

Results: There was a significant difference in the mean baseline and three-month BSCS scores (-2.17, 95% CI of -0.62 to -3.72), PHQ-9 scores (-5.08, 95% CI of -1.65 to -8.51), and the GAD-7 scores (-2.93, 95% CI of -0.48 to -5.56). Participants agreed that the supportive text messages helped them cope with addiction-related stress (89%), anxiety (81%) and depression (69%).

Conclusions: The Text4Hope-Addiction program effectively reduced cravings, anxiety, and depression among subscribers, with high satisfaction rates for the program. Healthcare practitioners and policymakers should consider implementing supportive text-based strategies to complement conventional treatments for addiction.

Disclosure of Interest: None Declared

EPP0057

Digital mental health: Perceptions and opinions of Tunisian patients

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Introduction: With the rapid advancement of modern technology, many countries have adopted mental health care systems supplemented by digital means of communication. Are Tunisian patients “ready” for the “digital revolution”?

Objectives: The aim of our study was to assess perceptions of people living with mental illness on digital mental health.

Methods: We developed a cross-sectional study where we randomly included patients who were treated for a psychiatric disorder in a public or a private practice. Inclusion criteria were: subject 18 years old or older, clinical remission for at least three months. We developed a questionnaire on sociodemographic and clinical variables. We also included questions on patients’ level of interest in using digital mental health services such as teleconsultation and mental health smartphone apps. Perceived obstacles in using digital mental health by patients were also evaluated.

Results: Our sample size was 260 patients. The mean age of our population was 36,4 years old with. The mean distance from the household to the mental health care provider was 17,3 km.

Two thirds of the sample had access to a wifi connection at home (172 patients). When asked about the content of internet searches, 66% have already looked for information on their mental health or mental disorders on web pages. Patients were very interested in video teleconsultation with their therapists (72%), psychoeducation apps (68%) and online mood journals (61%). They expressed little to no interest in online exchanges with other patients and medication reminder apps. The most reported obstacles in implementing digital mental health as noted by patients were : lack of perceived effectiveness, virtual communication with their therapist and confidentiality issues.

Conclusions: Mental health patients in Tunisia expressed a great interest in teleconsultations and online psychoeducation programs. Further research on the willingness of mental health professionals to adopt digital mental health services are needed.

Disclosure of Interest: None Declared

Ethics and Psychiatry

EPP0058

Attitudes towards Futile Treatments, Moral Distress and Intention to Leave Job in Nurses

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Introduction: The fact that nurses do not have a voice in the treatment decision of patients and that there is no framework about futile treatments can cause some psychological problems such as depression, burnout and moral distress (Yildirim et al., 2018). If not managed properly, moral distress leads to decreased job satisfaction, increased nurse turnover rates and intent to change the working area or leave the profession (Vieira & Doedato & Mendes, 2021).

Objectives: This study aimed to explore the nurses’ attitudes towards futile treatments and its relationship with the moral distress, intention to leave the job and the other personal factors.

Methods: This study has a descriptive and correlational design, carried out with 425 nurses, between April-May 2021 in Istanbul. The data were collected using a Personal Information Form, The Nurses’ Attitudes Towards Futile Treatment Scale (NATFTS), Moral Distress Scale (MDS) and Intention to Leave Scale (ILS). **Personal Information Form:** The form consists of 22 questions including the socio-demographics and professional characteristics. **The Nurses’ Attitudes Towards Futile Treatment Scale (NATFTS):** The scale was developed by Yildirim et al. in 2019, consisting of 18 items and uses a 5-point likert type scale. **Moral Distress Scale (MDS):** The scale, developed by Hamric (2012), adapted to Turkish by Karagözoğlu et al. (2017), consisting of 21 expressions, was designed to measure the level of moral distress in nurses. **Intention to Leave Scale (ILS):** The scale was developed by Wayne et al. (1997), and adapted to Turkish by Avcı ve Küçükusta (2008) in the form of 5 items. The data were analyzed by using descriptives, Kruskal Wallis test, Independent Samples t- test and ANOVA, Pearson Correlation analysis on SPSS 25.0 for Windows. For significance, $p < .05$ and 95% CI were assumed in the data analysis.

Results: A moderate negative correlation was found between NATFTS score and the ILS score ($r = -0.356$, $p < 0.001$). Nurses who think that futile treatments should be applied under the strict rules have less tendency to leave their jobs. On the other hand, there was a lower positive level of correlation between NATFTS score and the MDS score ($r = 0.295$, $p < 0.001$). That is, nurses who think that futile treatments should be applied under the strict rules have a

higher level of moral distress. A low-level negative of relationship was found between the MDS score and the ILS score ($r=-0,260$, $p<0,001$). As the level of moral distress increases, the tendency to leave work decreases.

