Social Psychiatry in the Age of Informatics

Summaries of presentations made during the
2nd European Congress for Social Psychiatry

Edited by

Yasser Khazaal - François Ferrero - Norman Sartorius

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General Introduction

We are pleased to present the abstract e-book of the II European Congress for Social Psychiatry.

Launched by the Swiss Society of Social Psychiatry with the support of a number of associations (i.e. the World Association of Social Psychiatry, the European Association of Psychiatry, the Swiss Society of Psychiatry and Psychotherapy, the Minkowska Center), the congress was held in Geneva (1-3 July 2015). The first meeting, in 2012, also took place in Geneva.

The Scientific Committee of the congress chose to focus on the developments and challenges in mental health in the digital age. Unsurprisingly, two of the main topics ("The digital age: opportunities for treatment of mental disorders" and "Internet-related disorders") were related to developments and concerns in the growing field of e-mental health.

Another topic ("New interventions and new models for better mental health care") covered improvements in care models and processes that aim to empower patients in relation to their own care and their full inclusion in society.

In consideration of the worldwide and European economic and political crises, an important part of the congress was to address the challenges of such crises for mental health.

The congress allowed rich interactions between researchers, clinicians, and associations from more than 30 countries.

This European Congress intends to promote and highlight the developments in the field of social psychiatry in Europe.

Yasser Khazaal, François Ferrero, and Norman Sartorius

2nd European Congress for Social Psychiatry

Social Psychiatry in the Age of Informatics

The Swiss Society for Social Psychiatry (SSPS-SGSP) has great pleasure in inviting you to participate in the 2nd European Congress for Social Psychiatry – co-sponsored by the World Association for Social Psychiatry (WASP) and under the patronage of the European Psychiatric Association (EPA) – to be held in Geneva on July 1 – 3, 2015.

The main theme of the congress will be *Social Psychiatry in the Age of Informatics* encouraging a correlation of clinical and research perspectives at various levels of understanding and action, from prevention to treatment.
Renowned European experts in the field will give keynote lectures, as well as leading symposia and workshops.

The scientific programme will include the following:

- **Innovation in social psychiatry**
- **Developments and perspectives from the internet and informatics**
- **The user's involvement**
- **Transition to community psychiatry**
- **Addiction and problems related to informatics**
- **Other topics**

Simultaneous translation (English-French and/or French-German) will be provided for some plenary sessions and some symposia.

For the Organizing Committee and Swiss Society for Social Psychiatry
Chair and Co-Chairs :
Prof. Yasser Khazaal
Dr. Ruth Waldvogel
Dr. Gea Besso

For the Scientific Committee
Prof. François Ferrero
Prof. Yasser Khazaal

Scientific advisor:
Prof. Norman Sartorius

For the World Association for Social Psychiatry
President:
Prof. Thomas Jamieson-Craig

Co-sponsored mee by the World Association for Social Psychiatry (WASP) and under the patronage of the European Psychiatric Association (EPA)

Geneva, Switzerland
1 - 3 July, 2015

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Scientific Programme

Wednesday, July 1st	**Welcome Ceremony**
18.00-19.15	**Public Conference & Prix de Genève**
19.15-20.00	**Get together**

Thursday, July 2nd	
9.00-9.30	**Opening Session**
9.30-10.00	**Plenary Lecture**
	Coffee Break/Poster Session
10.30-11.45	**Symposia & Workshops**
11.45-12.45	**Symposia & Workshops**
12.45-13.15	**Session**
13.15-14.00	**Free time for Lunch**
14.00-14.30	**Plenary Lecture**
14.30-15.45	**Symposia & Workshops**
	Coffee Break/Poster Session
16.15-17.30	**Symposia & Workshops**
17.30-18.30	**Symposia & Workshops**
19.30-22.30	**Geneva Night**

Friday, July 3rd	
9.00-9.30	**Plenary Lecture**
9.30-09.45	**Poster Award Ceremony**
	Coffee break/Poster Session
10.15-11.30	**Symposia & Workshops**
11.30-12.45	**Symposia & Workshops**
12.45-13.30	**Free time for Lunch**
13.30-1400	**Plenary Lecture**
14.00-15.15	**Round Table**
15.15-16.30	**Symposia & Workshops**
16.30-17.45	**Symposia & Workshops**
17.45-18.30	**Farewell Drink**

Section 1: The digital age: opportunities for treatment of mental disorders

With the growth of the digital age, the volume of information and the number of human-machine interactions have constantly increased, bringing humans face to face with new hopes and challenges.

One of the most important developments of the digital age is related to the emergence of computerized and Internet treatments for mental disorders.

A field that has emerged in parallel interacts with technologies of the digital age: games for mental health.

One consequence is better dissemination of available face-to-face treatments. Furthermore, such interactions between therapists, patients, and computers could lead to the improvement of these treatments, the potentialization of their effects, and/or the emergence of radically innovative approaches, as highlighted in a number of abstracts presented below.

When the presents meets the future: human-machines convergence

Christian Lovis

Division of Medical Information Sciences, University Hospitals of Geneva (HUG), University of Geneva (UNIGE), Geneva, Switzerland

Information and communication are major determinants of human kinds. The technological revolution started in 1459 with Gutenberg and the first move to improve access to written information. The technological move. It was followed, 500 years later, by the birth of the world wide web in 1989 by Tim Berners-Lee in the building 31 of the CERN, that was the communication revolution. In 1992, Al Gore decided to give free and public access to the gigantic database of the National Library of Medicine, it was the cornerstone of the free access revolution. Since then, at an accelerated pace, systems carrying data, information and knowledge have demonstrated a constant convergence and increasingly tight relation with humans, up to embedded human-machine systems. This is a societal movement. It will lead to the next generation of humans, in a merge between natural biology, genetic engineering, bio and nano technology, silico systems and software. New hopes and new challenges for human kinds.

Personalized internet-delivered psychological treatments for anxiety and depression

Gerhard Andersson

Department of Behavioural Sciences and Learning, Linköping University, Linköping, Sweden

Psychological treatments tend to be manualized and standardized in research, which does not reflect clinical practice where treatments often are adapted according to patient profile and presenting symptoms. An fairly novel approach to psychological treatment is to deliver treatment contents via the internet with minimal support from a clinician. This treatment format has been tested in more than 100 controlled trials and head to head comparisons against face-to-face treatments tend to show equivalence. However, a novel form of internet treatment involved tailoring the contents of the treatment according to comorbidities and patient preferences. For example, a depressed patient may suffer from comorbid social anxiety, insomnia and stress. Apart from to shared depressive symptoms the next patient may have a different profile with relationship problems, somatic problems and procrastination. Needless to say there is no one manual for all possible combinations, but research suggests that treatment can be personalized and tailored with sustained effects and potentially superior outcomes. A neglected factor in research is patient preferences regarding treatment ingredients and pilot work indicates that at least some decisions regarding treatment contents can be delegated to the patient. The talk concludes by highlighting new ways to tailor internet interventions, including choice of language to present the intervention and modern information technology.

Computer assisted therapy for auditory hallucinations: the AVATAR clinical trial

Tom Craig, Philippa Garety, Mar Rus Calafell, Tom Ward, Geoffrey Williams, Mark Huckvale and Julian Leff

Health Service and Population Research, Institute of Psychiatry, King's College London, London, UK

Many people who suffer from psychotic disorders including 25% of those with a diagnosis of schizophrenia experience distressing, critical or persecutory auditory hallucinations (AH) that persist despite adequate medication and psychological therapy such as cognitive behaviour therapy. A recent development uses a computer simulation in which patients create a representation of the entity they believe to be the source of their AH (Leff et al., 2013). Using this programme, they select a sample of speech and modify it until they are satisfied that it matches the quality of the AH that they experience and then select and modify a visual representation (AVATAR) of the entity that they believe to be the source of their voices. Therapy proceeds with patient and therapist at linked computers in separate rooms. The therapist is able to speak either as the avatar (which the patient perceives as appropriately lip and facially synced), or in his/her own voice when giving advice and coping instructions. Therapy is provided over 7 weekly sessions that last between 30 and 45 min (of which typically no more than 20 min is spent in trialogue with voice and therapist). The therapist encourages the patient to stand up to the AVATAR and shapes the dialogue so that the patient achieves greater control over the voice which becomes less hostile and critical. The sessions are audio recorded and patients are given copies of each session and asked to listen to these as 'homework# between sessions.

A pilot study compared AVATAR therapy with treatment as usual 26 patients in a cross-over design There was a significant reduction in the frequency of voices and associated distress and 3 patients stopped hearing voices entirely (Leff et al., 2013).

Results of this pilot study were striking, but the sample was small and had a substantial drop out. The current study is an attempt to replicate the positive findings in much larger randomised clinical trial (n = 142) comparing AVATAR therapy to supportive counselling in patients who have suffered from AH for at least 12 months despite treatment with adequate doses of medication.

The study has now recruited two-thirds of the target sample. In this presentation I will describe the new clinical trial present data on recruitment, retention and safety and focus on the AVATAR therapy itself, demonstrating the enrolment of patients and illustrating the key components of therapy with reference to case examples and some videotaped material.

Reference

Leff, J., Williams, G., Huckvale, M. A., Arbuthnot, M., and Leff, A.,P. (2013). Computer assisted therapy for medication-resistant auditoyr hallucinations: proof of concept study. *Br. J. Psychiatry* 202, 428–433

Un atelier sur le développement et l'utilisation clinique de la stratégie APAP en psychothérapie

APAP : Augmentation de la Psychothérapie par Amorçage Préconscient

François Borgeat[1,2,3] and Yasser Khazaal[4]

1. Institut Universitaire en Santé Mentale de Montréal, Montréal, QC, Canada
2. Université de Montréal, Montréal, QC, Canada
3. PsyXnovation, Montréal, QC, Canada
4. Université de Genève, Geneva, Switzerland

Cet atelier interactif propose une initiation clinique à la stratégie APAP qui s'appuie sur une convergence psychothérapie-ingénierie par l'utilisation de l'informatique et d'internet. Les participants pourront expérimenter en petits groupes l'utilisation du logiciel APAP pour des simulations cliniques de troubles anxieux, en particulier le trouble d'anxiété sociale et le trouble d'anxiété généralisée.

Une des bases de la démarche APAP est d'éviter l'enfermement dans une logique d'école de psychothérapie et d'aller puiser des stratégies susceptibles d'enrichir nos approches dans des domaines extérieurs aux thérapies habituelles. Ici ce fut en informatique et dans les recherches sur la perception préconsciente et le « priming » ou amorçage cognitif.

Les diverses psychothérapies aident à comprendre et à modifier les pensées, croyances et attitudes dysfonctionnelles génératrices de souffrance. Mais souvent malgré bien des efforts, le même discours intérieur automatique redémarre comme un vieux CD intérieur dont on n'arrive pas à se débarrasser ce qui alimente l'impression de retomber sans cesse dans de vieilles habitudes ou ornières cognitives creusées depuis des années. La stratégie APAP vise précisément cette résistance et semble pouvoir faciliter le changement cognitif constituant un complément potentiellement utile aux psychothérapies actuelles.

Les premières utilisations du logiciel APAP font ressortir trois facettes de cette nouvelle stratégie : une aide pour structurer une démarche de type cognitif, une technique de facilitation du changement cognitif par amorçage préconscient et une possibilité de thérapie autonome assistée à distance par internet.

Intervenants

1. Développement et utilisation clinique de la stratégie APAP en psychothérapie
   François Borgeat, Université de Montréal, Montréal, Canada
2. Utilisation clinique de la stratégie APAP
   Yasser Khazaal, Université de Genève, Genève, Switzerland
3. Utilisation clinique de la stratégie APAP
   Carmen l'Allier, PsyXnovation, Montréal, Montréal, Canada

New media in the prevention and treatment of problematic alcohol and drug use

Michael P. Schaub[1] and Michael Lucht[2,3]

1. Swiss Research Institute for Public Health and Addiction ISGF, Zurich, Switzerland
2. Hospital for Psychiatry and Psychotherapy
3. University Medicine Greifswald, Greifswald, Germany

This seminar provides an update on Internet and mobile phone based interventions for the reduction of problematic alcohol and drug use. Four up to date examples of SMS and/or Internet based innovative interventions tested in RCTs in adult problematic cannabis users, apprentices with problem drinking, patients with alcohol dependence, and problematic drinkers with moderate depression symptoms will be presented.

Speakers

1. Can reduce – the effects of chat-counselling and web-based self-help, web-based self-help alone and a waiting list control program on cannabis use in problematic cannabis users: results from a randomized controlled trial
   Larissa J Maier, ISGF
2. MobileCoach Alcohol: a web- and text messaging-based intervention to reduce problem drinking in young people
   Severin Haug, ISGF
3. Continuous monitoring of patients with alcohol dependence with short message service (SMS)
   Michael Lucht, Hospital for Psychiatry and Psychotherapy; University Medicine
4. First web-based dual disorder treatment trial among problematic alcohol users with moderate depression symptoms: study design and intervention contents
   Michael Schaub, ISGF

CANreduce – a web-based self-help intervention to reduce problematic cannabis use and the effectiveness of additional chat counseling

Larissa J. Maier, Andreas Wenger and Michael Schaub

Swiss Research Institute for Public Health and Addiction ISGF, Zurich, Switzerland

Cannabis is the most commonly used illicit drug in Europe. Frequent cannabis use is associated with negative health outcomes, impaired cognitive function, lower educational achievement, and mental health problems. However, among individuals meeting diagnostic criteria for a cannabis use disorder, only few seek professional treatment. Cannabis users rarely access face-to-face therapy due to incompatibility with working hours, costs, transport, concerns about confidentiality, and social stigma. Web- based interventions to reduce cannabis use are promising as they are cost-effective, anonymous, and available whenever required. Moreover, recent study results provide evidence for the effectiveness of web-based interventions in reducing the frequency of cannabis use.

Therefore, we investigated the effectiveness of a web-based self-help intervention to reduce problematic cannabis use in a three-armed randomized controlled trial. After responding to the screening questionnaire, eligible participants were randomly assigned to either web-based self-help intervention, web-based self-help intervention with chat counseling, or wait list. The self-help intervention consisted of eight modules designed to reduce cannabis use informed by the principles of cognitive behavioral therapy, motivational interviewing, and self-control. The two additional chat counseling sessions provided in one of the study conditions were informed by the same principles and were tailored to participants using the self-report data. The primary outcome measure was the quantity of cannabis used per week. Secondary outcome measures included days of cannabis use per week, cannabis use disorder symptoms, severity of cannabis dependence, cannabis withdrawal symptoms, cannabis craving, alcohol, tobacco, and other illicit drug use, mental health symptoms, and treatment retention. We hypothesized that individuals who were assigned to the self-help intervention would report lower frequency and quantity of cannabis use, lower levels of cannabis dependence, and fewer symptoms of cannabis abuse compared to the wait list control group. Furthermore, we hypothesized that the self-help intervention would be most effective in reducing cannabis use when combined with additional chat counseling. The final results will be presented at the conference. The trial is registered at Current Controlled Trials as trial number ISRCTN59948178.

MobileCoach alcohol: a web- and text messaging-based intervention to reduce problem drinking in young people

Severin Haug[1], Raquel Paz Castro[1], Tobias Kowatsch[2] and Michael P. Schaub[1]

1. Swiss Research Institute for Public Health and Addiction, Zurich, Switzerland
2. Health-IS Laboratory, Institute of Technology Management, University of St. Gallen, St. Gallen, Switzerland

Problem drinking, particularly risky single-occasion drinking is widespread among adolescents and young adults in most Western countries. Mobile phone text messaging allows a proactive and cost-effective delivery of short messages at any time and place and allows the delivery of individualised information at times when young people typically drink alcohol. The fully-automated intervention program MobileCoach Alcohol provides an online feedback based on the social norms approach as well as individually tailored mobile phone text messages to stimulate (1) positive outcome expectations to drink within low-risk limits, (2) self-efficacy to resist alcohol and (3) planning processes to translate intentions to resist alcohol into action. Program participants will receive up to two weekly text messages over a time period of 3 months.

The presentation focuses on the intervention components of the MobileCoach Alcohol and its acceptance in the target group of vocational and upper secondary school students in Switzerland. Based on the first results concerning participation and retention, potentials and limitations of this intervention approach will be discussed.

Continuous monitoring of patients with alcohol dependence with short message service (SMS)

Michael J. Lucht, Luise Hoffman, Severin Haug, Dörthe Pussehl, Anne Quellmalz, Thomas Klauer, Hans J. Grabe, Harald J. Freyberger, Georg Schomerus, Ulrich John and Christian Meyer

Klinik und Poliklinik für Psychiatrie und Psychotherapie der Universitätsmedizin Greifswald am HELIOS-Hanseklinikum, Stralsund, Germany

Background: Alcohol dependence is generally treated in an acute-care format aiming at enduring abstinence. Recent data support that continuous therapies with reduction of consumption as target are more successful. Mobile phone short message service (SMS) might be a cost-effective element for consumption reduction in ongoing treatment schemes.

Method: In a controlled open pilot study we tested the feasibility of a 2-months outpatient interactive mobile phone SMS intervention ($n = 42$) against treatment as usual (TAU; $n = 38$) in consecutive blocks. Patients were asked for help-need by automatically generated SMS twice weekly and called back by the therapist when required. After 4 and 8 weeks alcohol consumption was assessed via telephone with the FORM-90 telephone-questionnaire. Response was defined as attaining low risk consumption (WHO) after 8 weeks (primary endpoint).

Results: The system performed 3006 operations automatically to maintain contact (SMS-transmission, notification of the therapist). Only 20.5% of the SMS-replies led to a phone call, highlighting the efficient filtering performance of the system. 57.14% of the participants replied to at least 50% of the prompts. Patients reported a preadmission DDD of 281.25 $\pm$244.61 g. In the SMS group, 55.7% of 42 patients, and 40% of 38 patients in the TAU group, achieved low-risk consumption (risk diff: 0.16; 95%CI 0.06–0.37; $p = 0.122$). SMS patients reported a higher time to relapse ($p = 0.004$) and increased detoxification-readmission ($p = .48$).

Conclusion: Study results indicate that SMS based follow-up is feasible. The hypothesis that the SMS therapy has advantages over TAU is currently being studied in an adequately powered study (Continuity of care among alcohol dependent patients via mobile phone SMS; CAPS; ISRCTN78350716; funded by the DFG; Lu 849/2-1). Pilot study: ISRCTN35240647

Key words: alcohol dependence, e-mental-health, short-message-service, SMS, continuous care

First web-based dual disorder treatment trial among problematic alcohol users with moderate depression symptoms: study design and intervention contents

Michael P. Schaub[1], Matthijs Blankers[2,3], Dirk Lehr[4] and David D. Ebert[4,5]

1. Swiss Research Institute for Public Health and Addiction ISGF, Zurich, Switzerland
2. Arkin Mental Health Care, The Amsterdam Institute for Addiction Research, Amsterdam, Netherlands
3. Trimbos Institute, The Netherlands Institute of Mental Health and Addiction, Amsterdam, Netherlands
4. Division of Online Health Training, Innovation Incubator, Leuphana University, Luneburg, Germany
5. Department of Clinical Psychology and Psychotherapy, Friedrich-Alexander-University Erlangen-Nuremberg, Erlangen, Germany

There is substantial co-occurrence of mental disorders and substance use disorders. Prevalence of dual disorders is probably highest in the general population for individuals with depression disorders and problematic alcohol use. Co-morbidity of alcohol misuse and abuse is two to three times higher for those who suffer from depression disorders compared to the general population. Internet-based self-help programs to reduce subclinical alcohol use disorders or ameliorate moderate to mild depression symptoms have been reported to be effective in meta-analyses. Therefore we aim to develop the first web-based dual disorder self-help intervention for harmful or hazardous alcohol users with mild to moderate co-occurring depression symptoms and to test this intervention's effectiveness and potential cost-effectiveness in a randomized controlled trial.

This presentation will report on the intervention contents and the trial design of a three-arm multi-country randomized controlled trial that intends to test the effectiveness and potential cost-effectiveness of a combined self-help intervention aiming to reduce alcohol consumption and depression symptoms, a web-based self-help intervention focusing on problematic alcohol use only, and a waiting list control condition in hazardous and harmful alcohol users with co-morbid mild to moderate depression symptoms. The self-help intervention will consist of modules designed to reduce alcohol use based on the principles of motivational interviewing, self-control practices, and methods of cognitive behavioral therapy as well as additional modules for the reduction of depression symptoms based on cognitive-behavioral therapy in the combined treatment study arm.

The expected findings will extend the knowledge of designing effective Internet based treatment on dual diagnoses in general and more specifically for co-morbid alcohol and depression disorders. To our best knowledge, this is the first "dual diagnosis" Internet-based self-help research conducted. It is likely that proven intervention effectiveness will stimulate other research groups to conduct similar research on further comorbid substance use and mental health disorders of public health relevance.

La remédiation cognitive

Nicolas Franck

Centre Hospitalier Specialise Vinatier, Bron, France

Les récents développements technologiques ont particulièrement intéressé le domaine de la remédiation cognitive. L'informatique permet en effet de recréer des environnements susceptibles d'entraîner de manière ciblée les fonctions cognitives altérées par la maladie psychique (mémoire, attention et fonctions exécutives, principalement). Elle permet également de générer des personnages virtuels dont les réponses verbales et non-verbales pourront amener les participants à exercer leur cognition sociale (reconnaissance des émotions, théorie de l'esprit). Plusieurs concepteurs de ces différents outils montreront les effets thérapeutiques de ces programmes originaux lors de ce symposium.

Speakers

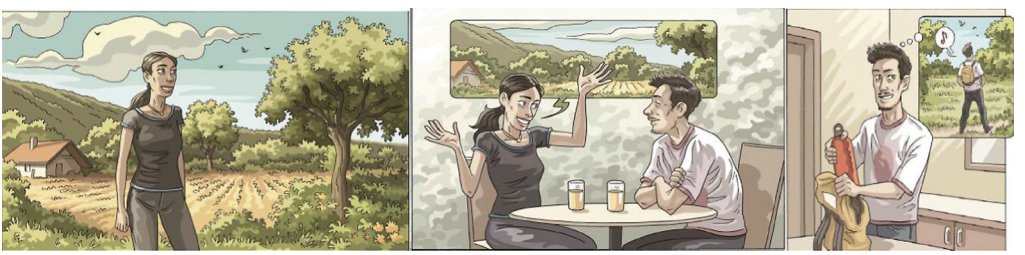
1. PEPS, une intervention pour améliorer le plaisir et la motivation dans la schizophrénie
   Jérôme Favrod
2. GAÏA, thérapie de remédiation cognitive ciblée sur le traitement des émotions faciales
   Baptiste Gaudelus
3. RC2S : un outil de simulation pour remédier aux troubles de la cognition sociale
   Elodie Peyroux
4. Cognitus et Moi : un programme de remédiation cognitive pour les enfants
   Caroline Demily
5. ToMRemed : une technique de soin de remédiation cognitive de la cognition sociale centrée sur la Théorie de l'Esprit
   Nadine Bazin
6. Remédiation cognitive- transfert aux activités quotidiennes : la place de la réalité virtuelle
   Isabelle Amado and Lindsay Brénugat
7. Apports de l'outil informatique pour la remédiation cognitive
   Pascal Vianin

Positive Emotions Program for Schizophrenia (PEPS): a pilot study on improving pleasure and motivation in schizophrenia

Jérôme Favrod[1,2], Alexandra Nguyen[1], Caroline Fankhauser[1], Shyhrete Rexhaj[1,2], Iannis McCluskey[3], Philippe Golay[2] and Charles Bonsack[2]

1. School of Nursing sciences la Source, University of Applied Sciences and Arts of Western Switzerland, Lausanne, Switzerland
2. Community Psychiatry Service, Department of Psychiatry, CHUV, Lausanne, Switzerland
3. Re-pairs, French-speaking Network of Peer Practitioners in Mental Health, Saint- Blaise, Switzerland

The efficacy of drug-based treatments and psychological interventions for apathy and anhedonia in schizophrenia remains limited. There is a clear clinical need for new treatments. This pilot study tested the feasibility of a program to reduce anhedonia and apathy in schizophrenia and assessed its impact on 37 participants meeting the ICD-10 criteria for schizophrenia or schizoaffective disorders. Participants were pre- and post-tested using the Scale for the Assessment of Negative Symptoms (SANS) and the Calgary Depression Scale for Schizophrenia (CDSS). They took part in eight sessions of the Positive Emotions Program for Schizophrenia (PEPS) – an intervention that teaches participants skills to help overcome defeatist thinking and to increase the anticipation and maintenance of positive emotions. Thirty-one participants completed the program; those who dropped out did not differ from completers. Participation in the program was accompanied by statistically significant reductions in the total scores for Avolition-Apathy and Anhedonia-Asociality on the SANS, with moderate effect sizes. Furthermore, there was a statistically significant reduction of depression on the CDSS, with a large effect size. Findings indicate that PEPS is both a feasible intervention and is associated with decreased anhedonia, apathy, and depression.



Cartoons by Sébastien Perroud, PET

GAÏA s-face (schizophrenia facial affects cognitive enhancement)

Baptiste Gaudelus

Service Universitaire de Réhabilitation/CL3R – CH le Vinatier, Lyon, France

Social cognition, defined as cognitive processes specifically engaged in interactions with others, is one of the seven domains of cognition commonly impaired in schizophrenia (Green et al., 2008). Recent studies suggest an important impact of social cognition deficits on social functioning (Fett et al., 2011), and promising effects of specific cognitive remediation on those deficits (Kurtz and Richardson, 2011).

Social cognition is a composite domain including different processes (Peyroux et al., 2013): emotional processing, theory of mind, attributional style, social perception and social knowledge. Social cognition remediation interventions can be classified as large (programs including neurocognitive, social cognition and social abilities training) global (programs taking into account of all components of social cognition) or targeted on one process.

GAÏA's-face is an individual social cognition remediation, computer assisted, program targeted on facial affects recognition (Gaudelus and Franck, 2012). The effects of *GAÏA's-face* on social cognition processes, symptoms and social functioning have been compared with those of a cognitive remediation of attentional processes program during a controlled randomised study. First results of this study will be presented.

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RC2S : un outil de simulation pour remédier aux troubles de la cognition sociale

Elodie Peyroux

Service Universitaire de Réhabilitation – CH Le Vinatier, Lyon, France

Dans la schizophrénie et les troubles apparentés, les processus qui composent la cognition sociale, définie comme la faculté de comprendre soi même et autrui dans le monde social, sont largement altérés. Cette composante cognitive est pourtant d'une importance fondamentale pour le fonctionnement social, professionnel et interpersonnel des individus. Depuis une quinzaine d'année, l'essor du champ de la réhabilitation psychosociale et de la remédiation cognitive a permis de développer des outils thérapeutiques permettant de remédier à ces déficits.

Le programme RC2S (Remédiation Cognitive de la Cognition Sociale, Peyroux & Franck, 2014) mis au point à Lyon est ainsi l'un des premiers outils de remédiation cognitive ciblant la cognition sociale de manière globale et développé en langue française. Cette intervention, individualisée et assistée par ordinateur, permet aux patients qui en bénéficient de travailler sur leurs difficultés dans le domaine de la cognition sociale en s'appuyant sur des situations de simulation informatisées. L'utilisation de cette technologie offre ainsi la possibilité aux personnes souffrant de schizophrénie ou de troubles apparentés de remédier à leurs déficits dans le domaine des interactions sociales dans un environnement protégé, sans répercussion négative sur le monde réel, puis de transférer les compétences développées dans la vie quotidienne.

Des études, utilisant la méthodologie du cas unique, ont mis en évidence l'intérêt de cette thérapie et une étude contrôlée et randomisée va être prochainement menée afin de valider cet outil.

Cognitus et moi : Un programme de remédiation cognitive pour les enfants

Caroline Demily

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A ce jour, aucun programme de remédiation cognitive n'a validé son efficacité dans la prise en charge de la déficience intellectuelle ou des troubles multidys de l'enfant et ne permet de répondre de manière précise aux problèmes rencontrés dans le fonctionnement quotidien. COGNITUS & MOI est le premier programme à proposer une prise en charge basée sur une évaluation neuropsychologique très précise, ciblant les fonctions attentionnelles et visuo-spatiales déficitaires chez l'enfant qui constituent un obstacle à une cognition sociale efficiente, ce qui peut engendrer des troubles relationnels ou du comportement.

Le programme COGNITUS & MOI permet:

- d'améliorer les capacités attentionnelles des enfants en les aidant à se concentrer sur des consignes et s'investir dans des tâches précises;
- de favoriser les fonctions visuo-spatiales des enfants afin qu'ils se repèrent mieux dans l'espace et puissent s'y diriger de manière plus autonome;
- d'améliorer les capacités de cognition sociale en permettant de mieux reconnaitre et comprendre les émotions des autres afin d'y réagir de façon plus adaptée.

Le programme se décline avec un thérapeute en individuel sur 16 séances (tâches informatisées et tâches papier/crayon adaptées aux forces et faiblesses de l'enfant). A l'issue de chaque séance, le thérapeute se met en contact avec les parents et/ou l'environnement éducatif de l'enfant afin de planifier la séance à domicile (16 séances à domicile). Le but est de favoriser le transfert de compétences en travaillant dans la vie quotidienne les mêmes fonctions cognitives que celles travaillées en séance.

Le lien entre l'enfant, les parents et le thérapeute est réalisé quotidiennement par un cahier de tâche à domicile, personnalisable par l'enfant.

Le programme COGNITUS & MOI va faire prochainement l'objet d'une étude de validation versus prise en charge aspécifique.

ToMRemed : une technique de soin de remédiation cognitive de la cognition sociale centrée sur la Théorie de pour les patients atteints de schizophrénie

Nadine Bazin

Centre Bleuler, Versailles, France

ToMRemed est une technique de remédiation cognitive dont la cible est la lecture intentionnelle, capacité de cognition sociale régulièrement altérée chez les patients atteints de schizophrénie (Brune, 2005; Sprong et al., 2007; Bazin et al., 2010).

La session initiale de ToMRemed se déroule sur 3 mois, à raison d'une séance par semaine, dans un cadre de soins ambulatoires, en groupes de 5 à 7 patients, animés par deux thérapeutes formés à la technique. Cette session initiale est suivie de séances de rappels organisées tous les 2 mois pendant au moins un an.

ToMRemed permet aux patients:

- de prendre conscience de l'existence de plusieurs hypothèses possibles, et surtout d'hypothèses alternatives à la leur : étape métacognitive;
- de constater que ce sont les éléments du contexte qu'il faut utiliser pour comprendre l'intention (éviter le *saut à la conclusion* et favoriser le travail par *hypothèses alternatives*) : étape cognitive.

Le matériel utilisé dans ToMRemed est un matériel vidéo (des extraits vidéo issus du cinéma) qui permettent d'aider le patient à franchir ces étapes à son rythme. Chaque extrait comporte deux ou trois personnages en interaction, dans un contexte riche. Lors de chaque séance un extrait vidéo est travaillé, selon une stratégie très structurée permettant, en s'appuyant sur l'analyse des éléments contextuels du film, de comprendre les intentions implicites de chacun des personnages.

En termes d'efficacité, l'outil d'évaluation utilisé est la V-LIS (Lecture Intentionnelle en Situation) (Bazin et al., 2009). L'amélioration observée est en moyenne entre deux et quatre points, différence statistiquement significative avant et après la session ToMRemed (Bazin and Passerieux, 2012; Passerieux et al., 2013).

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Remédiation cognitive-transfert aux activités quotidiennes : la place de la réalité virtuelle

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La schizophrénie est une maladie du sujet jeune invalidante qui se caractérise, outre les symptômes cliniques, par des anomalies cognitives précoces, touchant des domaines aussi variés que l'attention, la mémoire et les fonctions exécutives. Les difficultés des patients souffrant de schizophrénie sont étroitement liées à leurs difficultés dans la vie quotidienne, à leur capacité d'autonomie et de réinsertion. Les thérapies psychosociales et en particulier la remédiation cognitive sont un apanage indispensable aux traitements pharmacologiques de la schizophrénie. Mais la question du parallèle entre programme de remédiation cognitive et activités quotidienne de la vie réelle est encore sujette à caution. Peu d'études envisagent en parallèle d'évaluer les difficultés de planification des patients en vie quotidienne ainsi que l'effet de la remédiation cognitive. Notre centre, en partenariat avec le laboratoire LMC de Paris Descartes et l'Université d''Angers utilise des outils d'évaluation dans des situations proches de la vie quotidienne, comme par exemple planifier de faire des courses en condition de vie réelle (test des errances multiples, test du plan du zoo) ou de réalité virtuelle (test de mémoire prospective). 8 patients évalués avant remédiation cognitive présentent de nombreuses anomalies aux errances multiples comme en planification et en mémoire prospective en comparaison à des sujets contrôles appariés. Si la réalité virtuelle s'avère être un support intéressant pour l'évaluation, elle peut aussi être un support ludique à visée de remédiation cognitive pour des patients plus institutionnalisés qu'on souhaite amener à l'idée d'entreprendre un parcours de réhabilitation pour plus d'autonomie dans le soin et la vie en société. Dans ce but, nous avons développé une prise en charge à visée de remédiation, par groupe de 6 sujets via l'utilisation de l'outil virtuel afin d'aborder leurs problématiques quotidiennes en s'appuyant directement sur des situations concrètes, dans le cadre sécurisant que nous procure la réalité virtuelle. Deux groupes de 4 patients du centre d'activités thérapeutiques du 15éme arrondissement et souffrant de schizophrénie ont pu bénéficier de cette technique. Les premiers résultats pré/post prise en charge montrent une amélioration des performances aux épreuves neuropsychologiques de mémoire, d'attention et de planification. On observe surtout au niveau qualitatif une amélioration de l'autonomie ainsi qu'une émergence claire chez ces patients de souhaits d'évolution vers la réhabilitation socio-professionnelle. Ainsi, l'utilisation d'outils de réalité virtuelle, que ce soit à visée d'évaluation ou de prise en charge thérapeutique, vient nous aider à nous rapprocher toujours au plus près des difficultés rencontrées par nos patients dans leur quotidien.

Apports de l'outil informatique pour la remédiation cognitive

Pascal Vianin

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Le débat visant à connaître l'efficacité respective des programmes informatisés ou non-informatisés repose à notre sens sur une vision erronée des objectifs poursuivis par la remédiation cognitive. L'utilisation d'exercices informatisés, aussi sophistiqués soient-ils, devrait en effet s'appuyer sur des postulats théoriques et méthodologiques solides, et ne pas constituer une fin en soi.

Le programme RECOS a été conçu pour favoriser le transfert des compétences cognitives acquises en séances vers des objectifs fonctionnels décidés au terme de la phase d'évaluation initiale. Il considère que l'outil informatique permet d'intégrer et d'automatiser des stratégies qui se sont révélées efficaces durant les séances papier-crayon, plus propices à explorer différentes stratégies de résolutions de problèmes. Face à l'ordinateur, chaque participant doit cependant ajuster ces stratégies en tenant compte d'un contexte plus écologique et plus interactif. Le rôle du thérapeute est de l'inviter à identifier les similarités et les différences entre ces deux types d'environnement. Finalement, les tâches à domicile permettront d'appliquer dans la vie quotidienne les compétences acquises durant les séances avec le thérapeute.

Les capacités de transfert et de généralisation des apprentissages sont essentielles pour mener avec succès le travail de remédiation cognitive. Du fait qu'il génère des environnements interactifs et écologiques, le support informatique constitue un relais formidable entre ce qui peut être exercé sur papier et les multiples compétences cognitives sollicitées par notre vie quotidienne.

Promoting mental health at the age of informatics

Tom Craig[1] and Roy Kallivayalil[2]

1. Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK
2. Pushpagiri Institute of Medical Sciences and Research Centre, Tiruvalla, Kerala, India

The main challenge of social psychiatry for tomorrow lies in its capacity to use new resources to promote mental health as it is defined by the WHO. Nowadays, there are new ways to communicate and to relay mental health education, promotion of well-being and to prevent mental suffering.

It is one of the major challenges for the WASP: to lead every mental health professional to a better communication with its audience and with the concerned populations.

Speakers

1. Using computer simulations in therapy: clinical experiences from the AVATAR clinical trial
   Tom Craig, King's College London, Institute of Psychiatry, Psychology and Neuroscience, London, UK
2. Promoting Mental Health in the Age of Informatics in South Asia
   Roy Abraham Kallivayalil, Pushpagiri Institute of Medical Sciences and Research Centre, Tiruvalla, Kerala, India
3. Electronic media: a tool to be encouraged in clinical psychiatry
   Marianne Kastrup, Dignity-Danish Institute against Torture, Denmark
4. The place of ICT (information communication and technology) in the promotion of mental health: myths and realities
   Rachid Bennegadi, Françoise Minkowska center, Paris, France

Using computer simulations in therapy: clinical experiences from the AVATAR clinical trial

Tom K. J. Craig, Mar Rus Calafell and Tom Ward

Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK

The use of Audio-Visual Assisted Treatment Aids for Refractory auditory hallucinations was described by Julian Leff in a groundbreaking pilot trial that achieved clinically significant reductions in the frequency and distress associated with these experience after just seven short sessions (Leff et al., 2014). This therapy involves the creation of a computerized representation ('avatar') of the entity the patient believes is the source of the hallucination and its use in a trialogue between the patient, the 'avatar' and the therapist. The aim of the therapy is to help the patient to confront the voice, challenge it's authority and gradually bring it under their control, thus diminishing the power and omnipotence of their voices. We are now approximately half way through a larger randomized clinical trial (n = 142) comparing AVATAR therapy to supportive counselling. Although it is too early to report outcomes, we will describe and demonstrate the current system, with illustrative examples of the approach, typical therapy content and reflect on the implications the therapy has for the delivery of psychological treatments for schizophrenia and other psychoses in the future.

