago, in Canton Fribourg, Switzerland, a day hospital that aimed to provide an intermediate structure between outpatient and inpatient general adult mental healthcare was opened. The present study aims to (a) provide a picture of the population treated at this day hospital, (b) assess the treatment outcomes and (c) identify predictors of treatment outcomes.

Predicting successful stays

Diagnosis categories

Day hospital treatments seem effective for a broad range of psychopathologies. Most day hospitals do not select patients according to their diagnosis and thus a wide range of diagnosis categories are usually encountered [4, 15]. When day hospitals are not specialised in a specific diagnosis [16], the most frequent primary diagnosis categories are depressive and anxiety disorders and/or psychotic disorders [9, 17]. In addition, personality disorders may also be prevalent as secondary diagnoses [18]. Some studies report no difference in
effectiveness according to diagnosis [9, 15]. However, patients with alcohol dependence improve during a day hospital stay, but not more than outpatients and at a higher cost [19]. Patients with an affective [17] or a personality disorder seem to benefit more from day hospitalisation than other forms of treatment [20], in a cost-effective way [21, 22]. This was nevertheless not the case in Cluster B personality disorder patients; the outcome was better for inpatients [23].

**Affection severity**

A systematic literature review [7] showed that day hospital care is adequate for patients with an acute psychiatric disorder. However, there are contradictory results regarding the role of the severity of the disorder. Priebe and colleagues [15] showed that patients with a high symptom load at baseline had a better outcome with inpatient treatment than at day hospital. However, Arnevik et al. [24] found no difference in outcome according to the functioning level in borderline patients. Suicidality also indicates the severity of mental disorder [25] and is frequent in severely ill psychiatric patients [26, 27]. As patients go home daily, it can be questioned whether a day hospital setting is adequate for suicidal patients. Mazza and colleagues [28] provided preliminary evidence that day hospitals are suitable for at least some suicidal patients, as the level of anxiety and depression decreased and no patient of this cohort committed suicide. Episode length is another indicator of the psychopathology severity [29]. To our knowledge, no study has taken the episode length into account in evaluating day hospital treatment.

**Treatment intensity**

Severe psychiatric disorders suggest long-term intensive treatment [see 30]. However, long treatments are expensive, and not necessarily more efficient [31]. Moreover, it has been argued that too long hospitalisations could threaten patients’ autonomy, and a limited time-frame for psychotherapy has become established practice [32]. Among patients with severe psychiatric disorders, treatment adherence is often problematic [33]. Unlike the inpatient setting, coming every day to a day hospital can be challenging. Thus, the number of days people attend the hospital during their stay might affect the treatment outcome.

**Sociodemographic features**

Some studies found gender differences in the outcome of day hospital treatment. Priebe and colleagues [15] showed that women had a more favourable outcome in a day hospital setting than a conventional hospital ward; a systematic review showed that women improved more than men in social functioning [7]. This latter review also showed that age was positively associated with improvement, but Priebe and colleagues [15] did not find any association.

**The current study**

The literature reviewed above shows little consistency in the predictors of successful stays in day hospitals, probably owing to the wide diversity of settings, programmes and patients in different day hospitals. Day hospitals appear efficient, but how and for whom is still not clear. This study thus aimed to contribute to the empirical literature on psychiatric day hospitals.

Our first goal was to give an insight into the population attending the Fribourg day hospital. Our second goal was to assess treatment outcomes. More specifically, we hypothesised an improvement and measured it with the following indicators: enhancement of the level of general functioning, and a reduction of suicidality and self-harming behaviours. Our third goal was to assess improvement predictors. More specifically, we hypothesised that the outcome would be affected by the following factors:

a) Diagnosis at admission; patients with a depressive or personality disorder will show better outcomes, and patients with substance-related disorder will show worse outcomes.

b) Severity of affection, as measured by the level of functioning, psychopathological load, self-destructing attitudes (suicidality and self-harming behaviours), episode length; they were hypothesised to negatively affect the outcome.

c) Treatment intensity, assessed by stay length and attendance rate; it is expected to be positively related to the outcome.

