

In cooperation with:



**Hospital Trust of Verona
(AOU)**
DEPARTMENT OF NEUROSCIENCES
U.O.C. OF PSYCHIATRY
U.O.C. OF PSYCHOSOMATIC AND CLINICAL PSYCHOLOGY



University of Verona
SECTION OF PSYCHIATRY
AND SECTION OF CLINICAL PSYCHOLOGY
DEPARTMENT OF PUBLIC HEALTH AND COMMUNITY MEDICINE

 WHO Collaborating Centre for Research and
Training in Mental Health and Service Evaluation



**Local Health Trust
(ULSS20)**
DEPARTMENT OF MENTAL HEALTH



ENMESH 2013

www.enmesh.eu

**Tenth International Conference
of the European Network For Mental Health Service Evaluation**

**Recovery-Oriented Mental Health Services:
Therapeutic, Organisational and Economic challenges**

OCTOBER 3-5, 2013
POLO ZANOTTO, VERONA - ITALY



ABSTRACT BOOK

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Index

Committees & Secretariat	2	Oral Presentations	17
Index	2	Posters Sessions	24
Preface	3	Abstract Symposia	31
Programme	4	Abstract Oral Presentations	177
Symposia	7	Abstract Posters Sessions	259

Dear Colleagues,

On behalf of the ENMESH Executive Committee, it is a great pleasure to welcome you to the Xth ENMESH International Conference in Verona.

At the “Polo Zanotto”, a new building of the University of Verona, close to the historical city centre, you will have the opportunity to choose among about 150 contributions that will be presented as oral presentations or illustrated in posters. And you can attend the 26 symposia with about 130 further presentations. Overall, we have had 280 contributions delivered by mental health services researchers from 20 countries. In line with previous ENMESH International Conferences, general keynote lectures will open and close the scientific part of the conference. Further keynotes will open and close each of the four Conference Thematic Tracks: (1) Reducing socio-economic inequalities of places, individuals and services for better patients’ recovery, (2) Changing patterns of psychotropic drug interventions in mental health systems, (3) Psychosocial interventions that promote better outcome and recovery, (4) Improving communications skills for better mental health services.

The core scientific programme consists of 26 symposia with 4 or 5 papers each, 18 oral presentation sessions with 4 or 5 papers each, 80 posters in 2 poster sessions.

The book of abstracts will be published online on the ENMESH website (www.enmesh.eu) and it will be sent as a CD-ROM to all the subscribers after the Conference. The CD-ROM will also include pictures taken during the Conference and special contents that may be of interest.

Below please find the final programme. The first

section of the Programme (p. 4) shows the basic programme structure and time schedule. After that, you will find details on all contributions, i.e. symposia (p. 7), oral presentations (p. 17), and posters (p. 24).

We are grateful to all presenters for having submitted their work, to the distinguished experts for having accepted our invitations to give keynotes, and to the many colleagues who agreed to chair oral presentation or poster sessions. Finally, we are grateful to the Local Scientific Committee and to the ENMESH Board for their wonderful job in reviewing the submitted papers and in preparing the final version of the program. We are also grateful to Donatella Castiglioni for her organizational support.

Finally, we have to be grateful to the COGEST team, particularly to *Eleonella Righetti* and *Valentina Tognella* for their brilliant and professional organizational work.

Please visit the ENMESH website (www.enmesh.eu) for the latest news. And do not hesitate to contact us at verona.enmesh2013@ateneo.univr.it in case of questions or comments. We hope that the Xth ENMESH International Conference 2013 in Verona will provide a truly fruitful experience for everyone.

Francesco Amaddeo and Corrado Barbui
(Local Scientific Committee Coordinators)

Mirella Ruggeri
(ENMESH Chairperson)

Thursday, October 3			
8.30	Participants Registration opening time		
	Aula T.3		
	Welcome addresses Francesco Amaddeo, Corrado Barbui (Italy)		
9.00-10.00	<u>Flavio Tosi</u> , Mayor of Verona <u>Nicola Sartor</u> , Rector of the University of Verona <u>Sandro Caffi</u> , Director General AOUI Verona	<u>Maria Giuseppina Bonavina</u> , Director General ULSS 20 Verona <u>Alfredo Guglielmi</u> , President, Medica School, University of Verona <u>Domenico Mantoan</u> , Health Department, Veneto Region	
	Presidential addresses		
	<u>Mirella Ruggeri</u> (ENMESH Chairperson) - Recovery-oriented mental health care: the old, the new and the evergreen challenges		
10.00-11.30	General Opening Lectures Bernd Puschner (Germany), Mirella Ruggeri (Italy)	Using behavioral health technology to improve psychosocial treatments, communications, and outcomes From empowerment to emancipation: situating first person knowledge	
	<u>Robert Drake</u> (United States)		
	<u>Jasna Russo</u> (Germany)		
	<u>Discussant: Mike Slade</u> (United Kingdom)		
	Opening Themes 1 & 2 Antonio Lasalvia (Italy), Luis Salvador-Carulla (Australia)		
11.30-13.00	Theme 1: <u>Kristian Wahlbeck</u> (Finland) Theme 2: <u>Philippa Garety</u> (United Kingdom)	Policy and practice in mental health services: can research make the two meet? Psychological interventions and service organization to promote recovery in psychosis: learning from evidence and practice	
13.00-14.00	Lunch & Guided Poster Session I		
	Parallel Sessions		
	Aula T.3	Aula 1.1	Aula 1.2
14.00-15.15	S01 Implementing evidence based early interventions for psychosis in routine practice: the road travelled, the road ahead	OP1 Socio-economic inequalities 1	OP3 Socio-economic inequalities 3
15.15-16.45	S05 The stigma associated with mental illness: Studies on its societal context and interventions	OP2 Socio-economic inequalities 2	OP4 Socio-economic inequalities 4
	S02 Third Wave of Implementing Recovery in the City of Aarhus – Engaging Users in the Implementation Process and in Measuring Personal Outcomes	S04 Financing systems and quality of mental health care. The REFINEMENT Project	S03 Comorbidity of mental and physical disorders - a major challenge for medicine in the early 21 st century
			S06 Crisis alternatives to hospital admission
18.45	Welcome Cocktail at Museo Civico di Storia Naturale		

