S26.05

Treating postpartum depression in primary care in Santiago,Chile

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We compared the effectiveness of a multi-component intervention with usual care to treat postnatal depression among low-income mothers in primary care clinics in Santiago, Chile.

Methods: Randomised controlled trial. Two hundred and thirty mothers with major depression attending primary care clinics were randomly allocated to either a multi-component intervention or usual care. The multi-component intervention involved a psychoeducational group, systematic monitoring and treatment compliance support, and pharmacotherapy if needed. Data were analysed on an intention-to-treat basis. The main outcome measure was the Edinburgh Postnatal Depression Scale (EPDS) at 3 and 6 months post randomisation.

Results: Approximately 90% of randomised women completed assessments. There was a marked difference in all outcome measures at 3 months, in favour of the multi-component intervention. However, these differences between groups decreased after 3 months. In our primary analysis, the adjusted difference in mean EPDS between the two groups at 3 months was -4.5, 95% C.I. -6.3 to -2.7, $p<0.001$. There was a sharp decline in the proportion of women on antidepressants after 3 months in both groups.

Conclusions: This intervention considerably improved the outcome of depressed low-income mothers compared to usual care for the first 3 months. However, some of these clinical gains were not maintained thereafter, most likely because a large proportion stopped taking medication. Further refinements to this intervention are needed to ensure treatment compliance after the acute phase.

S27. Symposium: COERCIVE INTERVENTIONS FOR DISTURBED INPATIENT BEHAVIOUR AND ALTERNATIVES

S27.01

Legislation and practice in the management of violent patients in Europe. A case vignette study

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Background and Aims: Patients who exhibit violent behaviour or refuse medication during in-patient treatment are a challenge for clinical management. The management of those clinical situations is different in European countries with respect to legislation and clinical routine.

Methods: We selected three case vignettes which were considered as most typical and relevant by a vote among members of the European Violence in Psychiatry Research Group (EViPRG). Case 1 represents a voluntary in-patient who assaults a staff member, case 2 an involuntary patient who does not behave violently but refuses medication, and case 3 an out-patient who is violent against family members. In all three case vignettes the respective patients were presented as suffering from schizophrenia. From 12 European countries, each two experts were interviewed by a questionnaire about the typical clinical management and its legal requirements in these cases. Consensus among the country experts was reached after further discussion, if necessary.

Results: Considerable differences were found with respect to involvement of jurisdiction and police, application of involuntary medication, requirements for a transfer to forensic psychiatry, and use of coercive measures. Physical restraint, seclusion, and mechanical restraint each are common in some countries and forbidden or definitely not used in others.

Conclusions: More evidence from sound studies is required regarding safety, outcomes and ethical aspects of coercive treatment.

S27.02

The psychology of 'takedown': Emotional and cognitive processes during the emergency management of violence by physical restraint on the floor

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Background and Aims: Physical ('hands-on') restraint is used widely in mental health services around the world to control imminent and actual dangerous behaviour by people suffering acute mental illness. Its deployment in a supposedly caring environment generates acute ethical dilemmas for staff because of the risk of death, physical injury and/or psychological distress for both patients and staff. As a coercive intervention, it is increasingly framed professionally as a treatment failure and there is a significant effort around the world to develop alternatives at the individual and organisational level. This presentation will summarise some key findings from a series of UK studies on the psychological and social context surrounding the decision by staff to restrain a patient on the floor.

Methods: The studies have variously employed standardised instruments (e.g. ACMQ), audit data and qualitative interviews to examine the attitudes and experiences amongst patients and staff relating to restraint episodes.

Results: Attitudes toward restraint vary according to demographic factors and exposure to the technique and the decision to restrain the patient on the floor is associated with a number of contextual factors.

Conclusion: These findings will be embedded within a discussion of some relevant theories of human aggression and stress. In this way it is anticipated that our understanding of the interaction between staff and patients during crisis situations can be improved and ultimately decision-making by professionals during these episodes can be enhanced.

S27.03

The need to develop alternative methods than seclusion and restraint

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The use of seclusion and restraint (S/R) in studies of psychiatric inpatients varied between 0 and 66% of admissions. Frequent use was associated with e.g. psychopathy of the patient, but particularly with the ward culture of the unit.

