Bethel Clinic for

Psychiatry and Psychotherapy

Concept

Evangelisches Krankenhaus Bielefeld
within the
von Bodelschwinghschen Anstalten Bethel
and the Evangelische Johanneswerk

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Preface to the 2nd Edition by the executive board

Even today clinical concepts in the field of acute intervention cannot be taken for granted. Classically occupational groups in a hospital were more likely to orientate themselves using medical teachings or routine procedures. However slowly, under the premises of the unstoppable quality management and forced by political pressure, a rethinking process has been initiated.

What was accepted in wide areas of somatic medicine, had already taken a different development in psychiatry. The Bethel Clinic for Psychiatry and Psychotherapy has held a high reputation for its conceptual work for many years, doubtlessly representing one of the best known institutions of its kind in Germany. The simultaneous medical and therapeutic approaches, roles and functions of the different occupational groups, models, evaluation and research and not least economical considerations have become constituents of a general concept now available in a revised edition.

The clinic's task is the psychiatric care for citizens of Bielefeld and the surrounding area. Demographical and political changes in Germany are often reflected by the epidemiology of psychiatric diseases. A widely known example is the increasing importance of gerontopsychiatry. With this new edition of their concept the clinic has made it clear that they are facing up to social challenges and actively seeking answers to new questions, always with the view to assure the best possible care for their patients.

Nowhere else can one find the wide range of diagnostic and therapeutic possibilities as matured as here, no other field of assistance in a hospital shows so many individual approaches and options between in-patient, partly in-patient and outpatient care. This holistic approach stands within the tradition of our Christian deacon self-conception. At the same time the active research conducted at the clinic emphasises – the research department has just celebrated its 5th Anniversary – the modern orientation to the requirements of an academic teaching hospital.

I wish all members of staff the strength to convert this comprehensive concept in their daily practice and the courage to continually modify this concept within the scope of improvement

as they have demonstrated over the past years. I am already looking forward to the third edition.

Rolf Eickholt
Executive Director

Preface to the 2nd edition by the clinic administration

We are pleased that the concept of the clinic has received notable attention and has appealed to professional groups, organisations, patients, family members, associates and many others who have shown interest during the first three years following its publication. It would seem that it has managed to fill a gap. As announced in the first edition in 2003 we compiled and published a three yearly report showing the actual development of the clinic in the form of facts and data covering the period 2000 – 2002. Both the concept and report are publically available on the internet (www.evkb.de). We have also included an internet presentation of our scientific and publication activities, which are continually updated.(www.psychiatrie-forschung-bethel.de)

Even though the basic principle of our work remains unchanged, there have been substantial alterations regarding structure and content in the last three years which have made it necessary to provide a revised version. First the name of the clinic has changed, we are now called, "The Bethel Clinic for Psychiatry and Psychotherapy". This change on 1st January 2005 was brought about by the amalgamation of three evangelic hospitals in Bielefeld (Krankenanstalten Gilead, Krankenhaus Mara and the Ev. Johanneskrankenhaus) and has become the Evangelische Krankenhaus Bielefeld GmbH (EvKB), a hospital providing maximum care.
In the process the administrative centres were dissolved and the term solely used for main emphasis on medical functions across the clinics and institutes of the EVKB. Together with the clinic for psychotherapy and psychosomatical medicine we now form the centre for psychosocial medicine. Another structural change resulted from the taking over of the Pniel Clinic (medium-term treatment and rehabilitation) within the scope of a new management agreement. Also a series of staff changes have occurred, amongst others, Professor Rau left the clinic in January 2006 and on this occasion we would particularly like to thank him for his participation in the preparation of the first concept and the revised edition presented here.

Improvements and restructuring processes within the clinic and in cooperation with our partners have kept us busy and will continue to do so in the future. Work in task defined projects has proved exceedingly valuable in the past years and has led to a reduction in

regularly held committee meetings. On the other hand, the number of clinical, care-orientated, scientific and organisational projects has increased significantly.

With these changes our major concern has been primarily to take into account the patients' perspective in terms of the person-centred approach and to increase resources for work with our patients.

Bielefeld March 2006

Prof. Dr. Martin Driessen	Petra Krause	Dr. Georg Kremer
Senior Consultant	Head of the Nursing Service	Spokeman for the Psychosocial Therapeutic Services

Preface to the 1st edition by the executive board

Practise requires theory and vice versa. As a university teaching hospital, the Krankenanstalten Gilead gGmbH is committed to a permanent exchange of science and research. Our actions are deeply rooted in the christian idea of man. Our missionary imprint places great demands on our actions which can only be met by a constant process of development and revision of evidence based concepts in our medical centres and by adjustment of organisational structures, supporting the implementation of our concepts in practice.

The concept of the centre for psychiatry and psychotherapeutic medicine is remarkable for two reasons. In the process of extensive reorganisation of the Krankenanstalten Gilead, aiming to achieve quality improvement by integration of our services in medical centres and focal points, the CPPM orientates itself as the first and largest centre on a broad cross-departmental concept. Conceptually, principles are put to the fore, which have additionally become operational guidelines in other fields: a holistic, therapeutic approach and participation of patients in the therapeutic process in partnership. In somatic fields we often talk about the “mature patient”. Particularly in psychiatric care this pretension places high demands on us and that is why it is so crucially important.

I would like to thank the management and all staff members for their commitment and their impressive work and I wish them the strength to implement this consent in their everyday life.

Franz Streyl

Executive Director

Preface to the 1st edition by the clinic administration

We are pleased to present the new concept of the Centre for Psychiatry and Psychotherapeutic Medicine of the Krankenanstalten Gilead, Bethel. It is partly based on the first concept from 1997 but has been extensively revised in most parts. We hope this concept will illustrate our tasks, objectives and methods to all who are interested and that it will facilitate the vocational adjustment for new members of staff. [1]
Our work is based on a bio-psycho-social basic understanding of mental disorders of man. In principle, all these dimensions play an equally important role, even if an individual case may show predominance of a single dimension. During the last years the religious-spiritual dimension has gained increasing attention but until today we were unable to reliably assess its importance for the therapeutic process.

Work in psychiatry and psychotherapy is subject to a permanent development process which has considerably speeded up over the last couple of years. Responsible for this development are the increasingly shorter periods of time during which new insights are gained from fundamental and applied research in our field. Significant changes to the health care system and its financing, as well as changes in health policy. Particularly significant for our work is the increasing demand for interaction in partnership between patients and therapists. This means a higher level of participation in decision making concerning the therapeutic objective and the therapeutic process by our patients associated with an increased amount of personal responsibility.

As a centre for the treatment of mental health problems we conceive ourselves as part of a cooperating network of institutions for psychosocial and somatic help for people with mental disorders. Additionally we are an active member of a network of scientific and health political institutions, without which positive advancements in therapy and care would not be possible.

During the ongoing process, the concept at hand may only be a snap-shot of the current state of discussion and may invite further debate and development of our work. We therefore

[1] generally we refer to both genders, but in order to facilitate readability we have limited ourselves to the usage of a single gender. Choice of male or female gender is random. It will only be specified in the text if only one gender is addressed

intend to update the concept every two or three years. In order to illuminate the progression in the Centre for psychiatry and psychotherapy to all interested parties, we will publish the biennial report 2000-2001 in the near future. In this report there are also details on the Project Gilead 2010, elaborating the following objectives for the entire hospital: highest quality for all patients, assurance of a high level of motivation and qualification for all members of staff, expansion and attainment of a strong and characteristic position in the market, creation of cost-effective structures and production of steady earnings, and optimization of the team-oriented process flow. Additionally defined sub-projects and structures have been developed in this project.

Our aim is to encounter the people treated or working in our hospital with dignity and respect and in an open friendly manner, at the same time respecting the cultural and religious values and norms of the various national and international communities.

We are extremely fortunate to work in a professional field in which the members of staff of every occupational group are creative, enthusiastic and highly committed to the care of the people seeking our assistance. To this end we would like to express our gratitude to them.

Bielefeld June 2002

Prof. Dr. Martin Driessen	Petra Krause	Prof. Dr. Harald Rau
Senior Consultant	Head of the Nursing Service	Therapeutic Director

1 Work Assignment

Our primary task is the psychiatric-psychotherapeutic treatment of all mentally diseased citizens of Bielefeld in terms of a regional care responsibility. This responsibility has been defined in an agreement between the v. Bodelschwinghschen Anstalten Bethel and the Landschaftsverband Westfalen-Lippe on 10. January 1985 and was implemented on 1. March 1985. Secondly our work assignment is conducted within the Social Security Law V, which defines the treatment for healing, alleviation or prevention from deterioration and which is accredited by the Health Insurers when the treatment is deemed necessary, purposeful, effective, sufficient and economic (§ 2,12). Accordingly we offer our inpatient and day clinic treatment for patient therapy only if other available outpatient therapy has proven to be insufficient. Inpatient and day clinic treatment options for patients can, on the other hand, offer a reasonable expectation of effectiveness. These options, however are normally only available for a limited period of time.

Furthermore our work assignment is derived from our integration in the medical-psychological care network in Bielefeld, first of all the integration in the Evangelische Krankenhaus Bielefeld (EvKB). Through this we are able to achieve an effective collective treatment of somatic diseases. Psychiatric-psychotherapeutic collective treatment of patients in somatic clinics is Bielefeld is ensured by our consultation service. Equally important for a coordinated collective treatment concept is the close cooperation with psychiatrists, neurologists and psychotherapists in private practices, in the future probably even within the scope of integrated care schemes.

Additionally our work assignment is determined by maintaining a close network with numerous social-psychiatric and psychosocial institutions in the von Bodelschwinghschen Anstalten Bethel[2], in the Evangelische Johanneswerk and in Bielefeld, particularly the advice centres and facilities of the outpatient and inpatient integration service and assistance centres for the elderly and those suffering from addictions. A considerable number of our patients with a complex need for assistance are referred from these agencies or, respectively, are assigned to them.

2 Refer to “Positionpapier: Hilfen für Menschen mit psychischen Erkrankungen, 2000”
„Positionpapier: Hilfen für alte und pflegebedürftige Menschen, 2002“

Forensic patients (patients with a hospital treatment order) are treated as in- and outpatients in our clinic for a limited period and, if their prognosis for a future law-abiding behaviour is favourable, treatment and rehabilitation close to the place of residence is expedient and practicable. In the meantime this practise has been regulated in agreements with the commissioner for hospital treatment orders of the federal state North Rhine Westphalia. Mentally diseased criminal offenders shall be given the opportunity to return to their communities and to live, as far as possible, a healthy life without punishment. In order to ensure continuing outpatient care for this group an additional forensic-psychiatric aftercare unit was established in the year 2004.

Another work assignment is performed by the Psychiatric Institute Ambulance (PIA), a Care unit which operates day and night. Parallel to psychiatric emergency treatment, it is available for patients with intense and/or complex psychiatric-psychotherapeutic therapy requirements.

The active and systematic participation in quality assurance and scientific research has obtained an increasingly higher significance for our clinic’s work assignment. In a continuing process of gaining insight, clinical application and subsequent evaluation, this participation has served the gradual improvement of our diagnostics and treatment and assures a high level of knowledge among our staff members.

2 Diagnostics and therapy objectives

Comprehensive diagnostics and differential diagnostics cover partly the field of mental disorders. With this, the coexistence of more than one mental disorder in a person plays a large role, since the so called co-morbidity may have significant impact on the course taken by the illness. Furthermore, together with disorders of somatic functions, diagnostics include an extensive description of the social, economic and occupational situation. The analysis of interactions between these different fields is particularly important. Developing a bio-psycho-social diagnosis is not only a diagnostic but also a therapeutic challenge and therefore constitutes a therapy objective to be explicitly stipulated. The bio-psycho-social- diagnosis is important not only for selecting the therapy elements to be used in the current treatment case, but is also an instrument for the patient and his social environment to expand his psychosocial resources beyond the acute therapy and thus preventing cases of recurrence. Developing a comprehensive psychosocial diagnosis often requires, in addition to direct therapeutic contact with the patient, standardized methods and behaviour study in different fields of life as well as consideration to the observations and experiences made by persons from the social environment of the patient (“external anamnesis”).

2.1 Diagnostic approach

Target-orientated psychiatric-psychotherapeutic proceeding requires careful diagnostic clarification from different points of view. On first contact in emergency situations top priority is given to securing physical existence in respect of medical-somatic diagnostics as well as clarification of self endangerment and/or endangerment towards others: normally on the day of admission initial basic psychiatric-psychotherapeutic and social diagnostics are conducted, followed by a physical examination. Further diagnostics are intensified as required by the individual problem. In doing so we act in accordance with the following guidelines.

2.1.1 Medical-somatic diagnostics

Basic somatic diagnostics consist of a physical, ie. general and neurological examination

on the day of admission, to be conducted and documented in a standardised way, as well as defined basic laboratory values and an ECG (with an evaluation of different parameters, in particular QTc-time) which should be conducted on the day after admission in the case of normal admissions, on the same day in case of an accordant indication and immediately in the case of emergency indications.

EEG- and imaging diagnostics of the skull (CCT or MRI) are conducted in the case of first-time diseased and first-time treated persons, respectively, at regular intervals (particularly in case of psychotic and depressive disorders and when there is suspicion of psycho-organically determined disorders.

New EEG- and imaging diagnostics may be abandoned if preliminary diagnostic findings generated in or outside the hospital are available, unless medical insight reveals a renewed indication.

In the case of an accordant indication, and if necessary after involving the respective consultation service, further medical examinations are conducted in accordance with the level of medical knowledge available. This is particularly common in the case of additional somatic diseases or in the process of psychiatric-psychotherapeutic therapies requiring elimination of specific somatic diseases (eg. previous exposure or electric convulsive therapy). Frequent methods of examination in our professional field are, for example, ultrasonography of the abdomen and cerebro-spinal fluid analysis.

In the process of treatment heart rate, blood pressure and weight are monitored at regular intervals, at least once every week. Medication which could lead to pathological changes of physiological parameters requires additional checks of heart rate and blood pressure, as well as ECG- and laboratory tests on a regular basis. Specific monitoring and continuous recording of vegetative and psychopathological symptoms is obtained by means of the alcohol detoxication scale enabling an appropriate adaption of therapy.

2.1.2 Psychiatric-psychotherapeutic diagnostics

First of all psychiatric-psychotherapeutic diagnostics include semi-structured documentation of the current anamnesis leading to admission and recording of the psychopathological

findings following the criteria of the AMDP-System ("Arbeitsgemeinschaft für Medizinische Dokumentation in der Psychiatrie") in a standardised form. Further particulars of the anamnesis are taken down using a semi-structured anamnesis questionnaire which may initially be filled in by the patients themselves. Missing information will be completed when the patients are talked through the questionnaire in detail by the responsible therapist or, if applicable, the primary nurse. In combination with medical-somatic findings one or more working diagnoses are developed. Psychiatric diagnoses are generated following the criteria-orientated (operationalised) diagnosis system of the WHO ICD-10, Chapter F. For this purpose so-called diagnosis checklists are helpful which lead to a significant increase in reliability and validity. In situations of inadequate operationalisation by the ICD-10, the criteria of the American DSM-IV are used for diagnostics. In individual diagnostically difficult situations additional standardised interview methods are used (for example, SKID-1 and SKID-II or DIPS).

Behaviour analysis has shown itself to be necessary and helpful in many cases in order to be able to understand the situational and biographical conditions of actual experiencing, thinking and behaving. Similarly teaching patients to perform behaviour analyses themselves has shown to be helpful and effective and raises the patients awareness of their backgrounds, triggering mechanisms and perpetuating factors of undesired and desired behaviour.

For many years the OPD-system (Operationalisierte Psychodynamische Diagnostik) has provided an instrument for psychodynamic diagnostics reproducing for the first time explicit criteria for the psycho-diagnostic field. This is achieved in the dimensions disease appraisal and conditions for treatment, relationship, conflict, structure and psychic-psychosomatic disorder.

Alongside the diagnostics of psychosocial problem areas and personal deficiencies, the diagnostics of personal strengths ("resources"), which are systematically observed and recorded, have gained increasing importance for an adequate treatment strategy.

Different standardised diagnostic instruments are used depending on department and disorder, for example, BDI (Beck Depression Inventory), symptom and change-of-mood journals, as well as the recording of activities. Standardized primary diagnostics used at the beginning

and the end of treatment are the rule showing the therapeutic processes more objectively. Excluded are crisis interventions lasting only a few days.

2.1.3 Neuropsychological diagnostics

Many mental disorders are accompanied by neuropsychological disturbances of memory or concentration. Investigations of these symptoms have important differential diagnostic implications and serve the mapping out of a therapeutic strategy. In the clinic neuropsychological diagnostics are realised in a graduated concept, ranging from short standardised examinations and simple questions to examinations lasting several hours, individually adjusted to the patient and using very complex questions. Additionally memory consultation hours in our outpatient clinic offer extensive diagnostics including graduated neuropsychological examinations. Accordingly, the examinations are performed by staff members ranging from trained personnel through to neuropsychologically trained psychologists (clinical neuropsychologists). We offer professional supervision for all staff members working in neuropsychology. The department for research, quality assurance and records holds copies of the most important methodology in their library. In the case that the need for a neuropsychological diagnostic cannot be fully met within our own facilities due to a lack of space, patients can be examined in the neuropsychological outpatient's clinic at the Bielefeld University.

2.1.4 Social Diagnostics

Standardized social diagnostics providing detailed knowledge of the conditions of the immediate social environment (family, occupation, leisure time) as well as general economic conditions of patients are required. This is typically carried out by social workers and social pedagogues and includes the regular recording and completion of a detailed socio-biographic anamnesis. In order to obtain a complete and valid overview it is useful to collect and document information provided by dependants, custodians, ambulatory attendants and so on. The clinic participates in a standardised assistance strategy IBRP ("Integrierter Behandlungs- und Rehabilitationsplan", a scheme established in Bielefeld, to assist ambulatory and day patients with complex needs, who require further social assistance following their treatment.