Because outcome differences according to age and gender have been found, we controlled for them in our analyses.

**Method**

**The Fribourg day hospital**

The Fribourg day hospital pertains to the Fribourg Mental Health Network (RSFM/FNPG), which hosts all public psychiatric services of Canton Fribourg, Switzerland, which has about 300,000 inhabitants and two official languages, French and German. The Fribourg day hospital’s mission is the reintegration and rehabilitation of a psychiatric population, aged between 18 and 65 years, from inpatient facilities or from outpatient services, and to offer an alternative
to inpatient stays. The day hospital is a rather young facility, established in Fribourg in 2010 after a pilot phase started in 2007. The programme was designed on the basis of the experiences of other Swiss day hospitals. The formal admission criteria are to have a fixed home address, to be able to come to the hospital autonomously every weekday, and to speak French or German. Severe suicidal ideation or behaviour is a (temporary) exclusion criterion. Crisis management is part of the hospital’s mission and very brief inpatient stays, shorter than 5 days, do not interrupt the treatment. Patients are expected to participate in the programme for about 7 hours per day, every weekday. The facility closes at weekends. The therapeutic programme relies on two cornerstones: on the one hand, a group programme, based on standardised third wave cognitive and behavioural therapy, general psychoeducation and other group activities; and on the other hand, individualised therapies (including individual psychotherapy, couple, family and network meetings, and pharmacological treatment). Patient’s needs can be very different [34]. Thus, based on the individual needs, patients were assigned to one of two options for the group programme: (a) a programme emphasising psychotherapy and psychoeducation; (b) a programme mainly based on group activities such as art therapy and manual workshops. A psychotherapist (physician or psychologist) and senior clinician (nurse or social assistant) team is responsible for each patient. A multidisciplinary team provides social work assistance, art-therapy and a focus on professional life resumption. The day hospital collaborates frequently with the patient’s relatives and other community health professionals involved. A peculiarity of the Fribourg day hospital is the bilingual approach. It covers a catchment area of about 200’000 inhabitants (the rest of the canton’s being covered by a second French-speaking day hospital founded in 2012), offering 20 French-speaking places and 15 German-speaking places. Covering all positions, the staff consists of about 12 full-time-equivalents. Patients are separated according to their language during the verbal sessions (group therapy, assemblies) and united for the nonverbal therapies and activities. Individual psychotherapy is offered in the patient’s tongue.

Sample and procedure

The data of all Fribourg day hospital stays were gathered from 1 January 2011 to 31 March 2014. The original sample consisted of 426 stays of 327 patients, including French-speaking patients (261 stays) and German-speaking patients (165 stays). The 327 patients of the whole sample had a mean number of 1.30 stays during the study period (standard deviation [SD] 0.61, range 1–4), with one stay for 77.0%, two stays for 17.4%, three for 4.5% and four for 1.2% of the patients. They were adults of a wide age range (mean 40.63 years, SD 12.32, range 18–70), with 58.2% of women. Half (50.1%) of the stays were preceded by a psychiatric inpatient stay, and 42.4% by ambulatory treatment by a psychiatrist, psychologist, family doctor or in an outpatient institution. The data collection in this prospective naturalistic study was approved by the cantonal ethics commission and all patients signed an informed consent form.

Measures

During the data gathering period, at each admission and discharge, the patient’s main therapist (a psychiatrist or psychologist) completed a form recording various patient’s characteristics. All forms were checked and revised by the day hospital’s clinical head (third author). The following information was collected.

Demographics. Age, gender and treatment before admission were assessed.

Diagnoses were made according to the Tenth revision of the International Classification of Diseases’ Classification of Mental and Behavioural Disorders [35] at admission. The main therapist relied on all available information (from previous hospitalisation(s), contact with other therapists and initial interview). Thus, the diagnosis was based on clinical judgement, without a structured interview. For the analyses, diagnoses were grouped at the general category level.

Episode length. At admission, the current episode length was assigned to one of five categories: less than 1 week, 1 to 4 weeks, 1 to 12 months, more than 1 year, or unknown.