Friday, October 4				
Parallel Sessions				
	Aula T.3	Aula 1.1	Aula 1.2	Aula1.4
8.30-9.30	S07 Experiences in the use of the CORE-Outcome Measure to improve communications skills and outpatient service quality Aula T.3	S11 From Theory to Practice: Implementing Recovery into Mental Health Services in Quebec, Canada	S09 Research on recovery for recovery-oriented services	S10 Managing everyday life with psychosis: psychiatry, poverty, people and pills
9.45-11.15	Opening Themes 3 & 4 Christa Zimmermann (Italy), Arunas Germanvicius (Lithuania) Theme 3: <u>Helene Verdoux</u> (France) Theme 4: <u>Sir David Goldberg</u> (United Kingdom) How to translate into clinical practice findings from pharmaco-epidemiological studies? The example of psychotropic drugs in the elderly Improving the communication skills of GPs			
Coffee break				
Parallel Sessions				
11.30-13.00	S13 Towards a European Roadmap for Mental Health and Well-being (ROAMER): Identifying priorities for social inclusion and economic research	S12 Transition from Child to Adult Mental Health Care in Europe: Barriers and Opportunities	OP10 Psychosocial interventions 5	S14 Case management or treatment approaches for neglected or marginalised patient groups
13.00-14.00	Lunch & Guided Poster Session II			
Parallel Sessions				
14.00-15.15	S17 Research into mental health supported accommodation services: international perspectives and comparisons	S16 Specialization, integration care and continuity of care: how important are they for patients' outcomes?	OP11 Psychotropic drug interventions 1	OP14 Communications skills 2
15.15-16.45	OP13 Communications skills 1	OP12 Psychotropic drug interventions 2	OP16 Psychosocial interventions 6	OP15 Communications skills 3
Coffee break				
17.00-18.30	S18 Tackling stigma and discrimination in people with major depression: findings from the international ASPEN/INDIGO study	S19 Inpatient treatment in acute wards: patterns of functioning in Europe and future trends	S20 Outcome monitoring as a tool to improve patient-clinician communication: studies from the northern Netherlands mental health network	S21 Outcomes in times of recovery-orientation
20.00	S22 Clinical Decision Making and Outcome in Routine Care for People with Severe Mental Illness: CEDAR			
Opera Gala Dinner (in the historical center of Verona)				

Saturday, October 5					
	Aula T.3	Aula 1.1	Aula 1.2	Aula1.3	Aula1.4
8.30-10.00	S23 Prevalence, nature and prevention of victimization amongst persons with (severe) mental health problems: findings from a national research programme in the Netherlands	S24 Quality and effectiveness of mental health services for people with complex needs	S25 Process evaluation of an intervention to promote recovery and related outcomes	S26 Access to health services for persons with mental health problems and mental disorders in Málaga (Spain)	S27 Residential facilities: are they promoting recovery or are they 'homes for life'?
Coffee break					
10.15-12.15	Aula T.3 Closing Themes 1 & 2 Thomas Becker (Germany), Andrzej Cechnicki (Poland) Theme 1: <u>Martin Knapp</u> (United Kingdom) Theme 2: <u>Steffi Riedel-Heller</u> (Germany) Closing Themes 3 & 4 Aart Schene (The Netherlands), Michail Okolyiski (Bulgaria) Theme 3: <u>Scott Patten</u> (Canada) Theme 4: <u>Stefan Priebe</u> (United Kingdom)				
12.15-14.00	General Closing Lectures <u>Michele Tansella</u> (Italy), <u>Graham Thornicroft</u> (United Kingdom) <u>Lars Hansson</u> (Sweden) <u>David McDaid</u> (United Kingdom)				
14.00-14.30	Conclusions and final remarks <u>Francesco Amaddeo</u> , <u>Corrado Barbui</u> , <u>Mirella Ruggeri</u> , (Italy)				

S01 Implementing evidence based early interventions for psychosis in routine practice: the road travelled, the road ahead

- S01.1** **The feasibility and the effectiveness on objective and subjective outcomes of a multielement psychosocial intervention for early psychosis conducted in the real world routine: Findings from the GET UP PIANO TRIAL**
Mirella Ruggeri, Chiara Bonetto, Sarah Tosato, Katia De Santi, Sara Poli, Silvia Zoppei, Doriانا Cristofalo, Giovanni de Girolamo, Angelo Fioritti, Paola Rucci, Paolo Santonastaso, Giovanni Neri, Francesca Pileggi, Daniela Ghigi, Maurizio Miceli, Silvio Scarone, Angelo Cocchi, Stefano Torresani, Carlo Faravelli, Christa Zimmermann, Anna Meneghelli, Carla Cremonese, Paolo Scocco, Franco Giubilini, Emanuela Leuci, Fausto Mazzi, Massimo Gennarelli, Paolo Brambilla, Michele Tansella, Antonio Lasalvia and the GET UP Group (Italy)
- S01.2** **Building capacity in routine care professionals to provide innovative interventions for patients in the early psychosis phase in the frame of the GET UP PIANO TRIAL**
Anna Meneghelli, Sara Poli, Katia De Santi, Andrea Alpi, Laura Bislenghi, Tiziana Bolis, Francesca Colnaghi, Simona Fascendini, Silvia Grignani, C. Paglia, Giovanni Patelli, Doriانا Cristofalo, Chiara Bonetto, Mirella Ruggeri and the GET UP Group (Italy)
- S01.3** **Meeting the needs of caregivers in psychosis- developing focused interventions.**
Elizabeth Kuipers, Juliana Onwumere, Paul Bebbington (United Kingdom)
- S01.4** **Life events and outcome of care in early psychosis patients participating in the GET UP PIANO TRIAL**
Carlo Faravelli, Giulia Fioravanti, Katia De Santi, Mirella Ruggeri, F. Di Paola, C. Lo Sauro, G.A. Talamba, F. Rotella, Silvia Casale, Doriانا Cristofalo, Giovanni de Girolamo, Antonio Lasalvia, Paolo Santonastaso, Giovanni Neri, Francesca Pileggi, Daniela Ghigi, Maurizio Miceli, Silvio Scarone, Angelo Cocchi, Stefano Torresani, Franco Giubilini and the GET UP Group (Italy)

S02 Third Wave of Implementing Recovery in the City of Aarhus – Engaging Users in the Implementation Process and in Measuring Personal Outcomes

- S02.1** **Users take the lead – the production Dialogue cards**
Kurt Kyed, Ole Langballe (Denmark)
- S02.2** **Result documentation. A tool for service users, staff and management information**
Malte Pihl, Brian Kjaerulff (Denmark)
- S02.3** **Screenings of how Recovery orientated providers of social psychiatry are on an organizational level**
Runa Bjoern, Peter Boldsen (Denmark)
- S02.4** **About the Open Dialogue education program in Aarhus, and how to support different professionals to develop their own dialogic practices in the work with citizens with psychosocial disabilities**
Astrid Eiterå (Denmark)

S03 Comorbidity of mental and physical disorders - a major challenge for medicine in the early 21st century

- S03.1** **Mental-physical comorbidity: data from the World Mental Health Survey Initiative**
Giovanni de Girolamo, Viola Bulgari (Italy)
- S03.2** **Stigma and discrimination as barriers to physical health care for people with mental disorders**
Graham Thornicroft (United Kingdom)

Symposia

- S03.3** Meeting the challenge of physical comorbidity and unhealthy lifestyles: PHYSICO-DSM-VR study
Lorenzo Burti, Loretta Berti, Elena Bonfioli, Irene Fiorini, Mariangela Mazzi (Italy)
- S03.4** Exercise training in patients with dimetabolic disorders: interrelationships between physical, metabolic and psychological issues
Paolo Moghetti (Italy)
- S03.5** Causes and consequences of comorbidity of mental and physical diseases
Norman Sartorius (Switzerland)

S04 Financing systems and quality of mental health care. The REFINEMENT Project

Chairmen: Heinz Katschnig (Austria), Francesco Amaddeo (Italy)