2.2 Therapy objectives

Therapy objectives play a decisive role for therapy motivation, indication, strategy and the therapeutic process not only from the perspective of the therapist but also from the subjective perspective of the patient. Our therapy objectives are pursuant with our work assignment in principle the healing and alleviation of current as well as the prevention of renewed illness or deterioration of psychic disorders. However behind these global and plausible objectives, a complex arrangement of different objectives at different levels is concealed:
Short-term, medium-term and long-term objectives, minimal- maximal- and optimal-objectives, reference - vague – precise objectives, direct- indirect therapeutic objectives, Internal (=intervention) objectives – external objectives (therapy objectives), therapeutic objectives – patient objectives – common objectives, patient objectives – dependants objectives.
That is why the coordination process between the persons involved is so important. Therapy objectives must be worked out cooperatively in the first phase of therapy, well clarified and constantly reassessed. Therapeutic processes often take an unfavourable course if lack of clarity or unexpressed contradiction exists between the involved parties.

All therapies we administer are generally based on a classification differentiating between the following three phases of therapy:

1. Phase of stabilisation, diagnostics and therapy prearrangement
2. Phase of therapy and change
3. Transfer phase

The second and third phase will be discussed in more detail in the following two chapters. The phase of stabilisation, diagnostics and therapy prearrangement includes the planning of therapy objectives as an integral part. Diagnosed psychosocial deficiencies and resources play an important role during the joint formulation of these therapy objectives. Therapy research shows particularly that these coping skills are used in the patients everyday life, bearing the result of previous skills. The “resource-orientated” approach contained in our therapy concepts are based on this knowledge.

Determination of the therapy objective

Determination of the objective itself is regarded as an objective whose relevance is often underestimated. It deals with objectives of the patient, his custodians if applicable, his dependants and the therapeutic team as well as the coordination process between those involved.

In exceptional cases the psychiatric-psychotherapeutic treatment “only” consists of very short-term stabilisation during a psychic and/or physical crisis, for example an acute intoxication. In such short-term interventions further therapy objectives only have to be agreed in so far as they ensure subsequent necessary ambulant treatment.

Given the chronic progression of many mental disorders it is normal to follow the phase of acute stabilisation by a phase of therapy during which those psychological problems may be addressed which trigger such crises and/or which prevent patients from coping reasonably with such crises. In such cases it is necessary that the respective problems are identified in cooperation with the patients and precisely defined objectives are agreed with regard to the individual difficulties. Therapy objectives have to be as concrete (operational) as possible to enable the patient and the team of therapists to easily determine at any time to which extent the objective has been achieved. The definition of unambiguous and clear cut therapy objectives increases the transparency of the entire therapeutic process for all involved persons and makes it possible to review the efficiency of the individual treatment.

When expressing the various therapy objectives prioritisation of these objectives is important. Top priority is the securing of physical existence. If this is achieved a therapeutic work alliance capable of working under pressure is formed, constituting the foundation for further development and stipulation of objectives.

Restoration of physical integrity

This is often the predominant objective at the beginning of treatment since a certain amount of physical integrity is a prerequisite for comprehensive diagnostics. This therapy objective plays a notable role for example in treatment of senior citizens, after intoxication, attempted suicide and in detoxification therapy, in addition to somatic diseases which could not be adequately diagnosed and treated previously due to mental disease.

Reduction of psychic symptoms, particularly depression and angst

Amelioration of symptoms is in many cases the most urgent objective according to the patients. For example spanning disorders, particularly depression and angst, play an important role. Often this objective to reduce the symptoms is associated with a passive therapy expectation. If patients are able to replace the non specific objective to get rid of their symptoms by more specific objectives or at least are able to adapt their objectives, this may well be interpreted as partial success of the treatment. From a therapeutic point of view it is emphasised that not only negative ("behaviour degradation") but also positive objectives ("behaviour build up") are stipulated. For example the patients objective to "cure" his depression may be reached by giving up physical and social protection behaviour and by replacing it with physical exercise and social activities. Striving for the concrete objectives "build up of physical stamina" and "engagement in social activities" thus serves directly the objective of depressive symptom reduction. Formulation of specific objectives which can be achieved by the patient (possibly with assistance) demonstrates to those affected the influence of symptomatic behaviour and poses with that a contrast to the feeling of "learnt" helplessness.

Comprehensive understanding of the disease

In many cases the psychiatric-psychological treatment is impossible without active participation of the patient and parts of his social environment. Creation of a high readiness to actively participate and to assume responsibility is therefore of vital importance to the outcome of the therapy. Constructive participation in treatment and prevention however can only be achieved by the patients. If they "understand" the symptoms of their disease they are able to see it in a sense-making context. Information on their disease and its background is therefore a vital element of any psychiatric-psychological therapy. Therefore in line with psycho-education, our patients are confronted with a model of the disorder and the therapy and the prevention measures associated with it.

In addition to information about the disease and the associated therapeutic treatment it is often important for patients to be able to understand the symptoms of their disease in a biographical context. In this manner the symptoms appear more comprehensible, more calculable and consequently less threatening.

Coping with the disease

Aiming for a complete cure in the case of chronically physical and mental illnesses may appear unrealistic, given that in the nature of such illnesses the symptoms may re-occur. If the patient and/or the team of therapists strive for this unrealistic objective of a complete cure, each "relapse" and each recurrence of symptoms, respectively, will be experienced as a disappointment and the feeling of helplessness will be increased. Moreover, in many cases chronically physical and mental illnesses will lead to more or less severe consequences in various field of life ("after-effects"). For these reasons an important therapy objective in treating chronic illnesses is the acquirement of appropriate behavioural patterns in dealing with the illness and its after-effects. In possession of such coping strategies, a patient will have less fear of potential relapses and generally will be able to assess and control the illness more easily.

Coping with and managing mental strain

Generally psychosocial stress increases the chance of an outbreak of symptoms in many mental and somatic diseases, and in particular chronic illnesses. Therefore the analysis of coping abilities in dealing with psychosocial stress and, in many cases if applicable, the strengthening of existing abilities is an important therapeutic objective. Stress research has revealed that it is not only the characteristics of the stress factors ("stressors") which determine the amount of resulting stress. Alongside the perception of a situation as a stressor, the abilities available for coping with these stressors are the determining factor. Psychosocially aversive situations are less of a strain if one possesses suitable methods ("coping strategies") for dealing with them.

Favourable stress management is a frequent objective since unfavourable stress management plays an important role in the formation and in particular the preservation of mental disorders. On the other side favourable stress management is always advantageous in prophylaxis.

Coping with a Crisis

Most of our patients are admitted in the context of a crisis escalation. In this respect coping with a crisis is always one of several objectives (except for long term ambulatory treatment) For some of our patients learning to cope with an acute crisis is the primary objective of the treatment. This is, for example, in the case of short term crises following serious life events or for crisis escalations of a previously diagnosed chronically illness.

Activation

Since many disorders lead to retreat or inactivity, mobilisation on a physical, mental and social level is a frequent objective of therapy. Today we are aware that physical exercise has a favourable, ie. compensational and activating influence on our sensibility and behaviour.

Relearning favourable experiences, behaviour patterns and skills

From the perspective of the affected person, unfavourable behaviour patterns are often acquired in the course of psychological illnesses, which should be unlearnt and replaced by more favourable experience and behaviour patterns. Social retreat is frequent and can be understood, however unfavourable patterns, in addition to causing social isolation, mean that social skills are lost and convalescence is impeded. Therefore the relearning of basic skills eg. social competence is an important element of the overall treatment.

Relationship formation

Often mental disorders influence the experience and behaviour of the affected person in his relationship with his dependants, eg, in a partnership and/or in the family.

On the other hand a relationship has a considerable influence on the psychological condition. In many cases the therapy team recognise the need for action rather than the patients themselves. Modifications in the structure of relationships often have a favourable influence on sanity.

Finding a meaning

Psychological disease with all its consequences often leads to a breakdown of the inner perception which the affected persons have created of the world and of themselves, connected to this breakdown is a feeling of senselessness. Therefore finding a meaning plays an important role as a therapy objective and must include the persons religious spiritual level.

Making use of existing resources

A patient usually brings more than just his problems. Almost all patients possess resources (abilities, skills and a supporting social environment) which are important for recovery and later preservation of health. In some cases however, the affected persons are not aware of these resources because they are stuck in their own negative point of view. Therefore one therapy objective is almost always to rediscover jointly these resources and make them useful

for the individual person. Personal resources in combination with strengthening self-responsibility are always preferable to external help.

Reactivation and setting up of social networks, familial and professional reintegration

This involves reactivation of social networks if such networks generally exist, but have not been maintained due to social retreat. Even in the occupational sector jobs can be preserved more often than at first assumed. For families in distress it is an important objective to receive sufficient information and support. From a therapeutic perspective, the clarification and – if possible- the correction of problematic patterns of interaction are also frequent objectives. In the rare situation of total absence of a social network the objective must be to find new approaches.

Planning continuative measures

The objective of inpatient and partly inpatient treatment at our clinic is to plan and initiate the further necessary therapeutic, psychosocial, job-accompanying, care, and if applicable legal assistance. This objective is crucial for sustaining therapeutic success. On the other hand it is essential to avoid superfluous care and excessive “dependence” on the professional assistance network. The long term objective must always be the attainment of maximum possible autonomy.

3 Therapeutic Concept

3.1 Basics

Our therapeutic concepts are based substantially on basic scientific knowledge and the results of applied research in psychiatry and its related fields.

Sociological and socio-psychological research have shown on the one hand, the continuing impact of stigmatization attached to mental health problems in society with the result that many affected persons come too late for treatment. They point out however that a personal discussion on this subject can contribute to a reduction in prejudices. For the treatment to be effective, it is of great importance that the affected persons, their families, and if applicable, also the surrounding social and, for instance, the professional environment, are given sufficient chance to reduce their own fears of the mental disorder in order to develop an appropriate understanding of the disorder and be able to face the prejudices with self confidence. But also for other reasons the integration of the social environment, the treatment personnel and the caring facilities is required. Mental health disorders always develop and proceed in a social context, and therefore should be understood as a disorder of the social system. In the same way only well coordinated assistance of the participating institutions can be optimal. In the process the research must demonstrate if case management models can provide the optimal answer for critically and chronically ill persons or if coordinating functions such as mixed models are the superior response to the challenge in care.

The behavioural neurobiology has provided a continually growing knowledge on complex brain functions and their interaction with psychical experiences. In particular the cognitions on experience-dependant neuronal plasticity of the human brain demonstrate encouraging possibilities to realise positive change by new learning experiences, for instance in psychotherapy, and this (with limitations) up to old age.

Genetic research has shown the very different distinct influence of genes for the possibility to

suffer mental health disorders (genetic disposition or vulnerability)[3]. Even if it is considered that heredity is polygene for mental health disorders and that the disorders occur mainly spontaneously and not cumulative in the family, the genetic risk of children of patients is significantly increased for some disorders, mostly in relation to increased psychosocial stress ("vulnerability stress model"). This for instance should be taken into account if sick persons with an existing desire to have children, or the children themselves formulate a need for counselling.

Cognitions from therapy- and care research have taught us that some of the long practiced therapeutic approaches may be less effective and reasonable than previously thought while others prove to be more effective than thought possible. More therapeutic offers are not necessarily better than less, sometimes instead rather overstraining and thus counterproductive. In particular questions on therapy and care evidence-based knowledge are helpful. If available there is a need for constant self-critical dispute with our diagnostic and therapeutic action. There is a high and urgent further need for reliable knowledge in this field. This knowledge is available in a compact form amongst others by means of meta-analyses on the highest level (eg. the Cochrane Library) or current guidelines (eg AWMF = Arbeitsgemeinschaft Wissenschaftlicher Medizinischer Fachgesellschaften or NICE = National Institute for Clinical Excellence) available in our institution together with a multitude of current journals and reference books (increasingly available on line).

However this does not mean that clinical knowledge and experience will become unnecessary, quite the contrary: knowledge, experience and personal engagement of every individual member of staff will in the future continue to be an indispensable prerequisite to allow for the complex situation of every individual patient.

[3] The historical experiences from the period of national socialism have shown that a science that considers the patient to be an object of research runs the risk to turn against the human being. Due to the reform movement in psychiatry it came to a critical work-up of this history as well as the humanisation of care and treatment for mentally ill persons, establishing the basis of our clinical work today.

3.2 General characteristics of our therapeutic concepts

Therapeutic concepts must always meet some basic conditions to be reasonable and helpful.

- They must always be seen from the patient' view, since what finally counts is what reaches the patient.
- They must consider the patient's environment and include it if possible
- Target- and problem related therapeutic concepts have to be developed and realised. For this reason we have developed indication-based domains of emphasis
- Therapeutic concepts must be as clear, unambiguous and precise as possible to be transparent and comprehensible for our patients, co-workers and particularly new co-workers.

"Precise" in this context means that the individual steps and procedures are shown. This is achieved on the one hand by therapy standards (practice guidelines) which illustrate the most important work processes in detail, and on the other hand by utilisation of therapy manuals developed and modified respectively in other institutions or our own clinic.

From this it can be derived that our therapeutic work is executed in a structure of medium to high degree. This method of working is highly advanced in many areas but still requires further development in others. Next to contextual clarity the structure of processes in the treatment fields is important for our patients who generally come to us in a critically mental condition where lack of clarity and structure of the inner- and/or outer world are essential characteristics and are often accompanied by fear.

In this case reliable structures and equally friendly and competent treatment staff are helpful. Next to reliability, structured work also releases resources, creating more space for consideration of individual particularities.

Structured and indication-related concepts save resources because they simplify the workflow process. This is especially important in times of limited resources of manpower.

The door should be open wherever possible. This creates both confidence and calmness and gives our patients more personal responsibility than previously was imaginable in psychiatry. Thus with two exceptions all our wards are open. These exceptions exist for the ward for

qualified drug withdrawal where the closed door particularly protects against unrequested visitors from outside and one ward for disoriented dementia patients.

Therapeutic concepts usually describe the activities of a multi-professional medical team and must be integrated into the actions of the team respectively. To reasonably create preparation of a bio-psycho-social diagnosis and therapy it is important to coordinate the different specialist approaches and perspectives in a patient-related way. This process is reflected in the coordinated tasks of the different occupational groups. In the process the number of influence factors affecting the patients must be taken into consideration. On the one hand there is the therapeutic space in the narrower sense and on the other hand the real space (see fig 1) The real space is determined by internal conditions (eg. ward regulations and given processes, everyday needs etc.) and external conditions (for instance family etc). On the other hand the interactions between the patients play an essential role and considerably influence them. The more open the treatment system the more the factors have an effect. Clear focal points can be seen in the fields of work of the different occupational groups despite considerable overlapping. Thus doctors, psychologists, ergo-, music- and physiotherapists are working more in the therapeutic space and nursing staff and social workers more in the real space.

To optimally organise the care of our patients work procedures are needed that accommodate the targets clarity and transparency, security and continuity of relationships.

The method of working with the Primary-Nurse model as an organisational system in care and the model of therapeutic case responsibility of doctors and psychologists is realised.
This means that for the patients one primary nurse and one therapeutic staff member are the most important members of the therapeutic team. In some areas the mentor model is added on the (co-) patient level.

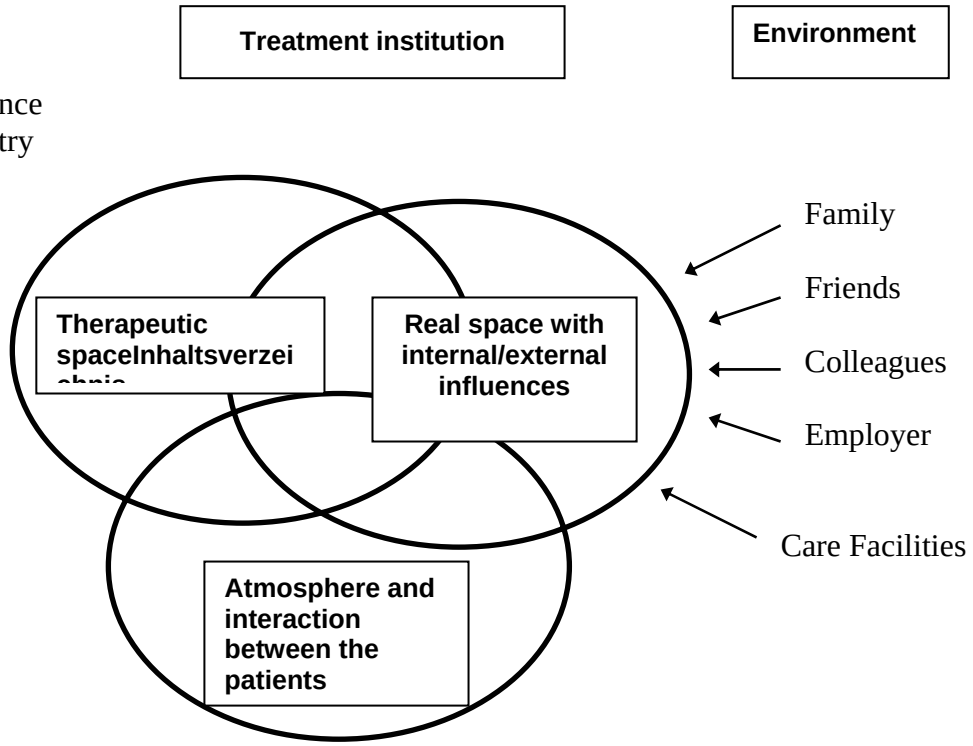

Figure 1
Spaces and influence factors in psychiatry and psycho-therapy (modified according to Wolk)

3.3 Psychiatric Care

Care forms an important part in the interdisciplinary treatment process and supports and accompanies, respectively, the persons entrusted to their care in their effort to remain balanced psychically, physically and socially and to find a new balance. The relationships between nursing staff and patients have a special therapeutic importance. Based on a collection of information as needed in negotiations with the patient, the objective is to plan measures of care which are orientated to the resources and problems. The care-therapeutic portion within the multi-professional medical team does not only focus on the treatment-relevant illness, but care includes in its considerations the individual illness process graph as well as important social and domestic contextual factors. This occurs against the background the hospital will accompany and treat the patient in the scope of a chronically continuing illness only for a limited time, but the actual centre of personal activities outside the hospital is also considered when selecting the measures. Thus the patient is involved as an active partner in the determination of care measures as well as in checking the objectives.