Promoting mental health in the age of informatics in South Asia

Roy Abraham Kallivayalil, Abraham Verghese and Arun Enara
Pushpagiri Institute of Medical Sciences and Research Centre, Tiruvalla, Kerala, India

Healthcare informatics (HI) is an outgrowth of medical informatics that focuses on the clinical aspects and applications of technology in the delivery of healthcare (Norris, 2002). Health informatics is central to patient care and it provides real links between patient care and what might otherwise seem abstract and time-wasting managerial activity. Clinical information management is central to both clinical effectivenes s and service quality. Training in this area should be a high national and local priority. A report by the market research agency GFK suggests that smartphone subscriptions are set to grow approximately five fold by 2019, while mobile data traffic in the broader Southeast Asia and Oceania region will experience a 1000% growth rate into 2019. In the first quarter of 2014 alone, 18 million smartphones were purchased in the region. Driving this growth are a number of factors, including more affordable smartphones, a high rate of adoption among a large and tech-savvy youth population and a concerted effort by mobile operators to expand and improve high-speed wireless networks, most notably 4G/LTE. Mental Health Care needs still outnumber the available resources in this part of the world. Exploring new avenues by tapping into this surge of technological advancements, will enable efficient promotion of mental health care in South Asia. Information processing and communication in the healthcare sector in the west are currently centrally involved in virtually all healthcare activities, from obtaining and recording information about patients, communicating with healthcare professionals and accessing medical literature to selecting diagnostic procedures, interpreting laboratory results and collecting clinical research data (Georgiou, 2001). Recently, electronic healthcare record (EHR) systems, decision support systems (DSS), hospital information management systems (HIS) have been developed and are being widely used in a clinical context as well as in enterprise resource management systems on the administrative side (Von Lubitz and Wickramasinghe, 2006). Almost all Asian countries are now using computers in healthcare centres or hospitals. The concept of HI has been an established science and has developed rapidly in some Asian countries since 1970s, such as Singapore. However, different countries have different political and budgetary issues and situations which affect the development of their healthcare provision based on current technologies (Lun, 1999). Tele-psychiatry applications tend to be most useful in settings with low population density, geographical barriers to transport, difficulties with professional recruitment and an advanced communications infrastructure. The mental health care needs still outweigh the available mental health professional and hence using informatics could provide a useful medium to reach the needy population and also to promote mental health awareness programmes. With the surge in usage of Information Technology in health care, and wireless connectivity being freely available and promoted extensively, our challenge ahead will be to utilize this in the most efficient way to promote mental health in this part of the world.

The place of ICT (information communication and technology) in the promotion of mental health: myths and realities

Rachid Bennegadi

Françoise Minkowska Center, Paris, France

One of the main myths of the XXI century was how Internet enabled easy and effective communication. When in reality things might not appear so straightforward, how a researcher and a clinician or health policy maker can keep informed regularly and appropriately on mental health is a complete different topic. Whether it is in the vast diversity of available definitions or the number of determinants involved in social welfare or mental suffering. One of the most important tools yet discovered is the establishment of a listserv. In this presentation, the speaker will examine the modalities of setting such a tool and the other promises that it will permit, like for the flow of information between professionals: If during the twentieth century people directly answered any question with this mantra: “Just Google it”, in the twenty-first century we will just have to say: “Just check on your listserv”.

Electronic media: a tool to be encouraged in clinical psychiatry

Marianne Kastrup

Dignity-Danish Institute against Torture, Frederiksberg, Denmark

The use of tele psychiatry in daily psychiatric practice has gained its popularity in particular in remote areas where psychiatrists are few and distances to cover large. Thus it has been extensively used in scarcely populated areas. In e.g., Greenland the availability of this method has allowed for easier assessment of mentally ill, thereby facilitating early and adequate treatment and saving valuable travelling time for patient or psychiatrist.

But the electronic media have many advantages also in other ways.

Via tele psychiatry it is possible to supervise younger colleagues and allow for clinical consultations with specific experts in complicated cases.

In Denmark tele psychiatry has for years been useful in the treatment of refugees and migrants in their own language by providing a native speaking therapist that may communicate with the patient via the telemedia. This has made it possible for the patient to speak freely without the use of interpreters, and the experience gained shows that patients are quite satisfied with this solution and do not report of a feeling of alienation or lack of trust.

The electronic media may also be valuable to communicate directly with patients in their homes and in this way monitor their condition, adjust the psychopharmacological treatment, carry out cognitive treatment, etc.

There is also an increasing use of smartphones, tablets, etc. for patients to self-monitor their disease and provide a better basis for subsequent contact with mental health services.

The paper will discuss the different uses, their advantages and shortcomings.

Accompagner et superviser les professionnels de santé mentale à l'ère cybernétique

Marie-Jo Bourdin and Stéphanie Larchanché

Centre Françoise Minkowska, Paris, France

À l'heure où la présence incontestable des technologies numériques nous a propulsé dans l'ère cybernétique, comment cadrer et accompagner les professionnels de la santé mentale dans l'appropriation des nouvelles technologies numériques ? Comment accueillir ces nouveaux outils dans la clinique et comment peuvent-ils aider les institutions de soins à remplir leurs missions? Ce symposium propose de montrer comment le centre Françoise Minkowska, qui propose des consultations de psychiatrie transculturelle centrée sur la personne, a mis le numérique au service de son offre de soins et de ses missions de santé publique.

Speakers

1. Historique de la mise en place du MÉDIACOR au centre Françoise Minkowska
   Marie-Jo Bourdin, Centre Françoise Minkowska, Paris, France
2. Évolution cybernétique de l'interface du MÉDIACOR avec les professionnels de la santé mentale
   Stéphanie Larchanché, Centre Françoise Minkowska, Paris, France
3. Enjeux de l'élaboration d'un outil multimédia sur les représentations sociales et culturelles de la santé mentale
   Rachid Bennegadi, Centre Françoise Minkowska, Paris, France Christophe Paris, Centre Françoise Minkowska, Paris, France
4. Comment contourner les résistances des professionnels de la santé mentale face aux nouvelles méthodes?
   Mélanie Deschamps, Centre Françoise Minkowska, Paris, France Rachel Wadoux, Centre Françoise Minkowska, Paris, France

Historique de la mise en place du MÉDIACOR au centre Françoise Minkowska

Marie Jo Bourdin

Centre Françoise Minkowska, Paris, France

Ce dispositif de MEdiation, d'ACcueil et d'ORientation mis en place en février 2009 a pour objectif :

- D'améliorer l'accès aux soins en santé mentale des populations issues des grandes migrations internationales, et les conditions de l'accueil au centre
- D'éviter les délais trop longs pour l'obtention d'un rendez-vous
- D'organiser l'orientation des patients dans les différents réseaux du système de soins
- De répondre aux demandes imprécises de professionnels qui s'interrogent souvent sur la part du culturel et/ou du pathologique, pour évaluer la pertinence de l'orientation.

L'équipe du MEDIACOR (psychiatres, psychologues, anthropologues, travailleurs sociaux) reprend l'historique de la demande pour la clarifier, afin de mieux la qualifier et la traiter en interne ou en externe (réseaux).

La qualification se fait dans le cadre de l'Anthropologie Médicale Clinique (AMC) qui met en avant la confrontation des modèles explicatoires et des représentations culturelles de la souffrance psychique sans cliver le social du médical et du psychologique

Nous verrons l'évolution de ce dispositif devenu un lieu d'évaluation des pratiques professionnelles et de formation ouvert à tous les thérapeutes de l'établissement mais également aux professionnels extérieurs et aux stagiaires. Le MEDIACOR s'est ouvert aux nouvelles technologies avec des rencontres de professionnels via Skype

Évolution cybernétique de l'interface du MÉDIACOR avec les professionnels de la santé mentale

Stéphanie Larchanché

Centre Françoise Minkowska, Paris, France

Le dispositif MÉDIACOR a été créé en 2009. Initialement développé pour améliorer la pertinence des orientations vers le centre Minkowska et pour réduire les délais d'attente des patients, le dispositif s'est progressivement doté de nouveaux outils, notamment, les évaluations avec les patients et les rencontres avec les professionnels de la santé. Un intérêt croissant pour ces rencontres nous a amené à réfléchir à de nouveaux moyens de répondre à cette demande professionnelle tout en l'adaptant à nos limites en temps et en ressources humaines. C'est ainsi que nous avons lancé les premières consultations Skype à destination des professionnels ayant accès à cette technologie. Dans cette présentation, nous aborderons les opportunités et les perspectives nouvelles apportées par l'utilisation des NTIC dans la clinique de même que leurs contraintes et limites. Nous réfléchirons sur la mise en place d'une telle technologie dans d'autres lieux de santé mentale ainsi que sur son impact dans l'amélioration de la communication entre professionnels et par conséquent, l'amélioration de l'offre de soin.

Enjeux de l'élaboration d'un outil multimédia sur les représentations sociales et culturelles de la santé mentale

Rachid Bennegadi and Christophe Paris
Centre Françoise Minkowska, Paris, France

L'impact des déterminants sociaux et culturels sur la santé mentale n'est pas une découverte depuis les travaux et les recherches en santé mentale et société (de Mailly) et santé mentale et culture. Il s'agit plus précisément, en ce qui concerne la personne, de représentations sociales et culturelles de la santé mentale. Comment former des professionnels de la santé mentale et sociale à cette réalité théorique et clinique ? Le champ de la formation est demandeur d'outils multimédias modernes et interactifs pour transmettre les savoirs et les pratiques en santé mentale. Le Centre Françoise Minkowska, avec le soutien de la WASP et de l'AFPS, s'est lancé dans cette aventure. Dans cette intervention seront présentés dans les grandes lignes le script et le pitch de la création de cet outil.

Comment contourner les résistances des professionnels de la santé mentale face aux nouvelles méthodes?

Mélanie Deschamps and Rachel Wadoux

Centre Françoise Minkowska, Paris, France

Le centre Françoise Minkowska, qui propose des consultations de psychiatrie transculturelle centrée sur la personne, a progressivement introduit les NTIC dans la clinique. Dans le cadre du dispositif de MEdiation, d'ACcueil et d'ORientation mis en place par l'équipe du centre (le MEDIACOR), l'équipe du centre a récemment lancé les premières consultations Skype à destination des professionnels ayant accès à cette technologie. Mais l'introduction de nouveaux outils numériques peut déstabiliser. Est-ce que les mécanismes du transfert et du contre-transfert peuvent être analysés de la même manière sans ce face-à-face thérapeutique ? Une réalité symbolique à travers la parole peut-elle se mettre en place et permettre une élaboration ? À en croire Jacques Lacan: "le réel c'est quand on se cogne". Comment alors élaborer cette frontalité dans un cadre thérapeutique virtuel?

Dans cette présentation, nous proposerons des pistes pour contourner ces obstacles.

Virtual worlds: new tools for mental health and rehabilitation?

Daphne Bavelier[1,2] and Swann Pichon[1]

1. University of Geneva, Geneva, Switzerland
2. University of Rochester, Rochester, NY, USA

Videogames have become an ubiquitous mass media in our society and virtual reality is now clearly following the same path. The popularity of these technologies has transcended the world of entertainment and might soon crossing into the world of health and rehabilitation. At their core, such technologies have important attributes that may benefit to interventions. Their engaging nature could help improve *patient's adherence* to *treatment*. The possibility of providing *individually tailored environments* together with closed-loop feedback are added dimensions which promote learning and may foster transfer of the learnt skills to real-life situations. How to best apply the power of these technologies to enhance therapeutic goals is a matter of growing research. Andreas Mühlberger (University of Wurzburg, Wurzburg, Germany) will outline the main applications of VR for exposure therapy in anxiety disorders and will give an overview of the current literature on its efficacy. Dr. Sylvia Pan (ICN, London, UK) studies social anxiety with VR and also investigates how virtual reality might help explore mechanisms of social cognition in individuals with ASD. Finally, Isabela Granic (Radboud University Nijmegen, Nijmegen, Netherlands) investigates how video-games with embedded relaxation and mindfulness techniques, attention bias modification methods, and neurofeedback mechanics, may be used to promote emotional regulation and resilience in children.

Speakers

1. The development and evaluation of games built for children's emotional health and well-being
   Isabela Granic, Radboud University Nijmegen, Nijmegen, Netherlands
2. Virtual Reality Exposure Therapy: Tomorrows first choice treatment for anxiety disorders?
   Andreas Muehlberger, University of Regensburg, Regensburg, Germany
3. Using Interactive Virtual Characters in Social Neuroscience
   Xueni Silvia Pan, Institute of Cognitive Neuroscience, UCL, London, UK

The development and evaluation of games built for children's emotional health and well-being

Isabela Granic

Radboud University Nijmegen, Nijmegen, Netherlands

Worldwide, anxiety and depression are the leading cause of disability, and the most prevalent mental health problems in youth today. Innovative, scalable and engaging prevention approaches that target these mental health concerns are urgently needed. We combine EEG technology and evidence-based techniques from clinical psychology with emotionally evocative game design to develop video games that promote emotional health and well being. I will present *MindLight*, a novel neurofeedback video game for children, to illustrate our multidisciplinary approach. MindLight is a 3D game that uses the mind as the game controller. Through neurofeedback mechanics, the game incorporates evidence-based relaxation techniques and attention bias modification methods to produce an immersive, "haunted" game world through which children learn to face and overcome their anxiety and fears. Data on the efficacy of the game will be presented and the promise of future innovations in neuro- and biofeedback tools for applied games will be highlighted.

Virtual reality exposure therapy: tomorrows first choice treatment for anxiety disorders?

Andreas Muehlberger

University of Regensburg, Regensburg, Germany

Virtual reality (VR) provides a new medium for the presentation of emotionally relevant, complex stimuli in an ecologically valid and at the same time highly controlled manner. Therefore, VR applications have attracted the attention of psychotherapists and researchers. In the past years, viable VR systems for varied applications in psychotherapy have been developed, most notably for exposure therapy in anxiety disorders. The presentation resumes the major applications of VR in psychotherapy, gives an overview of the current literature on its efficacy, and provides an outlook on future perspectives for psychotherapy and clinical research.

Using interactive virtual characters in social neuroscience

Xueni Silvia Pan

Institute of Cognitive Neuroscience, UCL, London, UK

Recent advances in the technical ability to build realistic and interactive virtual environments have opened exciting research venues in studying social cognition and behaviour in virtual reality. In the first part of this talk, I will present several state-of-the art interactive virtual reality scenarios, developed in the VECG group at UCL and the EVENT lab in the University of Barcelona, in the study and training for social anxiety, morality, and ethics. In the second part I will present how we use virtual reality to study the cognitive and neural mechanisms which underpin mimicry in autism, conducted in the Social Neuroscience group at ICN.

Designing games as a nurse: the science and the art behind it

Anna Sort

Universitat de Barcelona & PlayBenefit, Barcelona, Spain

Behavior-wise humans are prone to play, and games offer a wide variety of play, such as exploring, competing, collaborating and self-expression. Taking gaming into healthcare is a way to make taking charge of one's health more interesting, intriguing and motivating. It is not about making fun of having diseases or trivializing them, making it less important because it's a game. It's about providing the tools and inspiring the motivation and behavior change to be healthy and improve your lifestyle. Playful dynamic digital tools to facilitate patients' understanding of their disease, become more involved their health or illness management, or solve adherence problems.

This is why it's very important to understand the science behind game design, as well as the art of not losing the fun factor. Anna will introduce both of these subjects, give tools on how to tackle them and share some of her experiences.

As a health game designer, it is important to understand the science behind game design, as well as having the ability, the art, to keep the fun throughout the game.

De l'âge du probable à l'âge du Big Data: de la prévention à la prédiction

Dominique Deprins

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La précaution s'est érigée en principe à la suite d'une démythification du savoir expert; par son expertise, opérateur du processus de rationalisation de la société occidentale, on attend du spécialiste qu'il tranche à partir de ses connaissances et de ses savoir-faire. Dans le domaine de la santé mentale comme dans d'autres domaines soumis aux expertises, il y est question de se prononcer sur une «décision à prendre», sur des «problèmes à résoudre», sur l' «efficacité d'un traitement» et de faire des évaluations signifiantes; dans le domaine de la santé mentale, ces expertises ont la particularité d'être les pièces maîtresses de l'appareil judiciaire. L'expertise psychiatrique cherchera à situer un sujet sur une échelle de responsabilité, de performance et de dangerosité, notamment par tris et classification. À tout ce qui incombe à l'expert dans une écrasante responsabilité, la statistique décisionnelle peut fournir une réponse quantifiée et donner des éléments de preuve; c'est le règne de l'«argument statistique» (A. Desrosières) qui, par le passage à la quantification, performe et transforme les hommes ainsi gouvernés.

La prévention appartient au monde du probable en recourant à la science pour objectiver les risques; afin de mener des actions préventives, il s'agit de rechercher les causes probables – sociales, familiales, démographiques, psychiques – dans une démarche généalogique, pour tenter d'enrayer une tendance suicidaire ou empêcher un crime. La prévention recourt à des prévisions qui sont des prédictions agrégées à un niveau macroscopique; les prévisions (*forecasting*) vont chercher à estimer le nombre total de suicides ou de crimes dans la catégorie des schizophrènes du canton de Genève pour l'année qui vient alors que la technologie prédictive (*predictive analytics*) d'aujourd'hui nous dira à partir de la masse des data protéiformes à la convergence numérique, quels schizophrènes du canton de Genève auront le plus de chance de se suicider ou de commettre un crime.

Le monde des data s'affranchit du probable; pour passer de la prévention construite sur des catégories comme principe d'intelligibilité du réel à l'analyse prédictive individualisée, on recourt à une technologie statistique qui, au moyen d'algorithmes auto-apprenants, apprend de l'expérience enfouie dans les data afin de prendre de meilleures décisions fondées empiriquement. La prédiction devient *la* modalité de la temporalité contemporaine de notre société de la connaissance qui répond à un impératif de responsabilité du futur.

Dans un monde qui cherche l'harmonie par le nombre et le calcul, la statistique contemporaine a instauré ses gouvernementalités propres: une «gouvernementalité algorithmique» issue du *Data Mining* et du profilage qui participe du behaviorisme dont les comportements sont statistiquement prévisibles et qui gouverne les individus et une «gouvernementalité d'auto-contrôle», centrée sur les idées déjà introduites de "conduite des conduites" (M. Foucault) et de l'individu "entrepreneur de lui-même" qui concerne le gouvernement des individus pour qu'ils se comportent comme des patrons d'eux-mêmes; c'est poser la question de l'autonomie.

À l'heure où le DSM V révèle la crise du modèle quantifié et où la psychiatrie rêve d'être reconfigurée pour satisfaire sa quête de signes objectifs de la maladie mentale, que deviendra la Santé Mentale inscrite dans une médecine prédictive indissociable du régime de sur-savoir contemporain du Big Data?

Capitalizing upon the addictive properties of video games to promote wellbeing

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Concerns about addictive properties of certain video games subtypes such as MMORPGs are important in the scientific communities. Epidemiological studies, mainly in Asian countries, tend to consider the phenomenon as a major health issue. On the other hand, if those properties are used to enhance and motivate people to use so called serious games or games for health, it might be advantageous for specific situations (i.e., cognitive training and rehabilitation, psycho education for treatment adherence).

This presentation will focus on specific conditioning mechanisms (continuous versus partial reinforcements) present in video games and in gambling devices (slot machines). The specific rewards schedule implemented in MMORPGs or gambling machines are strong motivation factors to continue to play and start playing again after a session.

Reward mechanisms present in serious games will be compared to MMORPGs. As example, “Bipolife” by Ubisoft is supposed to help bipolar patients to understand their disease, the game shares the same mechanisms as “The Sims” games. Another example is “Woodment” a project of a browser-based serious multiplayer game for collaborative learning.

Hypothesis on what reinforcing mechanisms should be implemented in serious games will be discussed in regard to the addiction risks.

Internet-based cognitive bias modification in binge drinkers: protocol for a randomized controlled trial

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Attention bias (AB) towards alcohol has been acknowledged as an important vulnerability factor for alcohol misuse. Previous studies have shown that the AB can be retrained by Cognitive Bias Modification-Attention (CBM-A). Although CMB-A has been successfully used to diminish AB and alcohol consumption in problem drinkers, little is known about the efficacy of Internet-based CBM-A (iCBM-A) for binge drinking prevention.

The aim of the current randomized control trial (RCT) is to test the preventive efficacy of an iCBM-A platform. We hypothesise that binge drinkers trained to attend to alcohol-unrelated stimuli will decrease their AB towards alcohol and their alcohol consumption. We expect this effect to last for at least 1 month. We predict that the AB modification will mediate changes in alcohol consumption. Additionally, we will explore the effects of iCBM-A on the participants' craving.

Eighty binge drinkers aged 18–29 will be recruited in Geneva. Our main inclusion criterion will be drinking over 4 or 5 alcohol units in a row at least once in the past 2 weeks. All participants will be assessed on their AB towards alcohol, alcohol consumption, and craving for alcohol before and after the training. Alcohol consumption and craving will be re-evaluated at the 1-month follow-up.

The participants will be randomly assigned to either an active or a placebo condition. In the active condition, 95% of the probes will appear at the spatial location previously occupied by the alcohol-unrelated picture (contingency ratio of 95:05). In the placebo condition, probes will replace alcohol-related pictures as often as neutral pictures (contingency of 50:50). The contingency of 50:50 will also be used in the assessment version of the task. The participants and the experimenter will be blind to the group assignment. Eight training sessions of 20 minutes will be delivered within 4 weeks.

This RCT will further our understanding of cognitive processes associated with binge drinking in young adults. It will also provide knowledge about the preventive efficacy of web-based CBM-A for binge drinkers.

Computerized cognitive training of older adults. The Gradys project for attentional and memory functions

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The crucial component of individual's mental health is his/her cognitive effectiveness. Describing the process of cognitive aging, much space was devoted to memory and attention. Older people cope worse with remembering new material and with monitoring of the learning process. The research results on the effectiveness of cognitive training interventions in the form of a game indicate that it is higher or at least equal to the effectiveness of traditional training methods. At the same time, a computerized training with elements of virtual reality has an advantage over the traditional form of traditional training. We have developed scenarios of computer simulation exercises using elements of virtual reality, which are created to stimulate the competencies and skills for the functions of attention and memory. The content of the training tasks refers to real life situations and related requirements which should raise their effectiveness. We will present selected scenarios because the research verifying their effectiveness is planned in the next stages of our study. Thanks to the use of the appropriate hardware components it will be possible to coordinate participant's movements and decisions according to environmental changes. We shall present preliminary projects of simulative computerized games for attentional and memory functions. Currently, little is known about the efficacy of computerized cognitive training. Our research will give a new tool for cognitive improvement in healthy adults and our games might be helpful for old people who have problems with their cognitive functioning.

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How to measure computer/Internet use among people with schizophrenia in Finland and in Greece: methodology and challenges

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Introduction: Two European member states, Finland and Greece, exhibit very distinct levels of Internet use and computer skills. People search online for health-related information, including those with mental illness. Thus, we aimed to develop a study to measure: use, patterns, attitudes toward computer/Internet, and reasons for non-use, among Finns and Greeks with schizophrenia spectrum disorders (SSDs). In this presentation, we will discuss the process and challenges faced during the methodology development of this study.

Methods: First, we searched for previous studies aiming to evaluate computer/Internet use among adults. Second, we identified specific studies based on: similar research questions, suitability for the study population, measurement properties, burden on respondents, and practical aspects. Third, we contacted original authors and asked permission to translate and use the instruments. Fourth, we run a feasibility study to estimate important parameters that were needed to design the main study. Fifth, the instrument was adapted, based on the feasibility study results.

Results: First, we identified various studies about computer/Internet use, mainly from United States and Europe. None of the instruments were available in Finnish and Greek language. Second, the "Computer/Internet use" (Choi et al., 2013) questionnaire was selected as it aimed to access various aspects related to computer/Internet use such as: (1) Internet use patterns and reasons for discontinuation, (2) eHealth literacy, and (3) attitudes toward computer/Internet use. As we also wanted to measure the intention of computer/Internet use, we added questions based on a similar study for people with SSDs (Mausbach et al., 2013). Third, via email communication, original authors granted us permission to use their instruments and accepted the instruments' translated versions. Fourth, a main result of the feasibility study was that the questionnaire was considered lengthy (9 pages, 53 items), while many participants did not return it. Additionally, health and patients' record systems are different in Finland and in Greece. Fifth, the questionnaire was shortened, and patient recruitment was appropriately adapted for each country.

Conclusion: The development of an instrument and a study measuring computer/Internet use in various European languages can be a long and challenging process, partly due to the different health policies in each member state. Moreover, a short and clear questionnaire is preferable to this population. However, the data collected about computer/Internet use among those with SSDs are important, as they could help in the development of future eHealth strategies, while turn the Internet into a powerful health promotion tool, specifically designed to the needs of: (1) those with SSDs, and (2) each EU member state.

Un test d'auto-évaluation revisité par les nouvelles technologies

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A l'ère de l'informatique, il paraît difficile d'envisager l'utilisation et l'interprétation des tests classiques selon les modalités en usage depuis leur création. En effet les nomenclatures, les approches diagnostiques et sociales ont beaucoup évolué depuis une dizaine d'années. Dès lors, il importe de définir des critères qui permettent de développer l'actualisation, par les nouvelles technologies, d'un test susceptible d'offrir un certain intérêt en psychiatrie sociale.

Trois critères semblent essentiels:

- «Le test doit reposer sur une hypothèse précise qui a présidé à sa construction» comme le souligne M. Reuchlin.
- Il doit pouvoir faire l'objet d'une évaluation chiffrée.
- Le mode de correction doit pouvoir s'appuyer, à l'aide de technologies modernes, sur une étude statistique approfondie, favorisant un faisceau multiple d'interprétations.

Il en est ainsi du test d'auto-évaluation conçu par André Rey, qui a été actualisé par

G. Weinstein sous forme d'un logiciel.

Le test consiste à demander au sujet de s'auto-évaluer en se mettant des notes de 0 à 10 à divers aspects de sa personne physique, intellectuelle, sociale, affective. Il lui est ensuite demander d'imaginer l'évaluation qui serait celle de son entourage sur lui-même pour ces mêmes qualités. Le lien entre ces deux représentations de la personne, comment je me vois, comment j'imagine que les autres me voient, peut être d'un apport utile en psychiatrie sociale et constitue l'hypothèse qui a présidé à l'élaboration du test.

A la suite d''une étude génétique et psychopathologique portant sur 805 sujets examinés, il a été possible de concevoir un logiciel comportant divers modules: passation interactive du test d'auto-évaluation, pistes d'interprétations ouvertes.

Avec l'analyse d'un cas type, nous présenterons des indices divers intéressants en psychiatrie sociale tels que dévalorisation ou tension avec l'entourage et nous montrerons comment le recours à ce test contribue à mieux préciser les diverses facettes de la représentation de soi (démarche inscrite dans une analyse psychopathologique développementale interactive et sociodynamique) ainsi que la facilitation de l'interprétation par l'usage du logiciel proposé.

Les incidences des modes du réseau contemporain dans les processus du subjectivation

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L´homme contemporain est coincé dans le paradoxe suivant: plus il sait, plus il est terrifié face à ce qui l'ignore. Le Wikileaks a montré la pointe de l´iceberg.

Plus se développe la science et ses techniques, plus il est terrifié face aux accidents qui peuvent en découler. Surtout ceux du nucléaire.

Plus il développe les contacts sociaux avec les réseaux infinis, plus il sombre dans la masse qui l'ignore.

Plus il développe la raison et le choix dits démocratiques, plus il découvre combien les grandes solutions appartiennent à un empire supranational, gouverné pour le capital.

L´expérience historique de la guerre et de l´horreur nous enseigne inutilement, parce que l´industrie belliqueuse nous fait taire par ses drones.

D´un autre côté, il connaît la société de consommation qui nous offre le narcissisme flou, dispersé dans des innombrables objets dont la possession lui offre l'apparence d'une capacité de discernement.

Et son impuissance lui offre un semblant de conflit dans le moindre spectacle où il s'invente absolument tout pour ne pas être oublié.

Devant un miroir qui nous montre un homme sans qualité, sans futur et sans but, à la dérive, il invente pour la masse des milliards de "j´aime" avec ce livre-visage qu'est face-book. Ce visage gagne en proportion sur le registre de la vérité remplacée par la crédibilité qui devient d dé lors une approbation sans recul.

Et ainsi pour faire face à l'abandon nous approuvons la renaissance de la mystique, du mariage traditionnel, et des relations sociales endogamiques.

L´industrie pharmaceutique avec ses anxiolytiques et ses relaxants offre aux hommes des médicaments, pour s'en accaparer d'autant plus.

La parole est vide devant la lourdeur épaisse et sphérique où nos sommes enveloppés.

Nous avons besoin de lors d'un mythe, d´un sauveur et de boucs émissaires.

Back to the patient – pad and smart phone applications for assessment and care

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The introduction of computers at the end of the 90' in psychiatric services has mostly responded to hospital management issues or record keeping rather than served direct clinical activity. In some places, it even probably reduces the face to face contact with the patient. The *Back to the patient* project aims to develop tools for pads and smart phones that can be used directly in patient care. Now are available ELADEB and TIPP. ELADEB is frequently used in the initial assessment of difficulties and needs of psychiatric patients. It has the advantage of combining the clinical utility psychometric quality and ease of use. It covers the main areas of psychosocial functioning and filter as much as possible self-assessment of influences related to the investigator. It is also much appreciated by patients who feel heard and valued. The patient, considered an expert and actor of his situation, can select the areas of daily life considered as making problem and determine its importance. Then the patient selects the areas of life that need further assistance and determine the urgency and the source of thissupplementary help. The version for tablet or mobile phone functions like the original version with the advantage of providing results and a chart immediately.

TIPP is a comprehensive early intervention program for psychotic disorders. As part of this program, fact sheets have been developed. These cards are simple, attractive and illustrated by PET, a cartoonist. They aim to explain and normalize the psychotic experience, discuss the pros and cons of medication and cannabis use, and promote a positive view of recovery. A fun quiz version was developed for pads and smart phones. Complete information sheets are available at any time and provide information when needed. This tool allows the patient and his family to appropriate independently useful information on psychosis, treatment, recovery possibilities and risks related to drug use in order to discuss them with health care professionals. The goals of this application are to increase knowledge about psychosis, to promote empowerment in health management by patients and relatives and to increase the ability to develop informed collaboration in care.

The new facebook feature as a suicide prevention tool for adolescents?

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Facebook, like other social networking sites, attracts millions of users by offering highly interactive social communication. Facebook invites its users to share their feelings and thoughts. Several users of the social networking site share regularly suicidal thoughts. Facebook announced in February 2015 that in order to save lives, it would start using its interface to stop suicide through a new functionality, which detects when users are posting messages containing suicidal ideation. The Crisis Unit (Unité de Crise) is a partnership program between Hôpitaux Universitaires de Genève (HUG) and Foundation Children Action. This unit aims to support, take care of adolescents in distress and to ultimately prevent suicide. It includes the Centre for the Study and Prevention of Suicide (CEPS), the Centre for Ambulatory Intensive Treatment (CTAI), the Hospital Unit "Lits de crise" and offers preventive measures as well as inpatients and outpatients treatments.

Group discussions were held with adolescents being taking care at Unité de Crise to discuss the way they could use this new Facebook feature in the future, as well as the potential strengths and weaknesses of it as a resource. Adolescent's point of view and the potential usefulness of this feature as a new prevention tool will be discussed.

University training course on excessive gambling using Interactive e-learning tools

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In Switzerland, new gambling legislation has necessitated the expansion of services and social measures within gambling venues. In this context, the Lausanne University Hospital has developed a "Certificate of Advanced Studies" (CAS). This course entitled "Excessive gambling: prevention, treatment and community action" includes 6 face to face modules (lectures, presentations and workshops). Each module takes place over a 3 days period. Moreover, students have to develop an individual project, participate in an e-learning platform, and undertake therapeutic work with a virtual patient. During the program a tutor is responsible for overseeing participants' academic progress. The CAS is worth 18 ECTS (European Credit Transfer and Accumulation System).

The last two editions of the CAS (2009–2011 & 2012–2014) have included an average of 15 participants per module, with 14 participants completing the full certificate. Satisfaction questionnaires indicate that training was positively appraised by participants.

A qualitative evaluation of the virtual patient and e-learning platform is currently being carried out. Preliminary results are positive, however, further evaluation will be conducted in order to confirm these findings

The third edition (2015–2017) will start in November 2015 and will take place in Lausanne and Nantes.

The benefits of online questionnaires to prevent from attrition in longitudinal surveys: the example of the Swiss cohort on substance use risk factors (C-SURF)

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Attrition is probably the most important methodological issue to deal with in both epidemiology and research on therapeutic interventions. Indeed, attrition is associated to multiple factors, which makes study results less representative of the population that they intend to observe. For example, depression is related to high attrition rates. Nonetheless, thanks to recent technological progresses, questionnaire-based surveys can now be completed online, which can be done more easily and lower loss-to-follow- up. The aim of this paper was thus to compare online questionnaire and mail-based paper questionnaires in terms of loss to follow-up.

From August 2010 to November 2011, conscripts from 23 Swiss areas were invited during their military assessment to a study concerning substance use (C-SURF). Of these, 5,990 accepted to participate and completed the baseline questionnaire covering depression and alcohol and substance use and were invited to participate to a follow-up study 15 months later. The subjects could choose to complete the study either by filling the questionnaire online or by completing a paper version and by sending it back by mail.

A classification and regression tree (CART) model predicting participation to the follow- up survey was performed to detect groups with high risks to drop out. Depression was entered as a constrained first predictor of the model and the method chosen to complete the study (online VS paper) was entered as a second unconstrained predictor. A total of 767 (12.8%) did not participate to the follow-up. The CART model resulted in four groups differing by their attrition rate and by their response regarding depression: participants without symptom (n = 620, attrition rate = 17.3%), participants with some symptoms (n = 4,622, attrition rate = 11.3%), participants with many symptoms (n = 616, attrition rate = 15.9%), and participant with missing data regarding depression (n = 132, attrition rate = 28.8%). In each group except the group with missing information, the use of online questionnaires was associated with lower rates of loss-to-follow-up. Especially, attrition rate in participants without depressive symptom was 27.3% when the survey was completed by paper questionnaires and only 11.0% when completed online (OR = 0.33, $p < 0.001$). However, the negative association between online participation and attrition was consistent among the whole sample (OR = 0.45, $p < 0.001$).

Conclusion: The current results suggest that participants who can choose to complete questionnaire-based surveys online are more likely to complete the next stages of longitudinal studies. Yet such results would probably not be generalizable to elderly participants. Online questionnaires have both economical and scientific advantages; this is why they could be systematically proposed in order to prevent from attrition in longitudinal survey.

Section 2: New Interventions and New Models for Better Mental Health Care

The Recovery Paradigm is growing as a guiding principle for mental health interventions and mental health services. The trend is now supported in many countries by numerous laws and conventions, such as the UN Convention on the Rights of Persons with Disabilities.

Despite the wide acknowledgement of these principles, most societies and mental health care services are facing numerous barriers and challenges to achieve needed changes.

The abstracts below present an overview of the dynamics of such processes at the intervention, service organization, and system and policy levels.

Other models are also presented, including Open Dialogue, Trialogue, Housing First, Supported Employment, and Weddinger.

Grenzsituationen in der Psychiatrie: Chancen und Begrenzungen der UNBehindertenkonventionen und Recovery-Konzepte in klinischer Umsetzung über die professionellen Grenzen hinaus

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In diesem Symposium wird aus multiprofessioneller Perspektive aufgezeigt, welche Möglichkeiten die UN-Behindertenkonventionen und Recovery-Konzepte für die Psychiatrie-Tätigen und –Erfahrenden bieten. Durch Erfahrungsberichte sowie durch quantitative und qualitative Studien wird aufgezeigt wie Veränderungen von (Klinik-) Strukturen und Haltungen hinsichtlich einer Recovery-Orientierung auch in Grenzsituationen umgesetzt werden können. Darüber hinaus wird die Wichtigkeit der Individualisierung von Krankheits- und Genesungskonzepte aufgezeigt.

Speakers

1. Sinn und Unsinn zu Recovery-Orientierung in der psychiatrischen Praxis
   Michaela Amering, Medizinische Universität Wien
2. Weddinger Modell: UN-Behindertenrechtskonventionen und Recovery auch in psychiatrischen Grenzsituationen ohne Exklusion
   Lieselotte Mahler, Charité Universitätsmedizin Berlin
3. Der Stellenwert multiprofessioneller Zusammenarbeit bei der Umsetzung Recovery-orientierter klinischer Konzepte am Beispiel des Weddinger Modells
   Ina Jarchov-Jadi, St-Hedwig Krankenhaus Berlin
4. Recovery-Orientierung in der Psychoedukation – zwei Versuche einer Umsetzung
   Sebastian von Peter, Charité Universitätsmedizin Berlin
5. Die Auswirkung eines Recovery-orientierten, stationären Behandlung Modells auf erlebten und ausgeübten Zwang
   Alexandre Wullschleger, Charité Universitätsmedizin Berlin

Sinn und Unsinn zu Recovery-Orientierung in der psychiatrischen Praxis

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Recovery als Bewegung ist wesentlich geprägt durch das Engagement und die Konzepte, die Betroffene aus ihren Erfahrungen mit psychiatrischen Diagnosen, Behandlung und Rehabilitation entwickelt haben. Peer support hat in den letzten Jahren nun auch Einzug in traditionelle psychiatrische Hilfeangebote gehalten und Erfahrung und wissenschaftliche Evidenz haben rasch zugenommen. Auch für individuelle Therapieplanung sowie personen-zentrierte Rehabilitationsangebote gibt es mittlerweile sowohl Richtlinien und Instrumente zur Implementierung als auch eine Fülle von Forschungsergebnissen, die einen Paradigmenwechsel fördern sollten. Das gleiche gilt für Alternativen zur Akutbehandlung in der Klinik und für die Zusammenarbeit mit Familien und Freunden in der Gemeinde.

Trotzdem gibt es noch typische Missverständnisse wie z.B. die Haltung, dass Recovery- Orientierung nur für bestimmte Personengruppen oder zu einem späten Zeitpunkt in der Behandlung zum Tragen kommen kann. Häufig anzutreffen ist auch noch das Fehlverständnis, dass Recovery-Orientierung und Peer Support bedeuten, dass notwendige Unterstützungsleistungen billiger oder zurückgezogen werden können.

Wesentliche Entwicklungsbereiche für die Zukunft sind die Vertiefung des Verständnisses kultureller Dimensionen in der internationalen Zusammenarbeit sowie der Zusammenarbeit zwischen WissenschafterInnen mit und ohne eigener Psychiatrie- Erfahrung. Auch diesbezüglich verfolgen Recovery und die UN-Konvention für die Rechte von Menschen mit Behinderungen idente Ziele und fordern die Einbeziehung der SelbstvertreterInnen auf allen Ebenen. Die seit langem bestehende Forderung Nichts über uns ohne uns!' muss nun tatsächlich umgesetzt werden.

Weddinger Modell: UN-Behindertenrechtskonventionen und Recovery auch in psychiatrischen Grenzsituationen ohne Exklusion

Lieselotte Mahler

Charité Universitätsmedizin, Berlin, Deutschland

Lieselotte Mahler wird anhand des "Weddinger Modells" deutlich machen, dass Behandlungskonzepte, die der Un-Behindertenkonvention gerecht werden, in dem sie auch im psychiatrisch-stationären Raum konsequent Inklusion, Transparenz und Partizipation ermöglichen, auch in einer Versorgungsklinik praxistauglich sind. Zudem zeigen die Ergebnisse einer quasiexperimentellen kontrollierten Pilot-Studie, dass Recovery- und Resilienzfaktoren durch ein solches Konzept gesteigert werden können.