- S04.1** Mapping the state of the art in the financing of mental health systems. The REFINEMENT project experience
David McDaid, A-La Park, Tihana Matosevic (United Kingdom)
- S04.2** Financial incentives and disincentives in provider payments and user charges for mental health care. The REFINEMENT project experience
Christa Straßmayr, Sonja Scheffel, Heinz Katschnig (Austria)
- S04.3** Mapping mental health services in Europe. The REFINEMENT project experience
Ilaria Montagni (Italy), Federico Tedeschi (Italy), Damiano Salazzari (Italy), Gaia Cetrano (Italy), Mencia Ruiz (Spain), Juan Luis Gonzalez-Caballero (Spain), Laura Rabbi (Italy), Laura Grigoletti (Italy), Francesco Amaddeo (Italy), Luis Salvador-Carulla (Spain)
- S04.4** Pathways of mental health care in European countries. The REFINEMENT project experience
Barbara Weibold, Gisela Hagmair, Christa Straßmayr, Heinz Katschnig (Austria)
- S04.5** Quality of mental health and social care in Europe. The REFINEMENT project experience
Valeria Donisi, Gaia Cetrano, Laura Rabbi, Federico Tedeschi, Damiano Salazzari, Francesco Amaddeo (Italy)

S05 The stigma associated with mental illness: Studies on its societal context and interventions

- S05.1** What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies
Sarah Clement, O. Schauman, T. Graham, F. Maggioni, S. Evans-Lacko, N. Bezborodovs, C. Morgan, N. Rüsçh, J.S.L. Brown, G. Thornicroft (United Kingdom)
- S05.2** The mental health consequences of the recession: economic hardship and employment of people with mental health problems in 27 European countries
Sara Evans-Lacko, Martin Knapp, Paul McCrone, Graham Thornicroft, Ramin Mojtabei (United Kingdom)
- S05.3** Effective strategies to fight stigma associated with mental illness: a 15-year experience
Andrea Fiorillo, V. Del Vecchio, M. Luciano, G. Sampogna, C. De Rosa (Italy)
- S05.4** What predicts stigma against people with mental illness among university students?
Luca Pingani, Andrea Fiorillo, Sara Catellani, Marco Rigatelli, Sara Evans-Lacko, Patrick William Corrigan (Italy)
- S05.5** The efficacy of Coming Out Proud, a peer-led group intervention, to reduce stigma-related distress: findings of a pilot RCT
Nicolas Rüsçh, Elvira Abbruzzese, Eva Hagedorn, Daniel Hartenhauer, Ilias Kaufmann, Jan Curschellas, Stephanie Ventling, Gianfranco Zuaboni, René Bridler, Wolfram Kawohl, Wulf Rössler, Birgit Kleim, Patrick W. Corrigan (Germany)
Discussant - Antonio Lasalvia (Italy)

S06 Crisis alternatives to hospital admission

- S06.1** Optimal mental health acute care systems: what do we know?
Sonia Johnson (United Kingdom)
- S06.2** Service users' perspectives on acute care: findings from qualitative interviews in acute wards, crisis houses and home treatment teams
Sarah Fahmy, Sonia Johnson, Brynmor Lloyd-Evans, Angela Sweeney, Fiona Nolan (United Kingdom)
- S06.3** Results from National Survey of innovative practice in Crisis Resolution Teams in England
Beth Paterson, Sonia Johnson, Brynmor Lloyd-Evans (United Kingdom)
- S06.4** Optimising service organization and delivery in Crisis Resolution Teams: the development of a CRT fidelity measure
Brynmor Lloyd-Evans, Sonia Johnson (United Kingdom)
- S06.5** Development and design of a peer-support self-management programme for people following mental health crisis
Alyssa Milton, Sonia Johnson (United Kingdom)

S07 Experiences in the use of the CORE-Outcome Measure to improve communications skills and outpatient service quality

Chairman: John Mellor-Clark, United Kingdom

- S07.1** How to engage practitioners in collecting high quality data – Swedish experiences
Rolf Holmqvist (Norway)
- S07.2** Implementation of routine measurement of individual outcomes in outpatient services
Anders Hovland, Audun Røren (Norway)
- S07.3** Introducing practice-based evidence in psychological therapy services: An organisational change perspective
John Mellor-Clark, Simone Cross (United Kingdom)
- S07.4** How to engage practitioners in routine outcome measurement by Tracking Responses to Items in Measures (TRIM)
Simone Cross, John Mellor-Clark (United Kingdom)

S09 Research on recovery for recovery-oriented services

- S09.1** Is “Recovery” just the new buzz word?
Alessandro Svettoni (Italy)
- S09.2** The Italian Study on Recovery 2: quantitative results
Ileana Boggian (Italy)
- S09.3** The Italian Study on Recovery 2: qualitative results
Dario Lamonaca (Italy)
- S09.4** Recovery oriented interventions in recovery oriented mental health services
Silvia Merlin (Italy)

Symposia

S10 Managing everyday life with psychosis: psychiatry, poverty, people and pills

- S10.1** Psychosis and poverty
Alain Topor (Sweden)
- S10.2** Coping with psychiatry
Anne Denhov, Gunnel Andersson, Per Bülow, Alain Topor (Sweden)
- S10.3** Psychotropic drugs and everyday life
Per Bülow, Gunnel Andersson, Anne Denhov, Alain Topor (Sweden)
- S10.4** Everyday life and social relationships
Gunnel Andersson, Alain Topor, Anne Denhov, Per Bülow (Sweden)

S11 From Theory to Practice: Implementing Recovery into Mental Health Services in Quebec, Canada

- S11.1** Understanding the Issues: The Challenges of Implementing Recovery Within a Complex Health and Social Service System
Catherine Briand, Lise Labonté, Myra Piat, Annie Bossé (Canada)
- S11.2** Creating Hope: Recovery Stories of People with Mental Health Challenges
Annie Bossé, Myra Piat, Catherine Briand, Lise Labonté (Canada)
- S11.3** Agreeing on a Common Vision - Moving from Discourse to Action: Innovative Practices & Initiatives in Services
Lise Labonté, Annie Bossé, Myra Piat, Catherine Briand (Canada)
- S11.4** Sustaining Innovation: Translating the Evidence for Mental Health Recovery into Concrete Practice: A Participatory Research Project
Myra Piat, Catherine Briand, Lise Labonté, Annie Bossé (Canada)

S12 Transition from Child to Adult Mental Health Care in Europe: Barriers and Opportunities

- S12.1** Age of onset of adult mental disorders and the problem of transition
Giovanni de Girolamo, Jessica Dagani (Italy)
- S12.2** Transition process, outcomes and experience: Findings from the TRACK study
Swaran Singh (United Kingdom)
- S12.3** Can transitional care be improved: Findings from the BRIDGE Project
Moli Paul (United Kingdom)
- S12.4** The experience of transition: user and carer perspectives. Findings from the BRIDGE Project
Cathy Street (United Kingdom)
- S12.5** A research agenda for transitions
Swaran Singh (United Kingdom), Giovanni de Girolamo (Italy)

S13 Towards a European Roadmap for Mental Health and Well-being (ROAMER): Identifying priorities for social inclusion and economic research

