

Mental Health Care

O0043

A pragmatic randomised controlled non-inferiority trial of open-door policy versus treatment as usual in urban psychiatric inpatient wards

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Introduction: Open-door policy (ODP) is an approach to reduce coercion in psychiatric wards recommended by the World Health Organization and the Council of Europe. Observational studies from Switzerland and Germany have shown promising results in reducing coercion, but no RCTs have been conducted. Skeptics have been concerned the observational evidence could mask that ODP could increase risks and harms and / or increase the use of coercive measures staff use to assist patients with psychoses, while proponents have argued that de-escalation and alliance-building will result in no such increase.

Objectives: To evaluate open-door policy in an openly randomised, ethical-board approved trial of all patients referred to ward care at the Lovisenberg Diaconal Hospital in Oslo, Norway.

Methods: A 12-month pragmatic, randomised-controlled non-inferiority trial comparing two ODP and three TAU acute psychiatric wards. The trial was pre-registered (ISRCTN16876467) and conformed to CONSORT. Ethical committee exemption enabled waiver of consent rules for the study, meaning all regular patients were included. Patients were randomly assigned (2:3 ratio) by a clinical admissions team using an open list. The non-inferiority margin was 15 % on the primary outcome: the proportion of patient stays with one or more coercive measures, including involuntary medication, isolation/seclusion, and physical and mechanical restraints. Primary and safety analyses were based on intention-to-treat. Safety analyses included suicides and violent events against staff. Secondary outcomes were individual coercive measures, intensive care, resource use, and patient feedback.

Results: N=556 patients were included and randomised and were similar on all pre-admission demographics: Around 75% of patients were diagnosed with a psychotic disorder and were involuntarily admitted. Primary outcome: Use of coercive measures was within the non-inferiority margin (see table 1). Safety outcomes: No suicides occurred during ward care in any group. Violence against staff did not differ between study wards. Secondary outcomes: Use of intensive care ('skjerming') and number of days admitted was significantly less on open-door policy wards. Patients on open-door policy wards rated their experience of coercion and ward atmosphere better than patients on control wards.

Table 1. Absolute and relative risk of being subjected to coercion on open-door policy or usual-treatment wards.

Main outcome	Number (%)		Relative Risk (95% CI)	Risk Difference (95% CI)	Primary hypothesis confirmed
	Absolute Risk ODP wards (n=245)	Absolute Risk TAU wards (n=311)			
One or more coercive measures during the admission	65 (26.5%)	104 (33.4%)	1.3 (0.97 to 1.6)	6.9% (-0.7 to 14.5)	Yes

Conclusions: This first RCT found open-door policy does not increase use of coercion or resource use. It does not harm staff or patients and is experienced as better by patients.

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The relationship between mental-health-related stigma among psychiatrists and country indicators across Europe

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Introduction: Mental health-related stigma occurs not only within the public community but is also an issue among healthcare professionals. The relationship between national culture and provider stigma remains yet to be empirically attested.

Objectives: We performed a cross-sectional multicentre study across 32 European countries to investigate the attitudes of psychiatrists towards patients with mental health problems. We aimed to examine the relationship of attitude with country-specific indicators.

Methods: We measured stigmatizing attitudes using the Opening Minds Stigma Scale for Health Care Providers (OMS-HC) within an online survey among specialists and trainees in general adult, child and adolescent psychiatry. Its total score was correlated with the Human Development Index (HDI), the Democracy Index (DI), the Social Progress Index (SPI), the number of psychiatrists per 100,000 people, and the Hofstede dimensions. Latent class analysis was done to find subgroups of countries according to the stigmatizing attitudes of psychiatrists and the six Hofstede dimensions.

Results: Altogether, n=4245 participants completed the survey. The total score of the OMS-HC significantly correlated with the long-term orientation ($r=0.453$, $p=0.015$) and indulgence dimensions ($r=-0.629$, $p<0.0001$) and with the HDI ($r=-0.503$, $p=0.005$), DI ($r=-0.418$, $p=0.024$), SPI ($r=-0.348$, $p=0.040$). The latent class analysis separated high- and low-stigma countries. High stigma was associated with high power distance and uncertainty scores.

Conclusions: Findings from this study not only expand knowledge of factors related to stigmatizing attitudes of healthcare professionals, but also enlighten the cultural aspects of the stigma that could contribute to the further development of anti-stigma programs.

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O0044

Physical activity and treatment adherence in patients with mental disorders: a randomized controlled trial

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Introduction: Lack of adherence to pharmacological treatment is considered a multifactorial phenomenon, remarkably frequent in clinical practice. Non-adherence is associated with increased number of relapses, poor clinical and functional outcomes, and worsening of patient health status, with a resulting increase in healthcare costs, particularly in people with severe mental disorders (SMD). Treatment adherence rates remain extremely low, highlighting the need to develop innovative and integrated strategies; one of these is represented by the promotion of healthy lifestyle behaviours, including regular physical activity.

Objectives: The aim of this study is to assess how the rates of treatment adherence vary in patients with SMD after receiving a psychosocial intervention, focusing on the positive relationship between treatment adherence and physical activity.

Methods: LIFESTYLE is a randomized controlled trial comparing the efficacy of a structured psychosocial lifestyle intervention involving moderate physical activity exercises over a brief psychoeducational intervention. Levels of physical activity was assessed through the IPAQ scale, while treatment adherence was evaluated by the Morisky Medication Adherence Scale (MMAS).

Results: The sample includes 401 patients, with a mean duration of illness was 16.3 (± 17.8) years. All patients were receiving a pharmacological drug treatment; in particular, 59.6% (N=239) were treated with a second-generation antipsychotic and 54.9% (N=220) with a mood stabilizer. Our results show that moderate physical activity improves rates of treatment adherence. After 6 months, adherence to treatment increased from 35.8% at baseline to 47.6% at baseline in the experimental group, along with improvement in clinical health parameters (reduction in BMI, weight, and metabolic parameters). Another significant inverse correlation was found between adherence and quality of life (Rho di Person: $-.140$, $p<.005$). Furthermore, this study indicates that having a diagnosis of major depression, a better cognitive functioning, a shorter duration of illness and contact time with the local mental health centre are factors that positively influence treatment adherence. Remarkably, treatment adherence was not influenced by symptom severity and type of pharmacological treatment.

Conclusions: Moderate physical activity can represent a valid strategy to increase treatment adherence in patients with SMD.