

Symposium: psychiatry in humanitarian emergencies – Joint symposium with the WHO

JS03

Internally displaced persons in Ukraine

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As of May 21, 2015 UNHCR has information about 1,299,800 IDPs, the data provided by the Ministry of Social Policy of Ukraine. Since the process of establishing a centralized system for registration is still pending, the actual number of persons displaced within the country may be higher.

We have a complex psychopathological and clinical research psychodiagnostic 97 internally displaced people in volunteer center, located at the central train station in Kharkiv to study the clinical features of neurotic disorders.

The results showed that 75.9% of IDPs observed have violations of adaptation: long-term depressive reaction (F 43.21) and predominant disturbance of other emotions (F 43.23). The clinical picture is dominated by the depression, anxiety, inner tension, inability to relax, asthenic symptoms, various fears and paroxysmal autonomic instability.

The results of the diagnostic psychological studies have found that men reactive alarm indicators (average – $37,7 \pm 3,0$) were higher than trait anxiety (average – $32,6 \pm 2,9$). On the contrary, women figures trait anxiety (average – $38,6 \pm 2,9$) were higher than reactive anxiety (average – $34,7 \pm 3,0$). Severity of depressive symptoms also slightly prevailed in women. The mean score on the Hamilton scale for men was $17,0 \pm 2,3$ points, women – $18,0 \pm 2,3$ points.

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JS04

A new humanitarian emergency: Refugees and mental health in Turkey

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Warfare in different parts of the world has led to a humanitarian emergency: forced displacement of millions of people. Global forced displacement in 2014 was the highest displacement on record since WW 2. By the end-2014, 59.5 million individuals forcibly displaced worldwide, as a result of persecution, armed conflicts, general violence, wars, or human rights violations. The number of individuals forced to leave their homes per day reached to 42,500 in 2014, hence, increased 4 times in the last 4 years. Top five refugee hosting countries are Turkey, Pakistan, Lebanon, Iran, Ethiopia and Jordan. While Turkey hosted 1.6 million forced displaced people in 2014; it is estimated that this number reached 2.5 million by the end of 2015.

Forced displacement of people due to warfare may be considered as a psychosocial earthquake. Especially after the deaths of thousands of them in the Mediterranean in the last couple years has brought this issue sharply into the focus of the whole world. While the deaths of the forced displaced people on across the borders of the whole world in the first nine months of 2014 were slightly over 4000; it reached the same number of human loss only in the Mediterranean region in 2015.

Refugees fleeing with few possessions leading to neighboring or more developed countries face many life-threatening risks on the way, as they have nowhere to turn. A refugee is a person who has lost the past for an unknown future. Experiences of loss and danger

are imprinted in their selves. It is shown that, in the short/medium term, 60% suffer from mental disorders, e.g., posttraumatic stress disorder (PTSD), depressive disorders, anxiety disorders, psychosis, and dissociative disorders. In the long term, existing evidence suggests that mental disorders tend to be highly prevalent in war refugees even many years after resettlement. This increased risk may not only be a consequence of exposure to wartime trauma but may also be influenced by post-migration socioeconomic factors. In fact, “we are seeing here the immense costs of not ending wars, of failing to resolve or prevent conflicts.” Once more, psychiatry and mental health workers are facing the mental health consequences of persecution, general violence, wars, and human rights violations caused by the current prevailing economy-politics and socio-politics. So, a serious challenge here is avoiding the medicalization of social phenomena. This presentation will discuss the issue of forced displaced people considering it as a humanitarian tragedy with some examples of its mental health consequences from Turkey.

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JS05

Overview of European refugee mental health situation

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This presentation will offer information about latest number of refugees and internally displaced people across Europe, their (mental) health problems and activities and interventions coordinated by WHO. It will also suggest ways by which EPA and WHO could continue their effective partnership to assist countries.

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Symposium: advancing implementation – Joint symposium with European mental health programmes

JS06

Implementing the mental health action plan – experiences and challenges

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The WHO European mental health action plan was adopted by all countries in the European region in Izmir in September 2013. Its 6 objectives cover promotion and prevention, human rights, services and partnerships. Since its adoption, the WHO mental health programme is working in some 25 countries, supporting policy development and implementation. Priorities are the introduction of health promotion programmes for vulnerable groups; the competence of primary care to identify, diagnose and treat people with mental disorders; and the implementation of community-based service models sensitive to the culture and resources of countries. Particularly successful have been countries where a consensus was established between policymakers and professional leaders, and where different levels of government worked together. Obstacles

experiences have been funding cuts and lack of incentives. Some examples will be presented.

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Symposium: making medicines out of illicit drugs – ECNP symposium hosted by EPA

JS07

Can ecstasy treat the agony of PTSD?