Functioning level. At admission and discharge, the patient’s functioning and illness severity were assessed with (a) the Global Assessment Scale (GAF; [36]), which reflects in a single measure the rating of psychological, social and occupational functioning on a scale ranging from 0 to 100, and (b) the Clinical Global Impression severity scale (CGI-S; [37]). The GAF and the CGI can be usefully and validly implemented in daily clinical practice [38, 39]. Therapists assessed life-time (answer options: yes, no, unknown) and current suicidality (no suicidality, suicidality, suicide attempt, unknown), as well as self-harm behaviours (yes, no, unknown) at admission, and at discharge regarding the stay. We computed a score of self-destructive atti-
Data analysis
To provide a more accurate picture of what was actually happening in the day hospital, we performed all our analyses at the stay level, and not at the patient level. The characteristics of the entire sample were summarised (426 stays for 327 patients), to provide a picture of stay diversity. Some stays were removed from the statistical inference analyses, to give a more accurate reflection of general tendencies: missing admission data (n = 1) or discharge data (n = 4), outlier values on the studied variables (n = 35) or, because they were the sole instance of a diagnosis category (F7x, F8x and F9x; n = 3). The final sample for the analyses was composed of 383 stays for 292 patients.

To test the hypotheses for our second goal (improvement of the stay), Wilcoxon tests were used to compare the GAF and CGI-S at admission and discharge and McNemar tests to compare the differences in suicidal and self-harming behaviours. For our third goal (predictors of improvement at the GAF-scale), we first ran analyses for each predictor individually, using analysis of variance (ANOVA) models for the categorical variables (gender, diagnostic category, and episode length) and a regression model for the continuous variables (age, GAF at admission, self-destructive attitudes, stay length and attendance rate). The effect of gender and age was assessed before testing the hypothesised predictors and kept in the subsequent analyses only if found to be significant. Finally, all significant predictors were included in a single analysis of covariance (ANCOVA) model.

Results

Stay characteristics
Our first goal was to report the characteristics of the hospital stays. The majority concerned patients with a main diagnosis of affective disorder (F3x, 48.8%), followed by stays of patients with a personality disorder (F6x, 18.2%), a neurotic or stress-related disorder (F4x; 14.2%), a psychotic disorder (F2x; 9.2%), an organic disorder (F1x; 7.1%), and a disorder associated with physiological disturbances (F5x; 1.9%). One stay (0.2%) concerned a patient with a mental retardation (F7x), one with a disorder of psychological development (F8x), and one with an unspecified disorder (F9x).

Most admissions concerned patients with one (58.2%) or two (30.0%) diagnoses, but there were up to five (mean = 1.54, SD 0.77, range = 0–5). Table I summarises the entire sample’s stay characteristics. The initial functioning level was rather low, indicating moderate to serious impairment on the GAF scale. The CGI score also indicates a low level of functioning, with a mean score close to 5, corresponding to “markedly ill”. At admission, the current episode length was: 1–4 weeks (2.8%), 1–12 months (48.0%), more than 1 year (46.6%), unknown (2.6%). For subsequent analyses, the episode length was divided in less vs more than 1 year. More than half of the patients were currently at risk for suicide at admission. At discharge, most stays were followed by outpatient treatment either by a psychiatrist (48.2%), by a psychologist (15.7%), or in an institution (14.3%). Overall, 16.1% of the stays were followed by an inpatient stay. On average, the stays lasted about 10 weeks, but length varied considerably (SD 39.49, range 1–245 week days). The average attendance rate was high (mean = 83.03%), but also varied widely (SD = 15.87%, range 12.5–100.0%).

Our second goal was to assess with multiple indicators whether an improvement could be observed over the treatment (table I). The GAF score significantly improved, with a medium effect size. The overall symptoms (CGI-score) decreased significantly, even if the effect size was small. The mean therapist-rated improvement level was close to minimal (3 = minimally improved); 70.8% of the stays were rated as being associated with improvement (CGI-I from 1–3; n = 351) and 29.2% as unchanged or worsened (CGI-I from 4–7; n = 145). At the end of the stay, there were significantly fewer suicidal patients and fewer patients showing self-harming behaviour (table 2). This shows a consistent picture of improvement over the stay.