Psychiatric care participates in the scope of the treatment in process control and is responsible in cooperation with the other occupational groups that the patient is optimally led and

accompanied through the treatment process. Here it is necessary to continually improve coordination processes within the interdisciplinary team as well as with further internal and external service providers, to eliminate negative external influence factors as far as possible. To cope with these requirements, care offers a differentiated qualification profile covering the range from housekeeping up to highly specialised activities. Care is organised in such a way that each patient is allocated a responsible nursing staff member, accountable for the care plan and essential aspects of treatment coordination. Thus the structure of a trustful and continuous relationship is assured and the number of contacts in the interdisciplinary team – and consequently of potential interfaces – is reduced. The accomplished care interventions are constantly checked for their efficiency by a quality assurance system. Furthermore, new cognizance of (care)-science is adopted in the treatment for the purpose of continuous further development. Cross linking of care with national and international care-relevant institutions supports the exchange of management and staff and thus contributes to a contemporary development.

Following Viktor v. Weizsäcker, a member of the nursing staff is less an “achiever” but rather a “provider”, for example, the person is not offering care because he/she knows better what the patient needs, but rather helps the patient to perceive self-help and self-care possibilities.

3.4 Therapeutic case responsibility

The therapeutic responsibility for each patient rests with one person in the ward, normally a doctor or a graduated psychologist, sometimes a social pedagogue with additional therapeutic qualifications. This therapist is the key contact for the patient in all therapeutic matters from the admission examination (except for emergency admissions) until discharge. She coordinates her work closely with the responsible primary nursing staff member (PN) so that an unambiguous and clear competence exists. The therapist is also responsible for written correspondence with all departments within and outside the hospital, while the primary medical matters are always undertaken by a doctor.

This procedure has the following advantages:

- The development of a confidential relationship is established

- The continuity of treatment and care is assured
- There is more transparency on the therapeutic responsibility for the ward staff
- The medical activities are conducted by doctors, psychologists are available with respective share services for other activities (ie group treatments, psychological tests/ examinations)
- Staff shortages are reduced
- Doctors and psychologists lead the whole spectrum of diagnostic and therapeutic techniques in psychiatry and psychotherapy

Table 1 lists the therapeutic activities and responsibilities.

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3.5 Mentors

We have introduced a system of mentors and tutors in some wards to facilitate the entry for new patients into the often strange and incomprehensible routine of the hospital. Patients who have been undergoing treatment for a longer period and are thus experienced, and who are prepared to be available as a contact for new patients with inhibitions, assists during the first few days by answering their questions as far as possible, showing them the clinic facilities or facilitating the contact to the team. This system brings advantages for the experienced patients changing them from the role of the needy to that of an active helper, by experiencing their own competence and thus testing a changed perspective. For the new patient the mentor may help them to swiftly gain a feeling of security and to experience the perspective of the co-patients. Previous experiences with this model are positive and we are striving to introduce it to other wards.

Concept Bethel Clinic for Psychiatry and Psychotherapy, Bielefeld Evangelic Hospital

3.6 Treatment agreements – confidence building measures

As long as there is some scope for decisions, most people who are treated as patients like to participate in the responsibility for determining therapy objectives and methods of treatment.

In psychiatry, compared with many fields of somatic medicine, the chances for patients to use their influence have in the past been slight. Acute admissions in psychiatry are characterised by numerous stressful symptoms, such as fear, changed perception of reality and occasional self-endangerment and/or endangerment of others, and possibly connected with coercive measures. Many affected patients in the acute admission situation feel helpless, misunderstood and faint and are unable to adequately explain and represent their wishes. Due to their experience many patients come too late for treatment and often against their will. To change these dynamics, a joint initiative by the society “Experienced persons in psychiatry” and the staff of the clinic developed and introduced a “Treatment agreement in acute psychiatry” in 1994.

Since then it is possible to make written agreements on possible conditions of admission and treatment between former patients and the responsible ward team in the clinic in the case of future psychiatric treatment as an in-patient. This is not a matter of a one-sided declaration of intent but a partnership with a common intent, to improve the conditions for admission and treatment in the psychiatric clinic in terms of shared decision making. The therapy teams consider the possibility of the treatment agreement in principle with all patients with a foreseeable chronic course of illness and will inform the patients accordingly.

Another model of treatment agreements was developed in the department "Addiction." At the end of an in-patients stay, relapse and crisis situations are retrospectively analysed on a behavioural level and crisis plans are agreed in which the clinic, together with other helpers, actively participates. Agreements are made, in writing if applicable, before discharge, which on the one hand require the patient to utilise his/her own resources but on the other hand, assure as a precautionary measure supplementary assistance if the patients strategies of accomplishment are overstrained. Thus, in the best case, patients will contact the clinic in good time, before an impending lapse or shortly after to avoid a severe relapse. Patients with suicidal tendencies learn to recognise mental crises early and to contact the clinic before an escalation of the crisis. Relatives of patients with behavioural difficulties find back up for overstrained situations through comparable crisis arrangements. For the affected patient it is not a matter of handing over responsibility but rather to actively learn new behaviour, to improve their own competence – with support – and to develop an increased degree of self-responsibility, autonomy and independence.

3.7 Out-patients - Day Clinic patients - in-patients treatment: the therapeutic setting

The treatment offered by the Clinic for Psychiatry and Psychotherapy Bethel covers all sectoral types of treatment common in psychiatric-psychotherapeutic treatment

- Out-patients,
- Day Clinic patients,
- In-patient treatment and
- Rehabilitation

as well as a gerontology-psychiatric day care and the out-patient rehabilitation of persons addicted to alcohol in cooperation with the Bethel out-patient addiction aid.
Many of our patients do not require this overall spectrum of therapeutic measurers but use only one or two of the treatments offered. Other patients however have to make use of several forms of treatment. In these cases the form of interface, ie, the transfer between the treatments is important.

Generally the emergency treatment in a crisis situation must be distinguished from a treatment planned for a lengthy period. Accordingly, the treatment objectives and possibly the duration of treatment are different.

Because our clinic treats mainly persons with chronically illnesses, the majority of our patients undergo regular out-patient treatment. This may be in the private practice of a neurologist or psychotherapist. Some of these patients treated by specialists are additionally treated in our psychiatric out-patients department which provides, for example, diagnostics, group psychotherapy or special social worker services, which doctors in private practice may fall back on. In these cases co-treatment can take place in our psychiatric out-patients department.

The out-patient treatment – whether through our out-patients department or through established neurologists - is accepted as the key treatment level for each treatment measure. This is where the long term attendance of the patient, the planning of therapy objectives and contacts to various areas of life and to the relatives is established.

Day Clinic patient treatments may replace in-patient treatments or follow them if the daily distance to and from the day clinic can be accomplished and the therapy-free periods can be endured satisfactory. The treatment is effected on all working days, generally between eight am. and four pm. Thus corresponding almost to the structure of a normal working day. Since the staff members do not have to work different shifts, concentrated and continuous help is possible. A direct integration of the social environment is constantly given in diagnostics and therapy by the daily combination of therapy and a real home-like situation. Particularly when continuous maintenance of social references is especially important for people, (eg. care requirements for small children, specific socio-cultural background, stabilising security during illness), the day clinic offers an adequate form of treatment even in an acute phase of

illness or crisis. After all, day clinic facilities can be offered to people who would not be able to accept in-patient treatment when it is necessary to stay in a hospital as they would not be able to cope with the situation (for example, out of fear of social stigmatisation).

In-patient treatment is indicated only if other types of treatment are insufficient and patients require the complete care and treatment facilities of the clinic. Acute suicidal tendencies play an important role in decision making. In-patient treatment episodes are planned and organised except in cases of emergency admission in crisis situations. This planning procedure presumes contact between the allocated department and the person responsible for the admission into the clinic. If possible a preliminary out-patient discussion is held with the patient with a purpose of planning in-patient or day clinic in-patient treatment. This discussion enables both parties to get acquainted with each other, concepts are introduced and an initial understanding of objectives and therapy measures is made.

Elements of rehabilitation are found in almost all types of treatment, particularly in medium-term treatment. However explicit types of rehabilitation treatment are only offered on an out-patient basis to patients with addictions. Therefore patients requiring an explicit rehabilitation treatment will be referred to appropriate institutions.

With chronically ill patients it is particularly important to continuously adapt therapy targets beyond the individual treatment episodes and coordinate them with the participating cooperation partners.

3.8 Therapeutic methods

A multitude of treatment procedures is used for treatment of mental health problems. The origin and continuation of mental disorders take effect – roughly simplified – by the joint effect of biological, mental and social factors. Therefore biological, mental and socio-therapeutic therapy principles are used accordingly for the treatment and prevention of mental disorders. In this connection attention must be given that the individual therapeutic approaches are not carried out independently of each other. Indication-specific therapy concepts establish the framework for the individual therapy components, forming a reasonable mutual extension. The therapy objectives to be agreed at the beginning of a

treatment provide a further important reference for the composition of the therapy components. The therapy objectives will often change in the course of an overall treatment. A modified composition of the therapy components may then be required according to this change. The persons responsible for the case play an important role in determination of the therapy objectives and the overall therapy plan. The treatment team collect feedback concerning the course of the therapy from the individual therapy elements in the therapy discussions of each individual treatment unit which normally takes place weekly. In these discussions possible corrections of therapy objectives and the therapy plan are carried out

It should be annotated to the following classification of the therapeutic methods that those belonging to only one category do not exist. For example, the application of medicine often involves psychological participation (for example, subjective attribution of properties, placebo-effect, conditioned medical effects), which will add to the "purely" pharmacological potency. Thus the classification is just a rough attempt.

3.8.1 Biological methods

The biological therapy methods are based on the idea that individual physical function units are more or less directly influenced. This influence on the somatic level causes improvement of the mental condition, of specific symptoms and/or the state of activity.

Psychopharmacological therapy

The psychopharmacological therapy we use takes into account the current state of science. In a working group we have prepared a practical "Ratgeber Psychopharmacotherapie" (Berg et al. Darmstadt: Steinkopf Verlag 2002 – a reviewed edition is in preparation) because this knowledge is continually increasing and cannot be easily grasped by less experienced staff members With this we have, as far as possible, made an evidence-based choice of pharmacological strategies, enabling a consistent and transparent procedure for use in our daily procedures. An individually adapted psychopharmacological therapy requires a detailed medication anamnesis, also an external anamnesis from previous treatment, and if applicable a physical diagnosis for minimising the risk of side effects, a careful consideration with possible reservation towards recommended or necessary medication as well as an exact clinical observation of medicine intake and the occurrence of side effects. This is particularly essential for emergency- and compulsive medication. Required adjustments to medicines and

adjustment and change of medical doses is discussed in detail with the patients and, if possible, realised in the scope of a jointly prepared treatment plan.

In psycho-education (explanation and advice) patients will learn all the essential facts on the proven prophylactic effect of psychotropic for schizophrenic, schizoaffective and affective illnesses. The effectiveness and the undesired effects of drugs are discussed with patients in detail. Moreover, the choice of medicine in the individual case is subject to treatment agreements for possible future treatments for patients who repeatedly have to be hospitalized (see treatment agreements).

Despite this measure we have to accept that a large portion of the affected patients will, sooner or later, discontinue a long-term medicinal prophylaxis despite the knowledge of the effects of the missing treatment. This phenomenon, increasingly discussed in specialist literature, is little understood and is the subject of a current project and another project in concrete planning for our clinic.

Light Therapy

Light with a lighting power of at least 2500 lux for a one- to two-hour session per day has shown positive effect on depressive symptoms for seasonal affective depression (“winter depression”). Positive effects have recently been described also for depression, independent of seasons. We adopt this therapy particular in the dark months of the year because patients often experience light as comfortable and practically side effects do not exist.

Sleep deprivation (wake-) therapy

Depressive patients often have considerable subjective problems in sleeping and in the sleep-EEG (electroencephalogram) problems of the so-called sleep architecture. The sleep deprivation therapy has developed from the observation that refrain from the total night sleep or part of the night sleep leads to a considerable improvement of the mood and other depressive symptoms on the following day. We use the principle of partial wake therapy, ie. The patients do not sleep in the second half of the night. This treatment is currently organised in a group by staff members of ward A1 and is conducted under continuous monitoring and care in the rooms of the Occupation Therapy Gilead III.

Even if the subjective and also the observable improvement of symptoms is only short term, this first experience of amelioration is very important for the affected persons after often long depressive episodes and provides hope of a long lasting recovery.

Electric convulsion therapy (ECT)

The electric convulsion therapy, more frequently used in the English speaking and Scandinavian countries than in Germany, is based on the clinical observation that therapy-resistant and most severe depressive illnesses, as well as certain severe psychotic disorders, will show surprising and fast amelioration by ECT. Particularly for elderly patients with a raised rate of side effects under medicinal treatment, conduction of an ECT is an effective and by comparison, often a more gentle alternative. The principle of its effectiveness though is not yet comprehensively clarified. In electric convulsion therapy, an almost simultaneous electrical unloading of the neurones of the brain occurs by an individually determined flooding of electricity. The reorganisation of neuronal networks which takes place within the hours and first days after ECT is on a more favourable level than before treatment and may possibly account for the effectiveness, next to other effects. Each ECT treatment presupposes a detailed instruction and a special declaration of agreement by the affected person. The short-term narcosis is performed by an experienced clinic physician for anaesthesiology; the ECT treatment itself is performed by an experienced clinic physician.

In our clinic we use the ECT for the rare acute febrile and life-threatening catatonia (a sub-category of schizophrenia) and for therapy-resistant – or most severe affective disorders. The ECT is for affective disorders a means of third choice, more seldom also a means of second choice. Due to narrow application of indication we see a considerable and quick improvement in the condition of at least 50% of the treated persons (even for previous therapy-resistance). We rarely apply ECT for other chronic-psychotic conditions, only as a means of the last choice (ultima ratio).

Physical endurance training

Some mental illnesses, for instance, many fear disorders or even depression, with physical withdrawal behaviour, lead to a loss of physical endurance or fitness. On the contrary a good physical training status is a protective factor against a multitude of disorders. A mechanism for physical fitness to favourably influence mental health is to influence the stress system. In a well trained person, physical stress factors will only lead to minor physical stress response

(eg. increase of heart frequency) compared with that of untrained persons. The following activities are particularly used in our clinic to increase physical endurance: Bicycle ergo meter training, walking and swimming. After an encouraging pilot study we are now performing a large research project on endurance training in many areas of the clinic.

Bio-feedback

Biofeedback offers an opportunity to influence biological/physical processes non-invasively. The following physiological parameters can be gained via sensors and an appropriate measuring apparatus: heart frequency (photoplethysmographisch), pulse volume amplitude (photoplethysmographic collection of the capillary vasomotoric on the finger and the Arteria temporalis externa, respectively) electromyogram (EMG, surface-EMG on M. frontalis, M.trapezius, M. erector spinae, M. masseter as well as EMG of pelvic floor musculature via vaginal- or anal electrodes), and electric skin conductivity.

The awareness of often not realised physical processes and enhancement of desired changes allow patients to gain influence on the measured and feedback of physical processes. For this purpose the patients in individual therapies are given a computer-based feedback of the biological parameters and are encouraged to conduct the learned processes even without the bio-feedback arrangement in the intervals between the therapy sessions in the sense of transfer exercises (“dry run”).

Indications of bio-feedback are:

- Muscular-related pains for example, back pain, stress headache, facial and maxillofacial pain
- Vascular headache syndromes
- Bruxism (teeth grinding)
- All mental disorders associated with a raised state of excitement with the objective of the bio-feedback based relaxation induction
- All types of stress and impulse incontinence

Vagus nerve stimulation (VNS)

VNS is a method that electrically stimulates the vagus nerve in the area of the neck. For this purpose a small surgical intervention is carried out by a neurosurgeon where a stimulation electrode is positioned around the dissected nerve and the electric stimulation unit is placed in

the area of the chest muscle (similar to a cardiac pacemaker). The method of VNS has been used successfully for more than ten years in epilepsy. Patients suffering with epilepsy who have been treated with this method show an avoidance of seizures as well as experiencing an antidepressant effect. It can be considered confirmed that VNS is helpful for some severely depressive patients where other therapy methods have failed. We have conducted this therapy in cooperation with the neurosurgical clinic of the EvKB in individual cases for persons suffering from severe and therapy-resistant uni- or bipolar disorders.

3.8.2 Psychotherapeutic methods

Commonly, all therapeutic methods strive for change in thought, perception, experience and behaviour. In many cases chronic mental disorders are characterised by a limitation of the flexibility of these functions. Psychotherapeutic measures require active participation of patients. For this reason in each case, analysis or, if applicable, creation of a motivation for change, is made at the beginning of a psychotherapeutic measure. The further basis of each psychotherapeutic work is the creation of a trustful, empathic and stress-resistant work alliance between the therapist and the patient.

Psycho-education

In particular the patients' knowledge of their illness, its background, treatment and prevention is important for chronically physical and mental disorders. Comprehensive knowledge about the illness and its' treatment will increase the patients willingness to take effective medication. Furthermore, knowledge on the illness allows patients and their relatives, if applicable, to be more confident in deciding which measures they can conduct themselves and when the need for professional help is necessary. Therefore to impart respective knowledge about mental illnesses and their background (psycho education) is most significant for the treatment concept of our clinic. It is accomplished partly by in-patient as well as out-patient treatment. Although psycho education is important for all chronic illnesses, our clinic focuses psycho education on persons suffering from schizophrenic and schizo-affective and addiction. A work group under the supervision of G. Wienberg has developed a concept and published a manual for realisation "Psychoedukativer Gruppenarbeit mit schizophren und Schizoaffektiv Erkrankten" (PEGASUS). In accordance with this manual psycho educational group meetings are regularly held in Bielefeld. The concept has been adopted for in-patient use. Parallel

there are regular group meetings held ambulant for the relatives of schizophrenic or schizoaffected persons (PEGASUS-A). In the scope of treatment of patients with alcohol-related disorders PEGPAK was developed. (Psycho educational group program for persons with problematic consumption of alcohol – H. Westermann and T. Wessel). The basic components of PEGPAK are implemented in our out-patient, day clinic in-patient and in-patient treatments. The findings of the effectiveness of psycho education in the past years has dampened expectations. The involvement of relatives, although more complex, has proven to be more meaningful and efficient. In some sections we have already systematically implemented this approach.