Der Stellenwert multiprofessioneller Zusammenarbeit bei der Umsetzung recoveryorientierter klinischer Konzepte am Beispiel des Weddinger Modells

Ina Jarchov-Jadi

St-Hedwig Krankenhaus Berlin, Berlin, Deutschland

In diesem Vortrag soll aus pflegerischer Sicht aufgezeigt werden, dass die Implementierung partizipativ-trialogisch ausgerichteter Konzepte, die Auflösung traditioneller klinischer Strukturen notwendig macht sowie von allen Beteiligten eine Haltung fordert, die eine Individualisierung der Behandlung ermöglicht. Neben den Patienten und ihren Bezugspersonen, deren "Expertise aus Erfahrung" einen wesentlich höheren Stellenwert erfährt, müssen auch die Berufsgruppen untereinander eine auf Partizipation ausgerichtete Haltung gegenüber der Fachlichkeit des jeweils anderen entwickeln. Am Bespiel des Weddinger Modells soll beschrieben werden, wie ein solcher Paradigmenwechsel eingeleitet und prozesshaft umgesetzt sowie begleitet werden kann.

Recovery-Orientierung in der Psychoedukation – zwei Versuche einer Umsetzung

Sebastian von Peter

Charité Universitätsmedizin, Berlin, Deutschland

Sebastian von Peter spricht über den Vergleich zweier Psychoedukations-ähnlicher Gruppenformate, die qualitativ mit Hilfe einer teilnehmenden Beobachtung untersucht wurden. Dabei richtete sich die Analyse auf die Art wie Wissen vermittelt wurde, auf die räumliche Gestaltung der Sitzungen und die beobachteten Interaktionen der untersuchten TeilnehmerInnen, sowie auf die in den Gruppen jeweils verwendeten Wissensformen. Die Untersuchung zeigt, dass ein offener Erfahrungsaustausch unter den Beteiligten bevorzugt und die verwendeten Schulungsmaterialien und räumliche Gestaltung entsprechend angepasst werden sollten, um Recovery zu befördern.

Die Auswirkung eines Recovery-orientierten, stationären Behandlungmodells auf erlebten und ausgeübten Zwang

Alexandre Wullschleger

Charité Universitätsmedizin, Berlin, Deutschland

Alexandre Wullschleger spricht über die Auswirkungen von Transparenz und Partizipation in/ an der psychiatrischen Behandlung auf objektiv umgesetzte Zwangsmaßnahmen sowie auf das Erleben vom Zwang im stationären Bereich. Ein Überblick der bisherigen Literatur wird vorgestellt. Die ersten Ergebnisse einer prospektiven Evaluationsstudie des Weddinger Modells werden danach vorgestellt. Damit sollte die positive Wirkung eines Recovery-orientiertes Behandlungsansatzes auf objektiven und subjektiven Zwang deutlich gemacht werden.

Implementing housing first in Europe

Supported by CHUV Community psychiatry service

François Borgeat[1] and Charles Bonsack[2]

1. University of Montreal, Wentworth-Nord, QC, Canada
2. CHUV, Lausanne, Switzerland

Housing first promotes recovery with a direct access to individual housing for homeless people with mental health disorders with the support of a mobile team. This model represents an effective alternative to the progressive or "staircase" model which implies following several steps from hospital to shelter homes before individual accommodation. Implementing housing first in Europe implies major cultural changes among the population, stakeholders, psychiatric services and network collaboration with social services and landlords. Objectives are to examine conditions of successful implementation of housing first in Europe.

List of speakers

1. The dissemination and implementation of Housing first
   Judith Wolf, Netherlands
2. Stakeholder perceptions and the implementation of Housing First
   Sarah Johnsen, United Kingdom
3. The role of evidence-based floating support in Housing First
   Lars Benjamin, Denmark
4. Acceptability of mental health disorders among landlords
   Carla Garcia, Switzerland

Stakeholder perceptions and the implementation of housing first in the UK

Sarah Johnsen

Heriot-Watt University, Edinburgh, UK

This paper outlines findings from two studies: first, a review of the potential effectiveness of, and stakeholder receptiveness to, Housing First in the UK; and second, an evaluation of the first UK Housing First pilot project (in Glasgow, Scotland). It argues that the UK has been relatively "slow off the mark" in developing Housing First as compared with many other European nations. This results, in part, from the fact that many British service providers believe they are "doing it already", despite the fact that their projects typically contravene key principles of Housing First as advocated by Pathways to Housing, the organisation first developing it in the US. Moreover, British providers generally remain wedded to a "treatment first" philosophy, being convinced that placing people with complex needs into independent tenancies without on-site support risks "setting them up to fail". Many are also sceptical that the positive Housing First outcomes reported in the US, particularly cost-benefits, would be reproduced to the same extent in Britain. There are indications that attitudes are beginning to change, however, as a number of pilots are being developed across the UK. The Glasgow pilot reported very positive outcomes, especially as regards housing retention, and these have gone some way to increasing stakeholders' receptivity to the model elsewhere. The experience of the Glasgow pilot nevertheless suggest that many sceptics are apparently only "converted" to Housing First when the see the outcomes first-hand in their own context.

The role of evidence-based floating support in a Housing First programme in Denmark

Lars Benjaminsen

The Danish National Center for Social Research, Copenhagen, Denmark

This paper presents the experiences from a large-scale Housing First programme in Denmark, which has been part of a national homelessness strategy. The target group for the programme are homeless people with complex support needs due to a number of other social problems, in addition to homelessness, such as mental ill -health, substance misuse, physical ill-health, low incomes, poor social and family networks. The participants have been rehoused primarily in independent, scattered housing provided through the municipal priority access system to public housing. Mobile support has been provided through evidence-based intervention methodologies: Critical Time Intervention, Intensive Case Management, and Assertive Community Treatment. The evaluation of the Strategy shows that despite the complex support needs of the target group, the Housing First approach has been very successful as it enables homeless people to obtain housing and the supports required to sustain their tenancy – and with the right support, nine out of ten homeless people have been able to maintain their new home. Furthermore the evaluation points out that most homeless people are able to move into ordinary apartments, and are not in need of congregate housing. The results also show that a mindshift in local administrations, housing allocation systems, and on the service provider/practitioner level is needed to facilitate a transformation away from a Treatment First to a Housing First based approach.

Acceptability of mental health disorders among landlords

Carla Garcia and Charles Bonsack

Psychiatry Department, CHUV, Lausanne, Switzerland

Housing (having a « one's place ») is a basic right of any human being who is considered a whole entity with the right to live in the community among others. Giving people who suffer from mental disorders, the possibility to live their lives in an active way, which means, being able to decide and make choices of their interest regarding their values of life, implies a big change on the representations of mental disorders among the general population. Being able of choosing where and how we want to live is extremely important for the well being of a person. This choice has been forbidden for a long time among people with psychiatric disorders, which in one hand, have been considered not having the capacity of knowing which is best for them, and in the other hand, have being marginalised and stigmatised due to misrepresentations of psychiatric illness. In this presentation I explore the existing scientific literature on stigmatization of people with mental health problems and its effects on the acceptability of these people in the community and in private apartments. In order to enhance the acceptability of people with mental disorders among landlords and housing agencies in Lausanne, a first step is being made by the French validation of an English scale that m easures the attitudes, knowledge and behaviors of the general population toward people with mental illness. This scale will be distributed among futures employees of housing agencies to know their position toward mental illness, in order to create ways to reduce discrimination, if it exists, and increase acceptability of people with psychiatric problems in private and individual housing.

Interventions psychiatriques communautaires auprès d'une population de requérants d'asile

Ariel Eytan and Othman Sentissi
DSMP, HUG, Genève, Switzerland

Les patients requérants d'asile représentent une population vulnérable dans le sens où ils sont amenés à devoir faire face à des bouleversements majeurs de leur environnement qui peuvent avoir un caractère fortement fragilisant pour leur santé mentale. Après un parcours migratoire le plus souvent traumatique, ce sous-groupe de patients est exposé à des facteurs de stress post-migratoires dont l'intensité s'est accentuée ces dernières années suite au durcissement des conditions d'accueil qui leur sont proposées dans différents pays d'Europe. Dans ce symposium, nous nous efforcerons, en nous basant sur l'expérience institutionnelle genevoise de ces dernières années, de :

(1) Définir les caractéristiques psychopathologiques de cette population et son utilisation des soins psychiatriques et en quoi elles diffèrent de celles de la population « usuelle » de nos consultations (Rachel Baeriswyl);
(2) De proposer une réflexion sur les besoins prioritaires de cette population en nous basant sur une revue de la littérature et sur une étude menée auprès des soignants de premier recours à Genève (David Framorando; Rachel Baeriswyl);
(3) De proposer une réflexion sur les modalités d'intervention de crise auprès de cette population et les enjeux qui en découlent (Javier Bartolomei);
(4) D'expliciter la mise en place et le déploiement des Interventions psychiatriques mobiles dans les foyers des personnes requérantes d'asile en détaillant la sous-population à laquelle elles s'adressent avec ses enjeux et ses écueils (Didier Dechoux).

Intervenants

1. Caractéristiques psychopathologiques de la population des patients requérants d'asile
   Rachel Baeriswyl-Cottin, DSMP, HUG, Genève, DSMP, HUG, Genève, Switzerland
2. Besoins prioritaires de la population des requérants d'asile: revue le la littérature et étude genevoise auprès des soignants de premier recours
   David Framorando, Rachel Baeriswyl, DSMP, HUG, Genève, Switzerland
3. Interventions psychiatriques de crise auprès la population des patients requérants d'asile
   Javier Bartolomei, Pierre Bastin, DSMP, HUG, Genève, Switzerland
4. Interventions psychiatriques mobiles auprès de la population des patients requérants d'asile
   Didier Dechoux, DSMP, HUG, Genève, Switzerland

Caractéristiques psychopathologiques et utilisation des soins psychiatriques d'une population de requérants d'asile à Genève.

Rachel Baeriswyl-Cottin, David Framorando, Nikol Hiller, Javier Bartolomei and Natacha Premand

Département de Santé Mentale et de Psychiatrie, Hôpitaux Universitaires de Genève, Genève, Switzerland

Les personnes requérantes d'asile (RA) représentent une population vulnérable, confrontée à des facteurs de stress multiples pouvant avoir un impact sur leur santé mentale. A Genève, les personnes RA sont reçues pour des soins psychiatriques dans les différents services du département de santé mentale et de psychiatrie des HUG sur délégation d'un médecin de premier recours. Le Centre Ambulatoire de Psychiatrie et Psychothérapie Iintégré (CAPPI) de la Servette dispense des soins psychiatriques multidisciplinaires aux résidents genevois de son secteur géographique ainsi qu'aux personnes RA vivant dans les foyers communautaires de la ville.

Dans une étude rétrospective, nous avons documenté les caractéristiques sociodémographiques et psychopathologiques ainsi que les modalités de prise en soins d'un échantillon de patients RA (n = 119) suivi au CAPPI Servette fin 2012 afin de mieux appréhender cette population.

Cet échantillon est constitué d'autant de femme que d'homme, 2/3 des patients ont moins de 40 ans et la moitié est mariée. 40% réside en Suisse sans sa famille. Les patients RA présentent majoritairement un épisode dépressif majeur (64.7%) et un état de stress post-traumatique (34.5%) avec 22% de comorbidité de ces deux diagnostics, et peu d'antécédents psychiatriques (env. 9%). La prévalence d'idéations suicidaires est d'env. 30%. La durée médiane de prise en charge est de 14 mois et elle se décline principalement sous forme d'entretiens médicaux et infirmiers, à fréquence bimensuelle.

Besoins prioritaires de la population des requérants d'asile : revue de la littérature et étude genevoise auprès des soignants de premier recours

David Framorando, Rachel Baeriswyl-Cottin R, Javier Bartolome and Yasser Khazaal

Hôpitaux Universitaires de Genève, Genève, Switzerland

Il est aujourd'hui reconnu que la population des personnes requérantes d'asile doivent faire face à des événements stressants et fragilisants à la fois pré et pot- migratoires. S'il existe une littérature conséquente sur l'impact des évènements traumatiques sur le fonctionnement psychique de cette population, aujourd'hui plusieurs auteurs s'interrogent sur les réels besoins de cette population en pointant le fait qu'ils ne seraient pas toujours prise en compte par un modèle occidental de soins souvent à risque de réductionnisme.

Différents travaux ont mis en exergue des besoins prédominants dans le domaine des activités quotidiennes, des contacts sociaux, des problèmes de logement et de l'accès européens.

Nous avons mené à Genève une étude sur l'appréciation des soignants de premiers recours des besoins prioritaires des personnes requérantes d'asile. Elle s'est appuyé sur la création d'un questionnaire structuré de type échelle de Likert disponible sur internet qui a été proposé aux médecins de premiers recours affiliés au Réseau Santé Asile, aux médecins internistes et Généralistes des HUG en contact avec cette populations, aux infirmières de soins généraux travaillant dans différents foyers de l'Hospice Général, aux travailleurs sociaux travaillant dans ces foyers ainsi qu'aux interprètes du service d'interprétariat de la Croix Rouge

Nous avons obtenu 58 réponses, dont 55, 17% de la part de médecins, 17, 24% de la part d'infirmiers, 20, 69% de la part d'interprètes. Les besoins prioritaires concernaient pour 66, 67% des personnes interrogées les ressources financières, pour 75% l'accès à des conditions de logement de meilleures qualité, pour 89.47% l'accès à des activités même faiblement rémunérées, pour 80.7% un meilleur accès à des formations non rémunérées, pour 85.71% une amélioration de l'accès à l'aide juridique.

Les limitations principales concernent un nombre modéré de réponse provenant d'un réseau de soignants cependant lui- même limité. Différents développements sont à prévoir, notamment la mise en place d'un groupe contrôle et l'usage d'outils psychométriques permettant d'obtenir des réponses des personnes requérantes d'asile elle-même.

Intervention psychiatriques de crise auprès de la population des patients requérants d'asile

Javier Bartolomei, Pierre Bastin, Natacha Premand and Michel Amoros
Hôpitaux Universitaires de Genève, Genève, Switzerland

"Les interventions psychiatriques de crise auprès de personnes requérantes d'asile se déploient souvent lorsque des événements viennent bouleverser les représentations d'avenir qu'elles avaient. Il va s'agir principalement de l'annonce d'un refus d'octroi d'asile ou d'un changement de lieu de vie pouvant également signifier l'échec de cette procédure. Cependant, si ce même facteur de crise est fréquemment retrouvé dans ce type d'intervention, ses résonances vont fortement différer d'un sujet à l'autre, en fonction de son histoire, de sa culture et des particularités de son parcours migratoire. Ainsi à une clinique du trauma, de l'effraction, peut s'ajouter une clinique de la déception. En effet, face à la désillusion que représente l'échec de la procédure de demande d'asile, certains sujets seront amenés à remettre de manière consciente ou inconsciente toute une série de croyances et de représentations qu'ils pouvaient avoir sur le monde et sur lui-même. Dès lors, il s'agit d'un défi clinique permanent de pouvoir répondre de manière singularisée à des formes de souffrances mentales très hétérogènes, en tenant compte de l'importance de pouvoir articuler notre intervention à celle des autres intervenants de différents corps de métiers (avocats, travailleurs sociaux, médecins de premier recours, infirmière) impliqués dans ces situations."

Interventions psychiatriques mobiles dans les foyers pour requérants d'asile à Genève

Didier Dechoux, Michel Amoros, Francisco Gonzalez, Natacha Premand and Javier Bartolomei

Département de Santé Mentale et de Psychiatrie, Hôpitaux Universitaires de Genève, Genève, Switzerland

Parmi les personnes requérantes d'asile (RA) se trouvent des patients souffrant de troubles psychiatriques graves, se traduisant parfois au travers d'une discontinuité dans le lien thérapeutique et les soins et marquée par de fréquentes ré-hospitalisations. Une intervention de type « équipe mobile » a été mise en place depuis janvier 2014 au sein du Centre Ambulatoire de Psychiatrie et Psychothérapie Intégré (CAPPI) de la Servette, visant à favoriser le maintien de l'alliance thérapeutique et ainsi la poursuite des traitements psychiatriques. Ce type de prise en charge se décline sous forme d'interventions infirmières dans les différents foyers communautaires pour requérants d'asile de Genève.

Depuis sa mise en place, ce programme de soins a concerné 30 patients, ce qui représente env. 10% de la population RA suivie dans notre structure. Il s'agit essentiellement d'hommes jeunes, célibataires, résidant en Suisse sans réseau primaire, majoritairement issus de pays d'Afrique subsaharienne et frappés d'une Non Entrée en Matière (NEM) sur le plan administratif. Au niveau psychiatrique, la plupart a déjà bénéficié d'une ou plusieurs prises en charge hospitalières avant le traitement ambulatoire et une moitié présente une problématique psychotique.

Challenges of individual placement and support in Europe

Supported by CHUV Community psychiatry service

Domenico Berardi[1] and Charles Bonsack[2]

1. Institute of Psychiatry, Bologna University, Bologna, Italy
2. CHUV, Lausanne, Switzerland

Individual Placement and Support is a highly effective psychosocial method to help people with severe mental health disorder to obtain and to maintain employment. Originally studied mainly in the United States, it has been successfully implemented in Europe during the last years. Moreover, recent awareness of the huge economical burden of mental health disorders in Europe has increased interest in IPS, not only to meet the needs of severe mental disorders, but also inspire methods addressed to more frequent invalidating disorders such as personality or depressive disorders. The authors will present the challenges to implement efficacious IPS in European socioeconomic context: policy and implementation, research, fidelity to original model, specificities for early psychosis and adaptation to public mental health needs.

Speakers

1. Individual Placement and Support in Europe
   Domenico Berardi, Institute of Psychiatry, Bologna University, Bologna, Italy
2. Effectiveness of individual placement and support in The Netherlands
   Harry Michon, Trimbos Institute, Utrecht, Netherlands
3. Implementing IPS in Spain
   Débora Koatz, Avedis Donabedian Institute, Barcelona, Spain
4. IPS in early psychosis
   Logos Curtis, HUG, Geneva, Switzerland
5. Meeting public mental health needs with IPS
   Daniele Spagnoli, CHUV, Lausanne, Switzerland

Individual placement and support in Europe

Angelo Fioritti[1] and Domenico Berardi[2]

1. Department of Mental Health and Substance Abuse, AUSL Bologna, Bologna, Italy
2. Institute of Psychiatry, Bologna University, Bologna, Italy

Individual Placement and Support is a psychosocial intervention with a considerable body of evidence for its effectiveness in helping people with severe psychiatric disorders to obtain and maintain competitive jobs. In the last decades, several European studies have replicated earlier American outcomes, generating widespread interest about its implementation in Europe. The authors collected, described and compared details about achievements and challenges of IPS in four European countries; the United Kingdom, Italy, the Netherlands and Spain. In the UK and in the Netherlands empirical studies exploring the consistency of results over time and the effectiveness of IPS adaptations to local needs and special population are in course. In the UK IPS has become national policy, as well as in some regions of Italy and Spain. Training is quite extensive in the UK and in the Netherlands, developing well in Italy and Spain. Implementation seems to be less straightforward, mostly due to deeply rooted cultural values regarding both work and mental health care. Strong local leadership is still required. In all countries contingencies related to the current economic crisis seems to have increased interest in IPS. With the converging forces of strong local leadership, rapid economic changes and slow cultural shifts, IPS may soon become a priority intervention in Europa for ensuring that mentally ill people obtain competitive employment.

Effectiveness of the IPS model of vocational rehabilitation for people with severe mental illnesses in the Netherlands

H. Michon[1], J. T. Busschbach[2], J. V. Weeghel[3] and H. Kroon[1]

1. Trimbos Institute, Utrecht, Netherlands
2. University Medical Center Groningen, University of Groningen, Groningen, Netherlands
3. Phrenos Center of Expertise, Utrecht, Netherlands

The Individual Placement and Support (IPS) model of vocational rehabilitation is designed to result in better employment outcomes for people with SMI. IPS is integrated within mental health services and focuses on rapid paid job search. Numerous trials, mostly conducted in the USA, have demonstrated IPS to significantly increase return to open employment compared to regular vocational rehabilitation. In Europe one trial have been conducted which replicates the effectiveness of IPS (Eqolise study). However, conclusions for separate countries could not be drawn. We studied (cost) effectiveness of IPS specifically for the Netherlands and again, IPS has proven to be effective considering helping people in the target group find competitive jobs.

In this presentation the results of the SCION (a Study on Cost-effectiveness of IPS on Open employment in the Netherlands) are summarised. Scion is a multi-site RCT of the costs and effects of IPS at four mental health agencies in the Netherlands. Some new research, e.g., addressing the additional value of working on recovery and relating IPS to a specific recovery training model (WRAP) will also be presented. Special attention will be given to model fidelity and monitoring fidelity. Recent developments concerning the implementation of IPS in the Netherlands will be discussed.

Implementing IPS in Spain

Débora Koatz[1], Pilar Hilarion[1], Pere Bonet[2] and Rosa Suñol[1]

1. Avedis Donabedian Institute-UAB, Barcelona, Spain
2. Ministry of Health – Government of Catalonia, Barcelona, Spain

Individual Placement and Support (IPS) is a psychosocial intervention with an important component of evidence for its effectiveness in helping people with severe mental disorders to obtain and maintain competitive jobs. In Europe, the model is implemented in some countries which share experiences and achievements with Dartmouth University which started the project 14 years ago.

This work aims to describe achievements and challenges of IPS implementation in Catalonia, Spain. The project started in 2013 and three Regional Government Ministries are committed to integrate supported employment in regional policies, vocational programs based on IPS principles, involving training and supporting local development are in course.

Since October 2013, up to December 2014, 7 sites are adapting their own programs to implement IPS methodology. 555 persons with severe mental illness have participated in these programs. Tough the severe economic crisis, from them, 170 people found a competitive job during this period (30.6%). First fidelity reviews, during 2014 indicated that IPS models were still poor implemented. A strong local leadership and commitment is fostering the project with a territorial approach, and boosting IPS as a priority intervention to obtain and maintain competitive employment and recovery for people with a mental health condition.

Meeting public mental health needs with IPS

Danièle Spagnoli

Service of Community Psychiatry, Department of Psychiatry, CHUV, Lausanne, Switzerland

The development of the RESSORT program in Lausanne (Vaud Canton, Switzerland) offered the opportunity to test the actual feasibility of implementing the IPS model into the local labour market. Moreover, this program replies to long standing unanswered mental health issues: a high percentage of the beneficiaries of welfare benefits present untreated mental health problems, frequently interfering with their professional reintegration. The perspective of a specialised and professional support to their employment reintegration process is often an efficient incentive to their mental care engagement. The socio-professional integration programs addressed to young people aged between 18 and 25 years report several cases to RESSORT, promoting early interventions and reducing the risk of long-term disabilities.

Coercion in community psychiatry

Andrew Molodynski

Oxford Health NHS Foundation Trust, Oxford University, Oxford, UK

Coercion has always been a controversial and contested area of psychiatry. While most agree that coercion is sometimes necessary there are also clear examples of excesses, both in the past and present. Little is known about the concept but over recent years research has focused on the area and offers some interesting findings about the nature and extent of the issue, its effects, and potentially some interventions to reduce it and increase empowerment.

The first presentation will describe how coercion affects individuals and their families and will draw upon detailed qualitative research in this field. The second presentation will focus on issues of coercion internationally and describe a number of interventions that have been shown to reduce coercion or at least have promise. The final presentation will present the results of studies in Geneva of CBT supported advance directives and appraise the future potential of this intervention.

Speakers

1. Community Coercion from the perspective of families
   Jorun Rugkåsa, Akershus University Hospital, Norway
2. Coercion in psychiatry- how might we minimise it?
   Andrew Molodynski, Oxford University, United Kingdom
3. Advance directives, a way to reduce coercion: perspectives and barriers
   Yasser Khazaal, Geneva University Hospitals, Switzerland

Coercion in the community: family carers' perspectives and experiences

Jorun Rugkåsa[1,2]

1. Health Services Research Unit, Akershus University Hospital, Lørenskog, Norway
2. Department of Psychiatry, University of Oxford, Oxford, UK

Family members have always been central in caring for the mentally ill. Recently, deinstitutionalisation has shifted much of the day-to-day care for community patients onto family. Policy and services are increasingly based on partnership between services and families, and families are often given defined roles in assertive and coerced treatment forms. Very little is known, however, about how family carers experience this role. Drawing on new empirical evidence from the UK and the existing international literature, this presentation discusses the experiences of family in coercive practices in the community. Family carers want good services for patients, and they often accept coercive approaches (by themselves or by services) if that is needed. Family member may in different ways be involved in services' limit setting or coercion of patients in community settings. In some cases this is viewed as positive. However, some of the practices of community teams may also add pressure or leverage the family carers as well as patients. Experiences of lacking voice and being excluded from clinical decisions are common. The overarching aim for most family carers is to create a stable environment which can protect the patient's autonomy as well as their wellbeing Sometimes carers are intimately involved in many areas of the service users' lives in ways they would not with other relatives, such as making sure they keep socially active or looking after finances or medication. This may add pressure on the patient or cause conflicts about what is legitimate influencing behaviour within families and what constitutes coercive actions. The continuous involvement of services via both assertive outreach and community compulsion is usually valued if it means 'good' services for patients. There seems, however, to be a long way to go before services interact with family carers in a way that both parties experience as respectful and at the right level of involvement.

Coercion in psychiatry- how might we minimize it?

Andrew Molodynski

Department of Psychiatry, Oxford Health NHS Foundation Trust, Oxford University, Oxford, UK

Coercion is and always has been an integral part of mental health care and is now an increasingly recognized issue in community mental health care as well as within institutions. It is unlikely that coercion will ever disappear as a feature of care and most would agree that in some circumstances it is justified, for example with the use of mental health legislation in those with severe illnesses who may be a risk to themselves and/or others. However, it can have negative effects upon the individual and there is evidence to support this and numerous examples of excessively coercive practices.

Over recent years attention has turned to interventions that may ameliorate the effects of coercion or reduce its use. This presentation briefly outlines some practical approaches that have shown promise and then discusses the wider issues applicable to mental health care across Europe and further afield.

Advance directives, a way to reduce coercion: perspectives and barriers

Yasser Khazaal

Geneva University Hospitals, Geneva University, Geneva, Switzerland

Psychiatric advance directives (PAD) were seen as a possible way to reduce coercion. In Switzerland, advance directives have a strong legal value and their use by people with mental disorders was supported by some preliminary studies.

Surprisingly, only a small number of people used PAD. Possible barriers at patient and service levels may contribute to this phenomenon. Amongst others, implementation of PAD is probably influenced by the formal and legal values of PAD, the recovery style of the patient, the moment of PAD writing, clinicians' attitudes towards PAD, as well as by accessibility and honouring in case of crisis.

There are needs to systematically assess and overcome such barriers.

Furthermore scientific assessments of the impact of such approaches are needed from patients' and service use perspectives.

«aiRe d'Ados», une aire santé-sociale au service de la clinique et de la formation pour les réseaux des jeunes suicidants en grande difficulté

Nathalie Schmid Nichols and Yasmine Cebe

HUG-Children Action, Genève, Switzerland

Créé à l'initiative de l'Unité de Crise pour adolescents (HUG-Children Action) avec un collectif de professionnels de la santé et du social, aiRe d'ados s'engage sur la continuité auprès des jeunes à risque suicidaire en situation d'impasse et de leurs réseaux.

Ce dispositif transverse est au service de la clinique, des liens inter-institutionnels et professionnels, et de la formation. Il offre des espaces de rencontre et d'analyse pour faciliter la coordination de l'accompagnement en réseau de ces jeunes et chapeaute différents projets communautaires liés à la prévention du risque suicidaire.

Des professionnels attachés à son développement présenteront en quoi et comment ce dispositif peut servir le réseau, la collaboration et penser les clivages qui nous agissent tous au quotidien au détriment de l'intégration psychosociale des jeunes que nous rencontrons.

Speakers

1. *Anne Edan, l'Unité de Crise, HUG-Children Action, Genève, Switzerland*
2. *Anne-Marie Trabichet, Service du médecin cantonal Genève (DEAS), Genève, Switzerland 3.Xavier Baricault, Orif Vernier, Genève, Switzerland*
4. *Pierre Battut, Genève, Switzerland*
5. *Ana Belen Guinea Salinas, Genève, Switzerland*
6. *Christiane Stephano, DIP, Genève, Switzerland*
7. *Dimitri Anzules, HETS, Genève, Switzerland*
8. *Vincent Jobin, Dialogai, Genève, Switzerland*

Un dispositif transverse

Nathalie Schmid Nichols[1], Anne Marie Trabichet[2], Xavier Baricault[3] and Pierre Battut[4]

1. SPEA, Psychologue Responsable du Centre d'Etude et de Prévention du Suicide, HUG-Children Action, Genève, Switzerland
2. Conseillère en santé publique Service du médecin cantonal Genève (DEAS), Genève, Switzerland
3. Répondant Social Orif Vernier, Genève, Switzerland
4. Travailleur Social, Genève, Switzerland

aiRe d'ados s'inscrit comme un dispositif cantonal expérimental, innovant, fait de rencontres et de collaborations circulaires autour de la question du risque suicidaire chez les jeunes. Dans la pratique clinique et dans le champ du travail social et de la formation, nous pouvons constater combien chacun peut être tenté de renoncer à collaborer car il est plus simple de nous comprendre «entre mêmes». Ces résistances se répercutent sur les jeunes et leurs réseaux.

Sur le territoire riche en institutions et associations qu'est le nôtre, il ne s'agissait pas de créer une nouvelle institution mais bien une structure transverse au service du réseau santé/social qui permette à nos différends et différences de devenir des ressources pour les jeunes. Des professionnels d'horizons divers contribuant à ce processus témoignent, en fonction de leur sensibilité et de leur parcours, de la place qu'ils occupent, de leurs observations et questions face au champ de la prévention du risque suicidaire et des ruptures psychosociales chez les jeunes.

Un dispositif clinique au service des réseaux

Anne Edan[1], Ana Belen Guinea Salinas[2] and Christiane Stephano[3]

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Un adolescent va mal. Il passe d'une structure à l'autre, raconte parfois des bribes d'histoire douloureuse, chaotique, répète malgré lui un scénario inquiétant, fascinant, aveuglant chaque nouveau spectateur du théâtre de sa vie. Comment faire pour qu'une histoire apparaisse derrière tous ces clichés caricaturaux?

Comment détacher l'adolescent de ces courts-circuits de la pensée qui ne lui permette plus de prendre le temps de comprendre ce qui lui arrive ?

Notre ambition avec le groupe clinique d'aiRe d'ados est de penser un lieu, un lien et un temps possible pour que cet adolescent reprenne le fil de son existence, pour qu'un récit se dégage, que des témoins apparaissent et soient garants de la mémoire de cet adolescent.

Le travail mené dans le groupe clinique d'aiRe d'ados est ainsi d'interroger notre pratique et la clinique de chaque adolescent pour en relever la dimension de continuité, penser un dispositif pour que la parole portée par l'adolescent arrivent jusqu'à ceux qui se préoccupent pour lui, acteurs sociaux, professionnels du soin ou entourage plus direct.

Un dispositif d'information au service de la collaboration

Yasmine Cebe[1], Dimitri Anzules[2] and Vincent Jobin[3]

1. Psychologue au Centre d'Etude et de Prévention du Suicide, SPEA, HUG-Children Action, Genève, Switzerland
2. Chargé D'enseignement HETS, Genève, Switzerland
3. Chargé de projets en santé sexuelle Dialogai, Genève, Switzerland

En tant que dispositif transverse, aiRe d'ados est au service de la formation des professionnels de la santé et du social confrontés à la problématique suicidaire chez les jeunes. Le collectif réfléchit aux aspects de formation à partir des demandes émanant du terrain, par rapport à la solitude et au sentiment d'impasse que peuvent éprouver les professionnels face à ces jeunes en grande souffrance et souvent en processus de rupture (familiale, sociale et professionnelle), dans une démarche créative et innovante. Les réflexions et perspectives actuelles et futures menées par le dispositif seront présentées par des intervenants œuvrant à la Fédération LGBT et dans le domaine de la formation professionnelle (HETS). Deux projets liés à la prévention du risque suicidaire et chapeautés par aiRe d'ados seront aussi brièvement évoqués.

Vers une démarche participative des usagers dans le soin en santé mentale

Jean Luc Roelandt and Massimo Marsili
CCOMS, Lille, France

(1) Pour la première fois en France, le programme pilote «Médiateurs de santé/pair» (MSP) a conduit à l'embauche dans des établissements de santé mentale de personnes anciennement usagères de services de santé mentale. Le CCOMS appelle au renouvellement de ce programme: Après trois années d'expérimentation, ce programme a permis de faire avancer la réflexion sur les frontières entre soigné et soignant, savoir professionnel et savoir profane, savoir universitaire et savoir expérientiel. Il ouvre la voie à un questionnement entre thérapeutique et accompagnement, entre care et cure, et sur les fonctions et statuts de chacun dans le champ de la santé mentale.

(2) Les 30 et 31 janvier 2014, les 4èmes Rencontres internationales du CCOMS ont permis d'énoncer de nouvelles orientations en faveur de l'empowerment en santé mentale. Plus de 400 personnes, usagers, aidants, professionnels, élus, en provenance de 16 pays ont débattu du pouvoir d'agir des personnes usagères des services de santé mentale et des aidants. 21 recommandations en faveur de l'empowerment en santé mentale ont été définies. Le CCOMS poursuit ses travaux afin proposer un programme de recherche sur l'empowerment en santé mentale en Europe.

(3) L'OMS inscrit dans le processus de révision du chapitre concernant les troubles mentaux et le comportement de la Xème version de la classification internationale des maladies (CIM), un travail avec les acteurs concernés: les représentants des états membres de l'OMS, les professionnels, les usagers et les aidants. Cette participation doit permettre d'aboutir à une classification qui intègre des données probantes provenant des pays développés et des pays à faible revenu, et qui respecte les spécificités culturelles et linguistiques des acteurs. Les CCOMS de Lille et de Montréal élaborent actuellement des protocoles de recherches avec des usagers et aidants.

Speakers

1. La mise en œuvre du programme de formation et d'embauche des pairs aidants auprès des services publics de santé mentale

   C.Mastrangelo, EPSM Lille Métropole, Lille, France V.Vermeersch, EPSM Lille Métropole, Lille, France M.Marsili, CCOMS, Lille, France

2. L'élaboration conjointe (usagers, aidants, professionnels, élus) de recommandations en faveur de l'empowerment en santé mentale et d'indicateurs d'évaluation

   M.Koenig, CCOMS, Lille, France

   J.L Roelandt, CCOMS, Lille, France

3. L'implication des usagers et aidants dans le processus de révision de la dixième version de la CIM

   J.P Julien, hôpitaux de Saint-Maurice M.Marsili, CCOMS, Lille, France

La mise en œuvre du programme de formation et d'embauche de médiateurs de santé-pairs auprès de services publics de santé mentale

Cristina Mastrangelo[1], Valérie Vermeersch[1] and Massimo Marsili[2]

1. EPSM Lille Métropole, Lille, France
2. Centre Collaborateur de l'Organisation Mondiale de la Santé pour la recherche et la formation en santé mentale (CCOMS), Lille, France

L'insertion des médiateurs de santé/pairs dans les services de psychiatrie et de santé mentale vise à améliorer le recours aux soins et la qualité de la prise en charge des usagers. Elle est pensée comme l'une des multiples réponses possibles à la diversification de l'offre de soins en France.

En 2012 le programme pilote «Médiateurs de santé/pair» (MSP), porté par le CCOMS a conduit à l'embauche dans des établissements de santé mentale de personnes anciennement usagères de services de santé mentale, dans trois régions françaises: Ile-de-France, Nord Pas de Calais et Provence Alpes-Côtes d'Azur.

Une formation en cours d'emploi d'un an a mené à l'obtention d'un Diplôme Universitaire de médiateur de santé/pair, à la suite duquel les MSP ont poursuivi leur travail en tant que salariés dans les équipes de soins.

Les 16 médiateurs formés en poste à ce jour font désormais partie intégrante de ces équipes et travaillent en tant que professionnels du champ de la santé mentale.

S'appuyant sur plus de trois ans de recul sur la mise en place de cette expérimentation, le CCOMS appelle aujourd'hui au renouvellement de ce programme: celui-ci a permis de formuler des recommandations précises quant au choix des établissements et des services participants, au recrutement des MSP, leur formation initiale et continue, le suivi du programme et l'accompagnement des médiateurs.

Une évaluation qualitative menée par le laboratoire de sociologie du Clersé (Université de Lille 1), a montré qu'il permis que le programme médiateurs de santé- pairs a permis de faire avancer la réflexion sur les frontières entre normal et anormal, soigné et soignant, savoir professionnel et savoir profane, savoir universitaire et savoir expérientiel, mais aussi sur les notions de «sain» versus «bien portant». Il ouvre la voie à un questionnement entre thérapeutique et accompagnement, entre care et cure, et sur les fonctions et statuts de chacun dans le champ de la santé mentale.

Elaboration conjointe (usagers, aidants, professionnels, élus) de recommandations en faveur de l'empowerment en santé mentale et d'indicateurs permettant de les évaluer

Simon Vasseur-Bacle[1], Jean-Luc Roelandt[1] and usager à définir[2]

1. Centre Collaborateur de l'Organisation Mondiale de la Santé pour la recherche et la formation en santé mentale, France
2. à définir, France

L'Organisation Mondiale de la Santé (OMS) définit l'empowerment comme faisant

«*référence au niveau de choix, de décision, d'influence et de contrôle que les usagers des services de santé mentale peuvent exercer sur les événements de leur vie. (…) La clé de l'empowerment se trouve dans la transformation des rapports de force et des relations de pouvoir entre les individus, les groupes, les services et les gouvernements*» (Wallerstein, 2006). L'OMS mentionne également les aidants dans le Pacte européen pour la santé mentale et le bien-être (2004, 2007): «*L'empowerment des personnes avec un problème de santé mentale et des aidants sont des priorités pour la prochaine décennie*».

Suite aux 4èmes rencontres internationales du Centre Collaborateur de l'OMS pour la recherche et la formation en santé mentale (CCOMS, Lille, France), 21 recommandations en faveur de l'empowerment des usagers des services de santé mentale et des aidants ont été définies.

Cette première étape est le fruit d'un travail conjoint entre usagers, aidants, élus et professionnels. Une seconde étape, en cours, consiste à associer des indicateurs d'empowerment permettant de dresser une cartographie de l'empowerment en santé mentale en Europe.