Table 1: Descriptive statistics for stays characteristics.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Difference (Wilcoxon)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stay length (in week days)</td>
<td>51.46</td>
<td>39.27</td>
<td>1–245</td>
<td></td>
</tr>
<tr>
<td>Attendance rate</td>
<td>83.35%</td>
<td>15.87%</td>
<td>12.5–100%</td>
<td></td>
</tr>
<tr>
<td>GAF score at admission</td>
<td>50.37</td>
<td>7.63</td>
<td>25–70</td>
<td>Z = –10.42***, r = .38</td>
</tr>
<tr>
<td>GAF score at discharge</td>
<td>54.54</td>
<td>39.27</td>
<td>5–84</td>
<td></td>
</tr>
<tr>
<td>Difference in GAF score</td>
<td>4.07</td>
<td>9.53</td>
<td>43–35</td>
<td></td>
</tr>
<tr>
<td>score over stay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CGI score at admission</td>
<td>4.69</td>
<td>0.82</td>
<td>2–7</td>
<td>Z = 5.442***, r = .20</td>
</tr>
<tr>
<td>CGI score at discharge</td>
<td>4.47</td>
<td>1.01</td>
<td>0–7</td>
<td></td>
</tr>
<tr>
<td>CGI improvement</td>
<td>2.93</td>
<td>1.22</td>
<td>0–7</td>
<td></td>
</tr>
</tbody>
</table>

n = 426 stays for 327 patients. According to Cohen’s criteria, 0.10 < r < 0.30 is a small effect and 0.30 < r < 0.50 is a medium effect.
Predicting improvement over the stay

Our third goal was to assess predictors of improvement (i.e., the difference between the GAF at discharge and at admission) over the stay.

We first tested whether age or gender were significant predictors of improvement. This was not the case for age ($b = 0.01, t(378) = 0.22, p = 0.83$) or for gender ($F(1, 378) = 0.14, p = 0.70$).

We then tested our prediction that the outcome would differ according to the diagnosis category. This was the case: $F(5, 373) = 3.71, p <0.01$. Post-hoc analyses revealed that the difference was significant only between F1x (substance related disorders) and F3x (mood disorders; Tamhane $T_2 = -5.05, SE = 1.34, p <0.001$) categories, the stays with patients of the latter category being associated with a greater improvement. Next, we tested whether several indicators of the functioning level would affect the improvement. GAF at admission was a significant predictor, such that the lower the initial functioning level at intake, the more the GAF score improved ($b = -0.23, t(378) = -4.64, p <0.001$). However, stays of patients with a longer episode length before admission gave a significantly lower improvement ($F(1, 68) = 10.00, p <0.001$). Estimated marginal means for episode length shorter than 1 year were 5.93 (SD = 0.53, and for episodes longer than 1 year 3.46 (SD = 0.57).

Self-destructive attitudes did not affect the outcome ($b = -0.01, t(344) = -0.11, p = 0.92$). We then tested whether the treatment intensity affected the outcome. Stay length significantly and positively predicted the GAF score improvement ($b = 0.26, t(374) = 5.25, p <0.001$). The same applied to the attendance rate; the more intensively patients attended the day hospital during their stay, the better the GAF score improvement ($b = 0.11, t(373) = 2.16, p <0.05$). The final analysis, which included all significant predictors within the same model, revealed that most predictors remained significant: GAF at admission ($F(1, 355) = 28.39, p <0.001$), episode length ($F(1, 355) = 11.48, p <0.001$) and stay length ($F(1, 355) = 25.31, p <0.001$). Some predictors dropped to marginal significance: diagnosis category ($F(1, 355) = 1.95, p <0.10$) and attendance rate ($F(1, 355) = 3.74, p <0.10$) (table 3). This model explained 18% of the variance (adjusted $R^2 = 0.18$). Hence, the factors that appear to matter most in predicting the outcome are the initial functioning level, the chronicity of the disorder and the treatment length, and when we control for these factors, the percentage of attendance and the diagnosis category lose importance.