Behaviour therapy – cognitive and multimodal approaches

The basic assumption of cognitive behaviour therapy is that all approaches of thinking, experiencing and behaviour are influenced by experience and training. From this point of view all symptoms of illness are considered as learned patterns of thought, experience and behaviour, which may have the function to compensate for other psycho-social deficits.

In the centre of cognitive behaviour therapy are the descriptions of the undesired and the desired thinking, experiencing and behaviour, jointly defined by the patient and the therapist as well as an individual analysis of personal strengths (resources) and weaknesses (deficits). In the next step, by application of training techniques the desired patterns of thought, experience and behaviour are systematically learned and automated so that they become applicable for as many spheres in daily life as possible. Situations frequently to be trained and the corresponding methods in terms of a multimodal behaviour therapy are:

Coping abilities	**Objectives**	**Therapeutic method**
Socially competent behaviour	Security in dealing with other persons	Group training in social competence
Problem solving	Systematic procedure in dealing with new situations	Problem solving training
Ability to indulge	Search for comfort, being able to enjoy, treat oneself to something pleasant	Indulgence training, euthymic therapy
Coping with crises	Possession of prepared quick solutions for difficult situations	Emergency management “ Emergency suitcase”
Coping with stress	Availability of different methods to cope with stress training	Stress accomplishment training

Table 2 Multi-modal behaviour therapy for different spheres

A fundamental characteristic of all training-related spheres of life is that the exclusive training in the therapy or group time is not sufficient. The motto “the actual therapy takes place between the therapies” emphasises the necessity of frequent training and sampling in situations of daily life (for instance domestic situations), similar to learning to play a new music instrument.

In cooperation with the Psychiatric University Clinic in Freiburg, the dialectic behaviour therapy (DBT) for the treatment of symptoms of borderline personality disorders in accordance with M. Linehan, has been adapted for in-patient conditions in our clinic. Individual elements of the DBT are conducted either as in-patient or out-patient treatment. A DBT Working Group offers staff members as well as psychotherapists in private practice the opportunity for exchange and further education. The DBT takes the handling of suicidal crises, para-suicidal and self-harmful behaviour very seriously. Triggered conditions and respective possible alternative patterns of behaviour are systematically prepared and trained. A modified DBT has also been developed for patients with additional addictive traits, and some elements have proved helpful for other patients with different general psychological disturbances, and to this end, they have been systematically prepared for this group.

Supportive psychodynamic therapy

The psychodynamic oriented psychotherapy methods are deduced from psychoanalytic theory and practice and are based on some common basic assumptions. These include amongst others:

- The topographic model which differs between conscious and unconscious (and pre-conscious) mental processes
- The instance model (id, ego, super ego) where the “ego” acts as the integrating and reality-oriented mental instance
- The conflict model which differs between intra-mental and interpersonal conflicts
- The defence model which represents healthy and disorder-relevant patterns of accomplishment from ambiguous and jointly incompatible intra-mental content
- The object relation theory which describes the intra-mental representation of significant other objects and the own person (self) and plays an important part for the theory of the borderline personality organisation

- The narcissism theory which describes the healthy and the disturbed development of the ego and self esteem

In the clinical practice we use these models partly in terms of a general therapeutic basic understanding for our patients. In doing so a psychodynamic way of thinking does not preclude theoretical learning and systematic considerations but supplements them in terms of a scholastic overlap and problem oriented approach. Such an approach has the advantage that it does not focus on theory alone but makes use of the theory and practice of different schools for the patients and their specific problems.

On the other hand the above mentioned models are converted into specific individual- and group psychotherapies for patients who are able to benefit from these types of therapy. The prerequisite requires amongst others, the ability to concentrate for at least a 50-minute therapy session, the absence of constant severe symptoms, an adequate degree of self-perception and self-reflection and the willingness and stability to tolerate and accept a new and sometimes painful perception of their own person and their relationship to important other persons.

Objectives of psychodynamic individual and group therapy are:

- perception of systematically distorted patterns of perception, experience and behaviour.
- the development of the first steps to an understanding of the origin of these patterns in their own biography and their dysfunction as well as
- the modification of these patterns in daily ward life and during the transfer phase into the private environment

To achieve these objectives we use on the basis of transference and counter-transference particular therapeutic tenors and techniques which are supportive. This is meaningful and necessary in the light of the acute and severe mental stress of our patients. By supportive we mean that the integrating “ego” functions are strengthened (whereas the expressive psychoanalytic methods assume stable “ego” functions and at this time use stressful treatment methods). Thus the therapist plays an active role in the therapeutic process and leaves no doubt in the advocacy for the concerns of the patient (therapeutic neutrality instead of abstinence). The intervention techniques of clarification and confrontation (eg. with a discrepancy between what the patient says and what he does) refer mainly to the current

treatment and life situation, while the comprehensive interpretation (interpretation in the closer sense) with the biographic experiences is only rarely used.

The psychodynamic treatment is used in combination with other therapeutic approaches in the different work areas of our clinic.

Systematic therapy

Systematic therapies are deduced amongst others from cybernetic theory models on the functionality of living systems. This may be systems within a person or systems consisting out of several persons. Typically our work is concerned with couples, families or family groups, thus the social microcosm in which our patients live. In the systematic family therapy it is not one person, thus not centred on the patient but rather on the whole system and its functionality and the interaction of the members amongst each other. The patient is also the couple or the family. In family therapy (with or without actual family members present) the objective is to communicate to the participating parties how they treat each other and to point out possible unfavourable (dysfunctions) patterns of interaction. This is done using different techniques which will eventually lead to a new definition of the relationship between the parties (eg. by changes rules) and thus to a more favourable climate in the family. In accordance with the principle, “the action of one is the action of the other” it appears as a surprise for the participating persons, that the changed behaviour of one member of the family directly corresponds with the changed behaviour of the other members of the family. The final objective is to find new and appropriate steps of development for the entire system where previously rigidity and a standstill had occurred.

Systematic family therapy is used in our clinic by qualified family therapists and is almost always integrated into the overall therapeutic concept for the respective patient. It may begin during the in-patient stay and will as a rule only be terminated after discharge. In the year 2005 we started planning the enlargement of our family therapeutic facilities. The newly founded “Team Family Therapy” has been centrally coordinated for the entire clinic.

3.8.3 Occupational therapy

Occupational therapy belongs to the action-oriented therapies. The first responsibility is to participate in the diagnostics of mental, sensory, motoric and social functions and capabilities which are limited due to illness.

General objectives of occupational therapy are recovery, improvement, conservation and/or compensation of these capabilities and clarification in the sense of these objectives. Specific targets of treatment through occupational therapy are

- Increase of concentration and endurance
- Improvement of self-evaluation
- Increase of mental and physical ability to cope with stress
- Improvement of activity planning
- Support of autonomy, reliability and care
- Acceptance of responsibility
- Encouragement of social competence
- Discussion of own wishes and feelings
- Finding opportunities to express the momentary mood
- Encouragement of creativity, fantasy and flexibility.

For achieving these targets, the occupational therapy uses activating and activity-oriented procedures with technical and creative (non-verbal) techniques in addition to practical training for everyday life.

We can differentiate the following methods of occupational therapy.

- The competence-focused
- The expression-focused
- The interactive method

Occupational therapy treatment is oriented on the individual problems of everyday life. Individual habits and real life conditions are taken into account in the choice of materials and techniques. Practical activities in everyday life are used as preparation for the independent life outside the therapeutic setting. Consideration is given to the social environment. In the training of activities practical in everyday life, skills for coping with daily life are trained and/or newly learned.

Occupational therapy takes place as individual or group therapy within a ward setting. Furthermore the clinic (in this respect the EvKB) is the responsible body for two occupational therapy practices which are used by both patients who are treated in the medium- and long-term as in-patients and day clinic patients, and (subject to prescription) for patients treated ambulatory in the practice or in our out-patient department.

Moreover occupational therapy is available in Gilead IV, the Clinic Pniel and in the two occupational therapy practices. Here under therapeutic supervision workload testing is carried out by means of targeted work- and physical endurance training. Also opportunity can be made of the medical endurance test (MBE) at the place of work. Particularly in the Clinic Pniel measures for occupational testing can be arranged, since often young patients, who become ill for the first time, frequently have not completed occupational training.

Patients in occupational therapy are supported with a number of means for integration into the working life and with the search for opportunities for a meaningful day-structuring measure for the period following treatment. For this purpose there exists a close cooperation with the foundation sector “Pro Werk” at the “v.Bodelschwinghsche Anstalten Bethel.”
In recent years it has been shown that work-related measures considerably contribute to the mental stabilisation of patients with chronic mental health problems and severe recurrent and readmission of patients can be reduced.

3.8.4 Kinesiotherapy and physiotherapy

Kinesiotherapy is principally resource orientated, ie, it reverts to the existing capabilities of patients. It is never geared to physical peak performance but to physical awareness, social integration and emotional experience. Many kinesiotherapy measures take place in a playful context.

Emotional-cognitive aspects	*Social aspects*	*Physiologic-somatic aspects*
• Experience and new learning of awareness, if applicable , pleasure and comfort • Reduction of mental symptoms (depression etc.) • Reduction of aggression and physical expression of emotions • Activation and mobilisation • Rest and relaxation • Improvement of concentration, patience and physical endurance	• Establishing group capabilities (integration) • Experiencing group dynamic processes • Communication of opportunities for appropriate recreational activities	• Increase of cardiovascular endurance • Muscle built-up training • Regeneration of limited functions and movements • Loosening of muscular tissue • Improvement of posture and movement

Physical awareness is disturbed by many mental disorders. The new learning of appropriate and acceptable physical awareness is an important prerequisite to accepting oneself and being able to realise and communicate one's own wishes and needs.

Further objectives of the kinesiotherapy can be allocated to the fields "emotional-cognitive", "social" and "physiologic-somatic."

Theory led kinesiotherapy and physiotherapy measures are integrated into the treatment concept of a treatment unit. They are prescribed as fixed therapy elements. This includes also therapeutic riding which can be offered in individual cases in cooperation with the riding therapy Enon in Bethel. Beyond the already mentioned active principle of riding, there is the relationship to the horse, the nonverbal communication and build up of confidence which play an important role in therapeutic riding.

Next to the kinesiotherapy as a prescribed therapy element, there are motion-orientated opportunities for recreational activities. Participation in these activities is voluntary however should be coordinated with the primary nurse and/or the therapist in charge of the case.

In the treatment concept of each treatment unit it must be clearly defined which offer of kinesiotherapy and physiotherapy is the therapy element and which offer is an opportunity for recreational activity.

Endurance training has already been discussed in section 3.8.1.

3.8.5 Music therapy

Music therapy is a creative psychotherapeutic method where patients in free musical play can identify structures and patterns of their mental problems and their personality and communication patterns. In a playful experimental manner alternative forms of behaviour possibilities are experienced and contact to those feelings, which previously had only been experienced in pathological encryption, is established. Music arouses images, fantasies and coherent perceptions which slumber within our memory. Listening to music followed by therapeutic discussion is the main approach for music therapy methods. Specialized music therapy is accomplished by professional music and graduated music therapists and their work is integrated into the overall therapeutic concept of each field. Music therapy is planned for individual patients in coordination with the treatment team. It takes place as individual or group therapy. Patients, in a recently conducted study on the effectiveness of music therapy, report exceptionally positive effects.

3.8.6 Social therapeutic methods: from ensuring livelihood up to reintegration

Social workers and social education workers perform comprehensive tasks in their respective fields. They are responsible for ensuring that patients receive all the social benefits they are entitled to. This concerns in particular entitlements from the different social security (health, pension-, accident- and unemployment benefits etc.) as well as the welfare agencies. Contact with and intervention in the social, occupational and living environment are also often required to establish, maintain or improve the means of existence. Furthermore social workers and social education workers assist the clinic management in cost assurance by the preparation of cost transfer applications, raising primary welfare applications, making telephone calls and preparing correspondence with the budget holders in question.

The effect of illness in the daily life of a patient plays an important role in therapy planning. Changes in living, work, self-sufficiency and recreational activities are taken into account for treatment planning and execution. Further social-therapeutic tasks include group therapy, partly family therapy, information groups for patients and their relatives, theme-focused groups and groups for relatives.

Within the framework of a multi professional team the responsibility for the planning and introduction of aftercare and further measures of medical, social and occupational rehabilitation is predominantly a matter for social workers and social education workers. In this context they assure and maintain cooperation with many agencies outside the clinic and thus contribute to the orientation of community-psychiatry. Since 2005 the clinic participates in a project for systematic help assistance for persons with complex needs (with IBRP, Integrated treatment and rehabilitation planning, see para 2.1.4). Based on this help requirement evaluation, a votum shall be given relatively quick and unbureaucratic in the functional assistance planning conference of the City of Bielefeld on the question of cost transfer to the responsible budget holders. At this stage it is a model project, where the previously cumbersome splitting of responsibilities can be compensated and appropriate help, covering all needs of the help recipient (living, work, day-structure, treatment etc.) can be planned and granted.

3.8.7 Work with relatives

Psychic disorders should also be considered in each individual case against the family and partnership background. The relatives are often stressed and burdened to a high extent since many psychic disorders cause the affected persons to experience limitations in several life spheres. The mental disorder of a patient consequently can influence and complicate the partnership and family life.

The bio-psycho-social understanding of disorders, and their origin and maintenance assumes an important significance in the social environment. Under this aspect it should be considered which social factors may be involved in the maintenance of a psychic disorder and the symptoms. Generally it does not follow that the social environment should take over the therapeutic function. Rather such social, partnership and family conditions which unintentionally enhance symptoms should be changed and replaced by others.

The effect of the social environment as well as its possible co-participation in the origin and/or maintenance of psychic disorders are important reason for the close integration of the social environment in therapy and prevention. Regular visits of relatives, consultations for relatives, discussions for couples and families (see above) as well as groups for relatives serve these objectives and have been realised in all fields of work in the clinic.

3.9 Indication-related concepts and methods

The following concept presentation within departments is geared as an overview to the in-patient, day clinic in-patient and out-patient sections in the clinic. Experience has shown however that this separation into treatment sections for financial reasons is both artificial and inappropriate. Therefore different comments will be found in an effort to replace this division by integrated treatment modalities. The ideal of treatment episodes carried out in individual and indicative portions of in-patient, day clinic in-patient and out-patient patients can be realised through applicable structural requirements, however for the time being, only in initial stages (see Section 7). The different sections for psychiatry and psychotherapy in the clinic are working indicatively, for example on focus points. This procedure has proven valuable with regard to content and in particular for organisational reasons. In this way resource saving processes can be optimised and there is more time available for the individual patients. Though in a clinic for acute cases it is neither possible nor meaningful to realise special wards in a closer sense. Such a narrow concept would not do justice to the obligatory care assignment and the often multiple problems of our patients.

3.9.1 Departments for general psychiatry

The General Psychiatry Section includes 10 wards with facilities for 167 patients, 3 day clinics with facilities for 60 patients and the Clinic Pniel for medium-term treatment with facilities for 42 patients and split into two departments.

The Department for General Psychiatry I includes the wards A2, A3/4 and A5 with their transfer areas (see below) and two day clinics (Bethel and South). In accordance with the allocation of the town Bielefeld there are three care sectors (East, West and South) and sector-related treatment is carried out with the objective of continuity of treatment on the same ward, which has proven to be very meaningful in the face of the usual recidivating and chronically clinical picture.

The wards A1, A7, A8 and A9 as well as the day clinic (East) have intersectional treatment facilities and form the Department for General Psychiatry II. All the wards are working with indicative focal points: the day clinic treats patients from different fields of indication.

3.9.2 Department General Psychiatry I – Focal point for patients with psychotic disorders

In 4 wards with a total of 97 beds persons primarily suffering from acute schizophrenic and schizoaffective disorders as well as manias are treated. Additionally there are patients with chronically psychic problems and a complex need for help as well as to a small extent forensic patients within the scope of hospitalisation according to §63 StGB (German Criminal Code).
This is a group of people with severe, acute and often psychotic disorders and crises.

The treatment concept is based on a bio-psycho-social disease model. According to the type and acuteness of the underlying disease, psychopharmacologic, psychotherapeutic and social therapeutic methods are used in consideration of the individual context. Components of the therapy are:

- Biological therapies, in particular medical therapy and for respective indication electroconvulsive shock treatment
- Psychotherapeutic individual- and group therapies on an integrative behaviour-therapeutic, depth psychological and systematic basis, eg. psychological education, dialectic behavioural therapy, imagination, social competence training and special group therapy for patients suffering from first-time or early age psychoses.
- Active- and expression-orientated therapies such as occupational and work therapy as well as music therapy.
- Activating therapies such as movement therapy and sports therapy, ergo meter training and riding therapy
- Social therapeutic measures for ensuring a livelihood, establishment of a social basis and initiation of further assistance.

In the first phase of the treatment, the so called acute phase, reduction of acute psychotic symptoms, reducing fear and providing relaxation play a primary role. Next to acute medical treatment, the following measures are important in this phase.

- relaxing ward environment
- shield against excitement

- calm, for instance playing down attention
- clarification (about the subjective experience which is often not understood)
- Clear and reliable daily routine
- Unambiguous communication and rules

The acute phase can last hours, days but rarely weeks. Some patients who suffer short crises and relapses with a respective admission (eg. social-psychiatric assisted) may be discharged very quickly after stabilisation. Otherwise psychotherapeutic, occupational therapeutic and social- therapeutic stabilisation measures will follow. The following objectives are followed in a structured treatment setting.

- Mastering the acute disorder.
- Gaining knowledge about the disorder, its treatment and prevention
- Ensuring social and occupational livelihood
- Training of partly lost social competences
- Training of neuropsychological and technical skills
- Training of everyday skills
- Reduction of unfavourable behaviour patterns and learning more favourable alternatives.

Psychotherapeutic methods particularly in this phase have become increasingly important in the last few years. In addition clinical experience and the available scientific evidence have shown that early psychotherapeutic treatment can influence the course of illness favourably.