Cette communication présentera le concept d'empowerment en santé mentale, la promotion de cette notion par l'OMS et les 21 recommandations.

La discussion portera sur la question fondamentale suivante: comment promouvoir de manière concrète ces recommandations ?

L'implication des usagers et des aidants dans le processus de révision de la dixième version de la CIM

Marie Koenig[1], Jean-Pierre Julien[2], Anne-Claire Stona[1], Massimo Marsili[1] and Jean-Luc Roelandt[1]

1. CCOMS, Lille, France
2. Hôpitaux de Saint-Maurice, Paris, France

Contexte de l'etude: L'OMS a inscrit la participation de tous les acteurs concernés par la Classification Internationale des Maladies (CIM) dans son processus de révision qui aboutira à la XIème édition en 2017. Par acteurs, il est entendu aussi bien les représentants des états qui sont membres de l'OMS, les professionnels de différentes disciplines, que les usagers et les aidants. Afin d'impliquer, pour la première fois, les usagers et les aidants à la révision de la CIM, le Centre Collaborateur de l'OMS (CCOMS) de Lille a mis en œuvre une méthodologie scientifique de relecture, par les usagers et les aidants, des lignes directrices de la CIM. Pour cette première étude, le choix de la catégorie diagnostique – objet de la relecture – s'est porté sur la schizophrénie. En effet, ce trouble se démarque par son caractère controversé et son potentiel stigmatisant.

Objectif: Proposer à l'OMS des recommandations sur les lignes directrices de la CIM-11 concernant le diagnostic de schizophrénie afin d'aboutir à une classification jugée acceptable par les usagers et les aidants en santé mentale. Par acceptable, nous entendons: ce qui ne nécessite pas de modification.

Type d'étude: Il s'agit d'une étude multicentrique, internationale, participative, conduite auprès d'une population d'usagers et d'une population d'aidants.

Méthode: L'étude se déroulera en 3 étapes :

Étape 1: Entretien de recrutement, lettre d'information et consentement

Étape 2: Accompagnement individuel à la lecture et à l'analyse du matériel

Étape 3: Groupes de discussion structurés co-animés par un chercheur et, soit un usager-chercheur pour les groupes de discussions d'usagers, soit un aidant- chercheur pour les groupes de discussion d'aidants.

Analyse des données: L'analyse portera sur les documents de travail (étape 2) et la retranscription des échanges (étape 3). Elle fera l'objet d'un traitement à la fois quantitatif et qualitatif (à l'aide d'un logiciel d'analyse de contenu type Nvivo) afin d'identifier les éléments des lignes directrices jugés non acceptables par les usagers et les aidants et de recenser les formulations alternatives. Il s'agira par la suite de comparer les résultats obtenus entre les groupes d'usagers et les groupes d'aidants, puis entre les sites et enfin entre les pays d'étude.

Conclusion: Cette étude s'inscrit dans un processus visant l'amélioration des principes d'utilité clinique de la CIM, notamment sa valeur dans la communication entre les praticiens, les patients et les familles. Dans le contexte de la classification des troubles mentaux et du comportement, cette étude contribue à l'élaboration d'une santé mentale *citoyenne et démocratique,* favorisant la participation active des usagers et des aidants à tout processus de décision les concernant.

Open dialogue & dialogical practice: research & clinical experience on integrating and adapting into practice

Douglas Ziedonis

University of Massachusetts Medical School, Worcester, MA, USA

The Finnish Open Dialogue model and Dialogical Practice has raised great international interest for improving clinical outcomes for individuals with first-break psychosis and other psychiatric conditions. The University of Massachusetts Medical School's Department of Psychiatry has partnered with the University of Jyväskylä and other research / clinical teams in Europe to develop training and research tools which will help implement, adapt and further evaluate the Open Dialogue and Dialogical Practice. In the United States, this model is seen as pro-recovery, empowering, and a way to enhance family and network engagement in clinical practice. Implementing this model requires organizational change efforts, including staff training and ongoing support. Our team has developed tools to help implementation and do quality improvement and research, including a training program, written practical clinical guidelines, and a fidelity scale for supervision, self-review, or research. We have experience with implementation and research. This workshop will:

- Provide an overview of Open Dialogue & Dialogical Practice
- Explore the evidence for this approach and our studies to date in the United States
- Review our clinical guidelines, fidelity scale, and training programs
- Give case examples of implementation and some of the barriers (and solutions) to barriers, including treatment cultural differences.

Outreach services in Switzerland

Matthias Jäger[1] and Ralf Gebhardt[2]

1. University Hospital of Psychiatry, Zurich, Switzerland
2. Psychiatric Services, Thurgau, Switzerland

The UN convention on the rights of persons with disabilities and the Recovery paradigm as a central principle for mental health policy in many countries promote inclusion and full participation in society of all individuals and strengthen their autonomy, freedom of choice and accessibility of services. This includes the goal of living fully integrated in the community as the primary aim of all rehabilitative services. This paradigm shift challenges health and social policy makers as well as providers of mental health services. Outreach services provide flexible mental health care concerning different needs of individuals with mental illness. Several outreach approaches in Switzerland regarding practical and scientific aspects will be presented in this symposium. It includes presentation of a specialized unit for clinical decision making (UCDM) to identify patients who until now were treated in hospitals but for whom treatment in the community would also be suitable and possible, supported employment according to the principles of "Individuals placement and Support", Supported housing according to the principles of the newly introduced "Individuals housing and Support", and Poststationary Transition Treatment (PSTT) for complex cases.

Speakers

1. Does referral to inpatient treatment necessarily imply a need for inpatient treatment?
   Niklaus Stulz, Psychiatric Services Aargau, Switzerland
2. Prevention of Relapse in "complex cases" by means of Poststationary Transition Treatment
   Ralf Gebhardt, Psychiatric Services Thurgau, Switzerland
3. Individual Placement and Support
   Wolfram Kawohl, University Hospital of Psychiatry Zurich, Switzerland
4. Individual Housing and Support
   Matthias Jäger, University Hospital of Psychiatry Zurich, Switzerland

Individual placement and support

Wolfram Kawohl

Department of Psychiatry, Psychotherapy and Psychosomatics, Centre for Social Psychiatry, University Hospital of Psychiatry, Zurich, Switzerland

Supported Employment (SE), especially Individual Placement and Support (IPS) has been shown to be a powerful tool for vocational rehabilitation of persons with severe mental illness (SMI). Randomized controlled trials (RCTs) and meta-analyses reveal the superiority over traditional vocational rehabilitation (TVR)approaches concerning employment obtained, length of competitive employment and several secondary parameters such as financial variables, rehospitalisation, psychopathology, and stigma. SE contains elements of outreach due to the fact that job coaches counsel their clients concerning factors deeply embedded in the social environment of the users.

While IPS has been extensively tested in populations of persons with SMI, there is little evidence concerning other groups of patients (e.g., pensioners) and regarding the ability of IPS to support job maintenance. Moreover, little is known about the sustainability of IPS and possible predictive factors such as social network, social cognition, and neuropsychological parameters. We present the data from different recent RCTs that have been conducted in Switzerland and Germany along with evaluations of predictive parameters for coaching success.

Prevention of relapse in "complex cases" by means of poststationary transition treatment

Ralf Gebhardt

Psychiatric Services, Thurgau, Switzerland

The first 3 months after discharge from stationary psychiatric treatment are crucial for relapse and rehospitalisation. Thus, the Psychiatric Hospital Münsterlingen (PHM) implemented a Poststationary Transition Treatment (PSTT) for "complex cases" in 2011. Psychiatric nurses of the PSTT treat about 10% of the discharged patients for 3 months at home. During these 3 months the psychiatric nurses establish, if necessary, contacts to further supply networks conjunctly with the patients. No definition of including or excluding criteria was given for "complexity of case". As a consequence, the team of the discharge ward decides by implicit criteria which patient is classified as complex case and hence receives PSTT.

Are there any indicators of a higher case complexity in PSTT-patients than in patients without PSTT (e.g., longer index stay before PSTT, worse GAF or CGI)? Is the PSTT, that aims at preventing relapse and rehospitalisation, successful (reduction of hospital treatment the year after PSTT likewise or higher than in discharged patients without PSTT)?

All $N = 38$ PSTT-patients discharged in the first quarter of 2013 were included. Control group were $N = 64$ patients who were discharged from the same ward immediately before and after the PSTT-patients. The number of hospital days before PSTT, the number of hospital days the year after the beginning of PSTT, diagnosis, socio-demographical variables, and clinical variables of the general documentation data set were examined.

Does referral to inpatient treatment necessarily imply a need for inpatient treatment?

Niklaus Stulz, Matthias Hilpert, Lienhard Maeck, Urs Hepp

Psychiatric Services Aargau, Brugg, Switzerland

The balanced care model of the WHO proposes treatment in the community (e.g., in outpatient clinics or day-hospitals) whenever possible and appropriate. Mental hospitals play an important backup role in a comprehensive mental health care system for those patients who cannot be treated in the community appropriately and safely. In line with the balanced care model, the ongoing mental health care reform aims to strengthen services in the community and to reduce the number of psychiatric hospital beds. In Switzerland, however, the transfer from inpatient to community care is taking place more slowly than in neighboring European countries. This lag is in stark contrast to research findings indicating that a substantial proportion of inpatients could be efficaciously treated in less restrictive and more economic community settings, such as, e.g., day-hospital or home treatment.

The reliable identification of those patients who until now were treated in hospitals but for whom treatment in the community would also be suitable and possible is one of the necessary prerequisites to facilitate the shift from inpatient to community care. Therefore, the Psychiatric Services Aargau (PDAG) implemented a specialized psychiatric emergency service and triage site. This central unit for clinical decision making (UCDM) was set up to examine all emergency inpatient referrals to the mental hospital of the PDAG. Dispositional (level of care) decisions taken at the UCDM were analyzed: Hospitalization proved unnecessary for at least 17% of the $N = 2{,}026$ inpatient referrals over a 1 year period. Instead, these patients were admitted to day-hospitals or outpatient treatment, resulting in annual cost savings of approximately €3.3 million. Merely 8% of those non-admitted patients had to be hospitalized within 28 days of the decision for non-admission being taken. Thus, a specialized UCDM run by clinical experts may help identify cost-effective alternatives to hospitalization.

However, prevention of unnecessary inpatient treatment by means of efficient gatekeeping at mental hospitals requires sufficient capacity in community-based psychiatric services. We will provide a brief outlook on a recently implemented home treatment as an example of a community-based treatment alternative to inpatient care.

Individual housing and support

Matthias Jaeger

University Hospital of Psychiatry, Zurich, Switzerland

Adequate and stable housing conditions are fundamental for the psychiatric rehabilitation of individuals with severe mental illness. Consequently, the housing sector is an important part of the psychiatric care system and generates a substantial part of indirect health care costs due to mental illness. The usual approach in housing rehabilitation for persons with severe mental illness relies on sheltered housing facilities that provide combined housing and care arrangements. In contrast, the Individual Housing and Support (IHS) Scheme is a new model that aims at direct placement in an independent accommodation in the community. It relies on choosing, getting and keeping independent accommodation and fosters the client's role as a tenant and citizen rather than patient and mentally disabled person. Support is provided according to individual needs in a permanent housing situation without time limit. The residential coach is committed to fostering the service user's social inclusion, self-determination, and hope in terms of the recovery approach. There are a number of studies suggesting that supported housing for homeless individuals can significantly improve residential status, housing satisfaction, and quality of life. Non-randomized trials of the effectiveness of housing settings are usually in favor of least restrictive settings with as much choice to clients as possible. However, there is lack of methodologically sound evidence on the effects of the Individual Housing and Support Intervention in a non-homeless population with severe mental illness, particularly in the context of European welfare systems. In this presentation the literature on housing for individuals with mental illness, the principles of IHS and the design of a randomized controlled trial on IHS will be presented.

Treatment of the early phase of psychotic disorders: organizing structures and focusing on specific clinical problems

Philippe Conus and Charles Bonsack

DP-CHUV, Lausanne, Switzerland

Early intervention strategies have greatly developed over the last 20 years and specialized programs have been implemented in many countries. These are based on the concept that patients going through the early phase of such disorders have specific needs that must be approached in an adapted way, both in terms of organization and treatment content. TIPP, a specialized early intervention program has been developed in Lausanne in 2003. In this symposium we will describe its basic concepts, the main elements of its structure, the characteristics of the patients treated so far and some of the tools that are used in this context. We will then outline the critical role played by the mobile team and the characteristics of the subgroup of TIPP patients who need this type of approach. We will finally present one specific focus of clinical research which has explored the impact of childhood trauma on the functional outcome of TIPP patients in order to illustrate how clinical research can help identify specific needs in subgroups of early psychosis patients.

Speakers

1. Specific treatment of the early phase of psychoses: strategies and results
   Philippe Conus, DP-CHUV Lausanne, Switzerland
2. Mobile teams: a central element of early intervention strategies
   Charles Bonsack, DP-CHUV Lausanne, Switzerland
3. Childhood sexual and physical abuse: age at exposure modulates impact on functional outcome in early psychosis patients
   Luis Alameda, DP-CHUV Lausanne, Switzerland

Specific treatment of the early phase of psychoses: strategies and results

Philippe Conus

DP-CHUV, Lausanne, Switzerland

Early intervention programs have been developed around the world over the last 20 years. They are based on the principle that patients going through this phase of illness need specific treatment strategies and they basically aim at 2 targets: (1) to reduce the delay between illness onset and start of treatment, and (2) to provide treatments that are specifically geared to the needs of patients.

The TIPP program in Lausanne is based on three elements: (1) A clinical case management team which is specifically trained and provides continuity of care over the 36 months of treatment; (2) An assertive case management team that provides intensive community treatment to patients who have difficulties accessing treatment or go through periods of instability, and (3) an in-patient unit where patients are taken care of by specifically trained nurses and psychiatrists.

Since its launch in 2004, TIPP has included close to 500 patients. The treatment program has had a dramatic impact on patients' engagement, but additional efforts are needed to improve functional outcome and return to active life.

Mobile teams: a central element of early intervention strategies

Charles Bonsack, Philippe Golay, Luis Alameda and Philippe Conus
DP-CHUV, Lausanne, Switzerland

Background: First episode psychosis (FEP) patients are often difficult to engage and have a high rate of disengagement in standard care. Therefore, most FEP programs include assertive outreach (ACT) principles, either as main component (such as OPUS) or as an adjunction to clinical case management (such as EPPIC). The objective of this study is to examine prevalence, characteristics and outcomes of "difficult to engage" patients who need assertive outreach in a FEP program. Methods: prospective naturalistic study of 229 consecutive patients enrolled in Lausanne's FEP program (TIPP) at 0, 3, 6, 12, 18, 24, 30 and 36 months. TIPP case management patients are compared to patients who need supplemental assertive outreach (ACT).

Results: 60 (26%) of TIPP patients needed assertive outreach. Baseline characteristics of ACT patients were ($p \leq 0.05$) longer DUP, lower treatment adherence and functioning, more negative symptoms, no occupation and more cannabis and alcohol abuse. In both groups, adherence to efficacious treatment was attained for 80% patients after 18 months. 40% achieved functional remission and 11% disengaged at 36 months. More positive and negative symptoms remained in ACT group.

Conclusion: About one third or FEP patients were considered as "difficult to engage" and needed assertive outreach. Combination of TIPP and ACT was efficacious to engage and maintain in psychiatric care most FEP patients. Despite the high treatment adherence in both groups, psychotic symptoms remained higher in ACT patients. Efforts to improve functional outcome should continue after 3 years TIPP program.

Childhood sexual and physical abuse: age at exposure modulates impact on functional outcome in early psychosis patients

Luis Alameda[1,2], Carina Ferrari[2], Philipp S. Baumann[1,2], Mehdi Gholam-Rezaee[3], Kim Q. Do[1] and Philippe Conus[2]

1. Unit for Research in Schizophrenia, Department of Psychiatry, Center for Psychiatric Neuroscience, Lausanne University Hospital (CHUV), Lausanne, Switzerland
2. Service of General Psychiatry, Treatment and Early Intervention in Psychosis Program (TIPP-Lausanne), Lausanne University Hospital (CHUV), Lausanne, Switzerland
3. Department of Psychiatry, Center for Psychiatric Epidemiology and Psychopathology, Lausanne University Hospital (CHUV), Lausanne, Switzerland

Background: Evidence suggests a relationship between exposure to trauma during childhood and functional impairments in psychotic patients. However, the impact of age at the time of exposure has been understudied in early psychosis (EP) patients.

Method: 225 patients aged 18–35 were assessed at baseline and after 2, 6, 18, 24, 30 and 36 months of treatment. Patients exposed to sexual and/or physical abuse (SPA) were classified according to age at the time of first exposure (Early-SPA: before age 11; Late-SPA: between age 12 and 15) and then compared with patients who were not exposed to such trauma (Non-SPA). The functional level was measured with the Premorbid Adjustment Scale (PAS) in the premorbid phase and with the Global Assessment of Functioning (GAF) and the Social and Occupational Functioning Assessment Scale (SOFAS) during follow-up.

Results: 24.8% of patients had a history of SPA. Late-SPA patients were more likely to be female (p = 0.010). Comparison with non-SPA patients revealed that: (1) both Early and Late-SPA patients showed poorer premorbid social functioning during early adolescence, and (2) while patients with early-SPA had poorer functional level at follow-up with lower GAF ($p = 0.034$) and lower SOFAS ($p = 0.045$) scores, late-SPA patients didn't.

Conclusion: Our results suggest a link between exposure to SPA and the later impairment of social functioning before the onset of the disease. Early psychosis patients exposed to SPA before age 12 may present long-lasting functional impairment, while patients exposed at a later age may improve in this regard and have a better functional outcome.

Stigmatization as related to psychiatric treatment: how can psychiatrists reduce it?

Undine Lang and Christian Huber

UPK, Basel, Switzerland

Stigmatization and discrimination of psychiatric patients not only occur on an individual but also on a structural level, where laws, policies and practices are different when compared to somatic patients. We conducted a representative survey in the area of Basel-City, Switzerland. Participants were asked to answer the social distance scale with respect to a vignette that either depicted psychiatric symptoms of a fictitious character or a psychiatric service institution the fictitious character had been admitted to. In our study we show for the first time that treatment of psychiatric patients in general hospitals and well-established facilities might decrease perceived stigma in the general population. Further results of the study are being presented.Moreover we show results from a large naturalistic study, that, suicide attempts, absconding and suicides are not decreased in hospitals with a locked door policy. Another question is, how patients should be ideally treated in psychiatric hospitals and facts and fiction about the therapeutic relationship, alliance and recovery orientation will be presented. Moreover an example is shown on how integrated treatment can be introduced successfully in common psychiatric hospitals in Switzerland.

Speakers

1. Is the way we treat our patients alterable?
   Undine Lang, UPK, Basel, Switzerland
2. Empowerment – ein Weg zur Entstigmatisierung der psychisch Kranken und der Psychiatrie
   Christian Huber, UPK, Basel, Switzerland
3. On how to introduce integrated treatment.
   Regula Lüthi, UPK, Basel, Switzerland
4. Therapeutic alliance in schizophrenia: the role of recovery orientation, self-stigma, and insight.
   Roland Vauth, UPK, Basel, Switzerland

Is the way we treat our patients alterable?

Undine Lang

UPK, Basel, Switzerland

New psychopharmacologic strategies, new guidelines, new diagnostic criteria and new psychotherapeutic approaches: many innovative findings in psychiatric research create a modern picture of our profession. However, the translation of theoretical knowledge to clinical practice is difficult. Psychotherapeutic strategies have not been implemented in acute psychiatry, shared decision making is practised in up to 15% of patients, treatment guidelines are implemented in 25% of cases treated, the number of coercive measures is highly variable between hospitals and countries and assertive treatment for the sickest patients is often not available.

In this symposium modern treatment concepts and clinical research findings are discussed and an approach is made on how new trends, knowledge and developments might be implemented in clinical daily routine.

Therapeutic alliance in schizophrenia: the role of recovery orientation, self-stigma, and insight

Roland Vauth

Universitäre Psychiatrische Kliniken, Basel, Switzerland

The presented SNF supported study focused on variables predicting quality of the therapeutic alliance in out-patients with schizophrenia. We expected recovery orientation and insight to be positively, and self-stigma to be negatively associated with a good therapeutic alliance. We expected further these associations to be independent from age, clinical symptoms (i.e., positive and negative symptoms, depression), and more general aspects of relationship building like avoidant attachment style and the duration of treatment by the current therapist. The study included 156 participants with DSM-IV diagnoses of schizophrenia or schizoaffective disorder in the maintenance phase of treatment. Therapeutic alliance, recovery orientation, self-stigma, insight, adult attachment style, and depression were assessed by self-report. Symptoms were rated by interviewers. Hierarchical multiple regressions revealed that more recovery orientation, less self-stigma, and more insight independently were associated with a better quality of the therapeutic alliance. Clinical symptoms, adult attachment style, age, and the duration of treatment by current therapist were unrelated to the quality of the therapeutic alliance. Low recovery orientation and increased self-stigma might undermine the therapeutic alliance in schizophrenia beyond the detrimental effect of poor insight. Therefore in clinical settings, besides enhancing insight, recovery orientation, and self-stigma should be addressed.

Le rôle des facteurs sociaux dans nos interventions thérapeutiques? Perspectives de la psychiatrie adulte genevoise

Manuel Tettamanti[1] and Logos Curtis[2]

1. Programme Couples et Familles, Unité UPJA, Genève, Switzerland
2. Unité UPJA, Genève, Switzerland

Des revues de littérature et méta-analyses récentes montrent l'importance des facteurs sociaux (e.g., stress psychosociaux et isolement social) notamment dans l'étiologie (pour une revue voir McGrath et al., 2008; Van Os et al., 2010) et le traitement des troubles psychotiques (Morgan et al., 2008). Des études indiquent, par exemple, que les inégalités sociales et leur perception sont directement impliquées dans la proportion des troubles psychiques (Pickett and Wilkison, 2010). Ces données, qui s'inscrivent dans une longue tradition d'étude sur les effets des facteurs sociaux sur les troubles psychiques (e.g., Durkheim, 1897; Faris and Dunham, 1939), participent d'un renouveau de l'intérêt pour les approches sociales et communautaires en psychiatrie (e.g., Strauss, 2011; Priebe et al., 2013). Dans cet atelier nous proposons d'avoir un échange sur les outils thérapeutiques et les pratiques de soins intégrant les facteurs sociaux dans l'étiologie et/ou les interventions thérapeutiques dans la diversité des lieux de soins du Département de santé mental et de psychiatrie des Hôpitaux Universitaires de Genève. Les différentes présentations aborderont notamment l'intégration des facteurs sociaux dans certaines interventions en milieu ambulatoire ou hospitalier, dans les interventions familiales, les thérapies narratives ou dans les interventions à domicile. Cet atelier se veut également comme un forum sur cette question et tentera d'élargir le questionnement aux pratiques des participants lors d'une partie du temps qui sera réservé aux échanges.

Speakers

1. Quelle place du "social" en psychiatrie?
   Manuel Tettamanti, Programme Couples et Familles, Unité UPJA, Genève, Switzerland
2. Facteurs sociaux dans les interventions auprès de jeunes adultes Lise Vatré
   Unité UPJA, Genève, Switzerland
3. Le social dans les techniques de thérapie narratives
   Rodolphe Soulignac, Service d'addictologie, Genève, Switzerland
4. A l'interface du social et du thérapeutique dans les interventions à domicile, Equipe Mobile
   Serge Boulguy, HUG, Genève, Switzerland
5. Les interventions multifamilales comme laboratoire social
   Daliah Gintzburger, Programme Couples et Familles, HUG, Genève, Switzerland

Auto-évaluation des difficultés, besoins et ressources chez les patients en psychiatrie

Valentino Pomini and Tanja Bellier-Teichmann

Institut de Psychologie, Université de Lausanne, Lausanne, Switzerland

ELADEB (Échelles lausannoises d'auto-évaluation des difficultés et des besoins) est un outil psychométrique basé sur le principe du Q-Sort (tri de cartes) destiné à témoigner de l'appréciation subjective de patients en psychiatrie sur leurs difficultés et leurs besoins. Il s'agissait au départ de proposer une mesure qui permettait de dépasser les réticences ou limites de certains patients face aux chiffres ou à la manipulation des d'échelles de Likert habituellement utilisées. Publié en 2008, ELADEB connaît depuis une diffusion de plus en plus grande dans le monde francophone ainsi qu'un intérêt qui ne semble pas se démentir.

Souhaitant compléter cet instrument par une mesure des ressources, nous avons développé sur le même principe du Q-sort un instrument destiné à évaluer l'appréciation subjective des ressources de la personne. Cet instrument, AERES (Auto-évaluation des ressources) est dans sa seconde phase de validation. Les données pilotes ont permis la mise au point de l'outil et celui-ci est aujourd'hui utilisé dans un protocole de validation plus ambitieux comparant sujets sains et patients psychiatriques.

Mixant la présentation de données quantitatives psychométriques et les résultats d'analyses qualitatives d'entretiens sur la validité apparente et l'implantation clinique de ces deux instruments, le symposium propose de faire le point sur les connaissances acquises ces deux ou trois dernières années. Les résultats présentés permettent de confirmer l'intérêt clinique, les qualités psychométriques, les perspectives d'avenir d'ELADEB et d'AERES, tout en ouvrant quelques pistes de réflexion sur le bon usage de ce type d'instrument dans une pratique psychiatrique fondée sur les principes du rétablissement personnel.

Speakers

1. Structure factorielle des échelles lausannoises d'auto-évaluation des difficultés et des besoins (ELADEB)
   Valentino Pomini, Université de Lausanne, Lausanne, Switzerland
2. L'utilisation d'ELADEB dans le Case Management de Transition: l'expérience romande
   Pascale Ferrari, Centre Hospitalier Universitaire Vaudois, Institut et Haute École de la Santé, La Source, Switzerland
   Ariella Machado, Hôpitaux Universitaires de Genève, Genève, Switzerland
3. Étude qualitative de l'implantation d'ELADEB au sein de deux équipes professionnelles de santé mentale
   Cheryne Gherbi, Université de Lausanne, Lausanne, Switzerland
4. Développement et qualités psychométriques d'une échelle d'auto-évaluation des ressources chez les patients: AERES
   Tanja Bellier-Teichmann, Université de Lausanne, Lausanne, Switzerland
5. Validité apparente, utilité et praticabilité clinique de l'échelle AERES: une étude qualitative pilote
   Marika Fusi, Université de Lausanne, Lausanne, Switzerland
6. Quelle place pour les méthodes d'auto-évaluation Q-Sort au sein de la pratique actuelle en psychiatrie communautaire?
   Jérôme Favrod, Centre Hospitalier Universitaire Vaudois, Institut et Haute École de la Santé, La Source, Switzerland

Structure factorielle des échelles lausannoises d'auto-évaluation des difficultés et des besoins (ELADEB)

Valentino Pomini[1], Tanja Bellier-Teichmann[1], Claude Hayoz[2], Pascale Ferrari[3] and Philippe Golay[3]

1. Institut de Psychologie, Université de Lausanne, Lausanne, Switzerland
2. Fondation HorizonSud, Marsens, Switzerland
3. Service de psychiatrie communautaire, Département de psychiatrie CHUV, Lausanne, Switzerland

Les échelles d'auto-évaluation des difficultés et des besoins sont un instrument psychométrique de mesure subjective de l'importance des difficultés rencontrées et du niveau d'urgence des besoins d'aide dans vingt domaines de vie. Basé sur la méthode du Q-Sort, l'outil demande aux personnes d'effectuer divers tris de cartes permettant d'obtenir l'équivalent d'un profil quantitatif de leurs difficultés et leurs besoins. Doublé d'un entretien clinique semi-structuré s'appuyant sur le résultat du tri de cartes, ELADEB permet de mieux comprendre individuellement la signification personnelle de chaque profil obtenu.

Publié en 2008, puis légèrement révisé en 2011 (ajout de deux cartes supplémentaires ainsi que d'une carte à option), cet instrument a rencontré une diffusion et un succès grandissant auprès des équipes cliniques. Mais peu de données nouvelles sont venues compléter l'étude de validation initiale basée sur 94 patients. Le recueil de profils cliniques auprès de trois centres utilisant cet outil (unité de réhabilitation, foyers et ateliers protégés de la Fondation HorizonSud, service de case management de transition au sein d'unités psychiatriques hospitalières) a permis de conduire de nouvelles analyses psychométriques, en particulier sur la structure factorielle de l'instrument.

Les résultats montrent que si les analyses classiques en composantes principales restent décevantes, l'application de nouvelles méthodes de factorialisation permet d'aboutir à une structure intéressante combinant la présence simultanée d'un facteur général et de trois facteurs spécifiques. Ces résultats sont conformes avec l'hypothèse de diffusion des troubles et permet probablement de distinguer des sous-groupes de patients non seulement sur un degré général de difficultés ou de besoins mais aussi sur trois autres plans indépendants de ce degré général: le plan financier et administratif, celui des relations interpersonnelles, et celui du handicap psychosocial limitant la personne dans ses sorties et la fréquentation des lieux publics.

ELADEB appartient probablement à une nouvelle génération d'instruments cliniques largement inspirés par les principes du rétablissement personnel qui laisse une large place à l'expression individualisée des préoccupations, projets et besoins de la personne. Nul doute que de nouvelles études à son sujet mériteront de compléter celles qui existent déjà, afin notamment de mieux comprendre les mécanismes sous-jacents aux processus d'auto-évaluation activés par ce genre d'outil, les avantages mais aussi les limites qu'il présente en comparaison avec les échelles d'auto-évaluation plus classiques.

L'utilisation d'ELADEB dans le Case Management de Transition: l'expérience romande

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1. Unité de Psychiatrie Mobile, DP-CHUV, Lausanne, Switzerland
2. Service d'Addictologie, Hôpitaux Universitaires de Genève, Genève, Switzerland

Le case management de transition en psychiatrie, tel qu'il est pratiqué par l'équipe de Lausanne et de Genève en se basant sur les travaux de Bonsack et al., 2013, a pour mission d'assurer la continuité des progrès cliniques acquis lors d'un séjour hospitalier dans la communauté. Il a également pour objectif de relier le travail des intervenants hospitaliers avec celui des intervenants ambulatoires, ainsi que de prévenir l'aggravation des troubles et la rechute. Ce type de suivi se déploie à travers un accompagnement personnalisé jusqu'à un mois après la sortie de l'hôpital.

L'échelle ELADEB est l'outil de choix du case manager de transition pour préparer la sortie de l'hôpital psychiatrique. Cet outil d'auto-évaluation permet de cerner les difficultés et les besoins de la personne hospitalisée. La mise en lien entre les difficultés et les besoins d'aide évoqués permet d'effectuer un travail d'anticipation de la sortie qui se veut concret et réaliste. Cette démarche permet également de faire face aux obstacles potentiels, ainsi que de mobiliser les ressources du patient lequel est proactif tout au long de la démarche.

L'aspect structuré et pragmatique de cette auto-évaluation est très apprécié par les patients, tout comme le feed-back fourni aux intervenants de l'équipe ambulatoire. ELADEB recense les buts atteints pendant la période de transition de quatre semaines et met en évidence les objectifs à atteindre avec l'équipe ambulatoire, donnant ainsi au patient un sentiment de cohérence et de continuité de ses soins. De plus, cet instrument aide également les soignants à se distancier de leurs préoccupations habituelles, comme la gestion des symptômes, pour considérer les besoins importants et immédiats tels qu'ils sont perçus par le patient lui-même.

Cet outil rend possible une comparaison entre le projet hospitalier et celui du patient, parfois divergents, permettant une redéfinition commune du projet hospitalier et de la sortie. Cette mise en accord contribue à une collaboration paritaire et constructive entre les différents professionnels et le patient et produit un effet positif sur le stress engendré par le retour à domicile.

Etude qualitative de l'implantation d'ELADEB au sein de deux équipes professionnelles de santé mentale

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Les qualités psychométriques de l'échelle d'auto-évaluation des besoins et des difficultés (ELADEB) ont été confirmées. Toutefois, la validation psychométrique d'un outil ne garantit pas pour autant sa bonne implantation au sein des institutions qui l'emploient. Afin de mesurer la bonne implantation d'ELADEB, de même que sa mise en œuvre adéquate et sa diffusion, nous avons mené une étude systématique qualitative de l'appréciation, de même que du degré de satisfaction ou de critique exprimées par les professionnels de la santé sur le terrain.

La notion d'implantation a été interprétée selon le modèle de la performance de Parsons (1950), revisité par Champagne et al. (2005) et enfin adapté à ELADEB. Cinq axes de recherche ont été explorés lors de dix entretiens semi-directifs: (1) l'adaptation; (2) l'atteinte de buts; (3) la production; (4) le maintien et la création de valeurs et de sens; (5) le climat organisationnel. Les données ont été analysées selon une méthode de recherche qualitative par analyse thématique.

Les résultats montrent un taux élevé de satisfaction dans chacun des cinq axes étudiés. En effet, les professionnels de la santé attestent qu'ELADEB garantit des mesures subjectives, systématiques et standardisées. Il offre une vue d'ensemble approfondie des besoins et des difficultés des patients. L'outil est décrit comme étant adapté au plus grand nombre de patients, stimulant leur autonomie et leur engagement dans les différentes étapes de la prise en charge. La passation renforce tangiblement l'alliance et l'adhérence thérapeutique. Enfin, les professionnels constatent qu'ELADEB contribue à améliorer l'ambiance de travail et les rapports organisationnels.

Des critiques à l'égard de l'outil, en nombre restreint, sont également formulées. Toutefois, leur analyse détaillée montre qu'elles relèvent davantage du contexte d'implantation, des moyens mis à disposition ou encore d'une réticence face à l'utilisation d'outils d'évaluation psychosociale que de réelles limites de l'outil.

Développement et qualités psychométriques d'une échelle d'auto-évaluation des ressources chez les patients: AERES

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Depuis son origine le domaine de la psychologie clinique s'est essentiellement focalisé sur l'évaluation et le traitement des troubles psychiques. Si les évaluations orientées et focalisées sur les déficits ont amélioré le traitement d'un nombre considérable de psychopathologies, elles ont également créé un biais négatif tendant à réduire les patients à des catégories diagnostiques et considérant les ressources comme périphériques. L'évidence empirique montre que la focalisation sur les ressources internes et externes des patients favorise une fonction préventive face à la psychopathologie. Actuellement, il existe encore peu d'outils standardisés permettant l'évaluation du fonctionnement positif en psychiatrie et en psychologie clinique.

Nous avons développé un nouvel instrument permettant de mesurer un profil des ressources et compétences chez les patients en psychiatrie. Ce nouvel outil, AERES, Auto-Evaluation des RESsources est composé de 31 ressources mesurées selon trois dimensions: (i) les caractéristiques personnelles, (ii) les loisirs et passions, (iii) les ressources environnementales et sociales. Cet outil se base sur des items figuratifs, ainsi qu'un tri de cartes plutôt que sur un questionnaire, ceci afin d'être adapté aux patients ayant des difficultés cognitives ou langagières.

Une étude pilote avec 20 patients psychiatriques a montré que cet instrument est apprécié par les patients et facilement administré. Les qualités psychométriques d'AERES mesurées sur 60 patients sont bonnes. Les ressources les plus présentes dans notre échantillon et pour chacune des catégories sont la reconnaissance, la musique, ainsi que le soutien par les professionnels de la santé. La majorité des ressources sont considérées comme moyennement à fortement importantes pour le rétablissement. Les ressources que les patients souhaitent développer le plus sont l'estime de soi, les voyages et la présence d'amis.

Notre première expérience et résultats avec AERES sont prometteurs et les appréciations des patients et cliniciens largement positives. Les feedbacks des cliniciens soulignent les bénéfices à identifier des profils de ressources afin de favoriser et définir des objectifs cliniques réalistes basés sur les ressources présentes chez les patients et favorisant leur rétablissement. Une perspective future sera d'évaluer l'impact sur les patients d'une identification de leurs ressources personnelles.

Validité apparente, utilité et praticabilité clinique de l'échelle AERES: une étude qualitative pilote

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L'Organisation mondiale de la santé (OMS) a déclaré que la santé est: «un état de complet bien-être physique, mental et social et pas uniquement l'absence de pathologie ou d'infirmité». Toutefois, la création de méthodes d'évaluation et d'interventions cliniques focalisées sur la santé et non sur la pathologie s'avère plus difficile que prévu. L'outil d'auto-évaluation des ressources, AERES, a été développé en vue de pallier à un manque d'outils mesurant un profil général des ressources internes et externes chez les patients en psychiatrie. Les qualités psychométriques de cet outil ont été confirmées. Cependant, tout outil d'évaluation psychosociale doit répondre d'une part aux exigences psychométriques scientifiques, mais également à des exigences cliniques en terme de praticabilité et d'utilité.

Afin de vérifier la pertinence clinique de cet outil d'auto-évaluation, nous avons effectué et analysé 10 entretiens visant à évaluer la perception des patients face à cette démarche d'identification de leurs ressources. Les données ont été analysées selon la méthode de recherche qualitative consensuelle développée par Hill.

55 idées principales ont été dégagées des entretiens et réparties selon six thématiques extraites de l'analyse qualitative. Les hypothèses traitant de la validité apparente et de l'exhaustivité, de l'utilité, ainsi que de la praticabilité clinique et enfin de la nouveauté et originalité d'AERES tendent à être affirmées par les patients. 40 des 55 idées clés expriment une attitude positive des patients face à cette démarche d'évaluation, 4 correspondent à une formulation neutre et 11 se réfèrent à une appréciation négative.

AERES se veut adapté aux spécificités des patients psychiatriques, de même que centré sur leur expertise personnelle. Il serait intéressant d'évaluer si AERES est également un outil d'auto-évaluation capable de promouvoir le bien-être et comportant une fonction mobilisatrice développant ou renforçant les projets de rétablissement chez les patients. L'identification de ressources personnelles pourrait augmenter l'estime de soi du patient par une redéfinition de son identité et un espoir dirigé vers la croissance et le développement de soi.

Quelle place pour les méthodes d'auto-évaluation q-sort au sein de la pratique actuelle en psychiatrie communautaire?

What place for the methods of q-sort self-assessment in current practice in community psychiatry?