Chairmen: Graham Thornicroft, Martin Knapp (United Kingdom)

- S13.1** Overview of ROAMER (roadmap for mental health research in Europe) and the role of social and economic research in a fragmented and fast changing European landscape
David McDaid (United Kingdom)

S13.2 **Result of a systematic mapping of the state of the art in European research on promoting social inclusion, addressing social exclusion and stigma**
Emilie Courtin (United Kingdom), Andrea Fiorillo (Italy), Mario Luciano (Italy), A-La Park (United Kingdom), Graham Thornicroft (United Kingdom)

S13.3 **Result of a systematic mapping of the state of the art in European research on the use of economics in mental health and wellbeing research**
A-La Park (United Kingdom)

S13.4 **Results of DELPHI exercises to identify research gaps and priorities areas for future funding**
Sara Evans-Lacko, David McDaid, A-La Park, Graham Thornicroft (United Kingdom)

S14 Case management or treatment approaches for neglected or marginalised patient groups

S14.1 **Migration, social adversity and psychosis - recent findings and implications for mental health services research**
Ulrich Reininghaus (United Kingdom)

S14.2 **Illness perceptions and personality traits of patients with mental disorders: the impact of ethnicity**
Michael Franz, Hans Joachim Salize, Christian Jacke (Germany)

S14.3 **Outcome relevance of illness perceptions and personality trait profiles of German and Turkish inpatients**
Christian Jacke, Hans Joachim Salize, Michael Franz (Germany)

S14.4 **Treatment initiation in mentally disordered people on the edge of homelessness - the MOTIWOHN-Study**
Hans Joachim Salize (Germany)

S15 Women's Mental Health

S15.1 **An examination of the use of antipsychotic medication during pregnancy**
Clare Taylor, Matthew Broadbent, Ann Greenough, Simon Hannam, Richard Hayes, Richard Holt, Mizanur Khondoker, Dharmintra Pasupathy, Robert Stewart, Louise Howard (United Kingdom)

S15.2 **A meta-synthesis of qualitative research on the experiences of mental health services for women with severe mental illness, from pre-conception to parenting**
Clare Dolman, Ian Jones, Louise Howard (United Kingdom)

S15.3 **Pathways into care among victims of human trafficking in contact with a large inner city Mental Health Service**
Sian Oram, Charlotte MacKenzie, Cathy Zimmerman, Melanie Abas, Matthew Broadbent, Louise Howard (United Kingdom)

S15.4 **Mental Health Service Users' Experiences of Disclosing Domestic Violence in Mental Health Settings: a qualitative meta-synthesis**
Kylee Trevillion, Bryony Hughes, Gene Feder, Sian Oram, Louise Howard (United Kingdom)

S16 Specialization, integration care and continuity of care: how important are they for patients' outcomes?

S16.1 **Is there an association between continuity of patient care and clinical outcomes in the community care of patients with psychosis?**
Stephen Puntis, Tom Burns, Jorun Rugkasa (United Kingdom)

S16.2 **Coercion, therapeutic relationship and continuity of care**
Ksenija Yeeles, Tom Burns (United Kingdom)

Symposia

- S16.3** Effectiveness of functional and integrated systems: what do we know?
Domenico Giacco, Omer Serif, Stefan Priebe (United Kingdom)
- S16.4** Comparing policy framework, structure, effectiveness and cost-effectiveness of Functional and Integrated systems of mental health care (COFI project): rationale and methodology of a pan European study
Stefan Priebe, Aleksandra Matanov, Domenico Giacco (United Kingdom)
- S17** **Research into mental health supported accommodation services: international perspectives and comparisons**
- S17.1** How different types of supported accommodation contribute to recovery: Findings from the second Australian national survey of psychosis
Carol Harvey, Eoin Killackey, Aaron Groves, Helen Herrman (Australia)
- S17.2** The Italian 'dream' of community psychiatry without residential facilities: lessons for European non-dreamers
Giovanni de Girolamo, Valentina Candini, Chiara Buizza, Laura Iozzino (Italy)
- S17.3** Developing quality measurement for residential services with key stakeholders perspectives in Canada
Amélie Felx, Marc Corbière, Alain Lesage (Canada)
- S17.4** The QEST study - Quality and Effectiveness of Supported Tenancies for people with mental health problems; a national study of supported accommodation in England
Helen Killaspy, Stefan Priebe, Michael King, Sandra Eldridge, Paul McCrone, Geoff Shepherd, Jake Eliot, Sarah Curtis, Gerard Leavey, Sarah White, Maurice Arbuthnott, Gavin McCabe, Peter McPherson, Joanna Krotofil, Sima Sandhu, Sarah Dowling (United Kingdom)
- S18** **Tackling stigma and discrimination in people with major depression: findings from the international ASPEN/INDIGO study**
- S18.1** Evidence for Reducing Discrimination In Mental Health
Graham Thornicroft (United Kingdom)
- S18.2** Global pattern and cross-cultural variations in reported discrimination among people with major depression. Findings from the ASPEN/INDIGO study
Antonio Lasalvia (Italy)
- S18.3** Personal experiences of discrimination in various areas of life; formulating solutions through civil society engagement in mental health policy making
Tine Van Bortel (United Kingdom), Fiona Denny (United Kingdom), Marleen De Greef (Belgium)
- S18.4** Predictors of reported discrimination in obtaining and keeping employment among people with major depression. Findings from the ASPEN/INDIGO study
Jaap van Weeghel (Netherlands), E. Brouwers (The Netherlands), Jolanda Matthijssen (The Netherlands), Chiara Bonetto (Italy), Antonio Lasalvia (Italy)
- S18.5** Discrimination of people with major depression, social capital and European policy options: the way forward
Kristian Wahlbeck (Finland)
- Discussant - Nicolas Rüsç (Germany)*

S19 Inpatient treatment in acute wards: patterns of functioning in Europe and future trends

Chairmen: Giovanni de Girolamo (Italy), Norman Sartorius (Switzerland)

- S19.1** **General Hospital Psychiatric Wards: An evidence-based overview of the Italian situation**
Giovanni de Girolamo (Italy)
- S19.2** **Crisis resolution teams as an alternative to inpatient acute treatment in Norway**
Torleif Ruud, Rolf W. Gråwe, Nina Hasselberg, Torfinn Hynnekleiv (Norway)
- S19.3** **Prevention of involuntary treatment in general psychiatric care in Germany and lessons for other European countries**
Hans Joachim Salize (Germany)
- S19.4** **A comparison between acute psychiatric services in North-west Russia and Northern Norway: clinical profiles, involuntary admissions and differences in treatment**
Knut Sørgaard (Norway)
- S19.5** **Acute care in England: challenges and initiatives for improvement**
Sonia Johnson (United Kingdom)
- S19.6** **The future of inpatient care for people with mental disorders**
Norman Sartorius (Switzerland)

S20 Outcome monitoring as a tool to improve patient-clinician communication: studies from the northern Netherlands mental health network