In the following transfer phase, training and endurance tests are carried out, the patients discharge is prepared and further treatment assured. In this phase some of the patients spend the non-therapy time and the nights in a transfer ward without intensive care, whilst the treatment is continued in the therapy ward. This measure serves to partly detach the patients contact to the therapeutic team and to encourage independent behaviour activities prior to discharge. An integrated day clinic treatment can be accomplished to a limited extent in the wards if the transfer to a day clinic is not reasonable.

Ward A 2 and the Day Clinic Bethel are responsible for East Bielefeld

These work units are responsible for the in-patient treatment (27 places including the transfer ward) and day clinic treatment (24 places, including the West Sector) of the citizens in East Bielefeld. In comparison with the other two sectors of Bielefeld there are only a few facilities offering in-patients integration aid for persons suffering from chronic psychic disorders and disabilities. For this reason there is a lower demand for in-patient and day clinic treatment. The ward, which is located in the building Gilead IV, has an integrated closed intensive care unit with six beds. The Day Clinic Bethel can treat 24 patients (in the sectors East and West) and is located in the Gadderbaumer Str, in the immediate vicinity of Betheleck.

The wards A 3/A 4 and the Day Clinic Bethel are responsible for West Bielefeld (see above)

The wards A3 and A4 are responsible for the care in West Bielefeld, and therefore also for the residents of the psychiatric homes within the foundation of integration aid in the " v. Bodelschwinghschen Anstalten Bethel." Homes of the „Stiftungsbereich Behindertenhilfe" are also located here. Thus the portion of persons who are chronically mentally ill or disabled is relatively high. Both wards are situated in the same building Gilead IV and are open run with 42 beds (A3 with 22 beds, A4 with 20 beds including the transfer ward). The integrated routine of both wards is marked by the mainly overlapping character of the therapeutic offers and the regular long-term rotation of the nursing staff. Doctors and psychologists represent one-another if required. In justified individual cases the ward A4 can be temporarily closed.

The ward A 5 and the Day Clinic South are responsible for South Bielefeld

The ward A5 which was renovated in 2004 can treat 28 patients (including the transfer ward) and is responsible for the south of Bielefeld including the residents of the homes of the integration sectors and the residential care facilities in the neighbourhood of Eckardtsheim ("Stiftungsbereich Integrationshilfen"). The Day Clinic South with facilities for 20 patients, is located in the Sennestadthochhaus and is furthest away for the remaining facilities of Bethel.

Patients from the Department General Psychiatry II are also treated here. As an extra facility Ward 5 has a separate female section containing six beds. This female section is used especially for females with experience of violence, patients from different cultures, as well as females who need special protection. These patients are primarily cared for by female members of staff. Ward A5 also accommodates one of the two mother-child units of the clinic (see ward A8), this facility can also be used by patients from other areas of the clinic.

Clinic Pniel

The Clinic Pniel which is located separately from the acute clinic is in the Hoffnungsthaler Weg in the centre of Bethel and has a good tram connection to the town centre of Bielefeld. It has facilities for 42 patients and offers a differentiated treatment program for patients with chronically and chronically acute ongoing disorders and multiple disorders. Principally persons with schizophrenic and manic-depressive disorders, and also persons with severe neurotic disorders or personality disorders as well as persons with an additional diagnosis of addiction are admitted to the clinic. In individual cases persons, who are suffering from seizures and co-morbid disorders and who live in the surrounding area, can be admitted. This medium-term treatment serves in particular the objective to secure and strengthen the success achieved in the psychiatric acute treatment therapy. It contributes to the prevention of impending disabilities (secondary preventive approach), to eliminating or improving disorders, or to prevent deterioration (tertiary preventive approach) which otherwise could lead to the need for constant care or chronically disturbances. The overall target of the multi-dimensional treatment is to reach an extensive stabilisation of the patient's health and to assist in his re-integration into the work, living and social environment. Besides the psychotherapeutic and pharmacologic therapy treatment, depending on need, intensive training in the activities required for daily living, job-seeking and occupational training measures are offered.

The patients are treated here generally for a period of 3-6 months with a smooth transfer from treatment to re-integration measures. Careful preparation for the subsequent care is necessary since the patients have an almost exclusive need for complex help. At the same time patients according to their individual possibilities can take medical endurance tests also outside the clinic.

Day treatment in the Day Clinic Bethel and Day Clinic South

The day clinic treatment offered in the Day Clinic is aimed at persons on a cross-diagnosis basis who need more than out-patient assistance but do not necessarily require in-patient diagnostics and therapy. In particular the day clinic setting offers the best possible form of treatment for persons in an acute phase of illness or crisis for whom the continuous support of their social setting is important (for instance, care requirements for small children, special socio-cultural background, stabilising security during illness). The course of treatment depends on the individual therapy agreement between the patient and the therapist. In the same way as a ward for in-patients, diagnostics and stabilisation and reduction of symptoms form the primary focal point. In the process diagnostics include all levels of the bio-psychosocial understanding of the illness. After clarification of the situation and after sufficient stabilisation, the phase of contextual discussion in relation to the abnormal disturbances, their background and correlations as well as the planning of perspectives is carried out. At the end of the treatment further planning and assurance of the therapeutic perspective and re-integration into a regular work setting follows. An exceptional quality of the day clinic treatment is the ongoing transfer into the living environment. In accordance with the multi-dimensional understanding of the disorder, therapy treatments include group and individual therapy, somatic-orientated therapy, social-therapeutic and activity-orientated groups as well as family discussions, house visits and discussions with the employer and practical training assistance. Intensive psychotherapy follows on the basis of an integrating concept which includes depth psychology, behaviour-therapeutic and family-therapeutic approaches.

3.9.3 Department for General Psychiatry II - Transsectoral wards

The Department for General Psychiatry II was founded in October 2003 and in the meantime includes 4 in-patient wards with 70 beds in addition to the Day Clinic East which has facilities for 16 persons. The indication spectrum covers all general psychiatric clinical symptoms except for psychotic disorders and manias (indication spectrum of the Department of General Psychiatry 1 – please refer). For the disorders which occur most frequently such as depression, fear, obsession disorders, borderline personality disorders as well as disorders from the psychosomatic spectrum, evidence based- and with that successfully proven

therapies are used. Firstly bearing in mind previous findings, psychiatric-psychotherapeutic and somatic diagnostics are conducted for all patients. On this basis a substantiated recommendation for further therapeutic measures follows in the therapy phase.
In the following transfer phase with re-integration into the occupational and family life, emphasis is placed on the maintenance of social relationships. During the treatment the social environment will already be integrated as far as possible, which can be achieved because most patients are local (within the Bielefeld area) and the treatment is easier than for patients who live far away.

By the integration of the department into a hospital of maximum care it is possible in close cooperation with other somatic fields to treat patients with extremely severe and multiple disorders and difficult differential diagnoses (for instance, with psychic and somatic symptoms) and thus to develop holistic therapy strategies.

The individual sections are introduced below. They deal with the main focal points which do not exclude treatment of other clinical pictures.

Ward A l - For depressive patients from middle age upwards

The ward in Gilead IV offers treatment for 16 persons with depressive disorders who are middle aged or older and do not require intensive physical care (refer to Ward Fl, the Department for Gerontopsychiatry.) Mainly group therapies focus on structured cognitive behaviour therapy as well as occupational, music and kinesiotherapy. The ward offers special perceptual grouping as well as support for physical activity.

Individual therapy sessions are also offered. At the centre of the concept is the encouragement of the resumption of everyday life activities with the objective to develop anti-depressive effective strategies to cope with everyday life. Before the targeted change of behaviour, the objective is to modify the patients own perception and the cognitive-emotional handling of the depressive patterns of thought and behaviour. The role changes which are not yet realised or have already been accomplished (for example, change of occupational or financial situation, in the partnership, physical illnesses, experiences of loss) are also considered, especially if they are of substantial importance for the retention of the depression.

Ward A 7 – for patients with borderline personality disorders and patients in psychosocial crises

The ward with 17 beds is also located in Gilead IV and has two main treatment aims: (1) The treatment of patients with borderline personality disorders is accomplished in a highly structured setting with the disorder-specific targeted dialectic-behavioural therapy (DTB). This has been adapted for in-patient therapy and is integrated into an integrative concept (IDB) with participation of psychotherapists in private practice and our Institutes Out-patients Department. In this concept the in-patient treatment together with out-patient care is an element which should lead to stability of the affected person thus enabling the necessary long-term treatment to be carried out in an out-patient setting. (2) There is a psychotherapeutic crisis intervention concept (in cooperation with Ward B3) for patients suffering acute mental crises (with suicidal tendencies) following stressful incidents in their lives. The main objective is stabilisation and as soon as possible further out-patient treatment. These patients often require only a few days treatment as in-patients to overcome the acute crisis. Should further treatment however be required within the frame of crisis treatment (for instance, underlying adjustment disorders, personality disorders or posttraumatic stress disorders) the patients can remain on the ward for several weeks as in-patients. The treatment on the ward focuses on the present time, on the actual perspectives and targets taking into consideration the person's personal experience and background. Disturbing and stressful existential orientation and behaviour patterns are examined; resources and treatment objectives are prepared and practiced using targeted psychotherapeutic techniques (both in group and individual therapy sessions). Thus the treatment is oriented into everyday life and includes topics such as work, family, relationships, home and recreation. There are trauma exposition methods available for patients who are suffering from posttraumatic stress disorders, there are however only used on the ward for selected individual cases because of the first need for stabilisation.

Station A 8 – for younger patients suffering from depression

Ward A8 with 21 beds is located in Gilead III. On this ward younger persons suffering from affective disturbances and in particular depression are treated. The background for the age-related allocation for the treatment of affective disturbances (refer to Ward A1 and Ward F1) is the experience that the simultaneous treatment of several generations on one therapeutic unit may lead to an unsatisfactory treatment situation. The predominant psychotherapeutic

setting for treatment follows, depending on individual indication the concept of interpersonal therapy (IPT) of the depression or the depth-psychological concept. The cognitive behaviour therapy or depth psychology is used in the individual psychotherapy.

One of the two mother-child units in the clinic is also located on Ward A8, this unit may also be used by other areas of the clinic (refer to Ward A5). The ward has been integrated into the Association of German Depression Wards ("Arbeitskreis der Deutschen Depressionsstationen"), since 2000. The responsible Senior Doctor has been the spokesperson of this research group for the region of North Germany since 2003. Since regular meetings and professional exchange is maintained an additional professional quality is assured for the entire range of depressions.

Ward A 9 – for patients with angst-, compulsive-, obsessive- and somatoform disorders

Ward A9 with 16 beds was formed in April 2000 and is located in Gilead III. Persons suffering from angst-, compulsive-, obsessive- and psychsomatic disorders (pain disorders, somatoform disorders, namely physical symptoms without organic causes) are treated on this ward.
There is close cooperation with the somatic clinics of the EvKB Hospital particularly in the pain out-patient department. In a combined therapy concept (depending on individual indication), cognitive behaviour therapeutic and psychodynamic approaches are used in individual and group settings either parallel or sequential.

- Psycho education
- Cognitive therapy
- Exposition treatment
- Imagination training
- Group training for social competence
- Depth psychological psychotherapy (either as individual or group therapy)

Kinesiotherapy and ergo therapy as well as imagination and relaxation therapy are offered both indication-related and inter-ward for patients in Wards A8 and A9. Both wards share

the night duty. Admissions take place mainly following prior arrangement and indication consultation.

The Day Clinic East

The Day Clinic East is located on Detmolder Str. 280 (in the Elfriede-Eilers-Centre, House C) and has facilities for 16 patients. Firstly patients from the Department of General Psychiatry II are further treated in the day clinic, and secondly patients are admitted directly via the ambulant care systems after a preliminary and indication discussion. Patients suffering from affective disorders (mainly depression), angst- and somatoform disorders, personality disorders as well as patients in life crises. The group therapeutic program covers cognitive behaviour therapeutic approaches, psycho-educational interventions as well as kinesiotherapy and ergo therapeutic treatments. Within the scope of individual therapy, cognitive behaviour therapy, depth-psychological and systematic therapy approaches as well as social therapeutic advice are used.

3.9.4 Department for addictions

This Department has facilities for 63 beds and 16 day clinic patients and works transsectoral according to indicative focal points. In-patient, day clinic patient and out-patient facilities are closely linked within this department. All three in-patient units and the drug out-patient clinic are located in Gilead IV, the Day Clinic and the Out-patient Unit for alcohol abuse are in House Süßeck (at Betheleck, Gadderbaumerstr. 33).

Ward B3 – for alcohol detoxification, clearing and crisis intervention

This ward with facilities for 19 persons and two main areas for treatment since 2005 is available for acute planned and unplanned admissions and crisis interventions.
(1) The area alcohol addiction – detoxification is accomplished in accordance with international development standards of control using an alcohol detoxification scale.
The detoxification process begins in a separate intensive care area. This is in particular the case when evidence suggests intoxication during admission or complications may be expected. The detoxification phase is always used for first-time interventions with the objective to increase the readiness for change and for treatment. After physical detoxification

and diagnostics the patients, depending on indication and willingness for treatment are placed into out-patient or day clinic aid facilities including withdrawal treatments in accordance with SGB IX or are transferred for further treatment within the clinic to Ward B2. A professional and indication-based transfer requires a qualified process of clarification which completely covers and structures somatic, mental and social problem spheres of the patient and integrates them into an overall treatment concept that is sustainable for the patient and is realistic. Ward B3 is always is close contact with the out-patient department and also with other aid facilities outside the ward to minimize interface problems for admission and discharge.
(2) The second area for treatment is crisis intervention both for patients addicted to alcohol and severe mental crises and for patients from the indication field of the General Psychiatry II in acute crisis situations. Often suicidal tendencies play an important part for both groups. For these patients the ward offers intense care and shelter which cannot be granted within the facilities of the department for General Psychiatry II. Since the end of 2005 a structured crisis intervention program has been provided.

Ward B2 – for severely and multiple affected addicted persons, also elderly

The facilities of this ward with 24 beds focus on chronically multiple affected addicted persons and since the summer of 2001 also on similar patients who are elderly. These are patients with severe somatic and psychic, in particular with associated cognitive damage following a lengthy period of addiction. The intensive care and therapeutic spectrum includes the physical detoxification treatment (in a closed intensive ward area), measures for the support of physical health (such as mobilisation, physiotherapy and movement therapy) as well as measures to improve cognitive functions in neuropsychological training and training of daily life activities (ATL Training). At the same time, as a rule, chronically ill patients are motivated to get involved in changing their often desolate life situation, to tolerate relocation into a more stable environment, to accept day-structuring measures to help abstinence and to accept help to develop crisis planning. Cooperation with complementary institutions is especially important. Institutions of prime importance as cooperation partners are the institutions for the homeless, for ambulant and in-patient reintegration aid as well as the welfare assistance organisations for senior citizens.

Ward B5 – for the qualified detoxification treatment of persons addicted to drugs

This ward with 20 beds provides the treatment for drug addicted patients. Treatment assignments include complete detoxifications, additional use of detoxification for existing substitution treatment, crisis intervention, preparation for withdrawal therapies and treatment of co-morbid patients, provided they cannot be treated in the general psychiatric sector. This complex assignment for treatment can be achieved with two special facilities. On the one hand the ward is in possession of an intensive care unit which can be separated, but can be monitored from the Duty Room; on the other hand, the out-patient drug unit (see below) is directly attached to the ward, so that both areas are closely cross-linked also in respect of the staff members. In this way interventions may be commenced in the out-patient unit and the treatment continued on the ward as an in-patient and be terminated again as an out-patient without any disruption of the treatment.

Day Clinic for persons suffering from addiction

The day clinic with facilities for 16 persons primarily treats persons who do not require in-patient care but require more care than an out-patient. Additionally patients from the wards (B2, B3 and B5) who still require temporarily treatment and care at night and at weekends can participate in the therapy program of the day clinic. This is known as combined in-patient /day clinic patient qualified withdrawal treatment with a psychotherapeutic focal point (STEP). The motivation treatment as a part of the withdrawal treatment is focused on patients with a low degree of readiness for change together with a sufficient level of willingness to undergo treatment. This is for patients, who have contacted a Help Agency for the first time as well as for patients who have, after a long term of addiction, developed the intention to abstain. During the behaviour therapy program which is planned for three weeks and is focused on psychic education, important basic information is provided in six modules on the issue of substance dependence and coping strategies are presented and trained. Information on the different topics is reinforced in group study and transferred into the personal life situation of the individual patients. In the day clinic setting, the non-therapy time at home is used systematically and explicitly for the exposition and transfer of learned material into the natural environment. The aim of the treatment is the development of a possible stable abstinence capability and a medium-term aftercare and treatment plan (for instance, withdrawal treatment or regular visits to the doctor and the self-help group). The field of

psychotherapy is directed at addicted patients with co-morbid psychic disorders. The therapy is focused particularly on patients who are not capable of rehabilitation because of the severe ness of their addiction and/or their psychic disorders.

This includes patients with a chronically course of illness (alcohol, medication or drug addiction) as well as patients with severe personality disorders or a posttraumatic stress disorder. The therapy program is conducted mainly with groups and is behaviour therapeutically oriented to strengthen the competence of the patients in their everyday activities and does not offer symptom specific therapy. The duration of the treatment varies individually, and often requires 6 to 8 weeks. Continuation of the treatment in an out-patient unit is almost always required due to the complexity and severity of the illness. The day clinic works very closely with the out-patient department, which is located in the same building (House Süßeck at Betheleck, Gadderbaumer Str. 31) for patients with alcohol-related disorders and in the building Gilead IV for patients with drug-related disorders.

3.9.5 Department for gerontopsychiatry

The Department for Gerontopsychiatry has 52 beds and is located in Gilead III. The department includes a day clinic (16 places) and a day care unit (16 places) as well as An Advisory Centre (both located in House Moltkestraße in the vicinity of the town centre). The department is part of the network for the v. Bodelschwinghschen Anstalten Bethel and the City of Bielefeld providing assistance for the elderly. In particular the geriatric-internal and neurological diagnostics and therapy play an important role for the in-patients, and there is also a tight network with the somatic clinics and the geriatric areas of the EvKBs and other clinics in Bielefeld.