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2. Service de Psychiatrie Communautaire, Département de psychiatrie du CHUV, Lausanne, Switzerland

La mobilité et le partenariat sont des enjeux cruciaux de la psychiatrie communautaire. Les prestations qu'elle délivre vont du suivi intensif dans le milieu pour les patients qui refusent les soins au soutien à l'emploi pour les patients qui désirent reprendre une activité professionnelle. Ces prestations nécessitent des équipes mobiles pour rencontrer et accompagner les patients dans le processus de rétablissement. Les soins orientés sur le rétablissement impliquent le développement d'une relation de partenariat, soutenant l'espoir et l'auto-détermination pour permettre au patient de devenir l'acteur de sa vie. Ces interventions doivent également permettre de dépasser les conséquences fonctionnelles des troubles psychiatriques sévères, mobiliser et développer les ressources existantes et renforcer l'estime de soi.

Dans ce contexte, les outils d'auto-évaluation permettent de mieux comprendre la conception que le patient a de ses besoins, de ses difficultés, de ses symptômes et de ses ressources. Afin d'allier ces outils aux exigences de la mobilité, ceux-ci sont mis progressivement sur tablettes.

Mobility and partnership are crucial issues of community psychiatry. The services it delivers go from intensive community treatment for patients who refuse care to employment support for patients who wish to return to work. These services require mobile teams to meet and accompany patients in the recovery process. Recovery-oriented interventions involves the development of a partnership, supporting hope and self-determination, to allow the patient to become the actor of his/her life. The interventions should also help the patients to overcome the functional consequences of severe mental illnesses, mobilize and develop existing resources and build self-esteem.

In this context, self-assessment tools allow to better understand patients' conception of their needs, difficulties, symptoms and resources. To combine these tools with the requirements of mobility, they are gradually set on pads.

Mental health problems: the role of psychoeducation and family intervention programs

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1. Centre Hospitalier de Rouffach, Rouffach, France
2. WASP Scientific Section on Family Intervention Programs

Despite the fact that many methods of psycho-education were validated to improve the live of people with mental health problems and their families; despite the economic efficiency and gain, psycho-education has not been widely available to patients and their family members. The participants of our symposium will discusses the role and the effect of psychoeducation and intervention programs in a better management of patient with psychiatric disorders (schizophrenia, bipolar disorders and other related disorders), leading to a better coping of psychological burden of family caregivers. To prove the efficacy of such psycho-educational program, the speakers will discuss also the development of new easy-to-use evaluation tools. We, purposely, invite members of NGOs and Association of users, directly involved in such programs, to share with us their experience and their main difficulties encountered in the field of psycho-education programs.

Speakers

1. Cardiovascular risk for family members of patients with schizophrenia. Profamille psychoeducational program reduces it

   Yann Hodé, Centre Hospitalier de Rouffach, Rouffach, France

2. Amali: a Moroccan Association of families with relatives suffering from schizophrenia or related disorders

   Amina Bencherki, NGO Amali, Casablanca, Morocco

3. “Profamille”, a Model of an Evidence-Based Psychoeducational Interventions for Family Caregivers of Schizophrenics

   Saïd Fattah, Centre Hospitalier de Rouffach, Rouffach, France

4. Psycho-Social Intervention and Rehabilitation for Psychological and Psychiatric Aspects of Violence Against Women and Girls in Cairo

   Heba Habib, Psychological Health & Awareness Society in Egypt (PHASE), Cairo, Egypt

5. Long-term benefits of mindfulness-based interventions for bipolar disorders

   Béatrice Weber, Geneva University Hospitals, Geneva, Switzerland

Cardiovascular risk for family members of patients with schizophrenia. Profamille psychoeducational program reduces it

Yann Hodé

Centre hospitalier de Rouffach, Rouffach, France

The Profamille program is now used by more than 60 different teams in France. More than one out of two participants in these groups has an initial depressive symptomatology with CESd score above 16. This high score is likely to be associated with an increased risk of cardiovascular mortality. After fourteen sessions of Profamille, about one out of two of these participants has a reduction of this CESd score below the score of 16, suggesting a reduction of the cardiovascular risk. This health improvement of family member is confirmed by a significant reduction of the missed working day 1 year before the program and 1 year after. Then, half of the families attending a psychoeducational program suffer in two ways (being at risk of early death and at risk of having a child with schizophrenia). If family members of patient with schizophrenia do not benefit from an appropriate psychoeducation program, they have a double penalty.

Amali: a Moroccan Association of families with relatives suffering from schizophrenia or related disorders

Amina Bencherki and Naïma Trachen

Association AMALI (Moroccan NGO), Casablanca, Morocco

Since its creation in 2007 in Casablanca, Morocco, the Amali Association works to improve the quality of patient care and foster care families. Several actions were undertaken with the following objectives: to fight against stigma, promote proximity and access to care, free treatment for poor families, improving the quality of hospitals, encourage the creation of new legislation for the protection of patients as well as the creation of support structures for the patients and their families.

Faced with the distress of families without support, Amali lauched in 2008, with the help and cooperation of professionals in mental health Rouffach Hospital Center, the psycho educational program "Profamille."

Each year, a dozen families benefit from the program through an educational, behavioral and psychological dimension.

Families informed about the disease and its treatment, having acquired a knowledge and practical ways to deal with it, record a relief from their emotional burden and a marked improvement in their mood. These results lead to a very positive effect on the health of their loved with fewer episodes of relapse. About 80 families have been trained in this program since its initiation in 2008.

The challenges we face are physical, financial and human: local cramped with low capacity, inadequate working budget and lack of qualified staff.

"Profamille," a model of an evidence-based psychoeducational interventions for family caregivers of schizophrenics

Said Fattah, Wydad Hikmat, Magali Huentz, Loïc Brillouet, Claudine Clément, Fabrice Duval and Yann Hodé

Centre Hospitalier de Rouffach, Rouffach, France

International guidelines consider psycho-educational intervention for families of schizophrenics, as an essential part of treatment of schizophrenia. However these recommendations are rarely applied in the clinical routine practice. One reason could be the difficulty of evaluation. Therefore we try to prove the efficacy of family educational program like Profamille in a better management of schizophrenia, through easy-to-use evaluation tools.

Method: The last version of Profamille program includes 1 module of 14 weekly sessions followed by a 2nd module of 8 sessions over 2 years. The target population comprises groups of relatives of schizophrenics (10–12 participants by group). Two well-known easy-to-use self questionnaires were used: the LSP20, a 20 items self report allowing the family caregivers to assess their patient functioning and the CES-d, a 20 items self-report scale assessing the severity of depressive symptoms of family caregivers, predicting the patient relapse and the cognitive decline or morbidity of family participant with high score. The evaluation was performed at the beginning, at the 7th session, at the 14th session (first module) and 1 year after (2nd module).

Result: We present data collected among 13 consecutive groups. The results showed significant mood improvement in all the participating groups. This effect is stable over 2 years. A significant improvement of the LSP20 score is observed among the patients 1 year after the end of the first module.

Conclusion: Our data analysis highlights the role of Profamille program, in the improvement of mental health (and consequently on physical health) of family caregivers and of patient's functioning, measured with widely available and easy-to-use tools. These results suggest a better schizophrenia prognosis and better cost-effectiveness and may contribute to convince clinicians and decision makers to give more attention and resources to such psychoeducational programs.

Long-term benefits of mindfulness-based interventions for bipolar disorders

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Mindfulness-based interventions (MBI) are currently used for a variety of psychiatric disorders. Earlier studies provided preliminary evidence that MBI might be useful in bipolar disorders but little attention has been directed to the patients' feedback about the program over the longer term.

This cross-sectional study, bearing on seventy-six bipolar outpatients, was conducted in Geneva and Paris. It reports about patient perception of the program, up to 5 years after MBI participation.

Patients' responses to a questionnaire about their motivation to participate, perceived change, mindfulness practice and perception of sustained benefit will be presented. Some methodological limitations of the study will also be adressed.

Trialogue movement – history, meaning, perspectives

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Trialog is a vision, but also a very real event. It has a own theory, can influence daily practice and has implications to many levels. The psychosis-seminar and regular Trialogue groups are the basis of trialogue. There is a specific quality to such meetings – e.g., very different from psychoeducation.

There are several levels of trialog – in daily work, in antistigma campaigns, in newspapers/books, congresses (e.g., the WASP-Congress 1994 in hamburg "Bye, bye babylon"). The Hamburg Peer-project, which has established and explored peer-teams in all clinic outdoor-services, is a trialogical one. And there are research projects, which follow the idea of trialogue and participation. The trialog-practice is related to recovery-theory and to the anthropological point of view.

The workshop will give you a good insight about the power of this idea and inputs to start first steps with 4 short inputs

- Introduction to trialogue – psychosis-seminar, antistigma campaign, peer project: a movie including co-founder Dorothea Buck.
- Anthropological aspects – the philosophy of trialogue and basis of antistigma work (f.e. Irre menschlich hamburg) – Thomas Bock.
- Trialog and recovery – international aspects of trialog movement – Michaela Amering.
- Trialogue returns to daily psychiatric practice – the Hamburg peer project – Candelaria Mahlke.

Collaborative mobile psychiatry

Stelios Stylianidis[1] and Charles Bonsack[2]

1. EPAPSY, Athens, Greece
2. DP-CHUV, Lausanne, Switzerland

Mobile psychiatry and collaborative care have become essential ingredients of community psychiatry. Interventions such as assertive community treatment (ACT) proved their efficacy, but they need much resource and were designed initially for severe mental disorders without perspective of recovery. Collaborative care with primary care and social network is also considered as best practice to face the high prevalence of mental health disorders in the population. Recent models of ACT tend to be more flexible, to focus on critical periods, to be more oriented toward recovery, and to promote more collaboration with health and social network. Objectives are to present examples of such collaborative mobile psychiatric care in several European countries.

Speakers

1. Collaborative care in Mental Health Mobile Units in Cyclades islands
   Stelios Stylianidis, EPAPSY, Athens, Greece
2. Le Case Management de Transition après une hospitalisation en psychiatrie
   Cristina Garcia, CHUV, Lausanne, Switzerland
3. Integrating Mental Health and Primary Care in Italy
   Angelo Fioritti, Mental Health and Substance Abuse, AUSL Bologna, Bologna, Italy
4. Acute psychiatric care in community settings
   Sashi Sashidharan, Mental Health Rights, Glasgow, Scotland

Collaborative care in mental health mobile units in cyclades islands: the role of networking during socio-economic crisis

Stelios Stylianidis and Stella Pantelidou

Association of Regional Development and Mental Health (EPAPSY), Athens, Greece

Mobile Mental Health Units were developed in order to meet mental health needs in rural areas with limited health and social services, according to the main principles of community psychiatry and WHO policies. The Mobile Units of North-eastern and Western Cyclades Islands (EPAPSY) have developed several innovative community and therapeutic interventions, taking into consideration the socio-anthropological characteristics and the effects of socio-eonomic crisis in each local community. These actions include therapeutic programmes aiming at prevention and treatment of mental health problems in families belonging in vulnerable groups (unemployed parents, migrants, etc.), implementation of self-help groups for depression, interventions for the prevention and management of Domestic Violence, development of mental health promotion programmes for children and adolescents, therapeutic programmes for people suffering of dementia and their relatives, empowerment of service users and their families. Networking with local services is a primary aim in order to mobilize local resources and develop effective community interventions. Collaborative care was a primary aim of the Mobile Units in local communities. Developing and improving the links among the mental health professionals of the Mobile Units and the professionals working in Primary Health Care, in Social Services is a prerequisite in order to deliver effective care. The links were expanded to include also families and care givers, service users, local voluntary associations, pharmacists, school teachers and priests. A new model was emerged as an effective response to the increasing needs associated with socio-economic crisis.

Le case management de transition après une hospitalisation en psychiatrie

Cristina Garcia

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La période qui suit une hospitalisation en psychiatrie est une période critique. La réduction du temps d'hospitalisation et le développement des ressources ambulatoires nécessitent une collaboration étroite entre les intervenants hospitaliers et ambulatoires. Pour favoriser la continuité des soins, le case management clinique représente le modèle le mieux reconnu pour accompagner les patients dans cette transition. Il s'agit d'interventions qui débutent durant le séjour hospitalier et se prolongent sur une durée déterminée, à la sortie de l'institution.

Durant l'hospitalisation, différents outils permettent d'identifier les besoins de la personne à la sortie. Les outils utilisés sont la carte réseau, le plan de crise conjoint et l'ELADEB (échelle lausannoise d'auto-évaluation des difficultés et des besoins). Sur le plan organisationnel, il s'agit aussi de porter une attention suffisant aux attentes et besoins du réseau durant l'hospitalisation et à la sortie.

Le case management de transition commence pendant l'hospitalisation et se poursuit durant quatre semaines après la sortie. Les objectifs sont: (1) s'assurer que les changements acquis à l'hôpital soient maintenus dans la communauté. Rappelons que les jours qui suivent la sortie de l'hospitalisation représentent une période de crise avec une résurgence possible des troubles psychiques et une augmentation du risque suicidaire; (2) éviter les réadmissions. Le case manager soutient donc activement et de manière intensive les personnes durant la période d'adaptation à la sortie.

Integrating mental health and primary care in Italy

Angelo Fioritti[1] and Domenico Berardi[2]

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2. Institute of Psychiatry, University of Bologna, Bologna, Italy

In Italy, the importance of integrating Primary Care and Mental Health has only recently been grasped. Several reasons may explain this delay: (1) until 2005, Primary Care Physicians worked individually instead of in group practices, without any functional network or structured contacts with colleagues; (2) Community Mental Health Centers with multi-professional teams, were well-structured and widespread in several regions, but focused on people with severe and persistent mental disorders; (3) specific national government health policies were lacking. Only two regions have implemented explicit policies on this issue. The "G. Leggieri" Program started by the Emilia-Romagna Region Health Government in 1999 aims to coordinate unsolicited bottom-up cooperation initiatives developing since the 80s. In Liguria a regional work group was established in 2010 to boost the strategic role of collaborative programs between primary care and mental health services. Authors will present on the most innovative experiences relating to primary care psychiatry in Italy.

The future of psychiatry is a social psychiatry and has personcentred approaches and a humanistic synopsis as interrelated presuppositions

Wolfgang Rutz

Professor of Social Psychiatry, Stockholm, Sweden

The future of psychiatry may be a social one, person-centred, offered in interdisciplinary teams working multidimensionally with low thresholds on a community level, and offering an humanistic synopsis of integrating the "condition humana" of being body and mind as mutual and interrelated pre-suppositions.

This session starts with an introductory reflexion and aims at discussing the expected demands directed to a future social psychiatry, outgoing from present situations where human individuals and populations at risk are exposed to sometimes dehumanising, categorizing and instrumentalizing approaches and societal austerity policies, without taking respect to individual and cultural shortcomings and strengths.

Casuistics of people in need of mental and psychiatric analysis and support are discussed, experiences are exchanged and ways of concretizing a person- and people-centered rehumanising social psychiatry are elaborated on.

In an interactive discussion even the question will be addressed if this psychiatry also has a political and ethical societal and "human-ecological" responsibility for analysis and warning signal function in the political discussion.

The WHO – world suicide report

Alexandra Fleischmann

WHO Collaborating Centre for Research, Methods Development and Training in Suicide Prevention, Stockholm, Sweden

The WHO World Suicide Report "Preventing suicide: a global imperative" is the first global report of its kind. The report provides a systematic, evidence-based approach to policy and programme development which can be adapted to suit existing health and social structures and, where countries have already commenced this process, provide guidance on strengthening their approaches. The report aims to increase the awareness of the public health significance of suicide and suicide attempts and to make suicide prevention a higher priority on the global public health and public policy agendas. It aims to encourage and support countries to develop or strengthen comprehensive suicide prevention strategies in a multisectoral public health approach.

The target audience includes Ministries of Health, policy makers, planners, advocates, nongovernmental organizations, academics, researchers, health workers, the media, and the general public. Governments in particular are in a unique position to develop and strengthen surveillance, to provide and disseminate data that are necessary to inform action, and to bring together a multitude of stakeholders who may not otherwise collaborate.

The presentation focuses on the global and regional epidemiology of suicide and suicide attempts, which is the first theme of the report; other themes include risk and protective factors, and related interventions; current situation and working towards a comprehensive national response for suicide prevention; and the way forward.

The saving and empowering young lives in Europe (SEYLE) research project

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1. National Centre for Suicide Research and Prevention of Mental lll-Health (NASP), Karolinska Institutet, Stockholm, Sweden
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3. Section of Suicidology of the World Psychiatric Association (WPA)
4. International Association for Suicide Prevention (IASP)

The Saving and Empowering Young Lives in Europe (SEYLE) project aimed at promoting mental health and preventing suicide among adolescents in European schools. The SEYLE project was performed during January 2009 – December 2011, and comprised a consortium of 12 European countries: Austria, Estonia, France, Germany, Hungary, Ireland, Israel, Italy, Romania, Slovenia, Spain and Sweden (coordinating centre). In SEYLE, a pilot intervention study was implemented to assess the effects of three different health promoting/suicide preventing programmes: (1) a gatekeeper's program, training all adult staff at schools (teachers, counsellors, nurses, etc.) on how to recognize and refer a student with risk-taking behaviours or those suffering from mental illness to mental-health help resources; (2) an awareness increasing health promotion program targeting students awareness on healthy/unhealthy behaviours and students self-efficacy in diminishing unhealthy behaviours; (3) screening by professionals of at-risk students through a questionnaire. Three different evaluations were performed and a large epidemiological database on 12,395 cases was generated. Information regarding socio-demographic data, risk behaviours, lifestyles and well-being were acquired and their association with mental health problems and suicidal behaviour were analysed. Major findings from this project will be presented and discussed during this presentation.

The youth aware of mental health (YAM) programme: the adolescents speak their mind

Camilla Wasserman

Youth Aware of Mental Health (YAM) was evaluated in two EU-wide RCTs, initially created for one of them, the Saving and Empowering Young Lives in Europe (SEYLE) research project. YAM is a mental health awareness programme for 14–16 year olds promoting increased knowledge and discussion about mental health and the development of problem-solving skills and emotional intelligence. YAM offers a hands- on approach to mental health issues such as stress, crisis, depression and suicide through interactive lectures, guided discussions and role-play.

32 semi-structured interviews were conducted in four European countries to investigate the possibilities and limitations of YAM. The broad aim of this study was to attain additional information about the adolescents' experience of the programme as well as their thoughts on mental health and language pertaining to those topics.

The adolescents' memories and opinions of YAM and readiness to speak about mental health topics differed greatly within every country and school. Personal stories of, e.g., coping with stress, skipping school, having helped a friend in need and being interested in psychological and health questions were the most important indicators of their identification with and memories of YAM. To this day there aren't many examples of qualitative research as part of big international intervention studies. Through qualitative investigations, the scope of mental health research can be enlarged, not by compromising or replacing empirical methods, but instead by making an effort to further contextualizing the research while rendering it more self-reflective.

Introduction à la pensée métisse en psychopathologie à partir de la persécution: le traitement du mauvais destin

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La question de la persécution se pose souvent au psychiatre, notamment:

- dans le vécu persécutoire observé dans certaines schizophrénies, dans certaines démences, dans la paranoïa,
- dans le traitement de personnes ayant subi des persécutions comme dans la torture ou les violences interethniques,
- avec les patients avec lesquels l'approche interculturelle est convoquée lorsque sont rapportés à titre étiologique des faits de sorcellerie, de mauvais sort, de maraboutage.

La confrontations des données de la clinique psychiatrique avec certains travaux anthropologiques (Jeanne Favret-Saada) nous a conduit à tenir ensemble des données hétérogènes pour une vision renouvelée de ce que l'on pourrait appeler «le mauvais destin»; dans le cas de la persécution, ce mauvais destin est directement relié (d'une manière imaginaire ou réelle) à la malveillance d'autrui, mais aussi à la bienveillance de ceux qui veulent le transformer en un meilleur destin, comme par exemple les thérapeutes.

Penser les méthodes de traitement de la malveillance d'une manière métissée, non syncrétique, c'est-à-dire respectueuse des différences théoriques, conduit à une approche clinique qui permet de tenir ensemble la pensée magique et la pensée rationnelle, ce qui change notablement notre manière de soigner. La présentation de situations cliniques en témoignera. Il s'agit d'une contribution à l'approche transculturelle de la psychopathologie où l'hétérogène doit être préservé.

Si “loger” est nécessaire, “habiter” est crucial

Caroline Christiansen

Patiente au long cours en rétablissement, Prangins, Switzerland

Ballottée affectivement et géographiquement depuis la tendre enfance, l’instabilité douloureusement expérimentée a été déterminante sur le plan psychique, affectif et relationnel. Sans jamais avoir connu les vicissitudes de la rue, cette donne a pourtant conditionné toute mon existence, faite de départs, d’abandons, de ruptures, de fuites. La précarité connue est certainement en lien avec les troubles bipolaires qui ont fait irruption dans ma vie. L’apparition de ce handicap dans mon parcours a paradoxalement coïncidé avec une mise en route vers «moi-même». Dans ce chemin vers le centre, je ressens comme la naissance d’une sécurité que la plus parfaite sédentarité n’aurait pu me donner. Tout en affirmant que le logement est un droit qui – nié ou mis à mal – peut avoir des conséquences désastreuses, j’en suis venue à découvrir qu’il n’est pas seul à pouvoir garantir bonheur et stabilité.

Le patient au centre des soins: changer les pratiques à l'hôpital psychiatrique et les liens avec l'ambulatoire au sein d'un secteur

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Les concepts d'empowerment et de rétablissement sont des notions relativement bien intégrées par les équipes de soins à l'hôpital psychiatrique. Une assez large majorité de soignant est d'accord avec l'idée que le patient doit être, en tant qu'expert de ses ressources et de ses problèmes, le partenaire central de la planification des soins. Pourtant, les pratiques quotidiennes vont souvent à l'encontre de ces principes. La prise en soins hospitalière renforce bien souvent le manque de transparence et de partenariat dans les soins, accentuant le sentiment d'une participation insuffisante des patients aux prises de décision.

C'est face à ce constat qu'est née la réflexion d'une équipe de psychiatrie opérant dans le secteur de Wedding, quartier populaire de Berlin. Au travers de leur «Weddinger model» Ils proposent de repenser les soins psychiatriques hospitaliers, autour de concepts simples:

Rien qui ne concerne le patient, sans le patient.

Remettre la multidisciplinarité au centre du dispositif afin de dépasser des soins centrés sur une approche bio médicale et sur le déficit.

Dé stigmatiser l'hôpital psychiatrique et l'ouvrir sur l'extérieur.

Nous exposerons comment des changements simples nous ont permis d'être plus cohérent dans nos pratiques et plus efficace dans les soins: Remettre le patient au centre des échanges en supprimant les espaces de discussion qui le concernaient et se faisaient sans lui (synthèse clinique, colloques objectifs…). Ces espaces ont été remplacé sous forme d'échanges multidisciplinaires en présence du patient, dont l'un des objectifs est la co-construction d'une définition de son problème et donc de sa demande. L'ensemble des étapes du projet de soins sont par la suite directement discutés avec lui. Nous évoquerons également comment nous avons mis en place des soins intensifs à domicile, initiés progressivement depuis l'hôpital, dans la volonté d'ouvrir le plus tôt possible les soins sur l'extérieur et tenter de dépasser ce clivage historique entre l'institution psychiatrique et la cité.

aiRe d'ados, une cellule clinique de coordination santé-social au service des réseaux d'adolescents suicidants

Anne Edan and Nathalie Schmid Nichols

HUG-Children Action, Genève, Switzerland

En tant que professionnels d'adolescents nous sommes régulièrement confrontés à des jeunes ne demandant pas d'aide mais montrant que "ça ne va plus." Et régulièrement nous sommes face à nos limites pour accompagner ces adolescents en errance.

A travers sa cellule de coordination, aiRe d'ados, un collectif santé-social genevois créé à l'initiative de l'Unité de crise (HUG-Children Action), propose un soutien au long cours à la coordination des interventions proposées aux jeunes, dans un partage des risques et en apportant un niveau complémentaire à la réflexion. Le jeune et/ou son porte-parole sont invités à participer à la démarche visant le rétablissement et le développement de son projet.

Le discours du soignant et le discours de l'acteur social ne se sont pas équivalents. Se réunir et travailler avec cette double écoute permet de saisir les malentendus comme pouvant être au service du jeune en souffrance, et non comme une occasion de s'affronter devant l'impuissance que ces situations font vivre.

Speakers

1. *Anne Edan, HUG-Children Action, Genève, Switzerland*
2. *Nathalie Schmid Nichols, HUG-Children Action, Genève, Switzerland*
3. *Dominique Chautems Leurs, l'association l'Astural, Genève, Switzerland*
4. *Bernard Hofstetter, l'association AGAPE, Genève, Switzerland*

Predicting duration of hospitalization and psychiatric readmission from Health of the Nation Outcome Scales (HoNOS) scores

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The Health of the Nation Outcome Scales (HoNOS) was developed as a measure of thehealth and social functioning of people with severe mental illness. Since 2012, the French version of the HoNOS scales were routinely recorded for each entry and exit byhospital services of the Department of Psychiatry of the Lausanne University Hospital (DP-CHUV). This version included twelve items covering behavior, handicap, symptomsand social issues and one additional item related to problems in taking psychiatricmedication. The first goal of this study was to determine which items could predict (1)duration of hospitalization and (2) probability of psychiatric readmission in the followingyear. The second objective was to highlight specific HoNOS profiles within patients andto relate them to duration of hospitalization and readmission. A total of 6175 hospitalstays in adult psychiatry between June 2010 and September 2014 were screened forthe purpose of this study. Only the first Honos scores of each patients were analyzed ($N = 2722$). A series of linear and logistic regression were performed on the HoNOS itemsand indicators of duration of stay and readmission. A latent class analysis was alsoperformed on the 13 items in order to identify specific HoNOS profiles. Finally, the latentcategorical variable was used as a predictor of the two distal outcomes in order todetermine which profile could lead to longer psychiatric stay or more probablereadmission. Results indicated that four items significantly predicted the duration ofhospitalization (Problems with activities of daily living, Problems associated withhallucinations and delusions, cognitive problems and Problems in taking psychiatricmedication). While statistically significant, these four predictors explained only a modestshare of the duration of hospitalization's variance (5%). Results further showed that onlytwo items significantly predicted psychiatric readmission within 365 days (Problemsassociated with hallucinations and delusions & Problem drinking or drug-taking). Finally,Latent class analysis revealed 5 distinct HoNOS profiles: "(A) Psychosis and behavioralproblems with major social problems" (10.7%), "(B) Psychosis and behavioral problemswithout social problems" (14.8%), "(C) Multiple mental health problems and significant social problems" (19.7%), "(D) Depression and self-harm/suicide risk" (21.2%) & "(E) Preponderance of substance use problems" (33.6%). The mean duration of hospitalization significantly varied for these five profiles (A > B > C > D > E). The probabilityof psychiatric readmission also varied depending on the HoNOS profile (B > A > C > E > D).Clinical and institutional implications are discussed.

An integrated groups organization with bipolar patients and close relatives: enhancing illness understanding with an innovative psychosocial appliance

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Providing a continuous patient care in psychiatry is not any more the point in French mental illness policy as in many others European countries. The commitment of the psychiatric public institution has considerably diminished, increasing the burden of families and spouses. Families have not been prepared to this change and feel distressed and guilty without any psychosocial support. In collaboration with a French association of mentally ill patients families (UNAFAM), psychiatrists and psychologists of University of Strasbourg have developed a specific possibility for patients, family caregivers and closely related to share about bipolar disorders. A large support group was open 5 years ago. It is led by both a psychiatrist and a psychologist. This monthly group is based on free topics expression. It is followed one time or more by patients and parents, spouses, siblings even friends and neighbours.

- The advertising is made through emails to previous participants and psychiatrists on the UNAFAM site. The large group is considered as a hub-platform. An average of thirty persons comes regularly. The synthesis of the previous meetings is available on the UNAFAM website.

After 4 years of experience with the large group, two kinds of groups are now stemmed from it.

- One psychodynamic setting's group for parents of bipolar adults and one for bipolar persons.
- Psycho-educational group for patients. Bipolar patients can participate to all groups except parental one. Some parents are interested in both large and parents groups. Only patients share the psychodyanmic group and the psycho-educational group.

The thematic analysis of about 50 reports in the large group are summarized here:

- How to get a diagnosis? Ten years of «erratic» diagnosis search seem unbearable to both patients and significant others.
- Complaints about identity: are relative euthymia, hypomania, sadness or delusion representative of the true self of the bipolar person?
- The therapeutic management is like an enigma to both patients and close relatives. As for drugs, psychotherapies or social support seem unorganised.
- The episodic family decisions of hospitalization are often traumatic experiences with all classic symptoms and stigmas.
- Guilt is a leitmotiv in both patients and families. Close relatives accept to share in groups ambivalent feelings: distress and helplessness when the patient is in manic episode but respite when depressive state gives more calm and control.
- Quality of life of patients and families decrease consequently but sometimes in the opposite direction (families feel better when patients are in worse depression). In conclusion: the free participation to a large group is a first step to more autonomy and exchange in families and bipolar patients. By interactive understanding, sharing questions lead to a better acceptance of illness. Psychodynamic small groups become one relevant therapeutic issue and might be combined with psycho-education. Increasing skills of close relatives as well as training young psychiatrists and psychologists is also an important result of this integrated group organization.

Le Bistro: une experience citoyenne

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Le site de l'hôpital Psychiatrique de Belle-Idée accueille une forte concentration de personnes confrontées à des problématiques médicales et sociales complexes et à des situations de rupture avec le milieu naturel.

Une partie des patients subit des séjours non choisis et souvent incompris.

Le Bistro' est un projet permettant aux usagers de soin, aux proches, aux soignants et à des acteurs de la communauté de s'investir ensemble pour construire un lieu d'échange et de rencontre. Ce lieu participe d'une part à la déstigmatisation des personnes souffrant de troubles psychiques, et d'autre part à permettre aux usagers de soins de se retrouver, dans le domaine de l'hôpital psychiatrique, dans un lieu qui leur est propre.

Ce lieu, en favorisant les échanges continus avec les gens et acteurs de la cité, les associations, les patients et le site, représente un espace de Quadrilogue citoyen permanent. 18 mois après son ouverture, il a permis de modifier la dynamique du Centre d'animation Nicolas-Bouvier ainsi que celle des soins.

Le soin en santé mentale et la pratique de l'interprétariat

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L'augmentation des mouvements migratoires et le contact de plus en plus fréquent de groupes et de cultures différentes sur les territoires nationaux confrontent les professionnels du soin à des difficultés de communication avec une partie de leurs patients: les populations allophones, non-francophones. Cela est d'autant plus problématique que le soin en santé mentale passe essentiellement par la parole.

Cette nouvelle réalité sociale confronte les soignants en santé mentale à de nouvelles pratiques de soin. Elle les oblige à penser des manières de communiquer avec les patients étrange/ers allophones. Elle nécessite très souvent de travailler avec un tiers qui permettra la co-compréhension entre patient et soignant. Cette place peut être prise par différentes personnes ayant des statuts différents: des personnes proches du patient (*ad hoc*), les personnels bilingues de la structure de soin et les interprètes professionnels.

Ce tiers vient troubler la pratique de soin ordinaire des soignants. Elle vient mettre à l'épreuve les soignants et leur pratique clinique traditionnelle. Ils doivent faire face à une configuration étrange du cadre de soin. Et ce que les soignants attendent du rôle de l'interprète dans ce nouveau colloque à trois patient-soignant-interprète peut varier.

A travers un travail d'enquête qualitatif et quantitatif mené par des chercheurs en sciences humaines et sociales dans le cadre de l'Orspere-Samdarra (Centre Hospitalier le Vinatier, Bron, France) auprès de soignants en santé mentale, d'interprètes professionnels et de patients ayant fait l'expérience de soin avec interprètes, nous avons mis en évidence deux attitudes antinomiques quant aux attentes que les soignants ont envers l'activité d'interprétariat: «L'interprète machine» de qui les soignants n'attendraient qu'une traduction «mot à mot», pouvant se rapprocher des pratiques d'interprétariat par téléphone et à l'usage de l'outil internet pour traduire, faisant émerger une réification de la place de l'interprète dans ce nouvel espace de soin; et, à l'opposé, une activité de soin avec interprète qui leur donne une place plus grande, allant jusque son intégration dans les pratiques de soin dans le cadre de l'ethnopsychiatrie par exemple. L'interprète, qu'il soit vu comme une machine ou bien à travers ses dimensions humaines, apparaît ainsi comme le catalyseur d'une réflexion sur les pratiques de soins ordinaires, laissant voir des attitudes de changement ou de résistance vis-à-vis de ces nouvelles pratiques au regard d'une nouvelle réalité sociale.

Lors de notre communication, nous discuterons de cette antinomie quant à la place et au rôle de l'interprète dans les pratiques de soin en santé mentale; et des enjeux pour le soin en santé mentale et la santé publique en général de prendre en compte cette nouvelle réalité sociale.

Setting priorities for dementia research: a global mental health perspective

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Dementia has a significant impact on patients, families and society. 44 million people are affected worldwide, and this number is expected to triple in the next few decades because of demographic aging. Dementia is now a recognized global health priority. Since 2012 the World Health Organization has been leading the collective effort of world experts and stakeholders to inform governments of all world regions to respond nationally and globally to the challenge posed by dementia.

The 2015 First Ministerial Conference on Global Action against Dementia is a landmark event and an unique opportunity to improve the quality of life of people with dementia and their families in all world regions. We have two aims. First, to provide an historical perspective on this ambitious plan, illustrating the steps taken in recent years to raise political awareness of dementia that have led to the Ministerial Conference. Second, we report on the methods and process used to set investment priorities in dementia research, identified to propose a more rationale use of funds and resources aimed at reducing the burden of dementia within the next 10 years in all world regions, and we will present the results of this Dementia Research Priorities Exercise and will discuss its implications.

Peer-Involvement in Switzerland – an overview and a repport of challenges and opportunities for the practical implementation.

(Peer-Involvement in der Schweiz – eine Übersicht und ein Bericht über Herausforderungen und Chancen bei der Implementierung.)

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Internationale wie auch nationale Positionspapiere sowie Leitlinien zu psychischer Gesundheit und zu psychiatrischen Dienstleistungen (DGPPN, 2012; NICE, 2010, 2012; WHO, 2009) enthalten Forderungen bezüglich der Recovery-Orientierung psychiatrischer Dienstleitungen, Selbsthilfeangeboten und Selbsthilfekapazitäten sowie nach aktiver Partizipation von Menschen mit eigener Psychiatrieerfahrung und deren Angehörigen auf allen Ebenen des Gesundheitswesens. Die Betroffenen sollen dabei vielfältige Rollen übernehmen. In psychiatrischen Dienstleitungen können dies Rollen sein, in der direkten Patientenarbeit als Peer-Arbeitende im Einzel- oder Gruppensetting, oder in Fachgremien oder Beiräten in beratender Funktion bei der Evaluation oder Entwicklung von Konzepten oder Dienstleitungen sowie als Erfahrungsexperten in internen Weiterbildungen und Schulungen (Slade, 2009). Im Gegensatz zu grossen Teilen des englischsprachigen Raums scheint sich diese Forderungen sowie der Einsatz von Peer-Mitarbeitenden in psychiatrischen Dienstleitungen im deutsch- sprachigen Raum erst marginal entwickelt zu haben.

Seit 2008 gibt es in psychiatrischen Dienstleitungen in der Schweiz Peer-Anstellungen. 2010 kam dann die Möglichkeit hinzu eine Qualifikation für Peer-Tätigkeit mit einer entsprechenden Ausbildung zu erreichen. Diese wird seither alle zwei Jahre angeboten und basiert auf dem europäischen Ex-In (Experienced-Involvement) Studiengang Curriculums.

Eine Universitätsklinik und einer Privatklinik im Schweizer Mittelland engagierten sich schon früh für Recovery und Peer-Involvement Interventionen. Daraus entstanden einerseits viele Erfahrungen und Erkenntnisse bezüglich Herausforderungen und Chancen bei der Anstellung von Peer-Mitarbeitenden. Andererseits entwickelten sich daraus auch Interventionen u.a. das Konzept und Manual zur Durchführungen von Peer geleiteten Recovery-Gruppen (Burr and Winter, 2011), eine Peer geleitete Gesprächsgruppe zur Qualitätsverbesserungen auf psychiatrisc hen Akutstationen (Zuaboni, 2011) oder die Durchführung und Evaluation einer Gruppenintervention zur Reduktion der Selbststigmatisierung bei Menschen mit psychischen Problemen (Ruesch et al., 2014).

Im Vortrag wird einerseits ein Überblick über die Situation präsentiert bezüglich Recovery-Orientierung und Peer-Involvement in psychiatrischer Dienstleitungen in der deutschsprachigen Schweiz der letzten acht Jahre. Danach werden die grössten Chancen und Herausforderungen bei der Implementierung von Recovery und Peer- Involvement Interventionen in einer Universitätsklinik und einer Privatklinik im Schweizer Mittelland aufgezeigt und zur Diskussion gestellt.

Interventions and supervision in mental health services: the experience of a working group of professors and psychoanalysts in Brazil

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Created 10 years ago, a group of Professors and Psychoanalysts which currently has 16 members, developed, 3 years ago, annual interventions in different contexts and different cities, in order to discuss with workers of the mental health field their difficulties and contributions to the practice. Experienced supervisors in mental health from their personal practices, these professors and researchers try to verify what the every day work in mental health can contribute to the advancement of theory and vice versa. We will discuss the constitution of the health institutions in which we work, and which comprehend several mental health workers, not only psychiatrists. The proposed presentation of these experiences includes the account of two supervision experiences, the notion of what is the construction of the case, and the theoretical concepts on which we rely and which we expand. It also points to the main difficulties and issues that we face, while presenting the achievements that we do and the possible extent of the work.

Key words: mental health, brazilian experience, psychoanalysis and mental health

Untapped potential of community health workers in mental health services in India

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Prevalence of psychiatric disorders varies from 9.5 to 370 per 1000 population in India. Twenty percent of its adult population requires active intervention by psychiatrist. One of the major challenges in delivering comprehensive psychiatric services in the community is a lack of mental health manpower. There is a gross deficit in the number of psychiatrists in the country. At the same time insufficient training in the subject during under-graduation leaves non-psychiatrist physicians unprepared to competently manage various mental illnesses. To fill this huge mental health gap, global mental health community has increasingly realized the importance of non-physician health care workers in service delivery. We have reviewed the mental health related community-based participatory studies done in India to explore the role of community health workers in providing care. Some of the challenges faced by the country, viz. issues related to community worker training in the field of mental health, existing burden of responsibilities on them, etc. jeopardizing their effectiveness have also been highlighted. In the end, we have proposed some practical solutions to the aforementioned problems.

How to help distressed students: specific training program in the community

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Background: We know from the literature that university students present more psychological distress than non-students population of the same age. It is also known that they often do not seek proper treatment, mainly because of difficulties to access care as well as economic obstacles. When in distress, students interact in first line with university staff (receptionists, secretaries, deans, professors, social workers, etc.) for whom it is of importance to know how to deal with such situations, to give appropriate advise and to orientate students in the mental health care network.

