

## Mental Health Care 01

## EPP0065

### A qualitative investigation of healthcare professionals' viewpoints of the healthcare process of persons with a serious mental illness in prisons with a traditional model for mental health care provision in Spain

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**Introduction:** Healthcare delivery in prisons depends on the national Ministry of Interior in 14 of 17 autonomous regions in Spain. A traditional model for health and mental health care provision prevails.

**Objectives:** To increase understanding of the mental health care process of imprisoned persons with a serious mental illness (SMI) in Spanish prisons with a traditional model of health care provision.

**Methods:** 10 healthcare professionals (6 physicians, 3 nurses, 1 pharmacist) working in small (<450 prisoners), middle size (450-1,000) and big (>1,000) prisons took part in 3 online focus groups between 31<sup>st</sup> May and 2<sup>nd</sup> June 2022. The moderator used open-ended questions to research into the healthcare process (diagnosis, treatment, follow up, prevention) of prisoners with SMI. Focus groups lasted 2 hours, and were audiotape recorded and transcribed. Transcripts were analysed applying constant comparative method and theoretical saturation.

**Results:** Mental healthcare provision varies across prisons, but commonalities exist. Healthcare professionals reported that about 60% of SMI are diagnosed by the correctional general practice physician (GP) at incarceration. Severe cases are assessed by an external psychiatrist. Once a week (average) the psychiatrist visits the prison to either confirm diagnoses or adjust treatments. One third of prisoners who would benefit from a psychiatric assessment has it. Follow up occurs in the prison infirmary for close supervision. If addiction concurs, referral to therapeutic modules happen. Polypharmacy and overmedication are common. Simplification of therapies and slow-release injectable formulations of antipsychotics are desirable. Everyday mental health care and rehabilitation take place throughout a specific, little equipped, psycho-social support programme implemented in most prisons but restricted to the most disabled SMI persons. Acute psychiatric episodes occur due to treatment interruptions or deviations and are managed by the correctional GP. Hospital referrals are problematic without protocols. Prevention of relapses relies on prisoners supervision and staff observation. Healthcare records are only available to healthcare professionals working in prisons. Outside prisons, continued care needs of mental health and social support in the community. Due to healthcare services modest readiness to respond to needs and poor social networks, SMI persons are prone to relapse and recidivism.

**Conclusions:** Focus groups found that working in isolation from the public healthcare system, shortage of psychiatrists, poorly implemented therapeutic and rehabilitation programmes, and lack of mental health and social care services in the community negatively affect the care of prisoners with SMI in Spain.

**Disclosure of Interest:** None Declared

## EPP0065

### Does intensive home treatment change treatment trajectories of psychiatric disorders?

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**Introduction:** Intensive home treatment (IHT) for people experiencing a mental health crisis has been progressively established in many western countries as an alternative to in-ward admission. But is this a real alternative? We previously reported that patients treated in our IHT unit only differ from those voluntarily admitted to hospital in suicidal risk and severe behaviour disorders (not in other factors such as clinical severity) (Martín-Blanco *et al.*, Rev Psiquiatr Salud Ment 2022;15:213-5). Now we are interested in disentangle if those patients who used to require in-ward management can be successfully treated at home.

**Objectives:** To describe subsequent treatment trajectories of the first 1000 admissions to our IHT unit and to compare clinical characteristics among the different groups of trajectories.

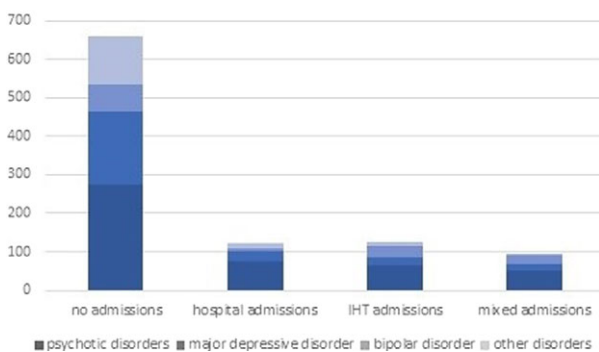
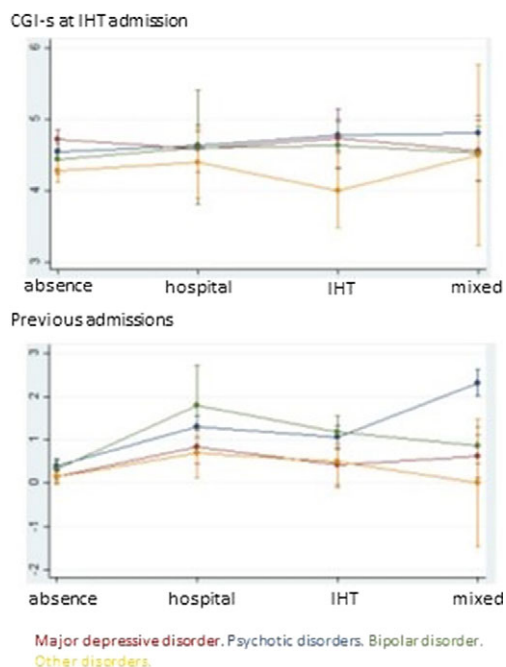
**Methods:** Retrospective cohort study. Subsequent treatment trajectories were collected from December 2016 to October 2022 and classified: absence, hospital, IHT, and mixed (hospital and IHT). Statistical significance was tested by means of ANOVA or Kruskal-Wallis test for quantitative variables (corrected for multiple comparisons) and chi-square tests for qualitative variables.