Ward F1 – for depressive older patients with an increased need for care

Older patients with depressive disorders are treated in this open ward which has 22 beds. These are often elderly patients who are limited in their mobility, suffering from multiple somatic disorders and/or less severe cognitive disorders, which require special therapeutic treatment due to their multi-morbidity. A cognitive behavioural therapeutic group program provides the centre of the treatment. Next to the medicamentous antidepressive therapy, physical and social resources are strengthened and newly learned, support is given to learning

to cope with the developing tasks of old age as well as dealing with specific psycho-therapeutic issues such as fear, old age, loss, bereavement and death. With a wide range of therapeutic offers of ergo, music, movement and sport therapy as well as a discharge- and competence group which have the objective to motivate the patients as firmly as possible with the intention of resumption of interpersonal contacts, a structured course for the day and activities for reducing stress. Also to reactivate the often lost psychosocial abilities and capabilities of daily life. This is learned step-by-step by means of an activity plan which is individually prepared with the primary nurse and/or the therapist responsible for the case. The main objective is to maintain an independent, socially integrated way of living in a supporting self-chosen environment using appropriate help structures available for the elderly.

Ward F2 – for patients with cognitive limitations and dementia illnesses

This closed ward has fifteen beds and focuses on treatment for persons suffering from dementia illnesses of varying degrees of severity. The reason for admission is often confusion due to medication or somatic reasons (delirium) as well as distinctive behavioural features which have occurred during the course of the dementia, such as nightly agitation and/or aggression or psychotic symptoms which overstrain the resources of the previous family care or institutional environment. Crisis situations often occur when it is no longer possible for the person to continue his/her independent life style either temporarily or permanently due to the dementia or somatic illness, and, because he does not understand the nature of the illness, can endanger him by rejecting care support. Alongside intense dementia diagnostics and the treatment of somatic illnesses, special emphasis is placed on intensive care training for maintaining capabilities of everyday life, personal hygiene as well as mobilisation. We use the in-patient observation phase to analyse the patient's need for care and the existing social structures so that we can arrange provision of appropriate care. An often difficult pharmacological adjustment of the day/night rhythm disorder and other noticeable behavioural problems are central in the commencing phase of treatment. Next to nursing care, guidance in accomplishing day structuring is given, using training, oriented to the resources of the individual patient, to cope with everyday activities as well as carrying out competence-focused occupational therapy in small groups. During a home visit, preferably together with the patient, the still existing resources can be recorded and the information required for the transfer phase is collected to plan further care needs. The integration of the relatives plays a major role during the entire in-patient stay in the clinic. Relatives, including

the patient, are kept informed and given extensive advice in multi-professional meetings. Detailed instructions on how to cope with the patient is given during the course of the patients stay.

There is a possibility for the relatives to stay on the ward temporarily for training In dealing with a patient suffering from dementia the treatment team uses a person-centred biographic approach, to reach the patient's level of feeling, maintenance of memories and the method of integrative validation. A special focal point on the ward is the treatment of dementia patients who also suffer from depression. For this we are able to offer cognitive-behaviour-therapeutic group therapy, relaxation techniques as well as individual customised cognitive activities. The necessary support structures ultimately serve an independent lifestyle in respect of social issues. Instruction for the close relatives as well as the transfer of care during discharge are an important factor, if possible a member of the team personally will accompany the patient and assure his well-being at the location and beyond his discharge if applicable.

Ward F3 – for patients with chronic (psychotic) disorders

This optional closed ward with 15 beds admits elderly patients suffering from acute, chronic and chronically-recurrent psychoses of different origin. These are mainly patients with schizophrenic, schizoaffective or manic disorders and the increasing group of patients with symptomatic psychoses. The frequent co-morbidity and multi-morbidity respectively require comprehensive multidimensional measures. Also age-typical cognitive limitations and dementia disorders with differentiated diagnostics must be considered. A further focal point on this ward is the treatment of acutely emerging disorders of perception and cognition often caused or accentuated by organic diseases as well as behavioural disorders. Different specialists participate in team-oriented cooperation using their competence for careful evaluation and ascertainment of the physical, mental and social situation of the older patients. The holistic treatment concept covers next to pharmacological therapy a basic internal-medical therapy, an adapted psycho-educational therapy program (PEGASUS), a medication group, social competence training, occupational- and music therapy, individual and group gymnastics and ATL-training. Again high value is placed on work with the relatives of patients. Cooperation with special somatic departments, out-patient facilities, care organisations and our day clinics are essential components in this concept. Some of our patients are cared for in the integration or care units for the elderly. The aim of the

therapeutic integration measures are, next to emotional, physical and social stabilisation, the support of resources and social contacts as well as an appropriate structuring of everyday life to enable patients to remain longer within their domestic environment.

Gerontopsychiatric Day Clinic

The Day Clinic for Gerontopsychiatry has treatment facilities for sixteen elderly persons with different psychic disorders. At least half the patients are suffering from affective disorders, approx 20% from schizophrenic and schizoaffective psychoses, the other disorder group is made up in similar proportions of patients suffering from dementia, angst disorders and personality disorders. Patients with addiction disorders make up the smallest proportion. Approx 60% of the patients are admitted from their homes when the out-patient treatment is no longer sufficient and fulltime in-patient treatment is not yet required. The remaining 40% are transferred to the day clinic following in-patient treatment before they are fully discharged. Next to diagnostic and medical therapy, the day clinic offers a psycho-therapeutic group program, in addition to social-therapeutic oriented training of everyday activities, cognitive training, occupational therapy as well as relaxation and movement therapy. The patients are, in relation to their treatment objective, allocated into individual groups in accordance with their individual physical stamina. Emphasis is placed on the planning and organisation of the aftercare and a search is made for suitable out-patient care services using contact to care organisations for the elderly and the initiation and training of out-patient group activities. Furthermore the work with relatives – including the placement into special groups for relatives – has a high significant value. A group- psychotherapeutic facility for the relatives of patients suffering from dementia is currently being organised.

Advisory Centre for Gerontopsychiatry

Patients, their relatives, therapists in private practice and members of institutes can obtain comprehensive advice on diagnostics, therapy and care facilities from the Advisory Centre.

Gerontopsychiatric Day Care

The Gerontopsychiatric Day Care Unit with facilities for 16 persons is located in “Haus Moltkestraße” (Legal Base: German Social Security Code XI). In accordance herewith the

institution must provide care and assistance. The persons who are admitted are suffering from different types of psychic disorders (dementia, psychoses, depressions and addictions. The objective of the care/therapeutic work is to provide a structure for everyday life for the visitors that can be experienced as meaningful and to strengthen and maintain, respectively, existing abilities required for everyday life. Furthermore to take the pressure off overburdened relatives, to advise and support them, so that the person suffering the disorder can be cared for at home for as long as possible. Care can be offered for two – five days during the period from 8 am to 4.30 pm.

The Gerontopsychiatric Day Clinic, the Day Care and the Advisory Centre form the Gerontopsychiatric Centre (see out-patient services in section 3.9.6.)

3.9.6 The Psychiatric Out-patient Department

In the last twenty years the Psychiatric Out-patient Department in Bethel has developed from a small facility limited to specific general psychiatric treatment to a competent and, at the same time, a differentiated institution providing treatment for the seriously ill persons of Bielefeld. The domicile of the Institutes' Out-patient Department is in the building "Haus Süsseck" near the Betheleck on Gadderbaumer Strasse. The General- and Gerontopsychiatric Departments, the Alcohol Department, the Victim Aid Department, the Department for Memory and the Gerontopsychiatric "Mobile Teams" are all located in this building. The Drug Out-patient Department is closely linked with Ward B5 in Gilead IV. The Gerontopsychiatric out-patient services are also carried out in the Gerontopsychiatric Centre. Also the General Psychiatric Day Clinic and In-patients Department of the clinic offer emergency out-patient services outside the regular consulting hours in addition to other services to a limited extent for those patients where personal continuity must be assured by the provision of further treatment prior- or following day clinic treatment. For purposes of organisation, the psychiatric-psychotherapeutic consultancy service is also integrated into the institutes' psychiatric out-patient department.

Work Assignment

The work assignment of the Psychiatric Out-patients Department is regulated by the German Social Security Code V § 118 and includes the treatment of those persons who require special

support due to the severity or type of their psychic disorder, which require treatment beyond the available treatment offered by neurological practices. Within this assignment, as laid out in the guidelines, more than 2000 cases per quarter are treated in our psychiatric out-patients department including psychotherapy. Multi-professional staff is provided by the institute to ensure appropriate therapeutic care. In this way an extensive offer of assistance can be provided to meet the different requirement of the patients. The team consists of doctors, social workers, specialist nursing staff, psychologists, and assistants for doctors and secretaries. The staff members have gained long-term professional experience in the fields of psychiatry and psychotherapy and are in possession of different additional therapeutic qualifications. Currently there are about 30 staff members employed in the psychiatric out-patient department of the institute.

Organisational Structure

The Institutes Psychiatric Out-patient Department is a department of the Bethel Clinic. The different sections of the Department, with regard to content and professional-conception, are in close exchange with the respective departments of the clinic and implement, where possible, the requests of the individual departments into their treatment strategies for patients and vice versa. Many out-patients are treated temporarily in the day clinic departments and require coordinated treatment programs without interruptions during the transfer period from day clinic to out-patient services. Staff members from the out-patient department regularly visit the wards and day clinics assigned to them with the objective of coordinating plans for their joint patients. In addition to these patients, there are a large number of patients treated who do not have any contact with the day clinic structure of the institute.

Working Methods

The working methods in the various out-patient sections and their consulting hours are organised differently. Generally they follow the maxim that the first contact of the patient shall as a rule be a medical diagnostic examination, followed by a case discussion with the objective of achieving an individual plan for the patient. Achieving the planned treatment may be very different, depending on the aim, both in respect of personal participation in the diagnostic- and/or the treatment process and in respect of the type of therapeutic strategy. Some patients require continuous structured assistance with the processing and mastering of their illness, whilst other patients have a disorder/illness, where it is foreseeable that it can be

overcome and there is only a limited need for some intervention. On the other hand, some patients come with a referral relating to a specific diagnostic- or therapy recommendation or for co-therapy via their neurologist with a clearly defined treatment assignment, for instance, participation in a disorder-specific treatment group.

In principle all appointments must be made at short notice and for acute needs within 24 - 48 hours. The emergency out-patients department in Gilead IV can be contacted outside regular consulting hours.

General therapeutic treatment offers

The general treatment offered covers diagnostic, psychiatric and psychotherapeutic measures, disorder-specific as well as socio-therapeutic treatment in both individual- and group settings, care seeking help for patients suffering acute crises or health impairment, also persons with low level contact, small parties and activities, including a cafeteria as well as a one-week summer camp for patients.

Section for general psychiatry

Based on treatment planning in the doctors' consulting hours, therapeutic measures are used in the general psychiatric section, which, depending on indication, are offered in an individual or group setting, disorder-specific or for various disorders. Medical contact is maintained to continually check whether the selected treatment is adequate or needs to be changed. In addition to the occupational group-specific individual therapies offered by doctors, psychologists, social workers and nursing staff, the following therapies are currently on offer:

1. Disorder-specific treatment options
    - Psycho-educative groups for psychosis patients
    - IPT- (Interpersonal therapy) group for depressive patients
    - Dialectic-behavioural therapy for patients with borderline disorders (ability training groups within an integrated approach with Ward A7 and therapists in private practice as well as a preparation group prior to the beginning of treatment)
    - Behaviour-therapeutic group for patients with angst disorders
    - Socio-therapeutic treatment groups for patients with psychotic disorders

- Brain activity training for cognitive disorders of schizophrenic patients
- ADHS- consultation for patients with attention deficit – hyperactivity disorders as adults with comprehensive diagnostics and treatment (individual therapy, medicamentous treatment and ADHS- training group)

2. Trans-disorder treatment options
   - Male group for training of everyday competences
   - Female group for the acquirement of social and communicative skills for older patients
   - Kinesiotherapeutic centred training of social competences
   - Endurance training (walking) in cooperation with the Department Rehabilitation Sports in Bethel

For all patients who are dependent, due to their limitations, on offers of support in their district, the sector allocation is the organisational principle in treatment planning.
Each sector of the city is allocated a therapeutic member of staff to achieve an adequate network using the complementary institutions and the distribution of patients within the out-patient department.

Victim Aid

Within the scope of the General Psychiatric Out-patient Department the Victim Aid Section has in the meantime achieved an independent status. Victims of violence (in accordance with the Victim Compensation Law), accident victims and all other mentally traumatised persons can turn to the Victim Aid Section for assistance, independent of type and severity of the trauma suffered. The Victim Aid Section offers next to diagnostics and consultation a structured short-term therapy program for traumatised persons. The Victim Aid Section will offer patients with complex trauma and a need for long-term treatment, either treatment which is available or will arrange treatment with other departments depending on individual need. The Victim Aid Department works in cooperation with the Clinic for Psychotherapy and Psychosomatic Medicine. They also have close cooperation with the Care Agencies, the Police in Bielefeld, the organisation “Weisser Ring” as well as the somatic-traumatological focal sectors of the EvKB.

Section "Addiction Disorders" – consultation for patients with alcohol related disorders.

Beside the accomplishment of outpatients detoxifications, also the preparation of indications and the control for the day clinic treatment has been transferred to the psychiatric out-patients department with the objective, to achieve willingness for change and the motivation to live in abstinence. Except for emergencies, all patients requiring day clinic treatment are admitted via the Out-patients Department. The Out-patients Department offers daily consultation hours which can be used without booking prior appointments. Specific offers include:

- For addicted patients with borderline personality disorders a modified dialectic-behavioural therapy concept has been developed and actioned in cooperation with the day clinic for addicted persons and the ward.
- The out-patient department is responsible for adequate treatment following detoxification or qualified withdrawal treatment will accompany the patients over a longer time frame.

The Advisory Centre "Bethel Out-patient Assistance for Persons with Addictions" which, next to consultation, also conducts out-patient rehabilitation (withdrawal treatment) on behalf of the Agencies LVA and BfA, is joined to the Alcohol Section of the Psychiatric Out-patients Department. This is, in detail, the application of rehabilitation treatments, the implementation of the out-patient rehabilitation and the aftercare groups to ensure the success of the rehabilitation.

Section "Addiction Disorders" – consultation for patients with drug-related disorders

The Drug Out-patient Department works in close interaction with the Drug Department in the clinic (see above Ward B5). Opportunities for low-level contact and careful intervention in motivating patients enable the preparation and aftercare of in-patients. Either complete or part detoxification treatments are organised. The treatment is not only directed to the addiction disorder but also to the co-morbid psychic illnesses which exist in most of the patients who are addicted to drugs. As in the Alcohol Department, the central control for the treatment is in the Drugs Section of the Out-patients Department. In the meantime there are

about 150 patients who are substituted with methadone. Since the end of 2000, buprenorphen is also used and has shown advantages for some of the affected persons. Currently life-quality is evaluated by comparing both forms of substitution.

Section Gerontopsychiatric Out-patients

For organisational reasons the Gerontopsychiatric Out-patients Department is located in Haus Süßeck at Betheleck. Twice a week a memory consultation surgery is held in which differentiated diagnostics with clinical neuropsychiatric examinations, detailed neuropsychological diagnostics as well as imaging and laboratory techniques are conducted. Next to the diagnosis, we also focus on continuation consultation in addition to therapy recommendations in both medicine and therapeutic directions and offer long-term assessment. Similarly in the surgery hours for older persons all psychic disorders are diagnosed and treated medically and therapeutically.

Since the year 2003 the mobile gerontopsychiatric team has been working in its function as pre out-patient and post in-patient aftercare. In many cases, a short-term visit with clarifying coordinating function and case-oriented structuring of the situation helps to avoid in-patient admission. In addition to clinical diagnostics, the concept includes low-level social-psychiatric treatment, medical therapy, close cooperation with family and/or specialist doctors, support for caring relatives and the coordination of further psychosocial assistance such as out-patient care services, advice services etc. in the sense of case management. The assignment is issued by our Department of Gerontopsychiatry, Family and Specialist Doctors, Complementary Services acting within the scope of assistance for elderly persons (for example, Service Centres and Town Care Consulting Agencies, Ambulant Care Services and Nursing Homes), and the caring relatives and the affected persons themselves.

Further work is carried out in the Gerontopsychiatric Centre on Moltkestr. Here the main focus is on the long-term care of chronic older patients in close interaction with the Day Clinic. In addition to psychotherapeutic group treatment of longer duration, crisis intervention and stabilisation treatment is carried out. Affected persons and relatives, therapists in private practice and institutions can receive consultation on diagnostics, therapy and care offers. There is also a gerontopsychiatric case conference for staff members in the Old-age Assistance Network in Bielefeld which is held every three months.

Consultancy Service

In the city alongside the EvKB, there is a consultancy service in the confessional "Franziskus Hospital" and the "Städtische Klinikum." The psychiatric-psychotherapeutic consultancy service must be assured for all hospitals. This provisioning is provided by some neurologists in private practice and our medical and psychological consulting service covering sectors of general psychology and psychotherapy, gerontopsychiatry and addiction disorders. Particularly in the addiction sector there is such a high demand that ideally an individual service with larger facilities would be appropriate, however cannot be currently financed. Next to diagnostics and treatment recommendations for the individual patient, crisis intervention (emergency consultancy) plays a large role. Often, if applicable, it is necessary to organise and to motivate persons to undergo further out-patient or day clinic special psychiatric and psychotherapeutic treatment.

3.10 Spiritual Guidance

The hospital counselling in the Bielefeld Evangelic Hospital is part of the pastoral service in the "von Bodelschwinghschen Anstalten Bethel" organisation and in the "Evangelisches Johanneswerk." It is connected to the "Evangelische Kirchenkreis Bielefeld", "Evangelische Landeskirche von Westfalen (EkvW)" and the "Evangelische Kirche in Deutschland (EKD)." As an evangelic-diaconic institution, the EvKB places special emphasis on the christian idea of man and the christian values as basis of its thinking and acting. The Evangelic Hospital counselling service participates in realisation of the objectives of the "EvKB" as formulated in the mission statement of our clinic.