Image 2:

Table 1. Regression analysis of Socio-demographic Characteristics, Professional characteristics, ILS and MDS scale scores with NATFTS |

Parameter	B	Beta	t	P	GA		VIF
					Min	Max	
NAFTS ($R^2=.204$; $F= 7.738$; $p<.001$)							
	31,901		5,131	<.001	19,656	44,147	
Gender	-3,84	-0,18	-3,24	0,001	-6,17	-1,51	1,02
Age	0,50	0,31	1,99	0,047	0,00	1,04	7,73
Professional Experience	-0,49	-0,40	-2,47	0,014	-0,08	-0,01	8,10
Health Vocational School	-1,91	-0,09	-1,34	0,18	-4,72	0,88	1,43
Associate in Science	-2,50	-0,07	-1,18	0,23	-6,67	1,66	1,31
Bachelor in Science	3,37	0,18	3,16	0,002	1,27	5,47	1,04
Oncology/Hematology/BMT	-3,68	-0,19	-3,06	0,002	-6,05	-1,31	1,18
Outpatient Service	6,93	0,16	2,74	0,007	1,95	11,91	1,11
Inpatient Service	2,88	0,12	1,87	0,06	-0,15	5,92	1,29
Emergency Service	1,35	0,04	0,68	0,49	-2,55	5,27	1,26
ILS	-0,72	-0,34	-5,23	< 0,001	-0,99	-0,45	1,25
MDS	0,01	0,07	1,10	0,27	-0,009	0,03	1,26

Conclusions: It is believed that educating nurses and strengthening them psychologically will prevent them from experiencing moral distress, increase job satisfaction and reduce intention to leave (Cicolini et al., 2014). Considering the negative effects of ethical dilemmas about futile treatments on health professionals, it is recommended that legal regulations be made on the subject and institutions determine their own protocol.

Disclosure of Interest: None Declared

EPP0059

Physical Restraints in a Mental Hospital Emergency Unit: Facts vs Perceptions of Healthcare Workers

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Introduction: Coercion is a general term used to refer to a series of actions, ranging from involuntary treatments to forced interventions, which can be ethically, legally and clinically challenging for both professionals and service-users. Perception of healthcare professionals on restraint practices is an important factor determining the clinical outcomes.

Objectives: The aim of this study was to determine i) the differences between the estimates of healthcare professionals working in the Emergency Unit of Erenköy Psychiatric and Neurological Training and Research Hospital (Erenköy RSHEAH) regarding physical

restraint practices and the real use and outcome values ii) the knowledge, attitudes and opinions of healthcare professionals on such procedures.

Methods: The study was designed as a descriptive cross-sectional online survey. All healthcare professionals working in the Emergency Unit of Erenköy RSHEAH (with a catchment area of 5 million people) who agreed to participate in the study and who were not part of the research team were included. Sociodemographic information, information about working experience, and estimates of physical restraint practices in the last month were questioned. Attitudes and opinions towards these practices were evaluated with 5-point Likert-type questions. Ethical approval was obtained from Erenköy RSHEAH Clinical Ethics Committee (Decision No: 40, 18.07.2022).

Results: A total of 55 healthcare workers (31 trainees, 10 specialist psychiatrists, 6 nurses, 8 security personnel) participated in the study. The mean age of the participants was 32 ± 6.4 years (24-50, min-max) and 52.7% were female. The mean duration of employment in the health sector and current institution were 6.6 ± 5.7 (1-22, min-max), and 4.1 ± 4.1 (1-17, min-max) years, respectively. The estimated mean rate of physical restriction was $13.5\pm 13\%$ (2-60, min-max). However, the actual median rate was 4% (0 - 8.8% min-max) in the same month. The estimated mean duration of physical restraint was reported as 87.8 ± 54.1 (20-300, min-max) minutes, whereas the median actual duration of physical restraint was 60 minutes. No significant relationship was found between the estimates of duration, rates and complication rates of physical restraint and the duration of professional experience ($p>0.05$). A significant difference was found between professional groups in terms of restraint duration and complication rate ($p<0.05$), as well as their opinions regarding the appropriateness of restraint practices with the legal framework (Table 1).

Image:

Professional Group	Question 1		Question 2		Question 3		Question 4		Question 5		Question 6	
	n	%	n	%	n	%	n	%	n	%	n	%
Security	7	87.5	8	100	1	12.5	7	87.5	7	87.5	0	0
Nurse	5	83.3	6	100	0	0	5	83.3	3	50	2	33.3
Trainee in Psychiatry	21	67.7	16	51.6	0	0	26	83.9	14	42.5	4	12.5
Specialist in Psychiatry	9	90	6	60	0	0	10	100	9	90	3	30

Table 1. Health Workers' Views on Physical Restraint (p value is calculated where available)

Question 1= I have enough knowledge about restraint methods and how they should be applied.

Question 2= I have enough knowledge about the standards and legal procedures in our country, on how physical restraint measures should be applied.

Question 3= Physical or chemical restraint (administration of sedative drugs to prevent the patient's movements) should never be used.

Question 4= Although physical restraint shall never be applied, chemical restraint (administration of sedative drugs to prevent the patient's movements) can be applied in some cases.

Question 5= I find the restraint practices in our emergency unit in accordance with the legislation in our country.

Question 6= I feel guilty after physical restraint interventions.

Conclusions: It was observed that healthcare workers had a misperception regarding the rate and duration of physical restraints, which were perceived as higher than the actual values. Thus, the restraint interventions were perceived to be more negative than they actually are. Correction of such misperceptions should become part of the continuous educational processes of all professional groups.

Disclosure of Interest: None Declared