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Introduction Two serotonin reuptake inhibitors (SSRIs) have received FDA indication for treatment of PTSD, however the effectiveness of pharmacotherapy for PTSD is limited. Psychotherapy, including several well established evidence based methods, is the mainstay of PTSD treatment. Despite advances in this area, a significant percentage of PTSD patients are refractory to existing treatments. Recent research has explored the possibility that certain drugs could increase the effectiveness of psychotherapy when administered intermittently in conjunction with psychotherapy sessions. The most robust published. Results to date using this approach have been in early clinical trials of \pm 3,4-methylenedioxymethamphetamine (MDMA)-assisted psychotherapy. These studies primarily involved civilians with treatment-resistant, crime-related PTSD. A more recent phase 2 trial, completed in 2015 yielded equally promising. Results in a cohort of military veterans, police officers and firefighters, mostly veterans from the wars in Iraq and Afghanistan.

Methodology In these double blind controlled trials subjects with PTSD refractory to prior treatment are randomized to an active dose of MDMA or an active or inactive placebo administered to each individual on only two or three occasions during eight-hour psychotherapy sessions one month apart, in conjunction with preparatory and follow-up psychotherapy sessions. Outcome measures are repeated one or two months after the second MDMA-assisted session before the blind is broken. Subjects who were randomized to full dose MDMA are then eligible for one additional, open label, MDMA-assisted session. Those randomized to placebo or a lower dose of MDMA are eligible for three open-label full dose sessions. Outcome measures are repeated two months following the third MDMA-assisted session. The primary outcome measure is the Clinician Administered PTSD Scale (CAPS). Additional measures include the Beck Depression Inventory-II (BDI-II), Global Assessment of Functioning (GAF), Pittsburgh Sleep Quality Index (PSQI) and Posttraumatic Growth Inventory (PTGI).

Results In the original study comparing MDMA with inactive placebo along with the same psychotherapy PTSD was resolved in 83% of the MDMA group vs. 25% of the placebo group receiving the same therapy. Improvement was maintained for at least 74% of subjects at long-term follow-up a mean of 45 months later. In a more recent, unpublished, study both the high dose and the medium dose of MDMA showed large effect sizes in reducing CAPS scores, and improvements in secondary measures: and BDI-II, PSQI, GAF and PTGI.

Conclusion Evidence in phase II trials suggest that MDMA-assisted psychotherapy is effective in treating PTSD in both civilians and veterans who have not responded to established treatments. Phase III trials are necessary to definitively establish safety and efficacy of MDMA-assisted psychotherapy for PTSD.

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JS08

Treatment of heroin dependence with ibogaine

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Background The use of the hallucinogen ibogaine as an anti-addiction agent has been described in several case reports, dating back to the eighties. The anti-addiction properties of ibogaine have been confirmed in a large body of animal work. Ibogaine has been shown to be effective in reducing withdrawal severity and substance use for a variety of substances, including cocaine and opiates. Animal studies also show some potentially dangerous adverse reactions, including cerebellar toxicity and potential cardiac effects. While pharmacological treatment options for opiate and cocaine dependence are still limited, ibogaine assisted treatment might be a promising new option. Therefore more systematic studies on its toxicity and efficacy are warranted. In our studies we address these two research questions: is ibogaine treatment for opiate dependence safe and effective for treating opiate withdrawal and relapse prevention? A secondary objective is to explore the pharmacokinetic properties of ibogaine.

Methods Animal work: first we performed a systematic review and meta-analysis of animal studies on ibogaine. Thirty studies were included in the systematic review, of which 27 could be analyzed in meta-analysis. Human studies: fifteen opiate dependent patients will be treated with ibogaine (10 mg/kg), on top of treatment as usual. Ibogaine toxicity will be assessed through close monitoring with electrocardiography, with QTc prolongation as main outcome measure, repeated assessments of ataxia using the (SARA) and observation of psychotic symptoms by using the Delirium Observations Scale (DOS). Ibogaine efficacy will be measured, using repeated evaluations of opiate withdrawal severity (Subjective Opiate Withdrawal Scale: SOWS; Objective Opiate Withdrawal Scale: OOWS), craving intensity (using a Visual Analogue Scale) and substance use, with a six-month follow-up. Clinical observations in ibogaine treated individuals will be compared with a cohort of opiate dependent patients treated with a rapid detoxification procedure. Both acute and long-term effects will be linked with serum ibogaine and noribogaine levels.

Results Animal work: overall, ibogaine reduced drug self-administration, particularly during the first 24 hours after administration. Ibogaine had no effect on drug-induced conditioned place preference. Ibogaine administration resulted in motor impairment in the first 24 hours after supplementation, and cerebral cell loss even weeks after administration. Data on ibogaine effect on cardiac rhythm as well as on its neuropharmacological working mechanisms are limited. Human studies: human data are still being collected. Treatment of the first patients confirmed strong effects of ibogaine on heart rhythm (QTc prolongation) and ataxia, while the opiate withdrawal symptoms were relatively mild. The first observations on the clinical effect of ibogaine on craving and substance use will also be shared.

Conclusions Based on our meta-analysis of animal data, there is strong evidence that ibogaine is effective in reducing drug self-administration in animals. This warrants further studies into the clinical efficacy of ibogaine in substance dependent patients in reducing craving and substance use. Our first clinical experiences in