Discussion

This paper provides an overview of the stay characteristics from a day hospital recently opened in a small Swiss city. The data, based on a large pool of patients and stays, showed a wide diversity and generally high affection severity, but overall patients’ functioning level significantly improved over the stay. An initially low functioning level, as well as a longer stay significantly predicted a favourable treatment outcome, whereas the chronicity of the disorder predicted a less favourable outcome.

High population diversity

In agreement with most literature on day hospitals [4, 15], the stay characteristics were very heterogeneous for a broad range of factors (diagnosis, age, stay length, functioning level and improvement at discharge, etc.). Moreover, the illness severity of the treated patients was rather high. Initial global assessments of functioning were generally rather low (about 50, indicating markedly ill patients with moderate to serious impairments). This is not surprising given that the target population was patients presenting a severity of illness justifying intense daily treatment, but with a level of autonomy and stability allowing them to go back home daily. Also indicating the severity of disorders in the treated population, about 40% of the stays concerned patients with comorbid disorders and about 50% patients with current suicidality (thoughts...
The most represented diagnosis category was mood disorders, which matches previous literature [9, 17]. However, in contrast to the literature, many patients had a main diagnosis of personality disorder, and few patients had psychotic disorders [9, 18]. Offering a treatment that suits this very heterogeneous population in a single facility represents a challenge.

**Improvement over the stay**
The day hospital appeared to be helpful in a majority of the cases, despite their heterogeneity: 71% of the stays ended with a global clinical improvement (CGI-I) and a significant medium-sized increase in functioning level (GAF scores) and a small decrease in illness severity (CGI severity scores) was found. Suicidality and self-harm behaviours also significantly decreased, even if many patients often disclosed their suicidal thoughts only during the stay (which may have biased our results in a conservative way [42]).

**Predictors of improvement**
Our third goal was to determine what predicted improvement over the stay. To begin with, gender and age did not influence the outcome, such that the day clinic seem to have been equally useful for male and female patients of all ages.

**Diagnosis category**
Stays of patients with different first diagnosis categories showed different outcomes. Stays of patients with substance related disorders brought a lower improvement than stays of patients with mood disorders. The better outcome for mood disorder is consistent with Mazza’s [17] results. Moreover, previous literature showed that general day hospitals are not optimal for patients with substance disorders [19]. These less favourable outcomes may be due to the challenges associated with these disorders (higher severity for dual disorders [43]). Current research recommends treatments integrating mental health and substance related disorder problematics [44]. In our facility, the problematics associated with substance related disorders were not specifically targeted. For some diagnosis categories, such as substance related, psychotic or personality disorders, a diagnosis-specific intervention (individual or group) might help address the particular difficulties associated with these disorders. 

**Severity of affection**
The lower the initial functioning level (GAF score), the higher the improvement. Previous literature has shown contradictory results; Arnevik and colleagues [24] found no difference in outcome according to the functioning level, but Priebe et al. [15] showed that patients with a high symptom load at baseline had a worse outcome in day hospital than with inpatient treatment. In our facility, stays of patients with a lower functioning level seemed to have higher improvement. In addition, improvement of the GAF score was predicted by episode length; stays of patients whose episode had lasted less than a year were more likely to be associated with an improvement, showing that less chronic cases are easier to treat [45]. Finally, self-destructive attitudes did not affect the outcome, indicating that, despite the potential threat to the treatment that suicidal thoughts or self-harming behaviour might represent, they do not seem to interfere with the therapy outcome. This shows that suicidal patients can be treated in a day hospital with a success level similar to nonsuicidal patients [28]. However, our data do not consider the severity of suicidality, and close monitoring of the suicidality level should always be a priority. In our day hospital, referring patients to an inpatient ward to protect them from a high suicidal risk was common.