- S20.1** **RoQua, a large scale Dutch project to improve patient-practitioner communication using outcome monitoring**
Sjoerd Sytma (The Netherlands)
- S20.2** **Phamous, an outcome monitoring tool for patients using anti-psychotic medication**
Agna Bartels-Velthuis (The Netherlands)
- S20.3** **An e-health tool to support shared decision making between practitioners and patients with psychosis**
Lian van der Krieke (The Netherlands)
- S20.4** **The Groningen psychiatric case register, connecting service use and outcome data to enable cost-effectiveness studies**
Ellen Visser (The Netherlands)
- S20.5** **Monitoring 'the move': from psychiatric sheltered housing programs to independent living arrangements**
Charlotte de Heer-Wunderink (The Netherlands)
- S20.6** **Using outcome monitoring data to start and evaluate lifestyle interventions in severe mentally ill patients**
Frederike Jörg (The Netherlands)

S21 Outcomes in times of recovery-orientation

- S21.1** **From objectivity to subjectivity: conceptualisation and measurement of well-being in mental health**
Beate Schrank, Simon Riches, Mike Slade (United Kingdom)

Symposia

- S21.2** **Factors contributing to stigma resistance**
Ingrid Sibitz, Walter Kollmann, Beate Schrank, Michaela Amering (Austria)
- S21.3** **Recovery – a human right?**
Michaela Amering, Marianne Schulze (Austria)
- S21.4** **Social outcomes in Psychiatry**
Stefan Priebe (United Kingdom)

S22 **Clinical Decision Making and Outcome in Routine Care for People with Severe Mental Illness: CEDAR**

- S22.1** **Desire for autonomy in clinical decision making**
Arlette Bär Deucher, Wolfram Kawohl, Wulf Rössler (Switzerland)
- S22.2** **Clinical decision making style: preferences, agreement and satisfaction**
Eleanor Clarke (United Kingdom), Mike Slade (United Kingdom), Paul Williams (United Kingdom), Bernd Puschner (Germany)
- S22.3** **Patient involvement in clinical decision making**
Malene Krogsgaard Bording (Denmark), Signe Olrik Jensen (Denmark), Helle Østermark Sørensen (Denmark), Margareta Østman (Sweden), CEDAR study group
- S22.4** **Understanding the predictors and process moderators of change in quality of life in people with severe mental illness**
Marietta Nagy, Anikó Égerházi, Tibor Ivánka, János Sándor (Hungary)

S23 **Prevalence, nature and prevention of victimization amongst persons with (severe) mental health problems: findings from a national research programme in the Netherlands**

Chairman: Jaap van Weeghel

- S23.1** **Victimization of Psychiatric Patients: Results of a Nationwide Multi-Site Study**
Astrid Kamperman, J. Henrichs, S. Bogaerts, D. van de Mheen, C.L. Mulder (The Netherlands)
- S23.2** **Prevalence of victimization in Amsterdam amongst service users with depression, addiction, severe mental illness and dual diagnosis**
Martijn Kikkert (The Netherlands)
- S23.3** **In-depth insight into the victimization of persons with severe mental health problems; a qualitative study**
Mirjam Siesling, Jolanda Habraken, Inge Bongers, Jaap van Weeghel (The Netherlands)
- S23.4** **Monitoring incidents with violence against clients in treatment for psychosis: prevalence, context, awareness, potential preventive interventions**
Jooske van Busschbach, Durk Wiersma, Cees Slooff, Marieke Pijnenborg, Richard Bruggeman (The Netherlands)

S24 **Quality and effectiveness of mental health services for people with complex needs**

- S24.1** **The Rehabilitation Effectiveness for Activities for Life (REAL) study; a national programme of research into inpatient mental health rehabilitation services in England**
Helen Killaspy, Frank Holloway, Tom Craig, Michael King, Sarah Cook, Cathy Hill, Tim Mundy, Gerard Leavey, Rumana Omar, Louise Marston, Paul McCrone, Leonardo Koeser, Nicholas Green, Isobel Harrison, Melanie Lean, Maurice Arbuthnott (United Kingdom)

- S24.2** The “GetREAL” intervention; development and evaluation of a hands on staff training intervention to increase service user engagement in activities in rehabilitation units
Sarah Cook, Helen Killaspy (United Kingdom)
- S24.3** The PromQual study: a national study of mental health rehabilitation services in Portugal
Graça Cardoso, Catarina Pacheco, Ana Luisa Papoila, José Caldas-de-Almeida (Portugal)
- S24.4** Meeting complex needs through community mental health service delivery: findings from the 2010 Australian national survey of psychosis
Carol Harvey, Lisa Brophy, Dan Siskind, Sam Parsons, Margaret Grigg, Kristen Moeller-Saxone (Australia)

S25 Process evaluation of an intervention to promote recovery and related outcomes

- S25.1** Process evaluation of REFOCUS (recovery) intervention evaluated in cluster Randomised Controlled Trial
Mary Leamy, Victoria Bird, Julie Williams, Eleanor Clarke, C. Le Boutillier, Mike Slade (United Kingdom)
- S25.2** Staff experiences of implementing a recovery intervention
Eleanor Clarke, Mary Leamy, Julie Williams, Victoria Bird, C. Le Boutillier, Mike Slade (United Kingdom)
- S25.3** Service user experience of a recovery-focused intervention
Victoria Bird, Mary Leamy, Eleanor Clarke, Julie Williams, C. Le Boutillier, M. Janosik, Mike Slade (United Kingdom)
- S25.4** Using INSPIRE to assess staff support for recovery: preliminary analysis from the REFOCUS trial
Julie Williams, Mary Leamy, Victoria Bird, C. Le Boutillier, Eleanor Clarke, Mike Slade (United Kingdom)
Discussant - Aart Schene (The Netherlands)

S26 Access to health services for persons with mental health problems and mental disorders in Málaga (Spain)

- S26.1** Prevalence and use of services in personas with schizophrenia and related disorders in Málaga (Spain)
Berta Moreno Küstner, Carlos Martín, Pedro Angona, José Maria García-Herrera, Desiree-Campana Navas, Fermín Mayoral, Fabio Rivas (Spain)
- S26.2** Relationship between readmissions, social needs and functioning among severe mental psychiatric patients in an urban area of Málaga (Spain)
Fermín Mayoral, José Guzmán Parra (Spain)
- S26.3** Demands for prehospital emergency medical services: factors associated with psychiatric problems
José Guzmán Parra, Ana I Martínez-García, Cristobalina Guillén-Benítez, Manuel Jiménez-Hernández, Serafina Castro-Zamudio, Berta Moreno-Küstner (Spain)
- S26.4** Frequent users of a psychiatric emergency department in Spain and Portugal
Ingeborg Warnke (Switzerland), Graça Cardoso (Portugal), Gema Fernández-Gómez (Spain), José Ramos, Pedro Paulino, Wulf Rössler (Switzerland), Berta Moreno Küstner (Spain)
- S26.5** Space-time suicide clustering in rural area of Málaga
Lucía Pérez Costillas, N. Benitez, R. Comino, V. Ramos, L. Madrigal, Y de Diego (Spain)