Method: The general psychiatry service of CHUV has a specialized psychiatric consultation for students on the campus of Lausanne University and EPFL. In order to facilitate the access to mental care, we developed a specific training program for non-health care professionals who deal with students in distress. We first discussed participants' needs in term of skills and education. We then constructed a 4 hours training in 3 main parts: (1) Role play based on a specific real life vignette transmitted by the participants, (2) Group discussion on common preconceptions and knowledge on psychological distress and psychiatric disorders, (3) Information on access to mental health care.

Results: This program began in March 2014 and 70 staff members participated so far. Satisfaction rates on the training course are high. This training has an impact on the collaboration between psychiatric services and university services, with more students in distress being addressed to mental health care.

Conclusion: Non-health care professionals working at the university benefit from a short training on students' psychological distress. This program contributes to early detection of psychiatric troubles among the young adult population.

Models of psychotherapy for the human needs of the future

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Change is a part of life. At the present time, much of the world is going through a transition from the industrialized to a post-industrial society. Although the post-industrial society will ease many of the problems of the industrial revolution (e.g., sweat shops, urban slums, massification, dehumanization, etc.), it will bring in new problems of its own. Breakdown of families, estrangement from the society, loneliness, erosion of social support, transitoriness of human relationships, and ecological change will all create their own problems. Genetic engineering and organ transplant may assault the sense of personal identity.

Different parts of the world are already undergoing such stress. There has been a sea change in the United States, for example, in the last 30–40 years in family integrity and support. The development not always occurring in a linear fashion, many developing countries, just being ushered into the industrial revolution are, at the same time experiencing many stresses of post-industrialization, the developing not always occurring in a linear fashion.

All of the above would require greater and varied psychotherapeutic resources. Mental health manpower constraints, particularly in the developing countries, will however necessitate evolution of alternative strategies, such as self-analytic and meditative techniques and the development of self-help groups.

In the future, psychotherapy may increasingly move from being an intervention to an ongoing nurturing activity. Finally, greater awareness of our uniquely human needs and potentials may facilitate the use of psychotherapy for personality growth leading to self-actualization and self-realization.

Evolution conceptuelle du soin psychiatrique à Genève: le traitement à domicile et la mobilité

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Le traitement à domicile (TAD) et la mobilité des soignants dans la cité sont des suivis psychiatriques font partie des stratégies mises en place en 2014 à Genève par le département de psychiatrie afin d'éviter les hospitalisations et/ou de diminuer leurs durées pour des patients ayant des troubles psychiques sévère et chroniques. Cette forme de prise en charge a été initié d'abord en Angleterre, à partir des années 2000 et en France sous l'acronyme ERIC (Equipe Rapide d'Intervention de Crise) ayant comme résultat la diminution du nombre d'hospitalisations et l'augmentation de l'accès aux soins psychiatriques. Les équipes englobent des professionnels avec différentes expertises (médical, infirmier et social . . .) qui travaillent ensemble de façon intensive et articulée autour des patients avec comme avantage la prise en compte les difficultés in situ, surmontant les possibles effets négatifs de l'institutionnalisation.

Dans ce travail, nous présentons les résultats préliminaires du centre ambulatoire du secteur 2 de la Jonction concernant les premiers mois de la mise en place de la mobilité et du TAD. En effet depuis septembre 2014 à ce jour, il a été effectué 627 interventions à domicile entre visite a domicile, case management de transition (articulations entre l'hôpital et le centre ambulatoire au sein du secteur) et traitement à domicile. Nous avons effectué 7 TAD comportant chacun un minimum de 3 interventions à domicile pour des patients souffrants de troubles dépressifs sévères ou chroniques ou de troubles psychotiques. Nous n'avons noté pour le moment aucune hospitalisation et la majorité de ces interventions ont abouti à un suivi régulier à la consultation ou au programme de jour du secteur. Cette forme de prise en soins est novatrice et complexe, nécessitant un recul plus important pour établir des conclusions.

Compulsory psychiatric patients: the Portuguese liberty issue

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Compulsory internments are complex but needed situations. They shall be demanded whenever a person, due to imparity caused by a mental condition, puts herself or others at risk. The purpose of this presentation is to call upon the extreme caution needed in order not to overlook patients basic rights, that have to obligatory be conditioned, but should be so in the least amount possible, exposing the Portuguese reality in what concerns compulsory patients freedom access. In order to do so, comparing this population with the criminal one, although apparently senseless, revealed to be a very important step towards rethinking the way mental illness is approached. The major difference found regarded the interpretation of the 173rd article of the Portuguese Criminal Code where can be read "The permanence at open spaces occurs individually and has the duration of two daily hours…", whereas in the Portuguese Law of Mental Health we can read in the point 4 of the 8th article of the second chapter "Restrictions to basic human rights secondary to the compulsory internment are the strictly needed and adequate to the effectiveness of the treatment and the security and normality of the facilities in the eyes of its internal rules". It can be inferred from this comparison, that the right of a psychiatric patient to contact with the exterior, not being thoroughly described and legislated is dependent on the professional´s and institution´s good-will, more than the same right regarding convicted citizens, who have the minimum external contact granted by the existence of a law that quantifies the exact obligatory amount they have the right to get. In order to bring equality to society and to the psychiatric patients in particular, this a issue that requires discussion and solutions.

La réhabilitation psychosociale du malade mental errant au Cameroun analyse d'une activité pilote

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La place et la fonction occupées ainsi que le niveau d'adaptation des individus, des familles ou des sociétés face à des évènements de vie, sont garanties par des mesures qui visent, soit à éviter l'éclosion des cas de maladie, soit à apporter des réponses appropriées aux maladies lorsque celles-ci sont dépistées. La réhabilitation psychosociale du malade souvent abordée au sortir de l'épisode curatif, est dominée par les actions de prévention tertiaires.

Lors d'une évaluation rapide de la situation (Rapid Assessment Procedure: RAP), menée sur 12 semaines allant de avril à juin 2002 au sein de la population des malades mentaux errants de la ville de Yaoundé, nous avons regroupés 55 personnes au sein du Service de psychiatrie de l'hôpital Jamot de Yaoundé pour y être suivies. L'objectif général était de renforcer la prévention du phénomène des malades mentaux errants dans la politique nationale de santé mentale au Cameroun. Sur le plan plus spécifique nous avons étudié quelques variables démographiques avec 21,8% de cas de sexe féminin, contre 78,18% de sexe masculin; les tranches d'âge 26–30 et 31–35 étaient les plus représentées 18,18% chacune. Parmi les pathologies mentales rencontrées, en tête nous avons eu les dépressions 27,27%, suivie des états d'inhibition sur problématique de l'échec à 27,27%, 9% ont été présenté comme schizophrénie ou psychose chronique. 45,45% des familles ont été retrouvées; 10,90% des familles ont collaboré au retour du parent; nous avons réussi à placer 7,27% dans leur famille. Parmi les personnes placées, 01 est restée en famille soit 1,81%, et une incidence de rechute observée de 75%. Les considérations psychosociales évoquées comme étant les facteurs d'échec à une réinsertion réhabilitant le sujet sont: l'absence des structures d'état pour la prise en charge psychosociale (40%), la charge du cas face à la pauvreté familiale (32%) le rejet avec désinvestissement familial (20%), la dislocation de la cellule familiale (8%). La prise en charge des malades mentaux errants demeure un défit pour le Cameroun en particulier. La politique de santé mentale doit tenir compte des spécificités sociales et culturelles, accorder une priorité aux programmes de prévention en santé mentale et à l'implication appropriée des familles par le truchement d'une approche de psychiatrie à base communautaire.

Peer – support for individuals with complex mental health needs: psycocis, affective disorders and personality disorders – a randomized controlled trial

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Severe mental illness like affective disorders, psychoses and personality disorders comes along with the phenomenon of cyclic hospital re-admission, heavy losses in quality of life, high suicidal rates and stigmatization. In these diagnoses – a refinement of intervention is still required, for patients themselves and their relatives. There is an international trend toward recovery-oriented interventions, like Peer- support. In countries like England, Australia and the United States this alternative approach for patients is already researched and partially implemented in mental health services. In Germany this is the first try to implement peer-support area-wide in a metropolis to provide a low-threshold service. Peer-support was expected to increase self-efficacy, global functioning and quality of life, and also lower inpatient days. After a one-year-qualification at "Experienced Involvement", people with own experiences of mental disorders support others with aforementioned diagnoses additional to their standard care, the control group received standard care alone. Participant were recruited in four psychiatric hospitals in the city of Hamburg. The intervention could be attended for 6 months. This presentation will show the experiences and results of the first randomized, controlled, multicentre trial on peer support in Germany. This project forms a part of "psychenet – Hamburger Netz psychische Gesundheit", a project supported by the Federal Ministry of Education and Research (Bundesministerium für Bildung und Forschung BMBF) in Germany during 2011–2014 (support-code: O1KQ1002B).

Les usagers sont aussi des citoyens

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CH La Chartreuse, Dijon, France

Préserver une image de citoyennté, aux usagers de la Santé Mentale, reste encore un objectif difficile. Ainsi autour de cette notion, nous essaierons d'en comprendre les raisons.

Si Pinel au 19ième siècle, dans un grand élan d'aide, de protection, défend la création de lieux spécifiques pour accueillir les aliénés, malheureusement l'Histoire nous montre que cette politique aboutit à un enfermement.

Ainsi, le sujet en souffrance va progressivement être exclu du groupe social et rejeté derrière les murs de cet asile qui avait la prétention de lui faire retrouver la raison.

Comment peut-on définir ce terme de citoyen? Comment expliquer cette intolérance et l'image rejetante d'un individu qui souffrirait d'une «maladie honteuse» que l'on appellera tour à tour, folie, aliénation, maladie mentale?…

Ainsi, nous reviendrons sur l'image de la santé mentale, au sein de la population, réalité de terrain qui montre bien le retentissement social de certaines pathologies au sein de la communauté.

Certains dénoncent la faillite de notre système, notamment lorsque nous évoquons la dépression qui arriverait en deuxième position, dans la fréquence des maladies, après les atteintes cardio-vasculaires, d'ici 2020…

Redonner une image réelle de citoyen auprès de la population à ces usagers en souffrance, reste un problème majeur dans leur réadaptation. C'est tout le débat que nous pouvons évoquer, en laissant une place toute particulière à l'Histoire et à ces psychiatres qui après la Seconde Guerre Mondiale, ont dénoncé cette situation intolérable.

Il est important en tant que professionnel que nous prolongions cette vue de l'esprit qui ne doit pas être qu'idéologique. Le Mouvement International Citoyenneté et Santé Mentale, souhaite contribuer à redonner une autre image qui serait synonyme d'intégration au groupe social.

Implementation of WHO's mental health action plan 2013–2020

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Adoption of the Comprehensive Mental Health Action Plan 2013–2020 by the World Health Assembly in May 2013 provides the clearest example to date of the increasing commitment by governments to enhance the priority given to mental health within their health and public policy. The fact that all countries – large and small, rich and poor, and from all regions of the world – have agreed on a common vision for mental health along with objectives to reach defined targets within a specified time period, gives ample testimony to the strength of current political commitment for mental health across the world. The implementation of the Action Plan has included preparation of a minimal data set, collection of data on this from more than 150 countries, assisting countries in developing/revising their policies and plans and in scaling up community based services and providing guidance in countries with complex emergencies. In addition, WHO has published the first World Suicide Report, in view of suicide rate being recognized as a specific target in the Action Plan. Challenges in implementing the Action Plan, especially in low and middle income countries will be discussed.

The benefits of the short term assessment of risk and treatability (START) in crisis resolution and home treatment teams

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The Short Term Assessment of Risk and Treatablity (START) is a risk assessment tool that addresses some shortcomings in other risk assessments. (1) The START focuses on dynamic variables, not on static variables. (2) It is a short term assessment providing a scope of a few days up to a few months. (3) Beside risks strenghts in the individual or system are also weighed. (4) Finally the risk assessed is not only violence toward other persons, but also suicide, self-harm, self-neglect, unauthorized absence, substance use and victimization. These specific aspects yield a promise for use in crisis resolution teams where a broad mixture of psychiatric disorders and types of risk are being dealt with. The START –like other risk assessment tools- has several goals: comprehensive and thorough evaluation; it provides a common language between professionals; it offers a structured professional judgement and it may help to make clinical decisions. Research has shown the START to be a reliable tool with moderate to good predictive validity. The research available has been conducted in forensic psychiatric samples, both for inpatients and outpatients. There is a need for further research for other risks beside aggression and in other patient samples.

No data are available on the use of the START in crisis resolution teams. In crisis resolution and home treatment teams there is a need for thorough examination and assessment tools can sustain this process. We propose the START to have good validity to predict both verbal and physical aggression, as these are a common cause for referral to a crisis resolution and home treatment team. Our triage system enables professionals to detect cases who have a higher risk for future aggression. For the assessment of suicidality the START can be used as a checklist for professionals to carry out a thorough examination.

Timing of clinical improvement in assertive community treatment for adolescents: a pilot naturalistic observational study

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Background: To provide appropriate care to adolescents in crisis and to help them recover an equilibrium, it is of primary importance to consider their social environment and their developmental fragility. Consistently with these assumptions, assertive community treatment (ACT) model is an intervention provided in the adolescent's natural environment by health professional with an expertise about developmental aspects of this period.

Objective: To determine the timing of clinical improvement for youths followed by ACT teams.

Method: 70 youths (aged from 12 to 18 years of age) were assessed at admission (T1), after 3 months (T2), after 6 months (T3) and upon discharge (T4) with the Health of the Nation Outcome Scales Child and Adolescent Mental Health (HoNOSCA).

Results: Analyses of variance revealed a significant effect of time on the total score ($F(3, 161) = 4.00$, $p = 0.009$) and in particular on disorder ($F(3, 162) = 5.60$, $p = 0.001$), symptoms ($F(3, 162) = 4.26$, $p = 0.006$) and social scores ($F(3, 161) = 5.59$, $p = 0.001$). More specifically, post hoc tests revealed disorder decrease between admission and 3 months, symptoms between 3 months assessment and discharge and social and total score decreased between admission and discharge.

Conclusion: This study is the first one examining the timing of improvement in youth's functioning when they are followed by ACT team. Our results could help optimizing the efficacy of ACT. Indeed, these results allowed us to gain a sense of the ideal treatment time needed depending on the type of difficulties, and thus to maximize the cost-efficacy of the ACT. This provides important clinical advices about the clinical effort that has to be made depending on the stage of treatment and on the targeted difficulties.

Intensive outpatient care psychiatric clinics in Geneva. Preliminary results of a large and prospective study

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For the past several decades, Geneva has benefitted from a network of intensive outpatient care psychiatric clinics. The care provided in these centers is multidisciplinary and primarily involves one on one patient – physician and patient – nurse interviews, couple and family interviews, participation in therapeutic groups as well as assistance in social care. The average length of these interventions is between 6 and 8 weeks.

In this prospective and naturalistic methodology study we aimed to describe the social-demographic and diagnostic characteristics of patients admitted in three participating intensive outpatient care clinics during the period of 2013–2014. Standardized assessments were also carried out systematically at the beginning and at the end of treatment.

The sample covered 1,160 people, 60% of which were women. The median age was 41. A third of patients were single, a third were married and the final third were separated or divorced. At the time of treatment, 45% were self-employment. Motives for admission to the clinics were primarily due to patients undergoing familial (40%), professional (24%), health-related (23%) or financial (19%) problems.

Half of all patients were referred to the clinic by a hospital based institution (i.e., from the emergency department or from the psychiatric hospital), a fourth of patients were referred to the clinic by colleagues in private practice (17% psychiatrists, 12% GP). Over a quarter of patients had no psychiatric history; while others had a positive psychiatric history consisting primarily of anxiety and depressive disorders (approx. 70%, with 53% of previous depressive episodes). Notably, a third of patients had already benefited in the past from an intensive outpatient care intervention.

In the future, we hope to refine our understanding of the psychopathological characteristics of the patients being treated in our clinics and we hope to identify prognostic factors by using different measurements at the beginning and end of follow-up.

Rehabilitation center hospital dia, hospital das clínicas

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This paper shows the therapeutic action of the Rehabilitation Center Hospital Dia, established in 1996. Our proposals focus on the recovery of patients with psychiatric disorders, especially those who are in great psychological distress. Our goal is to promote and help patients to improve their physical and mental health also finding alternatives to enhance their social skills and quality of life.

The CRHD promotes and offers ways in order to stimulate our patients to achieve their wellbeing. The methodology is based on the rehabilitation and stimulation regarding their biopsychosocial context. We have an interdisciplinary team that consists of psychiatrists, music therapist, psychologist, occupational therapists, nursing staff, residents of medicine, social workers among others. The aim of our work is to help patients to improve their activities of daily living and to learn how to deal with adverse events. Professionals are allowed to propose and coordinate activities regardless of their professional category.

The great majority of our patients are referred from medical clinics, public service and research groups from Hospital das Clínicas which is a medical reference throughout Latin America.

We believe that music therapy provides a way of access communication that can be helpful to those who lack the ability to express themselves in words. Furthermore, it helps improve motor skills, memory and balance, providing motivation to become engaged in their treatment.

ENSEMBLE: a brief early intervention for caregivers of people with severe psychiatric disorders

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Background: Severe mental disorders have harmful impact not only on patients but also on their relatives. Interventions should be available as early as possible and be individualized to the needs of relatives. This may facilitate access to emotional support and promote well-being at the beginning of the illness. The focus of the intervention is to promote the well-being of families' caregivers and the harmony of the family system. This could contribute to the recovery of people with psychiatric disorders.

Goal: This project involves the construction of a brief early intervention focused on the support of family caregivers of people with psychiatric disorders.

Method: The development of effective interventions requires taking into account the context, scientific evidences and preferences of affected individuals. The "Mapping Intervention Design (MID)" was selected as a methodological framework. This method consists in six main steps: (1) needs assessment, (2) preparation of detailed planning of project development stages, (3) selection of methods derived from theoretical and practical strategies, (4) design of the intervention, (5) implementation of the intervention and (6) evaluation of the intervention developed.

Result: Current results describe the construction of the ENSEMBLE intervention which corresponds to the four first steps of the MID. ENSEMBLE includes five meetings between the caregiver or members of the same family (without the presence of the patient) and the nurse. Following a first evaluation meeting, the support is adjusted: two meetings are planned for a concrete assistance focused on hope and recovery. A fourth meeting is focused on helping the relatives to perform the role of family caregiver in the most optimal conditions and with answers to their concerns. The last meeting reviews the professional support.

Conclusion: This project permitted to develop the ENSEMBLE program. A pilot study is underway to assess the feasibility and acceptability of the brief early intervention for caregivers of people with severe psychiatric disorders.

Enhancing access to mental health care and adherence to treatment through the email: experience in the students' community

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Introduction: university students present more psychological troubles than non- students population of the same age. They often do not get proper treatment, mainly because of difficulties to access mental health care as well as economic obstacles. The general psychiatry service of CHUV provides a specialized psychiatric consultation for students on the campus of Lausanne University and EPFL. In order to facilitate access to mental health care, the first session is free for the students (paid by the University of Lausanne and the EPFL). In order to further facilitate access to mental health care, we created an email address that allows students to directly contact a mental health care professional to make an appointment.

Method: students have direct access to the email address. They are not asked for any previous administrative or personal information. Every entering email receives an immediate automatic reply specifying that we will answer on the same day from Monday to Friday, 8 AM to 6 PM, and providing the emergency ward phone number. We then contact students by email to let them know when their appointment is scheduled. We guarantee confidentiality, expertise (the consultants answering the email are senior clinicians with FMH or FSP degree) and a high degree of fidelity.

Results: in 2014, we scheduled a total of 227 appointments through the email. 9/227 did not show to the first session, constituting a dropout rate of 4%. 81% (218/266) of the students who consulted made appointment with us using the email address, and 14% (39/266) made phone appointments or came in person to make an appointment. When analysing the email's content, we identified 3 main kinds of demands, (1) seeking for immediate help, (2) help for specific symptoms, (3) counselling for crisis situations.

Conclusion: making appointment with the email is an efficient method for facilitating access to mental health care in a students' population and for lowering dropouts at first session. Initiating email communication also allows further exchange during the follow-up (i.e., inform the psychiatrist in case of impediment) that contributes to the adherence to treatment.

Consultation psychiatrique et psychothérapeutique sur un campus universitaire: détection des troubles psychotiques chez les étudiants

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L'état de santé des étudiants représente une préoccupation de santé publique. Diverses études montrent des prévalences élevées de troubles psychiatriques chez les étudiants universitaires. En 2014, la Consultation psychothérapeutique pour étudiants UNIL-EPFL du Service de Psychiatrie générale (PGE) du Département de Psychiatrie du CHUV a reçu 266 étudiants. Parmi eux, 19 étudiants (7%) ont été diagnostiqués avec un trouble psychotique (schizophrénie paranoïde, trouble psychotique non-spécifié, trouble de la personnalité cluster A, trouble dissociatif de type dépersonnalisation-déréalisation avec symptômes psychotiques) selon les critères du DSM-IV-TR. Parmi ces 19 étudiants, 13 sont des hommes, 14 viennent de l'étranger pour étudier et 3 d'un autre canton. Leur moyenne d'âge est de 21 ± 2 ans. 17 ont pris rendez-vous à notre consultation par mail, se plaignant pour la plupart de symptômes les gênant dans leurs études. Nous observons dans ces situations qu'une part significative de notre travail consiste en une activité de liaison avec la communauté de professionnels (soignants et non-soignants) sur et hors campus, cela au cours de toutes les phases de la prise en charge. En effet, divers services pour étudiants jouent un rôle prépondérant dans le fait de favoriser la venue en consultation des étudiants présentant ce type de troubles et s'occupent, en parallèle à notre travail d'investigation, d'autres problèmes (économiques, de logement) ou d'autres enjeux concernant leur vie quotidienne et leurs études. Parmi ces étudiants, certains présentent une symptomatologie psychotique aigue mais avec peu de conscience morbide et pour lesquels nous collaborons étroitement avec nos collègues de l'Unité de Psychiatrie mobile du Service de Psychiatrie communautaire du Département de Psychiatrie du CHUV, lesquels interviennent directement dans le milieu de vie afin de favoriser l'engagement dans le traitement. Enfin, pour l'ensemble de ces situations, un travail soigneux de transmission est effectué auprès de nos collègues de la Section Minkowski du Service de Psychiatrie générale (PGE) du Département de Psychiatrie du CHUV, spécialisée dans le traitement des troubles psychotiques. Notre expérience sur le campus de l'UNIL et l'EPFL ainsi que notre bonne connaissance du réseau interne et externe à notre Département nous permettent une utilisation efficace des ressources à notre disposition, ceci favorisant la détection des troubles psychotiques et la mise en place d'un plan de traitement adapté.

Un modèle de traitement des déficits psycho-sociaux au sein d'un centre ambulatoire de psychiatrie communautaire

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Les soins psychiatriques ambulatoires sur Genève ont longtemps été connus pour leur modèle de traitement concernant la crise selon un modèle psychothérapeutique psychanalytique.

Au fil des années, ce dispositif de soins a dû s'adapter; c'est dans ce contexte qu'a été créé, il y a 2 ans, un programme de jour pour répondre aux besoins d'une partie de la population souffrant de troubles psychiatriques sévères et présentant d'importants déficits psycho-sociaux.

Le programme de soin s'appuie sur les concepts de rétablissement, d'empowerment et d'éducation thérapeutique.

Afin de répondre de manière personnalisée aux besoins des personnes en demande d'aide, ce programme est en constante évolution et les prestations évoluent également suivant les saisons.

Ce travail présentera dans sa première partie, les différents soins proposés pour permettre aux usagers d'augmenter leur autonomie afin d'apprendre à s'adapter aux défis auxquels ils doivent faire face et de trouver de nouvelles façons d'être dans la société. Dans une seconde partie, nous exposerons les résultats obtenus au cours de ces 2 dernières années.

Le support des pairs, facteur de résilience

Brigitte Perrin-Crottaz

HUG, Genève, Switzerland

Dans la suite d'un traitement en service d'addictologie dans un groupe orienté sur le concept de résilience, des patients stabilisés ont eu l'envie de se retrouver pour partager leurs réussites et pouvoir s'ouvrir sur l'extérieur (cité) en partageant leurs savoir.

Le groupe vise à se constituer en un collectif d'entraide de pairs, ouvert aux autres patients capa. Le groupe s'intéresse à promouvoir l'entraide dans les difficultés rencontrées, la prévention et le partenariat avec les milieux associatifs. L'actioncitoyenne.

Le collectif se réunit une fois par semaine et a créé un journal. Au delà de l'aide à faire face aux addictions, il offre un support d'espoir et de résilience. Il se conçoit dans la cité et se projette à terme dans une action citoyenne entière et au besoin politique.

Le groupe animé et géré par le collectif de pairs qui l'a créé, interpelle au besoin, selon son appréciation, le support des soignants de la structure.

le poster illustre le concept du groupe et ses activités.

Modèle weddinger: le modèle de rétablissement intégré à l'hôpital

Konstantina Ligoutsikou

Belle Idée, Geneva, Switzerland

Le modèle Weddinger a été développé depuis décembre 2010 dans le département de psychiatrie, psychothérapie et psychosomatique a l hôpital Saint Hedwiwng. Visant à intégrer le modèle du rétablissement dans les soins hospitaliers, il réorganise les soins pour mettre la personne au centre de ses traitements. La personne participe activement, et sur un pied d'égalité avec les soignants, à la construction de son propre projet des soins. Ce modèle favorise la transparence entre les patients et les soignants dans des hôpitaux psychiatriques.

Dans des unités d'admission, les objectifs les résultats du traitement sont déterminés par le patient en fonction de ses propres valeurs et objectifs pour promouvoir son empowerment. L'accent est mis sur l individualisation, du traitement par le renforcement des ressources et de l'auto-efficacité. D'emblée, l'intégration des réseaux ressources externes de la personne est pensée dans une vision trialogique.

De plus, l'équipe de soins se réunit avec le patient ce qui devrait renforcer le travail multidisciplinaire, améliorer la qualité de l'information inchangée et assurer une plus grande cohérence du travail avec le patient.

Second level rehabilitation for pathological gamblers

Francesco Maisto, Beniamino Leone, Stefania Chiappini, Roberta Testa, Franco De Crescenzo, Mariapia di Paolo, Lucio De Alessandris, Gianluca Ruggiero and Gianluigi Conte

Catholic University of Sacred Heart, Rome, Italy

Pathological gambling is recognized as a behavioral addiction like Internet Addiction, Compulsive Shopping, Workahoolism, Exercise Addiction, Emotional Dependency and Sexual Addiction. Often, it is in comorbidity with Drugs Addiction and it shares some features with it: continuous occupation of the individual in the behaviour of abuse, despite adverse consequences; gradual reduction of the control over the behaviour of abuse; compulsive commitment in the behavior of abuse; state of craving before the acting-out; establishment of the phenomena of tolerance and withdrawal; repeated failures in trying to stop or reduce the behaviour; interference in many functional areas of life. Psychopathological nuclei of addiction in general are detectable in fragility of Ego, dysfunctional relationships, emotional dyscontrol on a background of alexithymia (deficits in mentalizing of its own needs and in understanding of its own and others' emotions). The present study aims to evaluate the effectiveness of a second level rehabilitation (focused on the achievement of a greater self-awareness and a greater emotional competence as well as on the better recognition and management of one's experiences), in patients who have already finished a first level treatment (based on the restraint of the symptoms of compulsive gambling and its derived social and economic damage). The second level rehabilitation is made up of three modules (Life skills, Self- Emotional Regulation, Mindfulness), for a total of forty meetings, two per week, in closed groups of eight-ten individuals. The present study is structured as a quasi- experimental pre-post non-randomized study between two equivalent groups of comparison. Firstly, changes occurred in patients, between the start and the end of each module, will be compared; then, the global results of the second level treatment will be compared with those of different treatments (maintenance treatment and monthly psychiatric consultation) into two equivalent groups. We expect that the second level rehabilitation may provide better relationship skills, more valid emotional regulation and relaxation capacity, necessary for a long-term recovery of the patients. Data of the first twenty patients who will complete the treatment will be analysed. Finally, it has been estabilished a six-months and twelve-months follow-up evaluation in order to assess the manteinance of the acquired skills.

Section 3: Internet-related disorders

The digital age is associated with the emergence of several concerns related to the widespread use of the Internet, such as the development of addictive behaviours facilitated by the Internet.

The so-called Internet addiction phenomenon shares with other addictive behaviours an individual's inability to control the use of on-line products such as games, social networks, and cybersex.

Similarities and differences related to such activities and among Internet consumers challenge the understanding and assessment of these addictive-like behaviours.

The congress offers a number of valuable abstracts related to such questions.

The spectrum of internet-related disorders

Joël Billieux

Laboratory for Experimental Psychopathology, Psychological Science Research Institute, Université Catholique de Louvain, Louvain-la-Neuve, Belgium

Problematic Internet Use or Internet addiction is generally considered as an inability to control the use of the Internet, which eventually involves psychological, social, academic, and/or professional problems in a person's life. Dysfunctional use of the Internet has been related to a variety of different activities such as cybersex, online gambling, online video game playing, or social network involvement, thereby emphasizing that this problematic behavior can take very different forms across individuals and should not be viewed as a homogeneous construct.

In this talk, I will first review the epidemiological studies from the last decade, and also emphasized their limitations. Then, I will review the main risk factors for cyber addiction. Empirical illustrations will be presented with regard to excessive involvement in online video games and cybersex addictions.

The double face of video games

Romain Martishang

University of Geneva, Geneva, Switzerland

We face today a serious issue about video games addiction. These activities tend to become an addiction in the gamer. An impressive number of the players will become dependant on these types of game instead of studying, making sport and sometime in the depends of their nutrition and their sleep. We could call this addiction the primary mental health problem. Then, the increased tendency towards video games and the high constraints of some online games makes them become more and more time- consuming and finally deprive the vulnerable population from their social environment. This isolation is an important proved risk factor for emerging health issue. In some cases, the sleep deprivation and the stress coming from this addiction can play also an important role in the development of mental health problems. These are therefore the secondary mental health problems.

We can conclude that video games present a double burden, without counting the other basic health problems created by an increasing sedentarity.

As medical students and future contributor of the Public Health, we can participate to improve this situation by creating informative campaigns, raising awareness among the general population and advocating the serious of this concern among organizations.

Internet addiction: etiology, comorbidity, and treatment

Supported by the addiction unit of the Geneva University Hospitals/Service d'addictologie des hôpitaux universitaires de Genève.

Joël Billieux[1] and Zsolt Demetrovics[2]

1. Catholic University of Louvain, Louvain-la-Neuve, Belgium
2. Eötvös Loránd University, Budapest, Hungary

Problematic Internet use or Internet addiction is defined as an inability to control the use of the Internet, which eventually involves psychological, social, academic, and/or professional problems in a person's life. Dysfunctional use of the Internet has been related to a variety of different activities such as cybersex, online gambling, online video game playing, or social network involvement. The current symposium first aims to provide some recent evidence regarding the psychological and social factors involved in the development, maintenance and recurrence of problematic Internet use. Three talks will address this issue. The first talk (Demetrovics and Király, Hungary) will address the role of online gaming motives (e.g., immersion, achievement, escapism) in problematic involvement in online games. The second talk (Achab, Switzerland) addresses the influence of self-regulation and reward drive in excessive online gaming. The third talk (Schimmenti, Italy) will address, through a longitudinal study, the influence of lack of social support in the onset of problematic Internet Use. A talk of Weinstein (Israël) will address the question of comorbidity among problematic Internet users, drawing upon existing neurobiological evidence. To conclude the symposium, the final talk (Kuss, UK) consists of an analysis of psychotherapists' perceptions of Internet-related disorders.

Speakers

1. The role of motives in the background of online gaming
   Zsolt Demetrovics and Orsolya Király, Eötvös Loránd University, Budapest, Hungary
2. Self-regulation and expectancies as predictors of excessive online gaming
   Sophia Achab, University Hospitals of Geneva, Geneva, Switzerland
3. Lack of social support and Problematic Internet Use: A longitudinal study
   Adriano Schimmenti, Università Kore di Enna, Enna, Italy
4. Internet addiction, co-morbidity and the brain
   Aviv Weinstein, Hadassah University Hospital, Jerusalem, Israel
5. Internet addiction in psychotherapy
   Daria Kuss, Nottingham Trent University, Nottingham, UK

The role of motives in the background of online gaming

Zsolt Demetrovics[1] and Orsolya Király[2]

1. Institute of Psychology, Eötvös Loránd University, Budapest, Hungary
2. Doctoral School of Psychology, Eötvös Loránd University, Budapest, Hungary

Nowadays online gaming is one of the most popular leisure time activity. Unfortunately, a minority of gamers play excessively in a way that has detrimental effects on their lives. Several studies pointed out that gaming motives are associated with problematic online gaming (POG). In order to be able to assess the broad range of online gaming motives our research group has developed the Motives for Online Gaming Questionnaire (MOGQ) (Demetrovics et al., 2011). The MOGQ comprises of seven factors: social, competition, fantasy, skill development, recreation, coping, and escapism. In an online survey targeting online gamers (N = 3186, mean age 21.1 years, 89.7% male) we found that among the seven gaming motives Escapism and Competition were associated with POG, and the same motives mediated between psychiatric distress and POG (Király et al., 2015). In another study (N = 4345, mean age 22.1 years, 92.5% male), we expanded the model with motives from another motivational questionnaire (i.e., the Gaming Motivation Scale) and time spent on gaming. The results showed that psychiatric distress had a significant positive direct effect and a significant indirect (mediating) effect on POG via three gaming motives: introjected regulation, escapism and amotivation. Time spent on gaming had a negligible effect on POG, therefore there were no considerable indirect paths between distress and POG through gaming time. Overall, the recent findings support the idea that gaming motives play an important role in problematic online gaming.

Self-regulation and expectancies as predictors of excessive online gaming

Sophia Achab

University Hospitals of Geneva, Geneva, Switzerland

Impairment of self-regulation and reward seeking is a hallmark of addictive behaviors. Excessive online gaming is conceptualized as a behavioral addiction disorder. Automatic and controlled aspects of self-regulation and types of rewards sought in- game, can play a role in development and maintenance of excessive gaming.

Pleasant sensations sought by the gamer through a certain gameplay style can represent expected external positive rewards (EEPR). They consist in specific motivations to play to a type of videogames. Pleasant internal states sought by the gamer not directly mediated by video game characteristics can represent expected internal positive rewards (EIPR). They consist in general motivations to play to videogames. Some of these expectancies can predict excessive online gaming. These aspects will be introduced and discussed. These can represent relevant targets of cognitive-behavioral interventions in clinical samples of excessive online gamers.

Lack of social support and problematic Internet use: a longitudinal study

Adriano Schimmenti[1], Ugo Pace[1] and Carla Zappulla[2]

1. Università Kore di Enna, Enna, Italy
2. Università di Palermo, Palermo, Italy

Lack of social support has been identified as one of the most important factors in the onset and maintenance of dysfunctional behaviors. This could also apply to the excessive use of the Internet among adolescents. In this longitudinal study, we first (T0) administered three self-report questionnaires to a group of 282 adolescent students (49% females) aged between 15 and 17 years old, in order to investigate the relationship between social support, attachment styles, and internalizing and externalizing symptoms in this sample. We found that higher social support was associated with lower fearful attachment scores ($r = –0.24$, $p < 0.01$) among these adolescents. One year later (T1), we assessed their Internet addiction symptoms by means of another self-report screening measure. The prevalence of significant symptoms of Internet addiction was 10.4% in this group. We also found that social support at T0 uniquely predicted problematic Internet use among the adolescents [Beta = –0.12 (C.I. 95%: –3.59 to –0.03), $p < 0.05$]. The results of the present study might be relevant for both prevention and treatment purposes. On a side, these findings suggest that promotion of social support, especially in school programs, may help the adolescent to better cope with the negative feelings associated with fear of intimacy and fear of rejection involved in fearful attachment, which may foster problematic Internet use. On the other, clinical work with adolescents suffering from problematic Internet use may benefit from interventions aimed to enhance their feelings of self-worth and their capacity to better relate with peers.

Internet addiction and co-morbidity with psychiatric disorders

Aviv Weinstein

University of Ariel, Ariel, Israel

Cross-sectional studies report high rates of comorbidity between Problematic Internet Use (PIU) and other psychiatric symptoms and disorders. The data, however, are severely limited by the frequent use of self-reports and questionnaires rather than validated tools or a structured psychiatric interview to diagnose comorbid conditions. Still, the picture that emerges is one where the presence of comorbidities is the rule rather than the exception. Comorbidity studies that meet acceptable criteria (adequate size, ascertained diagnostic criteria for PIU, accepted measures to assess comorbid psychopathology) showed significant comorbidity with depression, anxiety; ADHD, obsessive-compulsive symptoms and hostility/aggression. We now report a study using the Liebowitz Social Anxiety Scale that showed a significant association between PIU and social anxiety in two cohorts of 120 university students ($r = 0.411$, $p < 0.001$; $r = 0.342$, $p < 0.01$). Secondly, there was no difference between males and females on the level of Internet addiction. Third, there was no preference for social networks among participants with high levels of social anxiety. In a second study, investigating the association between ADHD and Internet addiction, we have found that 50 male children 14 year old with ADHD had higher Internet addiction test (IAT) scores, used the Internet for longer hours and went to sleep later than 50 male children age 14 without ADHD. These findings indicate an association between ADHD, sleep disorders and Internet/videogame addiction. We will discuss the results of these studies in view of existing studies of comorbidity of Internet addiction.

Internet addiction in psychotherapy

Daria Kuss

Nottingham Trent University, Nottingham, UK

Over the last decade, Internet addiction has been increasingly recognised by clinicians in their psychotherapeutic practice, and has been studied by researchers, with some suggesting it is a "21st Century epidemic". Currently, the treatment literature is limited, and Internet addiction experts have not yet established a consensus regarding the best treatment approaches. The present research intends to fill this gap in knowledge by addressing how treatment experts in Internet addiction experience the presenting problem of Internet addiction in psychotherapy. Twenty psychotherapists with expertise in treating Internet addiction across six countries (Germany, Austria, Switzerland, UK, USA, and Canada) provided their insights and expcerience of providing treatment to clients presenting with Internet addiction. Interview data were analysed with Interpretative Phenomenological Analysis. The superordinate themes "risk" and "addiction" emerged from the interviews. "Risk" included the individual, situational and structural characteristics that may increase an individual's vulnerability for developing Internet addiction. "Addiction" detailed Internet addiction as emerging mental disorder, including addiction symptoms, criteria and diagnosis, based on its parallels with substance-related addictions. The interviewed experts in Internet addiction treatment agreed on the clinical viability of an Internet addiction diagnosis as based on their own therapeutic experience. The results contribute to the understanding of Internet addiction and its relevance in the clinical context.