**Treatment intensity**
Finally, and importantly for the clinical implications, stay length and attendance rates were significant positive improvement predictors. They not only indicate a time but also a dose-response effect. After controlling for stay length, the effect of attendance rate dropped to marginally significant, showing that a key factor is to grant enough time to the patient to improve. Despite the financial burden represented by longer stays, our results indicate that patients with the best outcome need to have sufficient time and participation with the treatment. The day hospital setting allows contact with real-life conditions, and thus conserves or trains daily skills. Given the severity of disorder in the treated population, a longer stay seems important for patients to be able to benefit, as has been shown in other psychiatric settings with severely affected patients [31, 32]. This is in line with a recent study showing that adults from a psychiatric outpatient clinic showed better outcomes with longer treatments, especially if the patients improved slowly [46]; this was mostly the case in our sample, as improvements were modest. It should also be noted that the stays of patients dropping out from the treatment likely have been rated with a worse outcome, and that the longer stays concern more committed patients. Thus, working on the patient’s motivation and adherence to treatment appears important (e.g. [47]).
Limitations and future research

This study offers a comprehensive and ecologically valid picture of a day hospital and is to our knowledge the first to do so for a Swiss day hospital that is not specialised in a certain diagnosis or approach. Analyses were based on a large representative sample of the treated population, including 89.9% of all patients treated during the data acquisition period in French and in German. However, several limitations must be taken into account.

First, the effect sizes were small, such that the results should be interpreted with caution. This is, however, not surprising given the illness severity of the treated population, and that the treatment stops once the patient is stable enough to be treated in an outpatient setting, thus setting a natural ceiling on the potential improvement. Second, the results concerning the differences regarding the diagnosis must be interpreted cautiously. Diagnoses were not made with a structured clinical interview, and were often refined and changed during treatment, as part of the day clinic services [1]. Moreover, comorbid disorders were not taken into account and might have been more frequent if assessed with structured clinical interviews, because of overlapping symptoms between diagnosis [48]. Third, despite their general good measurement properties [38, 39], the GAF and CGI are very broad measures and their reliability can be affected by several factors, such as the rater’s attitude toward these measurements [49], the patient-therapist relationship history or the therapist’s memory [50]. Hence, in public psychiatric services, at least one rater-completed and one patient-completed instrument should be used [51]. Future research should assess patients’ self-reported general psychopathology, specific symptoms (e.g. with the symptom check list [52]) and user satisfaction. Fourth, our design did not allow conclusions about the influence of specific process factors such as individual therapy, group therapy, social support, therapeutic relation, etc. Fifth, as this was not a randomised controlled study, we have no data concerning the effectiveness of our day hospital compared with outpatient or inpatient services. A cost/benefit analysis is thus not possible. Finally, our study did not allow us to tease apart the effect of different therapeutic orientations, which varied according to the therapists’ individual training. However, the treatment concept seems to have little relevance and patients’ characteristics to be much more important [53].

Implications for practice and future research

The strength of this study was its naturalistic, real-life setting, based on the bilingual population of Canton Fribourg. Even with severely impaired patients with very diverse psychiatric disorders and comorbidities, small to medium improvements were observed, allowing good conditions for a subsequent outpatient treatment. The treatment intensity (stay length and attendance rate) was an important predictor of outcomes, demonstrating the importance of offering a sufficiently substantial treatment. Owing to the large variation in outcome, the question of admission criteria and indication (e.g. GAF thresholds) remains open and would be important to address in order to admit patients for whom day hospital treatment is best indicated. The different outcomes according to diagnosis raise the question of whether disorder-specific treatments might be important for at least a portion of patients.

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References

The full list of references is included in the online article at www.sanp.ch.
Interview mit Dr. phil. Niklas Baer (Leiter Fachstelle Psychiatrische Rehabilitation, Psychiatrie BL)

Warum ist die Arbeitsrehabilitation für psychisch Kranke so wichtig?

Karl Studer, Niklas Baer


Karl Studer: Wo stehen wir derzeit im Umgang mit der Problematik der Arbeit bei unseren Patienten?


KS: Was ist der Grund dieser einseitigen Sichtweise?


KS: Wie stellt Du Dir das vor?