In the hospital a multitude of religious, ethic and interpersonal experiences emerge. Many patients are suffering from existential crises. The ministers offer advice and assistance to our patients and staff members. The counselling includes regular services, meditations and ceremonies which are open for patients, relatives, clinical staff members and also visitors. The counselling is accomplished in different forms, eg. a visit to a hospital bed, a brief word, individual discussion, group discussions, assistance over a longer period, advice on specific problems and in crisis situations, casual conversations, Christian rituals, such as prayer, baptism, confession, Last Supper, benediction, anointing and churching. Many patients are responsive to the trans-confessional group offering "questions about meaning and life."

An on-call duty at weekends and on public holidays is provided for unplanned situations. The ministers also participate in transfer of services, patient-related talks, ethic discussions, concept meetings etc., and cooperate with other occupational groups. At the request of patients they can arrange contact to their parish.

The evangelic hospital counselling cooperates with counsellors of other Christian confessions and participates in the inter-religious dialogue. We are currently preparing a respective questionnaire survey to learn more about religious motivation of our patients and the interrelationship with their psychic condition and course of illness.

3.11 As far as possible – an Open Door Policy

Except for a few sections (for dementia patients and persons addicted to drugs) the wards are principally open, each of the three wards of the Department General Psychiatry I have however a facultative closed area with access to an own garden (exception Ward A5). In the course of the broad discussion on dealing with aggressive and auto-aggressive behaviour and open and closed door policy in psychiatric clinics, some structural and contextual measures have been respectively accomplished:

- All aggressive and auto-aggressive incidents are documented in accordance with a given structure and discussed; this results in transparency. Additionally a scientific evaluation is carried out with the objective to gain a better understanding of the origin and effects of aggressive behaviours and the following interventions.
- All sanctions (isolation, restraint, and arbitrary medication) are documented in a standardised form, regularly evaluated and discussed professionally in public as well as in the morning meetings. The ward-related data is discussed and reflected in the conceptual discussions.
- These debates and the written documentation on when the doors are locked on the wards with closed areas are raising the interest of all staff members.
- Principally beds should not be placed in corridors, thus creating a more relaxed atmosphere
- The practice guidelines (formerly standards) for handling (auto) aggressive behaviour are constantly enhanced, advanced training on this issue is held twice-yearly. This supports professionalism, more placidity and de-escalation competence.

- A team of qualified staff members from all occupational groups is used for consultation in psychiatric intensive situations. Escalated situations are structurally evaluated within the team and with the affected patients.
- Responsible staff members are appointed for all public clinics and ward areas to improve the milieu design.

Experience has shown that suicidal activities occur, independent of open or closed door policy. Obvious other factors such as early recognition of suicidal tendencies and the intensity of care are strongly involved. In the meantime the closing of individual areas or complete wards has become an exception. Thus in daily handling and thinking the open door policy is the norm.

Fortunately the number of placements in accordance with Psych KG NRW shows a clear regressive tendency; both for Bielefeld in total and for the placements in the clinic (see Three-Year Report 2003 – 2005 which will be published in Spring). The accommodations according to the Attendance Law have not increased.

4 Structure of the Clinic

The clinic for psychiatry and psychotherapy has facilities for 274 in-patient and 92 day clinic patients in the acute sector, facilities for 42 medium-term treatment (Clinic Pniel) as well as facilities for 16 gerontopsychiatric day care patients. Furthermore there are facilities for 8-10 patients with a hospital treatment order. In the past few years we have treated on average more than 96% patients and about 50 out-patients, thus up to 500 patients per day in the clinic.

4.1 Departments and sectors

The Clinic for Psychiatry and Psychotherapy Bethel is structured into the following departments and sectors:

- General Psychiatry I with five wards and two day clinics
- General Psychiatry II with five wards and one day clinic
- Addiction disorders with three wards and one day clinic
- Gerontopsychiatry with three wards, one day clinic and one day care facility
- Outpatient Psychiatric Institute (about 2300 patients per quarter) with a consultancy service (currently 700 to 800 consultations per year)
- Research, quality assurance and documentation as a Functional Department
- Occupational therapy as a functional Department
- Two occupation therapy practices.

The “Stiftungsbereiches Behindertenhilfe” is responsible for the Day Clinic West (General Psychiatry I), and the Gerontopsychiatric Day Clinic. The “Stiftungsbereichs Integrationshilfen” of the “v. Bodelschwinghschen Anstalten” organisation is responsible for the Day Clinic South and the Clinic Pniel (General Psychiatry I). The day clinics and the Clinic Pniel form, under the terms of a management agreement for all internal concerns, part of the clinic of the “Evangelischen Krankenhaus Bielefeld.

The functional department occupational therapy is spanned into all the clinical departments and is closely cross-linked with the occupational therapy practice I with the focal point on

working with psychic ill patients. The occupational therapy practice II, newly established in 2005, has in contrast a strong focal point on persons with acquired brain damages.

The department of research, quality assurance and documentation is spanned over the entire clinic and is closely cross-linked with the different departments depending on the contextual focal point of the respective project.

The structure is also depicted in the following figure: the contextual details were described in Section 3.9.

Clinic of Psychiatry and Psychotherapy Bethel

General Psychiatry I

East **Ward A2**

schizophrenia, schizoaffective, bipolar, adjustment disorders

West **Ward A3, A4**

see above

Day Clinic*

South **Ward A5/6**

see above

Day Clinic*

General Psychiatry II

Ward A1

affective disorders (older age)

Ward A7

borderline personality disorders, intervention crisis

Ward A8

affective disorders (younger age)

Ward A9

anxiety, psychosomatic disorders

Day Clinic*

Affective disorders, personality disorders, intervention crisis

Substance Disorders

Ward B1

UK

Ward B2

alcohol-detoxification,

clearing, crisis intervention,

chronic multiple dependence, severe substance-induced handicaps

Day Clinic

motivational enhancement and psychotherapy in alcohol (drug) dependence

Ward B5

illegal drugs – detoxification and motivational enhancement

Geriatric Psychiatry

Ward F1

affective disorders with somatic comorbidity

Ward F2

cognitive impairments, dementia

Ward F3

psychotic diseases

Day Clinic

(affective disorders)

Day Care Centre

social law XI

Outpatient Service, Consultation Service

Clinical Research, Quality Management, Clinical Documentation

Gilead III Gilead IV Haus Suesseck Detmolder Str Gadderbaumer Str Sennestadthochhaus Moltkestr

4.2 Management and Board – Communication and information

The “Klinik für Psychiatrie und Psychotherapie Bethel” with its size, differentiation and its huge network provide a particular challenge for the sectors of information, communication and management. The body must ensure that the daily work routine between and within all levels functions satisfactorily and remains transparent, and at the same time must limit the abundance of information.

4.2.1 Clinic Management and Department Management

The overall management of the clinic, including specialist and service supervision rests with the medical and nursing management. The medical management, as usual in hospitals with an acute supply, accounts for the medical overall and final responsibility and is ultimately responsible within the internal organisation for the medical, psychosocial and therapeutic services as well as for the administration services. The nursing management is incumbent on supervision of the largest group of employees, characterised by a particularly high degree of double-qualified and specialist nurses (about 20%). After dissolution of the former clinic management structure, the functions of the therapeutic supervision are administrated, based on division of labour, by the therapeutic department supervision: Graduate psychologists and music therapists, social education workers and social workers, occupational therapists and physio- and kinesiotherapists, respectively, are thus represented for all consulting and decision processes.

Medical and nursing supervision as well as a spokesperson for the therapeutic department supervision are represented in the Clinic Management Conference which meets weekly. In this board, the respective responsibilities are coordinated on a cooperative basis taking into account the respective competences and are directly executed or prepared for in the conference of the supervisors of the departments (see below). Monthly, or more frequently, if required, the enlarged clinic management conference together with the responsible divisional directors of the service centre of the “Dienstleistungszentrum Krankenhaus” (DZK) arrange for coordinated procedures in questions of business administration, engineering and construction, housekeeping and others. Comprehensive decisions are coordinated with the responsible boards of the hospital (management, enlarged business division conference,)

psychiatry-specific questions are coordinated with the boards of the "v. Bodelschwingsche Anstalten" organisation (eg. special committee psychiatry, management board of the "Stiftungsbereiche Integrations- und Gemeindepsychiatrie", management of the clinic for psychosomatic and psychotherapeutic medicine).

Except for the Out-patient department, the departments are managed each by a three-person board, consisting of medical, therapeutic and nursing heads of department. In this board, department-specific decisions of daily life are made and the direct specialist and service supervision for the in-patient and day clinic sectors of the department is administrated. The department supervision also further develops department-specific concepts and improves the therapy treatment according to the requirement of the patients' needs. In this process they are also responsible for the cross-linking of the day clinic and the out-patient facilities and assure the expert competence in the respective department. The department supervisors represent their special field in different public committees as well as supra-regional expert and science workgroups, partly interdisciplinary.

In order to ensure a smooth course of process, a conference of the Department Heads meets twice weekly as a consulting and decision making committee under the participation of:

- Clinic management (ultimate responsibility and decision)
- Department Management General Psychiatry I
- Department Management General Psychiatry II
- Department Management Addiction Disorders
- Department Management Gerontopsychiatry
- Department Management Out-patients
- Supervision of Functional Department Occupation Therapy (visitor status)
- Supervision of Functional Department Research, Quality Assurance and Documentation (visitor status)

All department specific points and cross-clinic issues are conferred at this conference between the participating parties and, if agreed, are decided by the management of the clinic.

4.2.2 Specific supervisory functions

In the wards and in the day clinics the medical-therapeutic supervision is effected by the Senior Doctor in Charge or by appointed qualified psychological psychotherapists. In the twice weekly conference of managerial personnel, medical and therapeutic and, if applicable, case-, department- and clinic related issues are discussed and agreed upon. Furthermore the specialist and service organisation and development of the medical sector plays an important part.

The ward supervision is responsible for the supervision of the care service and organisation of the ward. The supervision arranges for decision processes to be made in terms of an optimal treatment of the patients. This task is jointly accomplished in cooperation with the case-responsible doctors and psychologists as well as the Senior Doctor in Charge. The y ward supervision conference meets every fortnight, general issues of the clinic and development of the care service is discussed. The care supervision, the departments nursing supervisors, ward supervisors and a representative of the care research unit participate. The ward supervision conference meets once a month with representatives from the day clinics and the out-patient department. In this manner expert-specific issues are developed.

In the day clinics and in the clinic Pniel the overall supervision is administered by the senior Doctor in charge or in individual cases, by the appointed psychological psychotherapist.

Individuals are responsible for the supervision of the secretarial staff and office management, and the department of occupational therapy and the kinesiotherapy department.

The department of research, quality assurance and documentation is supervised by a graduate assistant. In the sector quality assurance and quality management, all assigned supervisors are responsible for their own areas.

4.2.3 Committees and instruments with the focus on consultation, information and communication.

In the clinic conference (formerly the centre conference) which is the main executive board meeting, committee members are represented from all sectors, occupational groups and all

hierarchic levels. It meets at least every two months with the objective of communicating important information and to discuss and debate essential internal and external development in the clinic. In this manner a wide basis for all processes is achieved and the essential information and development is communicated directly to all work areas, so that it can be discussed and implemented.

Members of the clinic conference are:

- All members of the department supervising conference
- Head Doctors
- Supervision Day Care
- Supervision Kinesiotherapy
- Supervision Occupational therapy
- Department of Research, Quality Assurance and documentation (2 representatives)
- Counselling (1 representative)
- Supervision Domestic Economy
- Supervision Offices
- Assistant Spokesperson (2 representatives)
- Psychology Spokesperson
- Ward Supervision (4 representatives)
- Supervision Clinic Pniel
- Admission and information (1 representative)
- Appointed individuals

At the departmental level, there is usually a once monthly enlarged supervision meeting, where issues of the department are communicated and conferred. The composition of these committee meetings is determined by the department supervision.

The internal EDP system of the clinic provides staff members with current information of different types in a graded system. We hope this will reduce distribution of paper and e-mails. This information includes invitations, protocols, special information, patient information, brochures, forms and so on.

4.2.4 Further Committees

Treatment teams

Regular therapy discussions with all members of the treatment staff participating are held on the wards, in the day clinics and in the out-patient sections. Here, case-related treatment strategies are discussed and determined. Together with the entire treatment team, contextual or organisational developments of the concepts are debated in concept discussions.

Meeting of the case-responsible therapists

The assistant doctors and psychologists (including the trainee psychological psychotherapists) meet once a week to discuss questions of official organisation, further education and questions concerning occupational policy. In this manner common ground is prepared for representation at the clinic conference.

PSG Sessions

The social workers and social education workers of the entire clinic meet quarterly for a joint discussion and once monthly for department-related discussions. The psychologists also meet once a month for psychological discussions.

Occupational Therapy Team

Staff members of the occupational therapy team in Building IV meet weekly for a team session. A professional meeting for all members of the clinic occupational therapy staff is held monthly.

Workgroup Secretaries

The workgroup of the secretaries exists since the year 2000. In May 2001 the workgroup was extended by their colleagues in the day clinics and the out-patients department. The secretaries meet every second month to coordinate the work in the light of the increasingly complex requirements.

Workgroup Counselling

The ministers of the clinic, deacons and other colleagues in the counselling workgroup meet four times a year to further develop the retention of the pastoral profile in everyday life in the clinic. Additionally, organisational matters are coordinated.

Workgroups with temporary and contextual limited tasks

Basically we attempt to limit structurally implemented committees to the utmost necessary extent and prefer to set up task-focused workgroups. These workgroups are more flexible and their activities are limited both in temporal and contextual respect

5 Interlink between hospitals

5.1 "Evangelisches Krankenhaus Bielefeld" and the Clinic Alliance Valeo

The integration of our clinic into a large general hospital (www.evkb.de) and into an alliance for evangelic hospitals in Westfalen (www.valeo-klinikverbund.de) is a great advantage for the care of our patients and the development of our work. The "EvKB" with currently 25 clinics and institutes and a multitude of out-patient facilities, (including emergency facilities, dialysis, home care and special consulting hours) is a hospital providing maximum care, plus an additional care assignment for the members of the British Army and their families. To meet the medical and economical challenges of the future, it was agreed to amalgamate the previously independent hospitals, Gilead, Mara and Johannes in January 2005 and name them the "Evangelisches Krankenhaus Bielefeld GmbH." This amalgamation is associated with considerable changes, which were brought about by combining different clinics, institutes and other facilities. The changes are briefly described by constructional changes, and the formation of centres with emphasis on special medical points. Currently, changes are still continuing.

Our clinic is closely interlinked with other clinics, institutes and centres thus providing numerous facilities, for instance, mutual consulting services, intensive medical treatment of psychiatric patients, short term anaesthesia for electric convulsion therapy and surgical implantation for vagus nerve stimulation.
Interdisciplinary focal points are, amongst others

- Psycho-traumatology together with the clinic for psychotherapeutic and psychosomatic medicine and the somatic traumatological working clinics
- Pain therapy where anaesthesiologists, neurologists, psychologists and psychiatrists cooperate closely,
- Gynaecological psychosomatic (is currently being set up)
- In cooperation with the Epilepsy Centre Mara, next to their scientific work (see below), there is a close cooperation for patients with seizure disorders and psychic disorders.

- Emphasis on medical care for the elderly is currently being reorganised (amongst others between the clinic for geriatrics and rheumatology and the department of gerontopsyhiatry in our clinic).

There are also a manifold of cooperation links with many other hospitals both in Bielefeld and the region

5.2 "von Bodelschwinghsche Anstalten Bethel " and "Ev. Johanneswerk

As a part of the „v. Bodelschwinghschen Anstalten Bethel," we are cooperating with many areas of this large institution of the "Diakonie." In our work in the psychiatric field we are closely linked with the "Stiftungsbereich Integrationshilfen." In the executive committee for psychiatry contextual and strategic questions regarding the field of work across the sectors of the foundation are continually discussed and further developed. Also a close cooperation between the sectors of the foundation "Help for the elderly" and "Help for the disabled" exists. Furthermore, the institutions and services for work and occupational rehabilitation of the foundation sector "ProWerk" are also important cooperation partners. A detailed overview is provided in the publication "Hilfen für Menschen mit psychischen Erkrankungen in Bethel" (Help for persons with psychic disorders in Bethel) which was published in 2000 and is currently under revision. The objective of interlinked resources is the planning, supply and realisation of assistance plans spanning the sectors of the health system and the social security system, particularly in respect of chronically psychically ill persons. At the same time, ensuring the livelihood, treatment, rehabilitation, social and occupational reintegration is interlinked both individually and optimally. Joint admission and transfer committees in the "v. Bodelschwinghschen Anstalten" together with the participation of our clinic serve the realisation of this objective. Therefore it is fact that in all sectors of the organisation, out-patient assistance has priority before hospitalisation.

Recently after signing a cooperation agreement between the "vBA Bethel" and the "ev. Johanneswerk," the cooperation with local facilities has been intensified. Besides psychotraumatology and medicine for the elderly within the framework of the "EvKB" this refers currently to the cooperation between the different addiction sectors (Clinic am Hellweg – Rehabilitation-, advisory centre of the "Ev. Johanneswerk" our clinical department for

addiction disorders, out-patient help for addicted persons in Bethel, rehabilitation and aftercare).

5.3 Regional Care Network

Our clinic is a crossing point in the widely enlarged social-psychiatric and psychosocial network in Bielefeld. Accordingly the interlinked relationships are both manifold and intense.

- To self-help groups and interested parties of affected persons and relatives, such as the "Verband Psychiatrieerfahrener Bielefeld (VPE)," the "Interessengemeinschaft der Angehörigen psychisch Kranker (IGA)" the "Verein für freiwillige Suchtselbshilfe" and others
- To doctors, psychiatrists and neurologists in private practice
- To medical and psychological psychotherapists in private practice.
- To the central services and service centres of the city
- To the agencies offering help within and outside the community-psychiatric combination including psychiatric home care, care societies and many others
- To the judges of Bielefeld and the applicable jurisdiction
- To the responsible facilities of the police
- To the numerous information centres from different fields of assistance.

