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Within its sociotherapeutical programme St. John Psychiatric Hospital has been continuously since 1963 conducting the treatment and rehabilitation of psychiatric patients accommodated in heterogeneous families according to the Belgian model. Research conducted in the West as well as the experience gained at our hospital suggests that this sociotherapeutical method is very effective in the process of prolonged treatment, rehabilitation and resocialisation as well as the improvement of the quality of life of psychiatric patients. The ultimate objective of this investigation was to examine the quality of life of the groups of schizophrenic and depressive patients under observation, and the impact of a heterogeneous family, primary or secondary family and hospital ambient on the process of treatment and rehabilitation. The assumption is that in the process of prolonged treatment patients accommodated in heterogeneous families psychosocially function better and attain a higher quality of life than those who are under long-term outpatient treatment and live with the primary or secondary family or, alternatively, have been hospitalised. Applied was a comparative method of investigating groups of patients affected by schizophrenia and depression that were in the process of prolonged treatment accommodated in heterogeneous families, primary or secondary family, or those who were hospitalised. Individually assessed by way of appropriate questionnaires, completed by the very subjects, were the health-related quality of life and the subjective quality of life.

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Socio-psychological problems in the families of patients with mental illnesses in republic of belarus

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The study was carried out at the Department of Psychiatry of the Belarusian Medical Academy of Post-Graduate Education.

The purpose of the study was investigating the problems connected with negative consequences of mental illness stigma and the family burden.

Method and objective: Study participants were: the caregivers of the patients admitted to the Republican Clinical Psychiatric Hospital, suffering from schizophrenia, affective disorders and the control group (participants from mentally healthy families).

The inclusion criteria were: 1) living with the patient in the same house; 2) age $>$ 18 years; 3) absence of somatic and psychiatric pathology; 4) informed consent.

We used the following assessment instruments: the Medical Outcomes Study Short-Form36 (SF-36) survey; Family Experiences with the Stigma of Mental Illness Questionnaire by H.Stuart; the Coping Strategies Questionnaire by E.Heim; the Questionnaire of Family Burden according to the WHO «Quality Assurance in Mental Health Care».

Result: The obtained results show that relatives of mentally ill patients suffer from negative consequences of stigma and discrimination. They have the burden in economic, psychological, social environment, family interaction areas. Relatives feel social isolation, shame, guilt, worry and distress.

Conclusion: One of the causes of such tragic consequences of stigma is the lack of specific information about mental illnesses and choice of inadequate coping strategies. We apply psychoeducational project in the families of patients with schizophrenia to reduce negative influence on their lives.

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Psychiatrist and social dialogue

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Background and aims: The authors presented their acitivities in prevention of mobbing, suiciality, pathological gambling, and antistigma programs aimed for the persons treated for combat PTSD.

Methods: Social dialogue is achieved through numerous outpatient activities that included systematic information and education, public discussions, conducted studies, public program promotions, performance presentations, koordination, and active engagement of various professionals (psychiatrists, psychologists, pedagogues, social workers, jurists, politicians, employees in civil service, associations and syndicate, employers, and volonteers).

Results: Numerous public disscussions and professional gatherings have been held, professional and scientific studies have been conducted, programs have been presented in public through various media, web-pages have been created and brochures have been written. The created positve atmosphere leveled up the awarenes, what resulted in propositions for drawing up broader, national strategies, and some pending legal solutions.

Conclusion: Social dialoge is represented by all types of information exchange, conslutations, and discussions between social partners and government representatives about issues of common interest related to social or economic policy. In situations when some primalily social events partially participate in the genesis of psychological disorders, a psychiatrist may take part in the dialogue, pointing out the existance of the problem, defining the problem and offering professional solutions for prevention. In order to have a social dialogue it is necessary to have most extensive public support and understanding that only with joint endeavor of all citizens the problem may be, and must be, solved.

P419

An investigation on spouses' mutual abuse behavior

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Introduction: The family plays an essential role in individual and social life. That is the first center to grow and blossom the talents appropriately and a starting point for all social charges each modification should start from the family.

Method: This is a descriptive analytic study. On 394 men and 404 women. The spouses' abuse behavior was defined by a questionnaire. Results:

The findings showed that there was a significant association between abuse behaviors such as aggression, screaming, punishment and physical fight, mutual scorning, contempt and criticizing, silence and not speaking, insulting not talking to each other, criticizing in public, throwing and breaking things, sleeping separately between men and women ($p<0.001$)

The findings showed 88% of the men and 51% of the women, stubbornness in 73% of men and 70%of women, aggression and screaming in 63%of men and 51% women, physical punishment

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and fight in 27% of men and 16%of women, leaving home in 14%of men and 22% of women, having undesired sexual relation with spouse in 47%of men and ignoring spouse's sexual needs in 35%of women and throwing and breaking things in 34%of men and 26%of women.

Conclusion: Regarding the findings, holding education before family formation is essential. Educating people concerning how to control their anger together with teaching appropriate communication skills are important.

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A randomised study comparing seclusion and mechanical restraint in people with serious mental illness

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Objective: Seclusion and mechanical restraint are widely used for people with serious mental disorders. In most countries one intervention is preferred while the other is considered as inhuman or not sufficiently safe, but identical arguments refer to different preferences. There is a lack of evidence from well-designed studies on compulsory measures in psychiatry.

Methods: We conducted a cohort study with optional randomisation comparing seclusion and mechanical restraint among inpatients with acute psychotic disorders. We determined an ethical aspect as main outcome variable: the restriction of human rights from the patients' point of view, measured by a scale developed for this purpose, Human DIgnity during COercive Procedures, DICOP-Score.

Results: 102 out of 233 patients exposed to coercive measures within 24 months could be included, 26 could be randomised (12 seclusion, 14 restraint). There were no significant differences between the two interventions referring to DICOP-score and duration of the intervention. The burdens most frequently reported were solitude, loss of dignity, and not having understood why the intervention was done. Watching pictures of several alternatives in the interview, including physical restraint and net bed (not available in Germany), most patients preferred seclusion.

Conclusions: Both from ethical and safety aspects the results do not yield evidence to prefer or forbid one of the interventions. Clinical decisions should take into account patients' preferences.

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