Symposia

- S27** **Residential facilities: are they promoting recovery or are they 'homes for life'?**
- Chairman: Giovanni de Girolamo*
- S27.1** **Residential facilities: an update of the Italian situation and the findings of recent research in this area**
Giovanni de Girolamo, Valentina Candini, Chiara Buizza, Laura Iozzino (Italy)
- S27.2** **Count and financing of residential facilities for severely mentally ill in balanced publicly funded health and social services systems**
Alain Lesage, Amélie Felx, Roxanne Bergeron, Marc Corbière (Canada)
- S27.3** **How should community-based residential settings be conceptualized: findings from a research project in Canada**
Amélie Felx, Marc Corbière, Alain Lesage (Canada)
- S27.4** **Residential facilities in Germany: a challenge for practice and research**
Thomas Becker, Ingmar Steinhart, Reinhold Kilian (Germany)
- S27.5** **Is this an era of re-institutionalisation in Europe? An analysis of drivers of institutionalised care**
Stefan Priebe, Winnie Chow (United Kingdom)

DRAFT

OP1 Socio-economic inequalities 1

Chairmen: Sara Evans-Lacko (United Kingdom), Francesco Amaddeo (Italy)

OP1.1 Payment by results, recovery and equalities: what is happening in England?
Michael Clark (United Kingdom)

OP1.2 Recovery and older people's mental health services: what is different and what are the issues in changing service delivery?
Stephanie Daley, Sube Banerjee, David Newton, Joanna Murray, Mike Slade (United Kingdom)

OP1.3 Norway versus USA: How is ACT working? Results from fidelity assessment of 12 Norwegian ACT teams with the American fidelity measure TMACT
Kristin Sverdrvik Heiervang, Sigrun Odden, Anne Landheim, Hanne Clausen, Hanne Kilen Stuen, Torleif Ruud (Norway)

OP1.4 The role of caregiver characteristics in mental health service use by young people aged 9-18 years
Petra Gronholm, Ruth E. Roberts, Graham Thornicroft, Kristin R. Laurens, Sara Evans-Lacko (United Kingdom)

OP2 Socio-economic inequalities 2

Chairmen: Michail Okoliyski (Bulgaria), Sonia Johnson (United Kingdom)

OP2.1 Recovery-Oriented mental health projects in Wales: the BIG Lottery 'Mental Health Matters' (MHM) Investment Programme
Peter Huxley, Nina Maxwell, Sherrill Evans (United Kingdom)

OP2.2 Days out of role due to common mental disorders in Bulgaria: public health and individual consequences
Michail Okoliyski, Hristo Hinkov (Bulgaria)

OP2.3 Extended freedom attained? – A case study of the design and construction of a free choice system in community mental health
Maria Andersson, Urban Markström (Sweden)

OP2.4 Results of a randomised controlled trial of evidence based supported employment for people who have recently been homeless and have a mental illness
Daniel Poremski, Eric Latimer, Robert Whitley (United Kingdom)

OP2.5 The barriers and facilitators to implementing a supported employment service (Individual Placement & Support) within a London catchment area
Meghan Craig, Brynmor Lloyd-Evans; Sonia Johnson (United Kingdom)

OP3 Socio-economic inequalities 3

Chairmen: Paul McCrone (United Kingdom), Laura Grigoletti (Italy)

OP3.1 Anti-psychiatry sentiments among the general population; explaining unequal access to mental health care services
Elise Pattyn, Mieke Verhaeghe, Piet Bracke (Belgium)

OP3.2 Needs of people with severe mental disorders treated in community psychosocial centers in São Paulo, Brazil
Andréia de Fátima Nascimento, Tathiana Soares, Machado Velasco (Brazil)

OP3.3 Development and psychometric properties of the Costs of Discrimination Assessment (CODA)
Paul McCrone, Steve Wright, Claire Henderson, Graham Thornicroft, Jessica Sharac (United Kingdom)

OP3.4 Offender mental health: individual and relational initiatives can initiate, but not sustain, healthcare equity, a case-study
Cath Quinn, Richard Byng, Rod Sheaff, Jill Annison (United Kingdom)

Oral Presentations

OP4 Socio-economic inequalities 4

Chairmen: Giovanni de Girolamo (Italy), Giovanni Perini (Italy)

- OP4.1** Analyzing schizophrenia care variability: an exploratory care pathway typology
Coldefy Magali, Nestrigue Clément (France)
- OP4.2** Predictors of quality of life among patients suffering from schizophrenia living in Residential Facilities: a longitudinal study using a structural equation model approach
Giovanni de Girolamo, Mariangela Lanfredi, Clarissa Ferrari, Valentina Candini, Chiara Buizza for the PERDOVE group (Italy)
- OP4.3** Epidemiology and health economics of depressive symptoms in old age – Results of the Leipzig Longitudinal Study of the Aged (LEILA 75+) and the German Study on Ageing, Cognition and Dementia in primary care patients (AgeCoDe)
Melanie Lupp, Claudia Sikorski, Sven Heinrich, Siegfried Weyerer, Hans-Helmut König, Steffi G. Riedel-Heller (Germany)
- OP4.4** Landlords experiences of tenants suffering from severe mental illness
Anita Bengtsson-Tops, Lars Hansson (Sweden)
- OP4.5** Examining Help-seeking for depressive symptoms - Mental health care services satisfaction and perceived treatment benefits in a Norwegian study
Eva Lassemo, Knut Sørgaard, Inger Sandanger (Norway)

OP5 Socio-economic inequalities 5

Chairmen: Angelo Fioritti (Italy), Luis Salvador-Carulla (Spain)

- OP5.1** Equity in mental health care provision to immigrants and natives in Italy
Paola Rucci, Antonella Piazza, Enrica Perrone, Roberto Maisto, Iliara Tarricone, Vincenzo Spigonardo, Maria Nolet, Rita Orsoni, Claudio Tenuzzo, Ivonne Donegani, Maria Pia Fantini, Angelo Fioritti (Italy)
- OP5.2** Modelling the quality and technical efficiency of the mental health system in Catalonia (Spain)
Carlos García-Alonso, Luis Salvador-Carulla, Javier Álvarez-Gálvez, José A. Salinas-Perez, Anna Fernández, Antoni Serrano-Blanco, B. Prat-Pubill, Esther Jordà-Sampietro (Spain)
- OP5.3** Use of the European classification of services 'DESDE-LTC 2.0' for mapping and planning mental care in two areas of Spain (Gipuzkoa and Bizkaia)
Mencía R. Gutiérrez-Colosía, José A. Salinas-Perez, M.L. Rodero-Cosano, Alvaro Iruin, Carlos Pereira, Carlos García-Alonso, Luis Salvador-Carulla (Spain)
- OP5.4** A comparison of mental health services in Verona and northern Norway
Daniela Pucci (Italy), Francesco Amaddeo (Italy), L. Myklebust (Norway), G. Rezvy (Norway), Alberto Rossi (Italy), Michele Tansella (Italy), Vidje Hansen (Norway)

OP6 Psychosocial interventions 1

Chairmen: Ingrid Sibitz (Austria), Mike Slade (United Kingdom)