These cooperations are currently maintained in regular meetings which are held at large intervals, but also in fixed institutionalised committees related to the clinic, section or project and persons- or patients, respectively. The institutionalised committees include amongst others:

- Trialogue: there is a meeting four times a year for psychiatry experienced persons, relatives and professionals to discuss psychiatry-relevant issues and develop common projects. Amongst others, the regular psychosis workshops in the adult education centre are initiated by means of the trialogue, regular psychiatry workshops take place in the city hall and a complaints helpdesk has been initiated.
- "Arbeitsgemeinschaft Suchtkrankenhilfe." Where the professional members of the addiction aid and self-help, as well as relatives are represented
- City conference on care of the population, where recently a comprehensive catalogue of measures has been prepared for improvement of the care system.
- Psychosocial study group

- Psychiatry advisory board of the city, which also advises the city council commission on social matters and health.
- Advisory board of the dementia service centre
- Alzheimer Society Bielefeld

Furthermore we actively participate in organising the central contacts in the sectors of the city.

The addiction aid and the psychiatric aid system in Bielefeld are, as is the case in many other cities, strictly separated for historical reasons. This separation is no longer appropriate with our present knowledge and requirements and gives way to an increasing link in the fields of work. The psychiatric aid system for the elderly has developed separately and is well integrated into the general care system for the elderly. The systems are joined again in the psychosocial working group and in the psychiatric advisory board of the city.

5.4 Psycho-social Crisis Service

The psycho-social crisis service of Bielefeld City offers assistance and keeps track by telephone out of hours by means of the social-psychiatric service, for persons in acute psycho-social and psychiatric emergency situations and closely cooperates with the police, fire brigade, neurologists in private practice within the scope of the PsychKGs NRW, amongst others, also providing in-patient accommodation. Staff members of the crisis service consist mainly from team colleagues from the clinic, they accompany persons to the clinic or organise further care. A fundamental restructuring took place in 2002 and since then the professional supervision is accomplished in the clinic (for the EvKB) and the management by "PariSozial."

5.5 Academic Cooperation Partners

Constant exchange and cooperation with competent academic- and research institutions is required to achieve a high standard of research thereby continuing our development of therapeutic techniques (see also www.psychiatrie-forschung-bethel.de)

In the first place we should mention the excellent inter-relationship with the University of Bielefeld. In particular the cooperation in teaching and research:

- With the Faculty of Science for Health Knowledge
- With the Faculty for Psychology and Sport
- With the Faculty for Nursing Science
- With other institutions and facilities within the framework of interdisciplinary activities.

The cooperations include joint courses, mostly research projects funded by third parties, supervision of academic theses (diploma, theses, and dissertations). They are often completed by staff members working both for the clinic and the university.

Within the "EvKB" a close academic cooperation with the Epilepsy Centre Mara was further established, along side the contextual interdisciplinary approach to epilepsy and psychiatry, whose prerequisites in Bethel are ideal, it also provides the pleasant opportunity to make use of care and science-related technology and large specialist equipment (such as the functional magnetic resonance tomography) and staff members with diverse skills.

As an academic hospital of the "Westfälische Wilhelms Universität Münster" we are integrated into the education of medical students within the scope of their practical training in psychiatry in the second year and, in their practical training year prior to the final third state examination we make an effort to win their growing interest.
Further projects have been realised with the Institute of Psychiatry (Maudsley Hospital London), the University Clinic Centre Schleswig Lübeck, the Universities Heidelberg, Greifswald, Konstanz and Bonn. Further firm cooperations exist with academic organisations, eg. the "Norddeutscher Suchtforschungsverbund" and are continuously expanding with the objective of forming a network of regional, national and international partners.

5.6 Partnership Krakow-Bethel

For the last fifteen years there has been a continuous partnership with the psychiatric university clinic, the psychiatric hospital J.J. Babinski and the relevant social services department of the City of Krakow in Poland who are responsible for psychiatric care.

Next to international understanding and the joint process of coping with the reality of the national-socialistic crime in Poland, this partnership has the objective to deal with thematic focal points from the field of psychiatry in the scope of joint meetings and visits and to work on forming projects of further education, care and research.

5.7 Further cooperation partners

The multitude of cooperation partners that we can relate to is so large that we have not be able to list all of them without going beyond the scope of this concept. We therefore kindly ask those partners not listed to accept our apologies.

5.8 Further education

We place a high value on further education of all staff members and offer a multitude of internal and external training opportunities. Only in this way is it possible to achieve and ensure an excellent standard of work.

- "Akademie für Psychiatrie und Psychotherapie Ostwestfalen-Lippe e.V." – the further education to become a specialist for psychiatry and psychotherapy is organised to an essential extent in the academy, which is a combination of 12 clinics and facilities in the region. A basis part of the content as required by the educational guidelines of the "Landesärztekammer" is imparted in the form of 6 block-weeks over a four year period. In the scope of the academy and in cooperation with the "Deutschen Gesellschaft für Verhaltenstherapie" we are planning an educational institute for psychological-psychotherapists which will probably commence in 2006.
- In the Department for Gerontopsychiatry medical specialists can gain the additional qualification "geriatrics" after 18 month further educational training.
- Further content is taught within the clinic, additionally, in the weekly colloquium that take place jointly with the psychological faculty of the University of Bielefeld as a semester course, and is organised each semester with contextual focal points from the overall field of psychiatry and psychotherapy. External course instructors, known experts in their respective fields, account for the main part of this course. The course is open to all interested staff members, students and external qualified persons and attracts considerable interest. Internal further education is offered in the weekly "Journal-Clubs" where current

publications or conference reports are presented in a row, as well as the internal educational meetings held within the departments.

- There are close contacts to several psychotherapeutic institutes of education (Tübinger Akademie für Verhaltenstherapie, Berliner Akademie für Psychotherapie, APV Münster, Deutsche Gesellschaft für Verhaltenstherapie, Lehrinstitut Bad Salzuflen). Students from these institutes work to some extent in our clinic and are also trained through our staff members. We also must mention the cooperation with the University of Bielefeld (clinical psychology) as well as the associated "Christoph-Dornier Institut" for psychotherapy.
- Schools: important cooperation partners are the educational facilities within and outside the "EvKB" and the "v Bodelschwinghschen Anstalten" organisation. Besides the nursing schools and schools for the care of the elderly, there is in particular the special care education in psychiatry and the school for occupational therapy in Eckardtsheim. Many students complete part of their practical education in our clinic and some of our staff members conduct part of the class work in the schools. Also many candidates training for an apprenticeship will later become staff members in the clinic.

6 Research, quality assurance and documentation

The focal point of our work in the Bethel Clinic for psychiatry and psychotherapy is the direct care of our patients. Practically all our activities are directly experienced by our patients and also partly by their relatives.

On the other hand, research, quality assurance and documentation are areas and activities which are not directly experienced by our patients. They occur mainly in the background and serve to produce steady improvement in our work and to achieve standardization.

The clinic has an independent department for research, quality assurance and documentation. Staff members of this department maintain close contact with the treatment teams of the clinic.

6.1 Research work in the clinic

Medicine as an academic scientific discipline is rooted in the study of life and empiricism. This means that the methods used in individual treatments should provide the best possible relationship between effect and benefit. Therapeutic methods, which require a great deal of effort, for example in the form of high input and/or frequent side effects are, in accordance with this principle subordinate to those methods which require less effort but have an equal or better effectiveness.

The term “art of healing” which is still represented by medical and therapeutic action, shows apparently that not all individual steps can be scientifically examined and derived from the therapeutic process. Professional experience must be applied if scientifically proven knowledge is not available.

In the field of medicine the use of scientifically proven therapeutic techniques play an increasingly important role. New therapeutic techniques should only be used if they have proven to be superior to previous therapeutic methods in respective research studies in the sense described above. This principle is expressed in terms of “evidence-based medicine”

and evidence-based therapy" respectively and future "evidence-based care" as well as "evidence-based prevention."

The treatment and prevention of psychic disorders depends to a high degree on the knowledge of such disorders and their background. In many of the special use- and provision of care-related sectors the existing knowledge is not sufficient to to achieve satisfactory treatment and prevention. For this reason there is an obligation for all persons participating in medical-therapeutic care to independently participate in further educational measures and to contribute with their own experience to the further development of knowledge.

The Bethel Clinic for psychiatry and psychotherapy is, as part of the "Ev. Krankenhauses Bielefeld," a part of the academic training hospital of the University of Münster. Also in this function the clinic is obligated to the propagation of knowledge.

The academic training of "care" in the Anglo-American countries looks back on a long and extremely productive tradition. The scientific field of care contributes a great amount of knowledge to the large field of medicine that has been evaluated using methods of empirical science. In Germany there is an increasing amount of educational facilities for the science of "care" amongst others also in Bielefeld. We are, to our knowledge, the first psychiatric clinic, whilst not a university clinic, which has implemented research on "care" as an important milestone of psychiatric research thus providing our own position in the "care" research.

6.1.1 Organisation of Research

The central organisation for most of the research projects takes place in the research department in building Gilead IV which has next to the space and the technical requirements permanent members of staff. One staff member is responsible for the area "Care research" and fills the position of care supervisor.

The tasks of the research department are:

- Initiation of research projects which are located in the clinic
- Support of research projects which are initiated by staff members of the clinic

- Application for third-party funding of projects, in particular public finance institutions such as “Deutsche Forschungsgemeinschaft (DFG)” in cooperation with the Public Relations Department and Foundations and Donators as well as Industry.
- Achievement of own research work, within the framework of diploma theses and dissertations
- Visit of national and international conferences and presentation of own theses in front of large professional audiences.
- Establishment and expansion of national and international scientific cooperations
- Preparation of scientific publications

For these activities, the staff members of the research department work in close cooperation with the staff members in our clinic, and if applicable, with other cooperating clinics.

6.1.2 Fields of research

The research in the clinic deals principally with all sections of psychiatric, psychotherapeutic and care-related fields of activity. The forming of focal points for research is however important to be able to possess a high degree of expertise in dealing with some lines of questioning.

In our research planning we follow various objectives (a detailed presentation is provided at www.psychiatrie-forschung-bethel.de).

Fundamental and application research

Our objective is to conduct fundamental research as well as application- and provision of care research.

The fundamental research serves in general the understanding of the origin and maintenance of individual disorders or their symptoms. Concrete applications often arise from fundamental research. The predominant objective of the fundamental research is however the collection of new knowledge of disorders and their background. Questions relating to fundamental research play an important part, particularly in cooperation with academic institutions and with projects sponsored by the “Deutsche Forschungsgemeinschaft.” In comparison the

application- and provision of care research is targeting the analysis of existing or new therapeutic, preventative or care-related methods in more detail and if applicable trying to improve them. The Bethel Clinic for psychiatry and psychotherapy is able in a specific way to conduct application- and provision of care research as practically all types of established psychiatric/psychotherapeutic treatments and preventions are provided.

Research on bio-psycho-social factors

Our second objective is to develop research activity for all sectors of the bio-psycho-social spectrum.
Research which deals with biological aspects of psychic disorders examines the effectiveness, effect mechanisms and aetiological meaning of biological factors.
These include the following fields of research:

- Investigation of the effects of medication
- Investigation of other biological methods such as endurance training
- Investigation of genetic participation in the origin of diseases
- Investigation of neurobiological factors of individual psychic diseases by use of imaging structural and functional methods, in particular the magnetic resonance tomography and recently by means of electrophysiological methods.

The investigation of psychological factors of diseases and their background, therapy and prevention includes:

- Investigation of neuropsychological abnormalities of psychic disorders
- Investigation of mechanisms of different psychotherapeutic methods
- Investigation of backgrounds for therapy adherence of patients in cooperation with the Institute of Psychiatry (Maudsley Hospital London)
- Investigation of existing and newly created psychological examination instruments, in particular questionnaires
- Development and evaluation of neuropsychological test methods
- Investigation of backgrounds of auto-aggressive behaviour and aggressive behaviour towards others

In respect of social and social-psychological factors, social- and interpersonal backgrounds and accompanying factors of psychic disorders are examined. Examples of such research studies are:

- Stigmatisation research: What attitudes do people have towards psychically ill persons?
- Effects of the integration of relatives
- Treatment agreements.

Indication-related research

Our third objective is that each department contributes scientifically to an aspect of their work. Examples of current and planned research activities are:

- Examination of dream memory (department of General Psychiatry II)
- Effect of acupuncture for alcohol withdrawal treatment (Department for Addiction Disorders)
- Neurophysiological diagnostics of cognitive disorders in old age (Department for Gerontopsychiatry)
- Psychic disorders in epilepsy (Psychiatric Out-patient Institute)

Religious motivation and psychic health

Two projects play a special role in the investigation of the interrelationship between religious attitude and psychic health, subjective disorder- and accomplishment concepts as well as the course of the treatment for our patients.

6.2 Quality assurance and quality management

The maintenance of high quality in all work processes in a clinic which employs over 400 employees requires a special effort. The methods of quality assurance have been adopted in all areas where our staff is employed, and a consistent high quality of work is assured and a constant improvement of quality.

An important constituent for assuring constant high quality is the written formulation of clinic-internal guidelines and procedural instructions (formerly somewhat imprecisely called

"standards"). These guidelines specify laid down procedures for activities in specific constellations. However guidelines can only be effective if they are suitable for daily routine, contextually professional to a high level, accessible for all staff members and are constantly updated and their adherence is checked, revised and modified, if applicable, individually. Further in 2001 a guideline for pharmacological treatment was completed and has been published as a book. A new edition will be published in 2006.

By the way, the guidelines, applicable for many areas of the psychiatry, psychotherapy and psychosomatic, have been edited by the "Arbeitsgemeinschaft Wissenschaftlich-Medizinischer Fachgesellschaften" (www.awmf.de).

The clinic participates in the hospital quality management procedure KTQ Procum Cert, which in the meantime applies for the overall "EvKB." The first training of selected members of staff has taken place. Quality management is a continuing process in which the medium-term targeted certification represents only a sub-project.

It will be important in the future to continue this process of quality assurance with a high degree of commitment into all areas of our work. In view of the limited resources it will be a challenge for the coming years to balance the requirements of the practical work with the patients and their description onto the meta-level (in terms of a possible certification) jointly and against each other in an appropriate manner.

6.3 Documentation

As with any other medical institution, our clinic is obligated to provide patients with comprehensive documentation in writing of all medical, therapeutic and care-related measures. The documentation serves the objective to trace individual courses of patients' treatments and also to record the treatment provided and the treatment facilities used (for instance, wards, departments).

The first objective, namely the collection of the individual treatment processes, is accomplished by the creation and improvement of preferably consistent and an easy to accomplish documentation system. Here the consideration of a "paperless hospital" plays an

important role. The documentation should preferably be accomplished via EDP and be obtainable on every computer in the clinic. To achieve this target two steps have been initiated. Firstly a working group has been set up to develop in cooperation with the IT Department of the “EvKB” an adaptation to the new clinic information system covering the requirements of psychiatry and psychotherapy. This working group had already achieved a considerable amount of this task in the previous system with great success. Secondly, the development of the necessary hardware including the requisition of computer equipment for the departments has been pushed so that a preliminary completion can be expected in 2006-

The second objective, the statistical acquisition and evaluation of treatment factors and processes, is achieved by the maximum possible (but at the same time contextually reasonable) standardisation of the documentation. “This “basic documentation” serves amongst others to enable the consistent acquisition of patient data. It has been designed following the requirements of the “Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde (DGPPN)”. The German Society for psychiatry, psychotherapy and neurology. Additionally a standardised basic diagnostics (self- and external rating instruments) has been introduced for all patients, which can, if necessary, be supplemented by disorder-specific instruments.

In 2006 newly revised admission-, anamnesis- and process documentation will be introduced, which takes into consideration the significant medical, therapeutic and nursing care details and avoids double documentation. Additionally we are hoping this will achieve a new dimension of statistical and scientific evaluation of our diagnostics and treatment.

7 Perspective

To improve the care of our patients further, it is necessary to constantly develop the problem- or disorder-specific treatment concepts in all the sectors of our clinic using the most up to date knowledge. This can only be achieved in a satisfactory manner using specialist teams, since in each case the entire team includes all participating professional groups which have been integrated into providing a contextual-professional design and improving the course of process. Only in this way a high level can be maintained or even increased with limited resources. Additionally there is a requirement to provide valid bases for future decisions by means of continuous documentation (in the future in the EDP-based clinical information system), by a continuous quality management system and by clinical research. We actively participate in this aim within the scope of our opportunities and we hope also to participate in the respective activities and knowledge of other clinics.

The development will always be limited where structural requirements constrict the principal existing scope. Currently it is only possible to a limited extent to accomplish treatments beyond the in-patient, day clinic and out-patient limits. However it is necessary to overcome such sectoral therapeutic thinking and try to find a way of thinking and acting in treatment episodes. Thus it is more favourable in many cases to adapt the treatment setting to the individual requirements of the patients without the need to change the treatment team. This means to treat a patient, for example, in the stabilisation phase as an in-patient, in the therapy phase in the narrower sense as a day clinic patient and an out-patient in the transfer and discharge phase. Subsequently or by overlapping, the patient may then be discharged to the medium-term or long-term out-patient treatment and care respectively. In such a framework wards would not exist in the conventional sense but as treatment units. It might be possible to perform treatments at home in the meaning of a home treatment approach. It will be necessary to have new models of financing to establish such flexible structures of treatment. Such discussions are just beginning to emerge in organisations, cost units and in politics.

Integrated care is a step in this direction. Currently we participate in this process with two concepts on integrated care for persons suffering from chronic backaches and depression. These models are presently in different stages of examination by the involved parties.

Independent from that, the so-called enhancement of ambulatory psychiatric-psychotherapeutic treatment (also acute treatment) will proceed further and open up new opportunities in the future in the light of the fast medical therapeutic progress. We have accommodated for this development by constant further development and differentiation of our out-patient therapy techniques.

In the “EvKB” a working group under participation of our clinic is engaged in the further development of an internal complaint management within the scope of quality management. This includes amongst others the appropriate collection of complaints in our clinic as well as the assurance of efficient handling. Our objective is to obtain an overview, to recognise systematic problems more quickly and if required, to undertake specific measures.

In summary, The Bethel Clinic for psychiatry and psychotherapy, as well as the complete work field of psychiatry is in a dynamic state of development, so that concepts represent the current state and the changes that can be predicted. There will also be a requirement in the future to critically reflect theoretical models and one’s own activity and to further develop models giving consideration to the changing requirements.