Wenn auch meist eine leichte. Aber drei vor vier Erwerbstätigen mit einer psychischen Störung geben an, aus gesundheitlichen Gründen nicht voll produktiv zu sein. Das sind immerhin 750 000 Personen, bei denen sich das psychische Leiden bei der Arbeit nie derschlägt. Aus diesem Grund sind es letztlich auch die Unternehmen, die den Löwenanteil der Folgekosten psychischer Störungen tragen, sei es via Produktivitätsverlusten oder via Krankheitsabsenzen.

Wenn Psychiater und Psychotherapeuten vermehrt am Arbeitsplatz präsent wären und von Arbeitgebern als hilfreicher Partner wahrgenommen würden, würde das auch dem Image der Psychiatrie enorm helfen. Eine Psychiatrie, die gesellschaftlich und ökonomisch substantiell relevant ist, würde vielleicht auch wieder attraktiver für junge Ärzte. Das wäre eine Psychiatrie, die bei Bedarf unkompliziert im Betrieb präsent ist, sich im kleinen Malerbetrieb wie auch in der internationalen Pharmafirma zurechtfindet und mit den Beteiligten fundierte und pragmatische Lösungen erarbeitet. Und eine Psychiatrie, die für diese anspruchsvollen und exponierten Interventionen ausserhalb der geschützten Praxisatmosphäre mindestens ebenso gut finanziert wird wie für das Führen von Betten – all das wäre für mich eine moderne Psychiatrie und ein moderner Finanzierungsbedanke.

KS: Welche Rolle spielen hier die Versicherungen?

NB: Die Versicherungen sind sehr wichtig, nicht nur die Invalidenversicherung, die immer wieder in der politischen Diskussion ist, sondern gerade auch die Privatversicherer. Die Taggeldversicherungen zum Beispiel, die die Problematik bereits erkannt haben und im eigenen Interesse in den letzten rund 15 Jahren eine neue Berufsgruppe ins Leben gerufen haben, die Case Manager oder Care Manager, die nun einen Teil der wichtigen Vermittlungsaufgabe zwischen Patienten, Ärzten und Arbeitgebern übernehmen. Seit drei Jahren schulen wir – der Psychiater Dr. Renato Marelli, die IV-Berufsberaterin Neisa Cuonz und ich – die Case Manager, wie sie mit psychisch erkrankten Versicherten umgehen können. Hier ist angesichts der steigenden Arbeitsunfähigkeit aus psychischen Gründen das Bewusstsein stark gestiegen.

KS: Welche Rolle spielt die IV derzeit im Rahmen der Arbeitsrehabilitation?


KS: Wie steht es in der Lehre und Forschung an unseren Universitäten zum Thema Arbeit


KS: Welche Anregungen und Wünsche hast Du noch zuhanden der SGPP?

Internationale Strategien und Konzepte

Früherkennung psychischer Störungen und Suizidprävention

Hanspeter Walti

Im Rahmen einer vierräumigen Studienreise durch Australien, Neuseeland und Hong Kong hat der Autor verschiedene Institutionen und Organisationen besucht. Der Reisebericht fasst die gewonnenen Eindrücke und Beobachtungen zum Thema «Internationale Strategien und Konzepte zur Früherkennung psychischer Störungen und zur Suizidprävention» zusammen. Wir publizieren hier die Zusammenfassung zu den einzelnen Ländern sowie die Schlussfolgerungen für die Schweiz.

Der vollständige, bebilderte Bericht inklusive Literaturverzeichnis ist als PDF auf der Website www.sanp.ch abrufbar.

Australien


Die Philosophie von Orygen und Headspace lautet: «Auf Jugendliche muss man zugehen und dabei ihre Kommunikationsmittel be nutzen, anstatt darauf zu warten, bis sie Hilfe suchen».

Neuseeland


Hong Kong

Hong Kong verfügt über ein renommiertes Forschungszentrum für Suizidprävention (Centre for Suicide Research and Prevention CSRP).

Dank vielfältiger Projekte zur Suizidprävention konnte die Suizidrate in Hong Kong seit 2003 kontinuierlich gesenkt werden. Besonderes Gewicht wird dabei auf einen Public Health Ansatz gelegt (Multiebenen-Strategie).