- OP6.1** Changes in hospitalization in mental health services among users in Norwegian Assertive Community Treatment teams
Hanne Clausen, Anne Landheim, Kristin Heiervang, Sigrun Odden, Hanne Kilen Stuen, Torleif Ruud (Norway)
- OP6.2** Reducing self-stigma in people with schizophrenia spectrum disorders
Ingrid Sibitz, Katarina Provaznikova, Madeleine Lipp, Richard Lakeman, Michaela Amering (Austria)
- OP6.3** WELLFOCUS: Positive Psychotherapy for people with psychosis
Beate Schrank, Simon Riches, Andre Tylee, Tony Coggins, Tayyab Rashid, Mike Slade (United Kingdom)

- OP6.4** **The Illness Management and Recovery program as a pathway to a recovery-oriented mental health service? A qualitative study**
Helle Stentoft Dalum, Lene Falgaard Eplov, Harry Cunningham, Inge Kryger Pedersen (Denmark)

OP7 Psychosocial interventions 2

Chairmen: Antonio Lora (Italy), Lene Falgaard Eplov (Bulgaria)

- OP7.1** **Quality of care for severe mental illness in Lombardy (Italy)**
Antonio Lora, Emiliano Monzani (Italy)
- OP7.2** **Transplanting Recovery - Research and practice in the Nordic countries**
Ulla-Karin Schön, David Rosenberg (Sweden)
- OP7.3** **The effect of an early supported employment intervention for patients with anxiety or an affective disorder - a randomised clinical trial**
Lone Hellström, Per Bech, Merete Nordentoft, Jane Lindschou Hansen, Lene Falgaard Eplov (Denmark)
- OP7.4** **The development and evaluation of a smoking cessation intervention for people with schizophrenia**
Debbie Robson, Tom Craig, Paul McCrone (United Kingdom)
- OP7.5** **Participation in IPS enhances empowerment and engagement in community life among service users, as compared to traditional vocational approaches**
Ulrika Bejerholm, Cecilia Areberg (Sweden)

OP8 Psychosocial interventions 3

Chairmen: Lars Hansson (Sweden), Chiara Bonetto (Italy)

- OP8.1** **Key elements in community-based programs over different target groups: a systematic literature review**
Monia Vereecken, Bea Maes, Anja Declercq, Koen Hermans, Chantal Van Audenhove (Belgium)
- OP8.2** **Mental health first aid in Sweden: a randomized controlled trial**
Bengt Svensson, Lars Hansson, Sigrid Stjernswärd (Sweden)
- OP8.3** **A Randomised Controlled Trial of Individual Placement and Support (IPS) on people with severe mental health problems in Nottingham: an implementation approach**
Athfah Akhtar, Naomi Boycott, Justine Schneider (United Kingdom)
- OP8.4** **Cost-effectiveness of psychotherapy for the treatment of depression in the UK compared to pharmacotherapy and combination treatment**
Leonardo Koeser, Valeria Donisi, David Goldberg, Paul McCrone (United Kingdom)

OP9 Psychosocial interventions 4

Chairmen: Jaap van Weeghel (The Netherlands) - Tom Craig (United Kingdom)

- OP9.1** **Caregivers role in social inclusion and recovery of people with mental disorders living in residential services: The experience in Sao Paulo city, Brazil**
Andrea Cardoso, D. Martin, A. Sousa, J.J. Mari, D. Razzouk (Brazil)
- OP9.2** **Predictors of personal recovery in people with severe mental illness receiving supported housing services**
N. A. (Neis) Bitter, D.P.K. Roeg, Christine van Nieuwenhuizen, Jaap van Weeghel (The Netherlands)
- OP9.3** **Improving public attitudes toward depression and help-seeking in four European countries: results of the OSPI-Europe intervention**
Chantal Van Audenhove, Ella Arensman, Claire Coffey, Evelien Coppens, Susana Costa, Katrin Gottlebe, Ricardo Gusmão, Rory O'Connor, Vita Postuvan, Marco Sarchiapone, Merike Sisask, András Székel, Ulrich Hegerl (Belgium)

Oral Presentations

OP9.4 A comparison of a traditional acute inpatient admission system and a novel triage admission system

Tom Craig, Emese Csipke, Til Wykes (United Kingdom)

OP9.5 Effect on empowerment of “Recognition of acquired competences” for vulnerable volunteers: a randomised controlled trial

Henry Michon, M. van Wezep, A.M. Rijkaart, H. Kroon (The Netherlands)

OP10 Psychosocial interventions 5

Chairmen: Chiara Samele (United Kingdom), Sarah Tosato (Italy)

OP10.1 Evaluation of follow-on support for people being discharged from recovery houses: Recovery Star and Personal Goal Scoring

Christopher Griffiths, John Larsen (United Kingdom)

OP10.2 Football metaphor, gender and mental health: An Evaluation of the It's a Goal! Programme

Helen Spandler (United Kingdom)

OP10.3 Lifestyle interventions for enhancing mental health

Mona Eklund, Lena-Karin Erlandsson, Elisabeth Argentzell (Sweden)

OP10.4 The recovery-orientation of community-based structured housing: resident and housing provider perspectives

Myra Piat, Richard Boyer, Marie Josée Fleury, Alain Lesage (Canada)

OP10.5 The length and breadth of community-based mental health services across 29 European countries (EuroPoPP-MH project - European Profile of Prevention and Promotion and Mental Health Systems)

Chiara Samele, Stuart Frew, Norman Urquía (United Kingdom)

OP11 Psychotropic drug interventions 1

Chairmen: Scott Patten (Canada), Michela Nosè (Italy)

OP11.1 Exploring collaborative psychiatric medication management in the UK. Presentation of findings from a Ph.D Study

Emma Kaminskiy (United Kingdom)

OP11.2 QTc-Interval prolongation in psychiatric inpatients: the role of psychotropic drugs

Michela Nosè, Irene Bighelli, Francesca Sozzi, Federico Bertolini, Corrado Barbui (Italy)

OP11.3 Epidemiology of clinical trials published in the last 30 years: the case of antidepressants

Marianna Purgato, Andrea Cipriani, Corrado Barbui (Italy)

OP11.4 The economic impact of antipsychotics polypharmacy on the health care costs of deinstitutionalized people with psychotic disorders in São Paulo city, Brazil

Denise Razzouk, A. Cardoso, A. Sousa, G.G. Oliveira, J.J. Mari (Brazil)

OP12 Psychotropic drug interventions 2

Chairmen: Markus Koesters (Germany), Corrado Barbui (Italy)

OP12.1 Cost-effectiveness of a community pharmacist intervention in patients with depression: a randomized controlled trial (PRODEFAR study)

Maria Rubio-Valera, Judith Bosmans, Ana Fernández, Maite Peñarrubia-María, Marian March, Pere Travé, Juan Ángel Bellón, Antoni Serrano-Blanco (Spain)

OP12.2 Exploring the efficacy effectiveness gap

Markus Koesters, Ann-Christien Holtrup, Ines Fiedler, Thomas Becker (Germany)

OP12.3 Association between neighborhood material and social deprivation and exposition to antidepressants in depression

Hichem Kadachi, Jean-Pierre Grégoire, Jocelyne Moisan, Alain Vanasse, Alain Lesage, Marie-Josée Fleury, Josiane Courteau, Claude Bergeron, Sophie Lauzier (Canada)