Key words: Internet addiction, psychotherapy, technological addiction, qualitative research, IPA

Reference

Kuss, D. J., and Griffiths, M. D. (2015). *Internet Addiction in Psychotherapy*. London: Palgrave.

L'addiction à la bourse à l'ère du numérique: enjeux et perspectives

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Les crises boursières qui se sont succédées ont mis en évidence les dangers de la négociation sur le marché boursier et les risques de perte financière. Malgré tout, l'investissement en bourse reste un des jeux d'argent les plus «socialement» acceptés (prestige social, investisseur reconnu comme un expert…). Cette pratique s'est fortement démocratisée avec le développement des nouvelles technologies. Aujourd'hui, il est très facile d'ouvrir un compte sur Internet et d'investir en bourse avec un capital faible. Si la majorité des investisseurs gardent le contrôle de leurs pratiques, certains d'entre eux développent une pratique problématique et demandent l'aide des centres de soins en addictologie. Nous appuyant sur la littérature scientifique et le parcours des patients rencontrés dans notre service à cause de leur addiction à la bourse, nous définirons cette problématique et décrirons les facteurs de risques qui y sont associés. Nous aborderons plus particulièrement les caractéristiques structurelles propres à cet objet d'addiction et traiterons de la question du «speed trading». Enfin, nous discuterons des perspectives possibles en termes de recherche, de prévention et de soins.

Les consommateurs de pédopornographie sur internet – une étude criminologique suisse – *Mémoire de master en collaboration avec la Police neuchâteloise*

Lilith Cattaneo

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Français

La forte croissance des infractions liées aux opportunités données par Internet a fait de la consommation de pédopornographie une préoccupation d'actualité, particulièrement pour les enquêteurs. C'est pourquoi la Police neuchâteloise et l'Ecole des Sciences Criminelles de l'Université de Lausanne collaborent à la réalisation de ce mémoire de master, dans l'objectif d'approfondir les connaissances sur les consommateurs de pédopornographie et leur façon de commettre ce type de cyber infraction. Une revue de littérature vise à présenter l'état des connaissances actuelles. Dans le but de créer une base de données, les dossiers de 247 consommateurs interpellés par la Police neuchâteloise entre 2000 et 2014 sont étudiés. Il en ressort une liste de variables articulées en cinq dimensions: les caractéristiques sociodémographiques, relationnelles et criminogènes, les informations concernant l'enquête et le matériel pédopornographique séquestré. Puis, la significativité des ces variables est statistiquement évaluée. Si les résultats de ces analyses le permettent, elles seront utilisés afin d'établir un ou plusieurs profils-types. Enfin, les limites de la recherche sont discutées. Ce poster présente la méthodologie du travail et les principaux résultats obtenus à l'état actuel de cette étude.

English

The consumption of child pornography has greatly increased due to numerous opportunities allowed through the Internet and therefore become a current major concern, especially for police investigators. Thus, the Police of Neuchâtel and the School of Criminal Sciences at the University of Lausanne collaborate to realize this master's thesis, with the objective of expanding the knowledge on child pornography consumers and their way of committing this cyber-crime. The existing research is presented in the form of a literature review. In order to create a database, the 247 police-files of consumers apprehended by the Police of Neuchâtel between 2000 and 2014 are studied. The emerging list of variables is divided into five dimensions: the sociodemographic, relational, and criminogenic characteristics, as well as information concerning the investigation and the confiscated child pornography material. The significance of these variables is then evaluated through statistical tests. Depending on the results of these tests, we will use these variables to establish one or more profiles. At last, the study's limits are discussed. This poster presents the work's methodology as well as the main results at the current state of our study.

Internet gaming disorder: from psychologists' perspective

Olatz Lopez-Fernandez

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Internet gaming disorder (IGD) was proposed by the American Psychiatric Association (APA) last 2013, inside the annex of the fifth Manual of Diagnostic and Statistical mental disorders. From this moment until the present, around 20% of the publications related with Internet addictions have been involved with this issue, although more of these peer-reviewed papers are comments and theoretical productions, rather than empirical. Those that are obtained evidence usually have started proposing scales to measure IGD in healthy young adults, following the criteria proposed by the APA. This presentation presents the preliminary results obtained in an exploratory study done after the advent of IGD from professionals' perspective. An online survey was distributed among the Catalan psychologists officially collegiate to know their opinion about these IGS criteria, as well as technological and behavioral addictions. A convenience sample size of 640 psychologists completed the survey (85% women, with a mean age of 41, standard deviation of 11), and being the 39% clinical psychologists. More than the middle part known about IGD, and have had clinical experience with this type problematic. They highly agree with each symptom proposed with slightly differences, as well as with other behavioral addictions, considering more prevalent some of them.Detailed preliminary findings and other considerations in relation with clinic professional perspective about technological addictions will be discussed.

Playing a lot does not mean addiction: comparing highly engaged online video game players and problematic online gamers

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When used in everyday language the term 'addiction' often refers to excessive use. For instance terms as 'chocolate addiction' or 'music addiction' most often refer to people eating lots of chocolate or listening to music most of their time. Experts on the other hand have pointed it out that excessive use should not necessarily be equaled with addiction or problematic use. This distinction is particularly important in the case of video game play, since playing video games have recently become one of the most popular leisure time activities in the developed countries around the world. The goal of our study was to test whether highly engaged video game players differed from problematic players on certain demographic, psychological, and motivational dimensions. An online survey was carried out with online gamers ($N = 4512$, mean age 22.3 years, SD = 6.3 [age range 14–59 years], 92.4% male). Weekly time spent on gaming, gaming type preference, problematic gaming, gaming motives, impulsivity, and general level of distress were assessed. The sample was divided in four different groups: (1) casual players (playing less than 4 h a day); (2) highly engaged players (playing more than 4 h a day, but not fulfilling the DSM-5 criteria for Internet gaming disorder); (3) problematic gamers according to the DSM-5 criteria who played less than 4 h a day; (4) problematic gamers according to the DSM-5 criteria who played more than 4 h a day. Our findings suggest that problematic gamers (regardless of whether they play more or less than 4 h a day) show much higher level of general distress and impulsivity than any of the first two groups. Highly engaged gamers on the other hand barely differ from casual players on these aspects – meaning they have scores close to the sample mean. In addition, problematic gamers score particularly high on certain motives (i.e., introjected regulation, escapism) that were argued to be associated with problematic use. Escapism refers to playing to avoid real life difficulties, while introjected regulation refers to playing to reduce inner pressures such as anxiety or guilt. Overall our findings suggest that gaming time does not differentiate well the gamers who play in a problematic manner from those gamers who are merely playing excessively or are highly engaged with games. Therefore the study supports the argument that criticizes pathologizing behaviors that in reality are not problematic.

Motivation pour l'achat online est-elle associée à l'achat compulsif offline?

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Dans le cadre de cette étude, deux hypothèses ont été testées: (1) la tendance d'achats (compulsifs ou non) est un facteur plus important que l'environnement (offline ou online) sur les comportements d'achats, ce qui entraînerai que les achats excessifs sont indépendant du lieu (offline ou online); (2) l'environnement est un facteur plus important que la tendance d'achats, en d'autres termes les acheteurs compulsifs offlines n'ont pas forcément des comportements d'achats compulsifs online. 1447 personnes ont été recrutées dans un grand centre commercial pour participer à cette étude. 159 d'entre elles font des achats online au moins une fois par moins. L' «Edwards Compulsive Buying Scale – Revised» (Edwards , 1993) et l'échelle de «Motivations to buy online» (Kukar-Kinney et al., 2009) ont été utilisées pour mesurer les comportement d'achats compulsifs. Il n'y a pas de différence significative en termes de motivation d'achats online entre les acheteurs compulsifs offline (11,9%) et les acheteurs non-compulsifs (11,6%). La *Latent Profile Analysis* a identifié trois différents patterns: les «Acheteurs non-problématiques», les «Acheteurs semi-invisibles» et les «Acheteurs invisibles». Parmi ces trois patterns, on observe des différences en termes d'achats offlines: 5,5% des «Acheteurs non- problématiques», 15,7% des «Acheteurs semi-invisibles» et 11,8% des «Acheteurs invisibles» ont des comportements d'achats compulsifs offlines. Il n'y a pas de différence significative en termes d'achats onlines ou de montants dépensés parmi ces trois patterns. Pour conclure, l'achat compulsif est un comportement réalisé dans un environnement offline (traditionnel), toutefois ce comportement n'est pas associé à des comportements d'achats compulsifs dans un environnement online.

Atelier «Jeux Video et Débat – Je vis des hauts et des bas»

Niels Weber

Centre de Prévention du jeu Excessif

Pouvoir prendre du recul par rapport à sa propre pratique est un excellent moyen de diminuer les risques de jeux excessif. Le jeu vidéo est entré dans notre vie quotidienne comme objet culturel. Les familles font souvent face à des tensions liées à une cohabitation difficile entre comportements de jeu et règles familiales. Les jeunes ont des compétences pour parler du jeu et les parents pour cadrer cette activité, mais chacun n'en est pas toujours conscient. Forts de ces constats, le centre de prévention du jeu excessif de Genève, Rien ne va plus, propose depuis deux ans un atelier dans lequel les participants sont amenés à jouer à des jeux vidéo puis à débattre de l'expérience qu'ils viennent de vivre. En partant de question assez pragmatique, comme «Quel jeu avez-vous préféré parmi les deux proposés aujourd'hui?», notre équipe de spécialiste amène les participants à discuter de manière constructive du jeu vidéo à plus large échelle, en abordant notamment des thèmes comme «Quelles sont les règles chez vous?», «Avec qui et combien de temps joue-vous?», «A quel type de jeu?», «Quels sont les raisons d'acheter tel ou tel appareil/jeu aujourd'hui?», «Quels sont les enjeux sociaux, économiques, écologiques, etc., de cette pratique?». Nous proposons ainsi de valoriser les connaissances de ces jeunes (14 à 18 ans) mais également leur compétence de dialogue pour sensibiliser à être critique sur un média attractif qui peut, parfois, prendre trop de place.

The importance of time spent gambling when considering the relationship between Internet gambling and problematic gambling

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Introduction: Previous studies showed that Internet gamblers shared a higher burden of disease than non-Internet gamblers. One hypothesis is that Internet permitted gambling activities to be more accessible and convenient, e.g., as in-home activity. Therefore, we can wonder whether the classification as problematic gamblers is due to Internet gambling itself, or to the large amount of time spent in gambling activities. Thus, the present study aimed to test whether controlling for time spent gambling, the correlations between Internet gambling and problem gambling persisted.

Methods: We used data from the 2011 French ESCAPAD survey of French 17-year- olds (n = 9,910 gamblers, 36.2% of the total sample). We assessed gambling activities with Internet/non Internet gambling, time spent gambling, gambling addiction (Canadian Problem Gambling Index), number of gambling activities, and money participants spent gambling the last time they gambled. Health and mental health outcomes included the self-evaluation of health and the presence of suicidal thinking. Associations were performed using negative binomial and logistic Generalized Linear Models.

Results: Participants were on average 17.38 ± 0.26 years old and 43.4% were girls. A total of 10.5% of the participants were regular Internet gamblers. Overall, participants gambled 42.56 times during the previous 12 months, and they scored 8.37 ± 1.29 on the CPGI ranging from 8 to 32. On average, they spent 10.27€ the last time they gambled and participate in 1.39 gambling activities. Regarding health outcomes, 5.1% of the participants evaluated their health as bad, and 10.8% had suicidal thoughts in the previous 12 months. Internet gamblers spent more time gambling more than non- Internet gamblers (respectively 95.86 and 36.29 times).

Associations of Internet/non Internet gambling with outcomes without controlling for time spent gambling showed that Internet gamblers had a higher score of gambling addiction (b = 0.03, p = 0.017), spent more money (b = 0.16, p = 0.005), and more likely to have suicidal thoughts (OR = 1.35, p = 0.004). When time spent gambling was taken into account, Internet gambling did not predicted gambling patterns anymore (gambling addiction: b = 0.01, p = 0.627; money spent gambling: b = 0.10, p = 0.086), whereas the association with suicidal thoughts decreased (OR = 1.30, p = 0.016). Time spent gambling was significantly associated with all outcomes (p < 0.001).

Conclusion: The study first replicated previous results regarding the deleterious association of Internet gambling with gambling patterns and health outcomes. However, when time spent gambling was controlled for, this association became non-significant for gambling patterns. Therefore, Internet gambling may not be considered as a main detrimental form of gambling for individuals' health. Further studies focusing on Internet gambling should take time spent gambling into account when assessing associated gambling problems, since it appeared as an important variable to understand gambling problems severity.

Section 4: Crisis and migration

The digital age is opening boarders. Europe and the world are facing economic and political crises. Distances appear to be smaller, increasing the likelihood of a worldwide domino effect from a given crisis.

A number of abstracts deal with financial, political, and military crises and their impact on mental health care.

Examples of international collaborations are presented, as well as experiences and proposals to alleviate the impact of crises.

Brain drain

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The European Federation of Psychiatry Trainees (EFPT) Brain Drain study, has been a cross-sectional survey, carried out in 33 countries in Europe, that has researched actual and future migration in this global context by recognizing the *push* factors that pressure people to leave the *donor* country, the *pull* factors that make the *recipient* country seem attractive, so to understand the root causes of migration, while confirming *patterns* and *duration* of migration.

The results provided by this international collaborative research bring an overview of migration among junior doctors in Europe training in Psychiatry and the different challenges faced in this pathway to a psychiatry career.

Despite the concern for the rise of these migration flows, moving it to the forefront agendas raising questions, considerable attention may be required into the health policy discourse, such as multilateral agreements between countries and advocacy for fair treatment to migrant workers.

The impact of migration within psychiatry urges for effective measures both in source countries and destination settings, enhancing the support to those who migrate and actually influence the mental health care provided internationally.

Mobility and migration – views from Switzerland and France

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EFPT Brain Drain Study has investigated in-depth opinions and experiences of mobility and migration of junior doctors training in Psychiatry in 33 countries in Europe.

Switzerland and France are examples of attractive countries to migrate, with Switzerland being the first destination for trainees to migrate to.

Reasons to move to Switzerland are the higher salary. The majority of immigrants reported that the financial situation in their countries of origin should be improved, whereas the working and social conditions need less improvement. Quality of training, working conditions and life style were other factors of attraction. Nearly all the colleagues living in Switzerland were satisfied with their life abroad.

Trainees' income in France ranges between 1500–1999 €, which is as the average of the other countries.

In France, more than two-thirds of trainees never had a short-mobility experience, and despite more than two-thirds have ever considered leaving the country, the majority believes that in the next 5 years they will stay in France. Financial reasons does not appear as a motivation to leave the country, since only one quarter of the trainees are dissatisfied with their income. The main reasons invoked to leave France are personal reasons, academic and the cultural environment.

Financial crisis and psychopathological consequences

Luigi Janiri[1] and Driss Moussaoui[2]

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2. Moroccan Association of Social Psychiatry, Casablanca, Morocco

The financial crisis that we are living at the present time may induce various consequences at the mental health level: (1) causing mental distress and disorders such as suicide, depression, anxiety, somatic syndromes, alcoholism and substance use; (2) exacerbating previous psychiatric disorders, and (3) decreasing funding for mental health services and access to psychiatric treatments. This symposium is aimed at showing data on the situation across three countries in Europe (Italy and Greece) and Asia (India) where economic problems are particularly heavy. The suicide rate can be assumed as a specific indicator of the impact of crisis on the populations' wellness. The question is debated whether context traumas or stressing events or conditions, such financial crisis, may trigger psychiatric disturbances per se or they are able to exert pathomorphic and modulating effects on previous individual symptoms and vulnerability elements. Suggestions are given about interventions to alleviate the impact of the economic recession on depression and suicide in Europe.

Speakers

1. Socioeconomic crisis and the impact on mental health human rights in Greece
   Stelios Stylianidis, Panteion University, Athens, Greece
2. Facing crisis in Italy: how to support mental health
   Luigi Janiri, Catholic University, Rome, Italy
3. Economic downturm: the pathogenic and pathoplastic dilemma
   Paolo Cianconi, Regina Coeli Psychiatric Services, Rome, Italy
4. "See Venice and not die: The Odyssey of boat people in Mare Nostrum"
   Luigi Janiri, Catholic University, Rome, Italy
   Driss Moussaoui, Moroccan Association of Social Psychiatry, Casablanca, Morocco

Economic downturn: the pathogenic and pathoplastic dilemma

Paolo Cianconi[1] and Luigi Janiri[2]

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2. Institute of Psychiatry, Catholic University, Rome, Italy

Economic crises are part of that set of conditions that push us towards a definition of the postmodern globalized society as a "high-risk society" or "vulnerable society". Crisis has turned into a sort of common vision, from the concept of sustainability to that of resilience. Economic downturns thunders a horizontal blow to the safety of individuals, families and institutions, while vertically involving transgenerational and social levels.

With regard to psychopathology, the effect of economic decline must be analyzed with respect to the quality of the crisis and the time of expansion and permanence in the community where the crisis has taken hold. Increased anxiety is among the first signs of a changing social system, whereas WHO forecasts provide direct connections with the increase of psychopathological conditions that we generally consider as only partially reactive, such as psychoses and mood disorders. Moreover, it appears that certain types of post-traumatic stress disorders are able to travel through generations and to disrupt social attachment and adaptations. Is the construction of a transmitted vulnerability associated with a new basic reactivity of those groups particularly affected by the crisis? The study of some changing paradigms is the goal of research work in the field of social neurosciences, psychiatry and social psychiatry along the ecosystems in which we find ourselves immersed.

Santé mentale après le génocide: 20 ans de collaboration entre le Rwanda et la Suissec

Avec le soutien de l'Association Suisse – Rwanda pour la Santé Mentale

François Ferrero

Université de Genève, Genève, Switzerland

Ce symposium évoquera différents aspects de la collaboration entamée il y a près de 20 ans entre le Rwanda et la Suisse dans le domaine de la santé mentale. Initié et soutenu à l'origine par la Coopération suisse, ce projet a été mené par les Hôpitaux Universitaires de Genève (HUG) en étroite collaboration avec le Ministère de la Santé du Rwanda.

Le document «Politique nationale de santé mentale», élaboré en 1995 avec l'OMS, a servi de référence: Il insistait sur l'urgence de développer les soins en santé mentale pour répondre aux traumatismes vécus par la population rwandaise. Le principe d'organisation était celui d'une décentralisation des soins de santé mentale qui devaient s'appuyer sur le réseau de soins de santé primaire et sur les hôpitaux de district. La formation d'infirmiers en santé mentale représentait la base de tout le système. Une autre priorité a été de réhabiliter l'unique hôpital psychiatrique du pays, afin d'en faire un hôpital de référence où viendraient se former les professionnels.

Les différents intervenants évoqueront quelques étapes de cette collaboration en soulignant l'importance du travail en réseau, de la concertation et de la formation du personnel soignant, ainsi que la place de la formation au travail groupal et son rôle dans l'acquisition de l'identité professionnelle, le développement des soins aux enfants et aux adolescents souffrants de troubles psychiques ou encore la formation des médecins psychiatres rwandais.

Speakers

1. Survol historique et formation des psychiatres
   Jean-Michel Aubry, Département de Psychiatrie et Santé Mentale, HUG, Genève, Switzerland
   François Ferrero, Université de Genève, Genève, Switzerland
2. Le groupe comme vecteur de différenciation dans les soins
   Suzanne Ehrensperger-Cuénod, Psychiatre-psychothérapeute, Genève, Switzerland
3. Reconstruire la santé mentale, Mobiliser toutes les énergies
   André Laubscher, Hôpitaux Universitaires de Genève (HUG), Genève, Switzerland
4. Les enfants du Rwanda au centre des questions du passé et du futur
   Naasson Munyandamutsa, Département de psychiatrie, Université du Rwanda, Butare, Rwanda
5. Le développement de la pédopsychiatrie au Rwanda, un investissement pour la société de demain
   Saskia Von Overbeck Ottino, Psychiatre-psychothérapeute d'enfants, d'adolescents et d'adultes, Genève, Switzerland

Survol historique et formation des psychiatres

François Ferrero[1] and Jean-Michel Aubry[1,2]

1. Université de Genève, Genève, Switzerland
2. HUG, Genève, Switzerland

Peu après le génocide de 1994, le «Corps suisse en cas de catastrophe» a sollicité les Hôpitaux Universitaires de Genève afin de développer un projet de santé mentale au Rwanda.

Ce projet s'est développé dans un contexte post-génocide particulièrement dramatique, marqué par la disparition d'un très grand nombre de détenteurs du savoir et des traditions et par une perte de repères touchant la majorité des rescapés.

Nous évoquerons quelques aspects de ce projet qui a contribué à reconstruire progressivement un réseau de soins en santé mentale au Rwanda ainsi que certaines difficultés rencontrées dans la formation des psychiatres, jusqu'à la création récente du département de psychiatrie de l'Université du Rwanda. Le programme actuel, porteur d'espoir et de nouveaux enjeux nécessite toutefois de nous confronter aux limites des modèles scientifiques occidentaux.

Reconstruire la santé mentale, Mobiliser toutes les énergies

André Laubscher

HUG, Genève, Switzerland

Reconstruire et consolider un système de soins psychiatriques dans un pays dévasté nécessite d'importants efforts de négociation et de coordination. Ceci d'autant plus si les soins psychiatriques ne sont qu'une priorité parmi d'autres dans un pays où l'ensemble du dispositif de soins était à reconstruire. Il s'agissait de permettre à nouveau l'accès aux soins psychiatriques pour une population de près de 8 millions et de prendre en considération les séquelles psychiatriques et psychologiques consécutives à la guerre et aux assassinats de masse.

La Direction du développement et de la coopération suisse (DDC) et les Hôpitaux universitaires de Genève (HUG) ont pris une part très active dans ce travail de reconstruction et de développement de soins de santé mentale et psychiatriques. Ceci en s'inscrivant dans la politique nationale de santé mentale élaborée dès 1995. La DDC et les collaborateurs des HUG ont fortement contribué à la définition de cette politique et son plan d'action. Les HUG ont été particulièrement actifs dans la formation du personnel soignant et la décentralisation des soins de santé mentale. Compte tenu de la multiplicité des intervenants, nous avons mis l'accent sur le travail en réseau et la concertation.

Les enfants du Rwanda au centre des questions du passé et du futur

Naasson Munyandamutsa

Département de psychiatrie, Université du Rwanda, Butare, Rwanda

Le projet Suisse-Rwanda est venu poser les jalons pour un pays qui voulait à tout prix renaitre des cendres.

On ne renait pas sans accepter symboliquement de redevenir un enfant pour s'ouvrir, sous d'autres repères, à une dynamique créative devenue indispensable.

Or les enfants du Rwanda poussent, à leur manière, la société à s'ouvrir à de nouveaux questionnements: des questions comme: pourquoi ceci est arrivé? A qui j'appartiens? Comment s'inscrit-on dans l'appartenance filiale? Et bien d'autres.

Les modalités de communications et celles qui consistent à poser des questions individuelles et collectives passent par des voies complexes chez les enfants et même pour ceux qui ont survécu à la machine d'anéantissement.

Le projet Suisse-Rwanda a placé les balises, a mis à disposition des professionnels les grilles de lecture, les outils de décodage, pour que la parole de l'enfant et celle de ceux qui sont nés des cendres devienne audible et que la société écoute.

C'est cette idée que je compte développer.

Le développement de la pédopsychiatrie au Rwanda, un investissement pour la société de demain

Saskia Von Overbeck Ottino

Psychiatre-psychothérapeute d'enfants, d'adolescents et d'adultes, Genève, Switzerland

La santé mentale et la qualité de vie des enfants et des adolescents constituent des enjeux majeurs dans les développements de la psychiatrie au Rwanda.

Les enfants étant les adultes de demain, il est incontournable d'appréhender les particularités concernant leur développement psychologique et les spécificités de leur prise en soin pour assurer des conditions de développement psychologique et somatique optimales.

Au Rwanda, faute de spécialistes formés, la pédopsychiatrie est longtemps restée dans l'ombre de la psychiatrie adulte, les enfants et les adolescents étant évalués et suivis comme des petits adultes, sans spécificités en lien avec les particularités de leurs âges. Certains champs de la pédopsychiatrie étaient et sont encore pratiquement inexistants comme les troubles de l'attachement ou les retards de développement psychomoteur d'origine psychique.

Le Rwanda compte actuellement 1 pédopsychiatre pour 11 millions d'habitants.

Il s'agit donc de soutenir la formation de spécialistes, mais aussi de former l'ensemble des ressources (psychiatries, psychologues, soignants, sociaux…) aux rudiments de la pédopsychiatrie. En suivant les recommandations de l'OMS, il s'agit d'utiliser, autant que faire se peut, les ressources locales et environnementales afin de développer un système de démultiplication à partir de quelques spécialistes vers beaucoup d'intervenants locaux.

Dans un volet plus spécialisé, les objectifs visent à développer des stratégies de dépistage précoce, d'évaluation et de soins en rapport avec les spécificités du développement psychologique et des conditions environnementales et culturelles des enfants et des adolescents.

Il s'agit aussi de développer des collaborations avec les autres institutions en charge des enfants comme les centres de santé pour les nouveaux-nés ou les écoles et de favoriser un travail de liaison avec les maternités et la pédiatrie.

Au fur et à mesure que les ressources d'étofferont, il sera possible de définir des stratégies spécifiques de soins en fonction de groupes particuliers comme, par exemple, les troubles de la relation mère-bébé, les troubles du développement, la maltraitance, les problématiques adolescentes…

L'ASMSR en collaboration avec le ministère de la santé et le CHUK vient soutenir le développement de structures et d'équipes orientées vers les particularités de la prévention, du dépistage, de l'évaluation et des soins concernant les enfants et les adolescents. L'auteur présentera les modalités concrètes de cette collaboration et son impact sur la pédopsychiatrie au Rwanda.

Le groupe comme vecteur de différenciation dans les soins

Suzanne Ehrensperger-Cuénod

Psychiatre-psychothérapeute, Genève, Switzerland

«Comment garder la distance thérapeutique dont vous nous parlez alors que l'histoire du patient est la mienne?». Cette question m'a été posée par un soignant lors d'une conférence donnée à Kigali à propos des groupes. L'apport théorique est en effet indispensable pour permettre d'acquérir une identité professionnelle et nous l'avons proposé de différentes manières depuis près de 15 ans. Une expérience personnelle des groupes est cependant tout aussi importante et cet aspect a pu être expérimenté, entre autres, à travers l'immersion dans un groupe de formation. Nous en décrirons quelques effets collatéraux intéressants.

Quant à la formation des formateurs de groupe, elle va plus loin encore et tente de répondre à l'interrogation suivante: «Existe-t-il une manière de créer une communauté thérapeutique bénéfique tant pour les patients que pour les soignants?»

Basic mental health care

Sunbaunat Ka

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After chronic wars and genocidal reign ended, a lot mental health disorders associated with different level of mental disability, among survivors represent a huge health, socioeconomic issues in the country. It causes is seen as an obstacle to development of the country and also it is observed as leading factor of mental disorders among young generations during after war period. It proves that needs for development of mental health care services to help survivors to get released from their mental disorder and to help the nation to rebuilt a potential resource for the participating the process of development of the country.

Experiences in training psychiatrists since 1994 bring us an idea on how to create mental health care system in Cambodia which would fit well to socioeconomic and cultural situation of the country as we needs to cure majority of those who were suffering from mental disorders and living in the rural areas. We could not adopt mental health care service as in developed countries or in neighboring countries. We have to adapt to mental health needs of the country and which could operate much better for the future.

An idea of creating Basic Mental Health Care was initiated and has been expected as a potential policy to create and develop a new Mental Health Care which would be appropriate to practical needs, as sustainable mental health care strategy. It would meet human right promotion, making mental health care to fit respects to human rights (rights of mentally ill patients), to fight against stigma and discrimination, to strengthen cost effectiveness and to support equity.

Such Basic Mental Health Care could be implemented in rich countries as well as in developing countries and in public sector as well as in private sector. It represent everywhere and everyday mental health care.

Dictatorships reflect societal faultlines?

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Objectives: Dictatorships afflict nations across the world randomly, from Africa where primitive man evolved to Greece, the cradle of western democracy. What does Hitler's *Germany* have in common with Pol Pot's *Cambodia*, Stalin's *Russia* with Pinochet's *Chile*, Mussolini's *Italy* with Mao's *China?* Are these random *acts of God*, or do they reflect a deeper, shared malaise which renders these otherwise culturally, economically and politically diverse countries vulnerable to despotic rule? This intriguing question admits no ready, simplistic answer. The issues involved are complex and merit interrogation from sociological and psychological perspectives.

Purpose: To examine the proposition that identifiable societal *faultlines* may have contributed to the divergent trajectories followed by India, a vibrant, if at time chaotic democracy, and Pakistan, chronically under military rule, following their creation in 1947, despite their common ethnic, cultural and political heritage.

Methods: India and Pakistan were one country, one people, one *civilisation* when they gained independence from British rule in August 1947. Subsequently, however, the two nations have followed divergent trajectories. Using the case study method, the presentation examines historical evidence to identify the causes underpining this dichotomy.

Results: The roots of military dictatorships in Pakistan may be traced back nearly three centuries to the ideological heritage of Shah Waliullah (1703–1762), militralised into *jihad* by Sayyid Ahmed Barelvi (1786–1831), articulated in an anglicised lexicon by Syed Ahmad Khan (1817–1898), eventually culminating in the Pakistan resolution passed in March 1940 at the Lahore session of the Muslim League. While Jinnah used the divisive *doctrine of distance* to achieve his goal of a separate *Muslim homeland*, he envisioned Pakistan as a modern, secular nation. Soon after his death in 1948, however, Pakistan embarked on the path of Islamic fundamentalism crafted by the *Godfather* of Pakistan, Maulana Maududi, and carried to its inevitable culmination, the Islamization of Pakistan and the perpetuation of military dictatorship by the *God's General*, Zia ul Haq.

Conclusion: Dictatorships mirror deeply entrenched and complex societal *faultlines* going back in time which, given a fateful combination of social, economic and political factors, widen and swallow democratic institutions. Nations need to look back into their collective historical *unconscious* to identify and deal with these critical issues if history is not to repeat itself, even as they struggle with macro level mental health issues related to the *radicalisation* of 2nd generation immigrants ("*home grown terrorism"*) and the almost inevitable backlash from extreme right wing ("*neo-Nazi"*) political forces which appear to be gaining electoral ground across Europe. Research is required to identify possible preventive mental health interventions and educational strategies.

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Mental health empowerment project in Rwanda

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Rwanda is known to have a high number of PTSD cases due to the 1994 genocide. This project was situated in the southern region of Rwanda and initiated by the Medical Mental Health Association in collaboration with the Mental Health Rwanda organization in Denmark, funded by several Danish organizations (CISU, DUF, and Amnesty International). The overall goal was to empower citizens from the Southern Province in mental health issues in particular PTSD. The objectives were to create a voluntary mental health task force skilled in counselling and psychoeducation who could: (1) facilitate psychoeducation group talks among secondary school students in the southern province thus to reduce PTSD-Stigmatisation; and (2) meet with the local community to increase their knowledge of PTSD and mental health related issues.

The project had 3 phases: (1) creation of a mental health task force within MMHA consisting of 40 medical or clinical psychology students through a 10 day workshop taught by mental health specialists; (2) training of 800 secondary schools students from 20 different schools in the area by the task force; (3) visit of community members to provide psycho education during national community service meetings, and to orphan survivors of the genocide. The same task force also hast to intervene in 10 different sectors during Tutsis' genocide commemoration period.

Phase1, the task Force of 40 students was empowered with counselling, psychoeducation and teaching skills. A guide manual was produced. Phase 2, the task force trained 784 secondary school students in 19 different schools and created 19 mental health clubs. Phase 3: (a) Rwandan citizens in 30 chosen sectors were taught about PTSD and other mental health related problems by 10 groups of 4 taskforce members. (b) The taskforce offered psychological first aid and counselling in PTSD at 8 chosen sites and 30 cells of the Huye district. (c) 200 Orphans were taught about PTSD, trauma and project planning. (d) 30 local leaders were taught about PTSD and got all information about MMHA and the project MHEP. Among them were 19 school leaders and 11 administrative sectors' local leaders.

All project aims were reached and the fund was renewed for 2 more years by the Danish NGO CISU. The project demonstrated a potentially hidden voluntary resource of activists among health professional students in Rwanda.

Facing crisis in Italy: how to support mental health

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Evidence exists in the literature that the occurrence of the financial crisis in the last years contributes to increase the incidence of psychiatric disorders and to exacerbate symptomatology in people already suffering from mental illness. The objectives of this study are to understand the current state of the problem, to identify at risk populations and to provide support for vulnerable subjects. To detect how much the incidence of social distress leads to significant psychopathological consequences in Italy, a group of patients referred to the Psychiatry Day Hospital of the University Hospital "Gemelli" in Rome was applied a specific questionnaire about the economic perturbation together with psychopathological tests particularly concerning mood and anxiety. The results show that the literature data are consistent with those obtained in these patients: in fact an increase in mood and anxiety symptoms and disorders was observed. In other studies a greater number of major depression, generalized anxiety disorder, suicide in psychiatric patients, alcohol related problems, use of psychotropic drugs, addictions and somatoform disorders was found. Such an increase was registered especially in subjects with varying degrees of economic difficulties. Self-help groups and psychosocial support were the most useful therapeutic instruments to alleviate the individual suffering.

Workforce migration – hot topic in Portugal

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Background: The increasing migration of health professionals to affluent countries, a phenomenon known as "brain drain", is not a recent phenomenon and has continued to fuel the huge inequities in global health. The migration of medical professionals reflects a balance of supply and demand, with professionals looking for better earnings and working conditions, in a timeframe of political, financial and social crisis lived in Portugal.

Aims: This work assessed junior doctors training in psychiatry in Portugal on their opinions and experiences of international migration. The main focus of this presentation is the factors that pressure trainees to migrate from Portugal as well as the features of an attractive job.

Methods: A cross-sectional survey was carried out in 33 countries, through a questionnaire designed specifically for the purpose of this research. Hard-copy questionnaires or an email invitation with an online link (surveymonkey) were circulated to junior doctors training in psychiatry in Portugal. The findings gathered through this pilot investigation were discussed based on a bibliographic search using PubMed/MedLine database with the key words: "Migration" and "Brain Drain".

Results: Less than half of the trainees considered staying in Portugal as a working perspective for the next years, and nearly four-fifths have ever considered leaving the country. Earnings range between 1.000 and 1.499€, and trainees state to be mostly dissatisfied with this income. Top reason to leave was financial, followed by work and academical. Working conditions ranked first as the priority condition to be improved in psychiatry in Portugal, followed by financial conditions. In fact, an attractive job for psychiatry trainees in Portugal must have as the most important feature a pleasant work environment.

Conclusion: Financial conditions and future perspectives of career seem to have a lead role in the migratory tendency of junior doctors training in Psychiatry in Portugal, that look for better paid job opportunities and better working conditions abroad.

Section 5: Other

This section is rich in abstracts related to important topics, among them, stigma, social psychology, training of psychiatrists, and well-being

Young psychiatrists and social psychiatry

Marianna Pinto da Costa[1] and Ramya Vadivel[2]

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2. Institute of Mental Health in Singapore, Singapore

Social Psychiatry is one of the proeminent areas of the current century and may shape psychiatry's future.

Since psychiatry trainees from the present, will be the future specialists, it will be crucial to give us a voice and the opportunity to speak on this regards at this International Congress.

Speakers

1. Workforce migration and brain drain
   Mariana Pinto da Costa, EFPT President, Hospital de Magalhães Lemos, Porto, Portugal
2. Mobility and migration, views from Switzerland and France
   Clara Feteanu, Psychiatry trainee in Paris, France
3. Psychiatrists as physicians
   Ramya Vadivel, Psychiatry trainee in Singapore, Singapore
4. The double face of video games
   Romain Martishang, Medical Student at the University of Geneva, Switzerland

"Psychiatrists are physicians first" – reflections of an early career psychiatrist

Ramya Vadivel[1,2]

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2. Institute of Mental Health (IMH), Singapore

Psychiatry has long been seen as one of the 'soft sciences', even as an inexact science. The journey starts from a poor representation of psychiatry from undergraduate medical education. Issues often addressed include a perceived vacuum between psychiatry and the remaining medical specialties, leaving the impression of psychiatric illnesses being one of exclusion. There exists a need for psychiatrists as well, to engage actively in co-managing other ailments. The debate always arises if psychiatrists are adept enough at identifying and managing non-psychiatric conditions. The speaker aims to address the current situation among junior practitioners, including the shortcomings with working in tertiary psychiatric centres with limited medical resources, the need for continued medical education and seeking liaison with other medical specialties aiming at holistic care to patients.

Buprénorphine et methadone: des traitements comme les autres? Points de vue des patients et des prescripteurs

Morgane Guillou Landreat[1], Caroline Victorri Vigneau[2] and Marie Grall Bronnec[2]

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Les traitements de substitution opiacés sont commercialisés depuis la fin des années 1960 aux États-Unis et depuis 1996 en France. Les objectifs de ces traitements se sont élargis: au-delà de l'arrêt des consommations d'héroïne, ils sont recentrés sur l'amélioration du fonctionnement psychosocial du patient et de sa qualité de vie. Mais après une réadaptation psychosociale et une amélioration des conduites addictives, comment envisager la décision de maintien ou d'arrêt du traitement? Les prescripteurs et les patients/usagers partagent des opinions très différentes sur ce sujet, et il n'existe pas de recommandations claires opposables. Nous nous sommes interrogés sur les représentations des traitements de substitution (buprénorphine, méthadone) chez les prescripteurs d'une part et chez les patients d'autre part. Nous avons mené un travail en 2 étapes: un premier volet exploratoire sur les représentations des patients vis-à-vis de leur MSO, un second concernant les perceptions des médicaments de substitution par les médecins et leurs modalités de prescription. La majorité des patients interrogés considèrent qu'il ne s'agit pas de traitements comme les autres. Cette ambivalence est partagée par les prescripteurs. Cette variable semble essentielle dans l'observance médicamenteuse et surtout dans la relation thérapeutique.