Ein umfangreiches Monitoring der Suizide und Suizidversuche bildet die wissenschaftliche Grundlage für die Suizidprävention. Für suizidgefährdete ältere Leute wurde angesichts der hohen Suizidrate im Alter ein spezielles Programm entwickelt (Elderly Suicide Prevention Program ESPP). Zur Früherkennung von Psychosen gibt es ein Netzwerk von spezialisierten Anlaufstellen (Early Assessment Services for Young People).

Persönliche Schlussfolgerungen

Die Schweiz braucht aus meiner Sicht:

– Eine nationale Strategie zur Suizidprävention oder zumindest einen nationalen Aktionsplan, wie er in der Motion Ingold gefordert und vom BAG zurzeit erarbeitet wird. Diese bilden den Rahmen, an dem sich die 26 Kantone bei der Planung konkreter Projekte orientieren können.

– Eine nationale Kampagne zur Entstigmatisierung psychischer Erkrankungen.

– Ein nationales, zeitnahes Monitoring der Suizide («Suizid-Register») bzw. der «vermuteten» Suizide nach dem Modell Neuseelands und Hong Kongs. Damit ließen sich Entwicklungen gesamt schweizerisch beobachten und gegebenenfalls mittels Frühinterventionen beeinflussen. Idealerweise würde das Monitoring auch die Suizidversuche mit einschliessen, was auf Grund der fehlenden Meldepflicht und der teilweise schwierigen Abgrenzung der Suizidversuche von selbstverletzendem Verhalten aus andern Gründen aber kaum möglich sein wird. Die Daten des Monitorings sind zeitnah an die für die Suizidprävention Verantwortlichen in den Kantonen für allfällige Interventionen weiterzuleiten.


– Eine nationale Plattform zur Koordination kantonaler und lokaler Präventionsprojekte.

– Wissenschaftliche Begleitforschung zur Suizidprävention.

– Vermehrung psychosozialer Gesundheitsdienste (vgl. «Headspace»-Modell in Australien).

– Verstärkte Bemühungen zur Früherkennung und Suizidprävention oder zumindest einen nationalen Aktionsplan (nationaler Aktionsplan Suizidprävention).

Mögliche Aufteilung der Verantwortlichkeiten:

National:
– Rahmenstrategie zur Suizidprävention (nationaler Aktionsplan Suizidprävention)
- Suizidpräventions-Projekte auf nationaler Ebene (SBB, Waffen)
- Monitoring der Suizide (Suizidversuche) zur Erkennung von Clustern und Hotspots
- Wissenschaftliche Untersuchung der assistierten Suizide
- Wissenschaftliche Begleitforschung und Evaluation
- Plattform zum Austausch von Best Practice
- Entstigmatisierungskampagne

Kantonal:
- Kantonal Aktionsplan Suizidprävention
- Suizidpräventions-Projekte auf Kantonsebene (z.B. Brücken)
- Kantonal Verantwortliche für die Bearbeitung der Monitoring-Daten
- Gesundheitsversorgung
- Früherkennung von psychischen Störungen
- Gesundheitsprojekte auf Gemeindeebene (z.B. «Gesund Altern in …»)
- Suizidpräventions-Projekte auf lokaler Ebene (Gemeinde)
- Ansprechpersonen für Interventionen auf lokaler Ebene (Gemeinde, Schulen, usw.)
- NGO’s
- Selbsthilfe

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VARIA

Luc-Ciompi-Award

In 2017, the Swiss Society of Psychiatry and Psychotherapy (SGPP) is awarding, for the second time, a prize donated by Luc Ciompi for scientific studies on the relationship between emotion and cognition and their importance in schizophrenia.

The prize can also be awarded for publications from other fields of the natural and social sciences that contribute to clarification of the relationship between feeling and thinking. Relevant works should be submitted electronically to the secretariat of the SGPP in Bern (sgpp[at]psychiatrie.ch) by 31 March 2017. They should contain a summary of the submitted paper and its possible relations to the concept of affect-logic (cf. www.ciompi.com/fields of interest/affect-logic), as well as a brief curriculum vitae.

For more information: www.psychiatrie.ch/Luc Ciompi Award.
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