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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