The comparison of the costs and benefits of S/R is problematic since there are no randomised controlled studies of their safety or effectiveness. S/R may save lives and prevent injuries in acute violent

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or suicidal incidences. However, S/R are used also in less serious situations. A national study reported considerable economic costs caused by S/R related psychological and physical injuries of staff and patients, and huge loss of working hours. Patients experienced S/R as frightening, dehumanizing, humiliating, claustrophobic, and punishing. A physical intervention may be stressful also for staff and other patients. The consequences of stress are particularly harmful for inpatients since genetic vulnerabilities and histories of stress or maltreatment are common among them. Frequent use of S/R instead of de-escalation may harm relations between staff and patients, the effect of medicines, and the recovery. In USA, S/R have been highly prioritized since 1998 when 142 S/R-related deaths, published in a journal, lead to congressional hearings. Asphyxia is a common cause of S/R related death. The deaths or injuries associated with S/R are not systematically registered in Europe.

It is difficult but not impossible to change practices and attitudes. Several countries, settings and nursing organizations (e.g. APNA) have projects committed to the reduction of S/R. Alternative, safer methods are needed.

S27.04

Experiences with a training programme in the use of methods other than seclusion or restraint

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Background and Aims: Prevention of patient violence should be initiated very early in the aggression process. In order to improve the early preventive interventions on a psychiatric intensive care unit (PICU), we introduced a training programme including the Bröset Violence Checklist (BVC) and structured preventive care plans.

Methods: We developed a standardized list of goals and interventions for patients at risk of becoming violent towards others, covering aspects of patient participation, information, support, general care, environment, observation and coordination. All members of staff were obliged to read the patients' care plans before entering the ward and carry out the interventions. The BVC estimates the patient's level of risk for violence during the next 24 hours. In the checklist six behaviour items are noted as present or not present; confusion, irritability, boisterousness, verbal threats, physical threats and attacks on objects. On the PICU, a nurse was assigned on each shift to assess the patients. If more than two items were present, interventions to prevent a violent incident had to be initiated.

Results and conclusions: The staff found the BVC easy to learn and use. An evaluation of the predictive capacity of the BVC on the PICU showed that the risk for violence in a short term perspective could to a high degree be predicted by the nursing staff. Similarly, we found that the standardized list for care plans was experienced as helpful and an often necessary tool, well suited to be combined with the BVC.

S27.05

Least restrictive interventions towards consensus

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Background: Recommendation (2004) 10 Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder binds member states of the Council of Europe to the principles of least restriction / least intrusiveness. There are however marked differences in how these principles are being interpreted in the context of coercive interventions across Europe. Current practice is the result of the emergence of national consensus on what is acceptable rather than evidence based with procedures banned in one country such as seclusion, in common use in another. In the light of moves towards greater European consensus on mental health issues more generally the absence of a European consensus is striking.

Aims: To identify how moves towards a consensus on the use of coercive interventions might be facilitated.

Methods: Literature review, discussion.

Results: The paper proposes a taxonomy of coercive interventions and critically examines the criteria that might be employed in determining what constitutes the least restrictive/least intrusive intervention in a given situation.

Conclusions: A pan-European consensus is possible but depends on better data collection across Europe on the use of coercive interventions in order to inform its development and a willingness by practitioners to critically reflect upon the cultural determinants of practice in their setting.

W08. Workshop: THE CLINICAL SAVOIRE-FAIRE OF ETHNO-PSYCHIATRY

W08

The clinical ''savoir-faire'' of ethnopsychiatry

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In a changing world with open borders, mental health caretakers (psychiatrists, psychologists and other therapists) interact in their everyday clinical practice with patients from all over the planet who belong to various cultural and religious universes. Thus contemporary mental health caretakers treat patients suffering from pathologies informed by notions traditionally foreign to psychiatry, psychology or psychoanalysis, notions such as God, Saints, faith, prayer, witchcraft, possession, curses, spirits, ghosts, defilement, etc. Often these patients simultaneously turn to antagonistic therapeutic settings, attending psychiatrists as well as healers or priests. This transpires particularly when Western therapies lack answers. Ethnopsychiatry is a methodology combining therapeutics and research whose purpose is the creation of a framework of acceptance, interrogation and understanding of Western as well as non-Western diagnostic theories and therapeutic methods. How these patients may be treated in the most efficient and respectful way and how to avoid applying contemptuous and reductive interpretations to theories and concepts from the patient's cultural world will be addressed. Specific characteristics of the ethnopsychiatric clinical setting will be described and analyzed. In addition, the therapeutic process that assisted a drug addict to confront his family and destiny (to be a master healer) and leave France for Africa will be explored. This clinical process is based on ethnopsychiatry theory and practice. Finally we will bring epidemiological psychiatric data and clinical vignettes concerning the cohort of patients of Ethiopian origin that has been hospitalized in an Israeli mental center.

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