Les travailleurs de la honte. Les malades mentaux du PIB

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Université du Québec à Montréal, Montréal, Canada

Dans tous les pays, les soldats revenus de guerre sont décorés et jouissent d'une reconnaissance publique. Les mutilés, les estropiés oui, mais pas les blessés nerveux. Tous ceux qui ont été traumatisés par le spectacle quotidien de l'horreur de la guerre, il fallait les cacher, parce qu'ils renvoyaient une autre image du front (Guillemain and Tison, 2013. *Du front à l'Asile 1914–1918*. Paris, Alma éditeur, 415 p.). L'histoire les appelle «les soldats de la honte». Ils sont des antihéros qui ne méritent pas la pension d'invalidité qu'ils réclament (Le Naour, 2011 *Les soldats de la honte*. Éditions Perrin, 276 p.). Cette épreuve de l'épouvante qu'est le champ de bataille a des airs de ressemblance avec certains milieux de travail actuels. La guerre peut rendre fou, le milieu de travail aussi. Ces travailleurs de la honte, nous les appelons dans cette communication les malades mentaux du PIB. Actuellement, il existe beaucoup de travailleurs ne pouvant pas subir le stress constant associé à leur emploi. Ils souffrent de troublent anxieux, de *burn-out* et s'absentent de leur travail. Assez souvent, ce sont même des professionnels, des soignants, des techniciens, divers corps de métier confondus, de 35 ans et plus qui ont traversé avec succès plusieurs épreuves de la vie, qui n'ont jamais imaginé un jour être traités de «fous» et qui appréhendent tout d'un coup une carrière brisée. Ils perdent la face aux yeux de leurs collègues, deviennent la risée de tous. Selon Santé Canada, sur 1000 travailleurs, une vingtaine vivra un arrêt de travail pour un problème de santé mentale. La durée moyenne des interruptions est de 65 jours. En plus des absences, la dépression entraîne le présentéisme. Souvent les employés pensent que la dépression va passer comme un mauvais rhume. Ils ont peur d'être mal perçus dans l'entreprise, c'est pourquoi trois individus sur quatre n'iront pas consulter un médecin (Journal des Affaires, 3 août 2011). La stigmatisation que vivent les travailleurs s'étant absenté en raison d'un trouble mental courant s'exprime, selon nos résultats, sous le sceau d'un double discrédit: (A) moral c'est-à-dire des individus considérés comme des simulateurs prêts à feindre un problème de santé mentale pour bénéficier d'un temps de répit payé, (B) capacitaire, c'est-à-dire le travailleur dans une situation de disqualification professionnelle au nom, bien souvent, de la «nouvelle» vulnérabilité psychologique menant au «tablettage», au déclassement professionnel, à la retraite anticipée. Cette communication présente les résultats d'une recherche intitulée «La stigmatisation des personnes aux prises avec des troubles mentaux dans les domaines du logement, de l'emploi et des médias de masse». Notre collecte de données comprend 30 entretiens semi-dirigés auprès d'employés de retour au travail après une absence pour des problèmes de santé mentale. Les sujets à l'étude sont des agents des métiers relationnels en santé et en éducation au Québec. Dans cette communication, nous exposerons l'analyse des résultats à partir de 4 axes: (1) la stigmatisation des troubles mentaux au travail, (2) de la prise de conscience d'un soi altéré au diagnostic de trouble mental, (3) la prise en charge médicale et socioprofessionnelle du travailleur (4) le retour au travail et les effets de l'étiquetage diagnostic et du congé maladie.

Les représentations sociales comme déterminant de la stigmatisation: traitement médiatique de la folie au Québec entre janvier 2009 et janvier 2015

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Les problèmes de santé mentale sont devenus un sujet de société et d'actualité de plus en plus médiatisé. Désormais, comme l'explique Bertini: «les pathologies mentales sont conviées à s'exposer, à se donner à voir, jusque dans les détails les plus singuliers» (Bertini, 2010). «Fragments d'une économie biopolitique de la lutte contre la stigmatisation», pp. 117–134, dans Giordana, J.-Y. (dir.) La stigmatisation en psychiatrie et en santé mentale, Elsevier Masson, 241 p.). De plus, malgré le nombre élevé de patients psychiatriques vivant dans la communauté depuis plus d'un demi-siècle avec la politique de désinstitutionnalisation, le grand public ne semble les rencontrer le plus souvent, qu'à travers les médias. Régulièrement, la presse écrite ou la télévision se fait l'écho d'un fait divers impliquant une personne souffrant de troubles mentaux. Et, depuis un demi-siècle à travers un angle de prise de vue inchangé, les malades y sont décrits comme des personnes imprévisibles, violentes, dangereuses. Selon le médecin-psychiatre Giordana (Giordana, 2010). «Le rôle des médias», pp. 35–44, dans Giordana, J.-Y. (dir.). La stigmatisation en psychiatrie et en santé mentale, Elsevier Masson, 241 p.), les descriptions et qualificatifs à propos des personnes ayant des troubles psychiques oscillent entre la peur et la dérision, entre l'épouvante et le ridicule.

Pour cette communication, nous présenterons les résultats d'une étude portant sur les représentations sociales véhiculées par le discours médiatique (la presse écrite), discours reconnu aujourd'hui comme influent dans la manière dominante de se représenter la maladie mentale et les personnes qui l'incarnent. Plus spécifiquement, notre étude porte sur l'analyse des faits divers répertoriés dans les journaux nationaux et régionaux du Québec et impliquant des personnes aux prises avec des troubles mentaux faisant face à la justice.

Nous présenterons comment les stratégies discursives employées par la presse consistent à ranger et à catégoriser les personnes aux prises avec un problème de santé mentale ayant commis un acte criminel du côté de l'inhumain et du monstrueux. Par ce processus, toute part d'humanité est niée laissant place à un vide dans la capacité à nous représenter ces individus comme pouvant être nos semblables (Kalampalikis et al., 2007). «De l'effet médiatique au fait politique: la santé mentale en question», L'Information psychiatrique, 83(10), pp. 839–843). Ensuite, nous verrons que dans leur tentative de profilage, les médias se penchent sur tout ce qui paraît hors-norme, déviant, inadapté, inusité et laissent de côté tout effort de contextualisation pouvant rendre compte de ces comportements. Au contraire, les lunettes utilisées pour définir le profil de l'accusé sont leurs propres normes, normes qui participent en dernière analyse au déni de reconnaissance de cet «autre».

Breaking down barriers: integrating research assistants into clinical teams

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Background: Mental health research investment is disproportionately low in relation to the relevant disease burden. This may be due to a lack of funding compared to other specialties as well as undoubted cultural issues within the NHS. A major obstacle appears to be the lack of integration of research into clinical services. Oxford Health NHS Foundation Trust has taken the innovative step of creating a dedicated research team to challenge this. Seven researchers are based within clinical services across the organization and work daily with those delivering clinical care. This team aims to embed research into clinical practice and increase service user participation.

Method: A number of approaches are used; direct communication with clinical staff regarding studies, "brokering" between research teams and clinical teams as well as direct communication with patients. There is also a strong focus on increasing patient involvement by attendance at public meetings. The researchers act as the key point of contact within clinical teams for any queries that arise, and they handle the referral process for patients, thus streamlining the pathway to recruitment. The researchers are supported to carry a small clinical caseload to develop their skills and to further enhance integration. They also operate True Colours, an online self-monitoring tool that promotes self-management of patient's symptoms. These activities free up clinician time and help to build positive relationships with both staff and patients.

Progress and outcomes: The initial barriers within clinical teams surrounding workload pressures, acceptability to patients and ambiguity around the researcher's responsibilities are being gradually eroded as clinical staff grow increasingly aware of the benefits to patients and the interest generated by the projects. Clinical staff report being more aware of research in general, as well as specific studies, and patients are more likely to be able to access novel treatments. Oxford health is now the top recruiting mental health trust in England, with a strong mixed portfolio of studies. Moving forward these roles aim to further improve participation, increase awareness, and as a result, gain further funding to conduct mental health research to improve the services and treatment we provide.

Introduction to new impulsivity scale and its relation to SOGS-RA and gambling activities among polish adolescents

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Gambling is becoming a serious problem among adolescents. This situation is partly related to easy on-line access to different kinds of gambling activities. Impulsivity is one of risk factors associated with gambling. The purpose of this study was to test a new Polish impulsivity scale (SPIM) addressed to adolescents and correlate its results with SOGS-RA (South Oaks Gambling Screen-Revised for Adolescents) and gambling activities undertaken by adolescents. The scale consists of 16 questions with 3 distinguished factors of impulsivity (cognitive, behavioural, emotional). There were 629 adolescents (mean age 16.9; 269 females; 360 males) who took part in the study. The results revealed that SPIM has good psychometric parameters (Cronbach's alpha = 0.87). Furthermore SPIM correlates with SOGS-RA. During the presentation the most common gambling activities presented by Polish adolescents and their relation to impulsivity will be discussed.

Conversion disorder: a review through the prism of the rational-choice theory of neurosis

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Conversion disorder remains a mystery that has only become more complicated with the decline of the scientific status of psychoanalysis (e.g., Piper et al., 2008, Rofé, 2008) and recent neurological findings suggest that this behavior is controlled by biological mechanisms (Van Beilen et al., 2010). Moreover, existing theories have difficulty explaining the efficacy of various interventions, such as psychoanalysis, behavior therapy, drug therapy and religious therapy. This article reviews research and clinical evidence pertaining to both the development and treatment of conversion disorder and shows that this seemingly incompatible evidence can be integrated within a new theory, the Rational-Choice Theory of Neurosis (RCTN; Rofé, 2010). Despite the striking differences, RCTN continues Freud's framework of thinking as it employs a new concept of repression and replaces the unconscious with self-deception. Moreover, it incorporates Freud's idea, implicitly expressed in his theory, that neurotic disorders are, in fact, rational behaviors.

Taking into account social/emotional difficulties in the treatment of alcohol-dependence

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Alcohol use disorder (AUD) is among the most frequent disorders worldwide and a disorder with an important mortality and morbidity, that causes an important burden to society. AUD and other addictions are, also among psychiatric disorders, the ones presenting with the highest treatment gap. This presentation will develop the different factors involved in the developement of social isolation in this population and how these factors may contribute to the treatment gap.

Among the different factors, a specific attention will be given to the sensitivity of AUD subjects to ostracism, while AUD and other addictions are subject to an important stigmatization from the population and also from the professionals working in the care system. Shame and autostigma have also been evoked as important factors to social isolation and reluctance to seek treatment. Studies that have tested the affective factors that most easily lead to drinking have pin-pointed the importance of social factors and self-stressors. Besides these dimensions that are due both to societal and individual factors, one should also pay attention to social cognitive abilities that have been shown to be impaired in AUD: the deficits are observed at the attentional level (difficulty to interpret the emotions of others), at the level of theory of mind, of humour, of distinguishing self-perspective from the perspective of others. Finally, general cognitive and executive deficits have been related to limited abilities for readiness to change and deficits in autobiographic memory to difficulties for disease recognition.

Special attention should be given by professionals involved within the care system to AUD patients, in order to develop specific approaches that would decrease the treatment gap.

Le traitement des troubles post-traumatiques: une experience clinique partagee basee sue la personne

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Notre groupe de travail, à partir des connaissances à ce jour concernant le champ de la psychotraumatologie, depuis environ quinze ans a développé son propre projet clinique interdisciplinaire. Les données et les réflexions relatives au rôle de la mémoire implicite et des automatismes interpersonnels qui en dérivent, nous a conduit tout d'abord à accorder une attention particulière à la modalité d'accueil (modalité d'accès, style communicatif, organisation du lieu dédié au soin) avec le but de favoriser la syntonisation relationnelle entre thérapeutes et patients. À notre avis l'analyse de ces modalités implicites du fonctionnement dans la relation de soins constitue une première étape essentielle dans la construction d'une alliance thérapeutique positive. En ce qui concerne la prise en charge, parallèlement à l'évaluation clinique traditionnelle des problèmes actifs (fondée sur le modèle biopsychosocial élargi aux aspects environnementaux, familiaux et psychocorporels), nous avons privilégié une approche personnalisée visant à individualiser le canal communicatif propre à chaque patient et en développant le setting en conséquence. Les interventions proposées (qui peuvent être associées à des collaborations de réseau) prévoient une psychothérapie individuelle avec une définition du style d'attachement et des défenses prévalentes, une psychothérapie de groupe, de couple et/ou de famille. Une intervention psychopharmacologique peut y être associée. Des techniques psychocorporelles et/ou d'expression artistique peuvent être employées utilement (comme en témoignent les images représentées sur le poster) dans le projet thérapeutique en contribuant à la reconnaissance, l'élaboration, l'intégration des vécus conflictuels dissociés ou scindés responsables de la souffrance et du dysfonctionnement.

Mental health and quality of life among thai psychiatrists

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Objective: To survey the mental health and quality of life among Thai psychiatrists.

Method: This cross-sectional descriptive study. The postal survey was mailed out to all Thai psychiatrists. The 3 part of questionnaires were a demographic data, WHOQOL- BREF-THAI and SCL-90-R-Thai edition. Correlation analysis was set up at 95% CI and $p < 0.05$.

Result: Response rate was 28% from 650 psychiatrists. The respondents described normal state of mental health but female psychiatrists had trend to more suppress the psychological symptoms than male psychiatrists. The most of mental problem that might disturb male psychiatrists under stress condition was obsessive compulsive symptoms. Female psychiatrists had tended to be disturbed when distress by anxiety, somatization, phobia, depression, and paranoid respectively. The quality of life (QOL) was in the average level (77.5%). The older psychiatrists had higher QOL than younger psychiatrists significantly ($p = 0.027$) QOL correlated significantly with not getting enough support from work place ($p = 0.007$) Better life quality s' group had better in social relationship and satisfaction with the environment.

Conclusion: Thai psychiatrists had mental health status within normal range. Male psychiatrists had obsessive compulsive trait in stress response, but female psychiatrists had more various traits. Thai psychiatrists'QOL was on the average level.

Pain behavior: new aplication of dire scale in patients with chronic pain syndromes

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Summary

Relevance: Pain behavior formation in patients with chronic pain depends on the interaction of a number of biological, psychological and social factors, among which patients' emotional state is dominated. Based on multifactorial nature of subjective pain perception and response, specific pain behavior is formed in some patients with chronic pain syndrome (CPS) and interferes with the healing process or significantly extend.

Aim: of the study was to assess predictors of forming pain behavior in patients with CPS, depending on the presence of comorbid psychiatric disorders such as depressive episode (MDD), generalized anxiety disorder (GAD), and anxiety-depressive disorder (ADD).

Methods: Were analyzed by socio-demographic characteristics and pain features in 135 patients with CPS non- cancer genesis and the non-psychotic mental disorders. A survey was conducted on a DIRE scale.

Results: Socio-demographic characteristics and individual CPS features had no significant effect on the formation of pain behavior. The presence of the non-psychotic mental disorders (MDD, GAD ADD) in subscale risk factor of DIRE scale significantly ($p < 0.05$) associated with pain behavior. The total score of DIRE scale in its reverse interpretation also indicates the tendency to the formation of pain behavior (MDD 11,7; GAG 11,8; ADD 11,3 VS CPS 19,0; $p < 0.05$).

Conclusion: It is necessary to diagnose the non-psychotic mental disorders (MDD, GAD, ADD) in patients with CPS to identify the risk of pain behavior formation. Possible extension of DIRE scale clinical application is to identify the pain behavior propensity in patients with CPS.

Keywords: mental disorders, chronic pain syndrome, depression, anxiety disorder, pain behavior

The main psychological predictors of poor adherence to antihypertensive therapy

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Introduction: Hypertension is a key risk factor for stroke, ischemic heart disease, other cardiac diseases, cerebrovascular diseases and renal failure. Despite the availability of effective drug therapy, more than half of all hypertensive patients do not receive treatment. Patient adherence to drug therapy has been recognized as one of the major reasons why antihypertensive therapy fails.

Poor adherence to treatment is the most important cause of uncontrolled blood pressure, accounts for substantial worsening of disease, death, and increased health care costs. Factors associated with nonadherence are multilevel, they relate to the patient, provider, health care system, health care organization, and community. Usually the therapeutic collaboration between doctor and patient is determined by subjective severity of symptoms. Typical model of therapeutic behaviour is based on patients taking drugs in the case of episodic health worsening. Many patients have negative attitudes towards taking medication, especially if they feel better.

The internal picture of the disease plays a key role in the behavioural pattern of patients during the treatment. The patient follows the doctor's recommendations only with a clear conscious understanding and acceptance of the disease and its implications for health.

Objective: To improve adherence to the treatment of hypertension by determining its psychological factors and by the development of psychocorrective program for patients.

Materials and methods: The research conducted in 2011–2013. 203 patients with essential hypertension and without any complications or end-organ damage participated in the study (average age was 53,5 ± 4,5 years), of which we selected 150 patients with low and medium adherence (Morisky 8-Item Medication Adherence Scale). These 150 patients were randomly assigned to two groups: the main group (participated in the program and received antihypertensive therapy, $N = 77$) and the control group (received only antihypertensive therapy, $N = 73$).

Results: The psychological predictors of poor adherence to antihypertensive therapy include the following personal characteristics of patients: a low level of intensity of attitude to health, internal type of subjective control, a low endurance to stress, strain of defense mechanisms, emotional instability and self-esteem, impulsivity, nonconformnism, tendency to independence, stability of attitudes, commitment to relying on their own experience, conflict behavior, rigidity, self-centeredness, introversion, the need for updating their own individuality, lack of deepening into serious problems. Designed psychocorrective program, based on cognitive behavioural therapy, was aimed at transformation of lifestyle of patients, formation of a conscious aspiring to health, mastering patients coping skills and improve communication capabilities. The program included individual and group regular contacts between the therapist and the patient for one year. Subjects treated with the psychocorrective program showed a significantly higher reduction of systolic and diastolic blood pressure than patients of control group.

Conclusions: The following research contains determination of psychological factors of adherence and influence on them by the created psychocorrective program. Designed psychocorrection showed high efficacy and, ultimately, improved the prognosis of the patients.

A new request to the social psychiatry in Ukraine: stress and post-traumatic stress disorder. What readiness?

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Introduction: Psychologists, psychotherapists and psychiatrists faced with a new important problem in modern Ukraine. This is unpreparedness for the massive social demand for psychological and psychiatric care for patients who underwent powerful stress and distress in a situation of war and radical social changes in the country.

Objectives: Identify the problems and prospects of providing professional psychological, psychotherapeutic and psychiatric care for patients with stress disorders.

Methods: We analyzed data from open sources of the Internet in Ukraine and the United Nations.

Results: Nowadays To date in the area of military conflict abides (fighting) 50,000 soldiers (their families remain in a situation of waiting and anxiety stress – about 200,000 people). In the area of conflict participates about 5,000 volunteers. Already killed 6,000 people, including 1,500 military personnel. Were displaced (internal migration) 1,000,000 people, of whom 200,000 children and 120,000 disabled persons and the elderly. About 2 million civilians remain in the conflict zone.

We modeled probability of developing stress disorders in Ukraine next 5–10 years on the example of countries participated in military conflicts (United States, Israel, countries of the Balkans, Russia, Georgia, Armenia). According to the most optimistic forecast, we expect that about 500,000 people will have problems social disadaptation, delinquent behavior, PTSD, psychosomatic disorders (mainly cardio vascular pathology, gastrointestinal problems, lung disease). Currently in Ukraine from our personal experience following problem:

Currently in Ukraine there are the following problems: a lot of enthusiasm and volunteerism, and little professionalism; unpreparedness of social and clinical psychologists to work with stress disorders; unreadiness of personnel primarily clinical psychologists and psychotherapists in somatic network; lack of national protocols of PTSD diagnosis, treatment and rehabilitation; lack of permanent training system in PTSD for clinical psychologists, psychotherapists and psychiatrists; lack of social services outside of health facilities to provide the accompanying psychological and psychotherapeutic support; lack of effective multidisciplinary teams of professionals working with trauma; lack of available both scientific and popular literature on PTSD, psychosomatic disorders.

Conclusion: We need systematic training of specialists in stress and PTSD with their periodic professional development. Necessary to develop a national protocol for PTSD and the appropriate modernization of Ukrainian health care system.

Adding music therapy and speech therapy to those who are in psychological distress

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We will demonstrate in this paper the importance of therapeutic action that allows contact of the subject with reality through music, which has the effect of promoting physical, emotional and psychic perception. This allows a change of meaning and coping with new situations that surrounds the subject in a creative or artistic way.

The therapeutic action that uses the sound elements is breaking paradigms in order to access and promote the welfare of those who are in psychological distress. Such therapeutic action has the intention of facilitating social inclusion through the sound language and spoken language, allowing the communication in the family and social environment. The promotion and the restoration of those with mental disorders allows the recognition of the self through the internal and external sonorization, encouraging and stimulating global communication, modifying and allowing signifier and signified the biopsychosocial context.

The singing breaks barriers to the ones who live under the stigma of psychological distress

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The art of singing can help individuals suffering from psychological distress to recover their health by breaking barriers and developing their creative potential, which allows them to give meaning to themselves. Thus, music presents itself as a singular expression on its external and internal dimension. With such uniqueness, creative potential can be developed through sound language and vocal range, recovering the individual's subjectivity as well as their self-esteem, autonomy and citizenship in the family and social context. Furthermore, the individual can establish emotional meaning to communication channels and a greater contact with reality, which helps to boost the changes and prevents the upsetting thoughts.

Due to the therapeutic potential of music, Music Therapy was implemented two years ago at the Psychological Care Center "Professor Luís da Rocha Cerqueira" – CAPS Itapeva, São Paulo, Brazil. CAPS was the first institution to perform in Brazil, in 1987, after the psychiatric reform, the assistance of individuals suffering from severe and persistent mental illness.

The Therapeutic Choir "Vozes Cantantes", created by the music therapist, enables the individual in psychological distress to overcome the stages of inner development in order to easily deal with their feelings, reaching a biopsychosocial and spiritual maturity both internally and externally.

CBT for post-traumatic stress disorder after mild traumatic brain injury: pilot study results

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Background: Cognitive behavioural therapy (CBT) focused on trauma is recommended for treatment of post-traumatic stress disorder (PTSD) NICE and APA guidelines. Despite large evidence-based information in this field a little data is published about CBT use in patients with comorbid PTSD and post-concussion syndrome after mild traumatic brain injury (mTBI). It is important to insure that such treatment will be effective in patients with these conditions.

Methods: 12 combatants meeting research diagnostic criteria for PTSD (from 6 weeks to 3 months after trauma) and post-concussion syndrome were randomized to receive brief CBT with usual care ($n = 6$) or usual care alone ($n = 6$). The primary outcome measure was improvement on the Clinician-Administered Posttraumatic Disorder Scale (CAPS) and the secondary outcome was improvement in Rivermead Post-Concussion Symptoms Questionnaire (RPQ). Brief CBT consisted of 4–5 session lasting from 1 to 1.5 hours. CBT was provided by trained physician and the program comprised psychoeducation about the trauma, Jacobson progressive muscle relaxation, imaginal exposure and cognitive restructuring of irrational beliefs.

Results: There was statistically significant improvement in both groups. CAPS score decreased by a mean of 38% in CBT group and by a mean of 20% in a treatment-as- usual group. Posttreatment mean changes on CAPS scale in CBT and treatment-as- usual group were 30,6 and 12,4 respectively with statistically significant difference between groups ($p < 0.05$). 5 patients from CBT group had total score on CAPS <20 points (asymptomatic or only few symptoms) while only 2 patients from treatment-as- usual group had total score less than 20. Before treatment according to RPQ all patients had moderate problems with symptoms. RPQ after treatment showed, that 4 patients from CBT group had mild problems with symptoms and 2 patients had symptoms but they have resolved; in the treatment-as-usual group 5 combatants had moderate problems with symptoms and only one had mild problems with symptoms ($p < 0.05$).

Conclusion: The current pilot study suggests that PTSD following mTBI can be effectively treated with brief cognitive behavior therapy.

Aggressiveness in schizophrenia: truth or myth?

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Introduction: Patients with schizophrenia are often perceived as aggressive and dangerous. Fear of being labelled has shown to delay the seeking and/or discontinuing the treatment, was associated with higher suicidal rates, less probability to find work, more social isolation and fewer relations. The aim of this study was to evaluate aggressive symptoms in deinstitutionalized schizophrenia patients using the Positive and negative syndrome scale (PANSS).

Methods: Forty stabilized DSM-IV diagnosed schizophrenia outpatient (20 women and 20 men) were clinically evaluated using PANSS-EC, a previously validated subscale of the PANSS that consists of 5 items: excitement, tension, hostility, uncooperativeness, and poor impulse control. Where the level of severity is as follows: 1 = absent, 2 = minimal, 3 = mild, 4 = moderate, 5 = moderate- severe, 6 = severe, and 7 = extreme. All patients were stabilized on one or more atypical antipsychotics, with no medical or neurological diseases and no concomitant axis-I or axis-II disorders. Patients with comorbid substance abuse were not included in this study.

Results: From the 30 clinical items evaluated by the PANSS, PANSS-EC items had the lowest severity scores (absent or minimal). Hostility ranked last 30/30 (mean = 1.82, SD = 1.02); uncooperativeness 29/30 (Mean = 1.85, SD = 1.21); excitation/hyperactivity 26/30 (mean = 2.15, SD = 0.98); tension 18/30 (mean = 2.68, SD = 1.01); poor impulse control 20/30 (mean = 2.59, SD = 1.13). Delusion ideation ranked first 1/30 (mean = 3.35, SD = 1.20), followed by hallucination (2/30) (mean = 3.30, SD 1.34), disorganization (3/30) (mean = 3.18, SD = 1.10), emotional withdrawal (4/30) (mean = 3.18, SD = 1.27), and blunted affect (5/30) (mean = 3.15; SD = 1.30).

Conclusion: Our results support the need to increase public awareness about the nature of schizophrenia, notably its changing face especially in the presence of more efficient medications, socio- cognitive rehabilitation therapies, individual and group psychotherapeutic programs, and patient aide programs.

Comparisons of non-disease mortality levels in Europe

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Introduction: The mortality rate from external (non-medical) reasons greatly reflects the socio-economic, socio-cultural and psychosocial conflicts in the society. The most striking reflection is the level of suicides, especially hidden ones. Overall, in the world more people die from suicide than from wars and violent killings combined. Experts believe the number of suicides could grow back in half by 2020. Official statistics of suicides includes only clear-cut cases of suicide, so the actual number of suicides is much greater than official figures – is that every year in the world more than 4 million people commit suicide. According to legal experts, the cause of most so-called "death by misadventure" (drugs overdose, traffic accidents, and so on) actually is suicides.

Methods: We analysed the most recent data available from open sources Eurostat and State Statistics Service of Ukraine (year 2011).

Results: According to analysis 2011-year data of external causes of death (A00-Y89 excluding S00-T98) (crude death rate by residence), top 5 countries in Europe comprise Bulgaria, Ukraine, Serbia, Latvia and Lithuania (respectively 1464.71, 1454.05, 1422.33, 1387.91 and 1339.12 per 100.000 people). Separately by rating of suicides (intentional self-harm), the top 5 countries – Lithuania, Hungary, Latvia, Slovenia and Ukraine (respectively 33.26; 24.20; 21.51; 21.48 and 19.63 per 100.000 people). However, largest share of suicides among all deaths (in%), the top 5 countries includes Lithuania, Slovenia, Belgium, Ireland and France (respectively 2.48; 2.36; 2.03; 1.94 and 1.93). Ukraine and a number of other, mostly post-Soviet countries, characterized by a high level of hidden suicides. In particular, Ukraine is in third place in Accidental poisoning by and exposure to noxious substances (14.01 per 100,000) and Transport accidents (V01-V99, Y85) (12,69 per 100,000 people). For these categories, respectively, ahead of Ukraine are only Estonia, Latvia (20.63 and 15.03) and Romania, Poland (12.89 and 12.73). According to the aggregate indicator of overt and covert suicides (Mental and behavioural disorders due to use of alcohol (F10) + Drug dependence, toxicomania (F11-F16, F18-F19) + Accidental poisoning by and exposure to noxious substances (X40-X49) + Transport accidents (V01-V99, Y85) + Intentional self-harm (X60-X84)) Ukraine is also on the 3rd place (48.52 per 100,000) after Lithuania (61.43 per 100,000) and Estonia (53.27 per 100,000). In 2013 the overall increase in suicides in Ukraine was + 0.7, a decrease of hidden suicides reached –1.5 per100 000 people. Additionally, in Ukraine we noticed a decrease in suicides by 2.4% and hidden suicides by 19.8% over last 5 years.

Conclusion: The high level of mortality from external causes mainly in post-Soviet countries reflects the incompleteness of the socio-economic, socio-cultural, psychosocial transformation and the presence of intra social conflicts.

Forecast: In 2014–2015, Ukraine has a difficult situation due to the military conflict in the east of the country: we foresee the worsening psychological and mental health of the Ukrainian population and an increase the suicide rates, including hidden suicides, especially among war veterans and internal migrants in nearest few years.

Psychosis risk syndrome: a controversy update

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Schizophrenia is a chronic psychiatric disorder that generally begins in early adulthood and often has a devastating lifelong impact on self-esteem, social abilities and work capacities of the affected subjects. In the last two decades, several sets of diagnostic criteria aiming to identify "high-risk patients" were developed and applied in clinical studies revealing short-term rates of onset of psychosis in the selected subjects ranging from 20 to 40%. However, the introduction of "Psychosis risk syndrome" as a diagnostic category in DSM5 triggered an inflamed controversy and the proposal was finally postponed. Instead, "attenuated psychosis syndrome" was included in section III of the new-published manual as a condition for further studies.

"Attenuated Psychosis Syndrome" is a clinically useful concept, identifying individuals who present a higher likelihood of developing a psychosis spectrum disorder in the years following the first contact with a mental health facility, if no treatment strategy is proposed. However, its inclusion in the newly published DSM revealed a series of potential pitfalls such as deleterious side effects of early antipsychotic treatment and the increase of stigma.

In this poster, we highlight the advantages and risks of the early assessment of psychotic symptoms and we discuss therapeutic options, both psychosocial and pharmacological.

Luminotherapy as a non-pharmacological treatment of seasonal depression in a community ambulatory psychiatry center

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Introduction: Seasonal affective disorders affect 2 to 3% of the general population and may be due to the increase in melatonin secretion provoked by the decrease in ambient light during the winter. Many studies have demonstrated the efficiency of luminotherapy in the treatment of sleep and mood disorders, especially of seasonal affective disorders with remission rates up to 80%. Luminotherapy is an interesting treatment alternative to traditional antidepressants because of its fast efficacy (as of the first week of exposure) and fewer side effects. The goal of this study is to describe the introduction of a luminotherapy clinic in a community ambulatory psychiatry center.

Methods: From October 2014 to March 2015, among patients regularly followed at a community ambulatory psychiatry center in Geneva, all patients with seasonal affective disorders and without ophthalmological disease were selected for inclusion in a pilot program of luminotherapy. The luminotherapy exposure consisted of 30-min sessions, 5 days a week for 4 consecutive weeks. The MADRS, SIGH-SAD and morningness-eveningness questionnaires were assessed at baseline and after 4 weeks of exposure.

Results and Conclusion: 14 consecutive patients were included during the study period. All patients completed all 4 weeks of treatment. All patients were very satisfied with luminotherapy and showed an overall increase in the psychometric testing.

Symptom checklist-90-revised rating scale: a data mining approach

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In this paper were applied Machine Learning and Data Mining methods to capture the psychological age group of students 18–26 years. For recording, tracing and evaluation of the psychological condition, was used the standardized scale Symptom Checklist-90 (SCL-90), which examines a wide range of psychological problems and symptoms of psychopathology.

The methodology adopted, in first phase consists of electronic questionnaires, which were created and posted through the website http://www.cicos.gr. Subsequently data were collected and preprocessed from the questionnaires and then introduced into the Weka (Waikato Environment for Knowledge Analysis) Machine Learning Platform for analysis and extraction of useful knowledge. More specifically, through using classification algorithms (ID3, C4.5) there was a production of prospectively decision trees. Decision trees are a powerful way in order to represent and facilitate statements analysis (psychological) principally, comprising successive decisions and variable results in a designated period.

Furthermore, clustering technique (*K-Means* algorithm), was applied, which is a well- known knowledge discovery process of extracting previously unknown knowledge, actionable information from very large scientific and commercial databases. The *k- means* is a very popular algorithm and one of the best for implementing the clustering process. Also, the parameters of the algorithm were set, depending on the application cases, and also the results were correlated with the birth-place and the place of present residence, educational background of both the respondents and first-degree relatives, professional occupation of parents and other parameters, in order to evaluate and assess the significance of exported rules / conclusions. In addition, the respondents were classified into clusters based on 9 clinical signs (subscales) of the scale SCL-90.

The results indicate among others, that the use of Data Mining methods is an important tool to export and receive the conclusions and decisions especially in the field of psychological assessment and in neuroscience.

Psychopatology in obese candidates to bariatric surgery; the Italian experience of the "obesity path"

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Obesity is a major public health concern worldwide because of rapid growing of prevalence and somatic comorbidities. Bariatric surgery has been shown to be effective in long term weight loss and it is indicated, according to the international guidelines, for patients with BMI>35 kg/m2 with severe comorbidities and for patients with BMI>40 kg/m2. Our University Hospital has created a specific *Obesity Path* where a multidisciplinary and multimodal approach is guaranteed. Therapeutic team is composed by different sanitary professionals and used different therapeutic approaches. It includes the psychiatrist and psychological support is provided throughout the path. This work aims to estimate the prevalence of psychopathological symptoms in severe obese patients selected for bariatric surgery. From June 2014 to March 2015 we enrolled 191 consecutive patients; 100 patients arrived from outpatient service; 91 patients were hospitalized for obesity comorbidity. Psychiatric assessment, socio-demographic, psychosocial and anamnestic variables were recorded on the basis of a psychiatric talk, a non-standardized questionnaire and psychometric assessment, including the latter the following tests: SCL- 90, EDI-2, BUT, BES, BDI, MMPI-2. Despite all guidelines suggesting a multidisciplinary evaluation for the obese patient only 26% of our sample had met a Psychologist either a Psychiatrist before. According to psychiatric assessment, 35% of the outpatient sample and 13,2% of the inpatient sample presented a psychopatology contrasting immediate bariatric surgery; in particular: around 24% of the outpatient sample presented an Eating Disorder according to DSM-5; data from the analysis of psychometric assessment of 120 person report: 28,3% of the sample had a pathological score in BES; 21% had a symptomatic score at SCL-90 (GSI>1); 33% presented depressive symptoms according to BDI; 36% had an elevation of the 1.Hs scale in MMPI-2, 16,7% had an elevation of scale 3.Hy and 14,2% had a symptomatic elevation both in 1.Hs and in scale 3.Hy (1-3 CODE). With the exception of very severe cases requiring a "life-saving" surgery, according with International Guidelines and Multimodal-approach, these patients were offered an integrated treatment before surgery. According with the assumption that behavioral and psychological factors play an important role in the surgery success a psychological support is suggested after surgery to every patient. Our data support the hypothesis that a multidisciplinary assessment in Weight disorders and early psychiatric intervention/psychological support in the treatment is recommended as a form of prevention from both development of further psychological problems and severe obesity. Regarding bariatric surgery a multidisciplinary assessment and integrated treatment encourage better compliance to treatment thus reducing the risk of complications.

The man who was a blow torch. A clinical case and an intervention proposal

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In this poster we present a clinical case for a proposed integrated treatment in a patient with psychotic onset in the context of a borderline personality pattern.

Treatment regards cooperation of different kinds of professionals in addition to the psychiatrist, such as psychotherapist, local operator, and supervision group.

According to Fonagy's mentalization theory and the role of mental images in Jung's Analytical psychology, the purpose was to make the patient able to represent his own state of mind instead of acting it.

To obtain this goal, an important instrument could be really supervision group such as a safe space in order to elaborating, mentalizing, symbolizing the patient's fragmented imaginary.

Empowerment – ein Weg zur Entstigmatisierung der psychisch Kranken und der Psychiatrie

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Trotz langjähriger Bemühungen zur Entstigmatisierung psychisch Kranker stellen Ausgrenzung, Zurückweisung und soziale Distanz gegenüber psychisch Kranken weiter ein bedeutendes und aktuelles Problem dar. Außer der am stärksten betroffenen Gruppe der psychisch Kranken unterliegen auch die Berufsgruppe der Psychiater, psychiatrische Institutionen und die psychiatrische Behandlung einer Stigmatisierung in der Öffentlichkeit. Stigmatisierung kann zu Resignation, Zunahme von psychiatrischen Symptomen und Passivität führen. Ein Empowerment der Psychiatrie und ihrer Patienten kann hier helfen, die Stigmatisierung zu verringern und zusammen mit Gesellschaft und Politik die Lebensbedingungen unserer Patienten zu verbessern: Empowerment kann zu erhöhtem Selbstwirksamkeitserleben führen, Hoffnung geben und eine aktive, optimistische Lebensgestaltung fördern. Das im Alltag führende Modell des emanzipierten informierten Patienten und die Wirksamkeit psychiatrischer pharmakologischer und nicht-pharmakologischer Therapieverfahren sollten mehr Bekanntheit erreichen, um überholten Vorurteilen entgegenzutreten. Eine integrierte, patientennahe und humanere Psychiatrie kann helfen, die Stigmatisierung der psychiatrischen Institutionen zu verringern. Um wirksame und überdauernde Verbesserungseffekte bezüglich der Stigmatisierung der Patienten in ihrem Lebensumfeld zu erreichen sind allerdings gemeinsame Bemühungen von Psychiatrie und Politik notwendig.

Einführung einer integrierten psychiatrischen Versorgung

Regula Lüthi
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In der Schweiz sind psychiatrische Institutionen immer noch mit einer hohen Bettenzahl ausgestattet und die Behandlung findet in erster Linie stationär statt. In verschiedenen Kantonen sind die letzten Jahre erfolgreiche Modellprojekte gestartet, die eine integriertere Versorgung anstreben. Betten werden abgebaut und stattdessen ambulante und aufsuchende Angebote ausgebaut. Diese Veränderungen erfordern eine sorgfältige Planung innerhalb der internen Strukturen und im externen Bereich. Sowohl die Mitarbeitenden der stationär ausgerichteten Psychiatrie als auch die Zuweisenden müssen sich an ein neues Behandlungsangebot gewöhnen, in dem die passgenaue und rasche Zuteilung der Patientinnen und Patienten in das Setting ihrer Wahl die grösste Rolle spielt und nicht die Frage, ob eine Patientin in ein spezifisches Programm passt oder nicht. Diese Veränderungsprozesse erfordern von allen Beteiligten eine hohe Flexibilität, ein Einbinden aller relevanten Kräfte und eine Portion Beharrlichkeit. Die Referentin berichtet aus eigenen Erfahrungen beim erfolgreichen Umbau.

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