**Results:** Tables 1 shows the characteristics of the whole sample. Of the 1000 IHT admissions, 12.1% needed subsequent hospital admission(s), 12.7% IHT admission(s), and 9.3% mixed admission(s). There were no differences among these groups in median severity at IHT admission, but there were differences in the number of previous admissions ( $p=0.0001$ ): the group with no subsequent admissions had less previous admissions than the other groups ( $p_{Bonf}<0.0001$ ), and the group with subsequent IHT admissions had less than the group with mixed admissions ( $p_{Bonf}=0.0123$ ). There were differences between groups regarding distribution of diagnoses ( $p<0.0001$ ) (Fig. 1). When considering subsequent admissions by diagnosis, there were differences in severity at IHT admission ( $p=0.0068$ ) and in number of previous hospitalizations ( $p<0.0001$ ) (Fig. 2).

**Table 1.** Clinical characteristics of the whole sample (N=1000).

	mean	SD
Age (years)	47.07	17.02
CGI-s at admission *	5	4-5
	N	%
Sex (female)	548	54.8%
Psychotic disorders	463	46.3%
Affective disorder	257	25.7%
Bipolar disorder	128	12.8%
Other disorders	152	15.2%
Hospital admission in the previous 5 years	313	31.3%

CGI-s: clinical global impression - severity. \* median and IQR

**Image:****Figure 1.** Distribution of diagnoses according to treatment trajectories.**Image 2:****Figure 2.** Subsequent admissions according to diagnostic group.

**Conclusions:** Patients that used to require inward management can now be treated at home when suffering an acute episode. Therefore, IHT has changed treatment trajectories for some patients with psychiatric disorders.

**Disclosure of Interest:** None Declared

**EPP0066****Lessons from the Impact of War in Ukraine on Combatants' Mental Health during the Last Decade**

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**Introduction:** The threat and preservation of the territorial integrity of Ukraine are not new issues. During the last decade, peacetime (Peace, until 2013) was disrupted by active hostility (AH, 2014–2015) and trench warfare (TW, 2016–2021). War exert acute and chronic impacts on mental health, may be a substrate for mental health disorders, especially worrisome since, today, the large-scale conflict has demanded the recruitment of adult civilians to defend and fight alongside armed forces troops.

**Objectives:** The analysis aimed to unveil the impact of those conflicts on the mental health of the army and help us to anticipate risk factors (ranks, time period) and need for resources (admissions and days of hospitalization per time period, rank and disease).

**Methods:** A retrospective cross-sectional analysis of an anonymized part of the internal database included 3995 anonymized records. Data are expressed as the frequency (%), fold-increase, or mean  $\pm$  SEM. Chi-square analysis and ANOVA with Bonferroni post hoc correction were performed with Jamovi.

**Results:** The temporal distribution of admissions (Figure 1) showed a 6.97 (AH) and 3.62 (TW) [5.02 (TW1, 2016–2017), 3.91 (TW2, 2018–2019), and 1.95 (TW3, 2020–2021)] fold increase per year compared to peacetime. The most frequent mental health problems, accounting for 76.1% of cases, were 'anxiety, dissociative, stress-related, somatoform and other nonpsychotic disorders' (F40–F48, ANXd, 40.1%) and 'mental and behavioral disorders due to psychoactive substance use' (F10–F19, PSUd, 36.0%). 'Reaction to severe stress and adjustment disorders (F43, 76.5%) and 'Alcohol-related disorders (F10, 89.3%) were the predominant mental health disorders, respectively.

The ICD-10 category depended on the war period (Figure 2), with peacetime to TW2 accounting for 90% of cases. 'ANXd' were the main mental health problem in any period, with 61.8% of cases occurring in peacetime. PSUd, residual in peacetime 6.1%, reached their peak in active hostility (47.4%), with 97.9% of 'Alcohol-related disorders' as the cause of these admissions, which could agree with the use of alcohol serving as a coping mechanism in front traumatic events. In trench warfare, PSUd decreased (TW1, 39.2%; TW2, 25.1%).

Hospital stays for people with ANXd or PSUd lasted at least one month in peacetime but significantly decreased in war periods (Figure 3). This could be explained by a 'need for free beds effect' and the distribution of admissions by ranks.