- OP12.4** **Antidepressant prescribing in Primary and Mental Health Care: is it possible to address appropriateness and keep a curb on costs?**
Antonella Piazza, Marco Menchetti, Iliara Tarricone, Paola Pagano, Danilo Di Diodoro, Anna Tomesani, Licia Minguzzi, Angelo Fioritti (Italy)

OP13 Communication skills 1

Chairmen: Bernd Puschner (Germany), Michela Rimondini (Italy)

- OP13.1** **Service User Research Panel – “They pay me because of what I know from being a patient!”**
Karl-Anton Forsberg, Mikael Sandlund (Sweden)
- OP13.2** **“What would you do in my shoes?” Information exchange among patient and psychiatrist in early psychosis**
Giuseppe Deledda, Michela Rimondini, Maria Angela Mazzi, Claudia Goss, Lidia Del Piccolo, Alessandro Bottacini, Christa Zimmermann (Italy)
- OP13.3** **The family and the therapist in patient’s eyes**
Dorota Wypich, Marcin Szuba (Poland)
- OP13.4** **Is UK care coordination recovery led? Exploring the perspectives of different stakeholder groups**
Toby Brandon, Deborah Helm, Louise Thomson, Caroline Kemp, Helen Atkin (United Kingdom)
- OP13.5** **The relation between content of clinical decisions with outcome**
Jana Konrad, Sabine Loos, Nadja Zentner, Benjamin Mayer, Bernd Puschner (Germany)

OP14 Communication skills 2

Chairmen: Paul McCrone (United Kingdom), Robert Drake (United Kingdom)

- OP 14.1** **Increased competence in community treatment for severe mental illness: results of a national two year training program for the frontline workforce**
Torleif Ruud, Tore Sørli, Karin Blix Flage, Ole-Bjørn Kolbjørnsrud, Jurate Saltyte Benth (Norway)
- OP14.2** **Variation in Duration of Untreated Psychosis in an 18-year perspective**
Wenche ten Velden Hegelstad, Inge Joa, Jan Olav Johannessen, Johannes Langeveld, Thomas McGlashan, Svein Friis, Tor K. Larsen (Norway)
- OP14.3** **Cost-effective analysis of a program of primary prevention for depression in primary care The PredictD-Spain CCRT study**
Ana Fernandez, Antoni Serrano-Blanco, Juan Ángel Bellón, Sonia Conejo-Cerón, Patricia Moreno-Peral, Michael King, Irwin Nazareth, Carlos Martín-Pérez, Carmen Fernández-Alonso, María Isabel Ballesta-Rodríguez, José María Aiarzaguena, Carmen Montón-Franco, Inmaculada Ibanez-Casas, Emiliano Rodríguez-Sánchez, Antonina Rodríguez-Bayón, María Cruz Gómez, Pilar LaFuente, María del Mar Muñoz-García, Pilar Mínguez-Gonzalo, Luz Araujo, Diego Palao, Maite Espinosa-Cifuentes, Fernando Zubiaga, Desirée Navas-Campaña, Juan Mendive, Jose Manuel Aranda-Regules, Alberto Rodríguez-Morejón, Luis Salvador-Carulla, Juan de Dios Luna (Spain)
- OP14.4** **Predicting psychiatric inpatient costs**
Paul McCrone, Ramon Sabes-Figuera, Emese Csipke, Tom Craig, Diana Rose, Til Wykes (United Kingdom)

OP15 Communication skills 3

Chairmen: Christa Zimmermann (Italy), Julie Ridley (United Kingdom)

- OP15.1** **Replacement of a psychiatrist centered bio-medical model by a user-centered on recovery oriented social model in mental healthcare**
Jan Verhaegh (The Netherlands)
- OP15.2** **Exploring the impact of legislative reform regarding compulsory treatment on professionals’ relationship with service users and their carers**
Julie Ridley, Ann Rosengard (United Kingdom)

Oral Presentations

- OP15.3** Discursive spaces: factors influencing the contribution of independent advocacy to improving communication with mental health professionals
Karen Newbigging, Stephanie de la Haye, Julie Ridley (United Kingdom)
- OP15.4** Intimate partner homicide and mental illness: a descriptive population-based study
Sian Oram, Sandra Flynn, Jenny Shaw, Louis Appleby, Louise M. Howard (United Kingdom)

OP16 Psychosocial interventions 6

Chairmen: Richard Byng (United Kingdom), Katia De Santi (Italy)

- OP16.1** Mental Health Recovery: Evaluation of a Recovery-Oriented Training Program in the Netherlands. Effects on mental health professionals and mental health consumers outcomes
Greet Wilrycx, M.A. Croon, A.H.S. van den Broek, Christine van Nieuwenhuizen (The Netherlands)
- OP16.2** The implementation of Recovery Rounds to support culture and practice changes in a commitment towards recovery-oriented mental health care
Linna Tam, Sanaz Riahi (Canada)
- OP16.3** Effectiveness of a psychoeducational programme for patients with bipolar disorders
Graça Cardoso, Gonçalo Carreteiro, Cláudia Gonzaga, Ana Lima, Natasha Oliveira, João Carlos Melo (Portugal)
- OP16.4** The ENGAGER study: Can we engage and retain prisoners with common mental health problems in treatment and research?
Richard Byng, Cath Quinn, Rod Taylor, Adam Qureshi, Deb Shenton, Jenny Shaw (United Kingdom)
- OP16.5** Challenges and results of the Norwegian “Job Prescription” RCT on Individual Placement and Support for first episode psychosis patients
Lena Heitmann, Inge Joa, Jan Olav Johannessen, Hans Langeveld, Randi Mobæk, Wenche ten Velden Hegelstad (Norway)

OP17 Psychosocial interventions 7

Chairmen: Antonio Lasalvia (Italy) - Vincent Lorant (Belgium)

- OP17.1** Psychiatric Advance Directives: a tool to promote therapeutic alliance, coordination of care, and autonomy of the user
Pablo Nicaise, Vincent Lorant, Vincent Dubois (Belgium)
- OP17.2** Improving the cost-effectiveness of primary mental health care by selectively investing and de-investing in interventions: a generalized health economic modeling approach
Joran Lokkerbol, Peter Verhaak, Rifka Weehuizen, Filip Smit (The Netherlands)
- OP17.3** Is a screening program for postpartum depression a long term sustainable and clinical-cost effectiveness strategy?
Elena Turella, Arianna Donolato, Belinda Ciulli, Rossana Riolo (Italy)
- OP17.4** An evaluation of Protected Engagement Time (PET) on staff and patient outcomes on acute mental health inpatient wards in England
Fiona Nolan, Sonia Johnson, Richard Gray, Alan Simpson, Brynmor Lloyd-Evans, Nicola Morant, Helen Gilbert (United Kingdom)
- OP17.5** Needs for care among mentally disordered offenders receiving treatment in a therapeutic forensic residency. Relationship with clinical characteristics and recidivisms risk factors
Luca Castelletti, Antonio Lasalvia (Italy)

OP18 Communication skills 4

Chairmen: Mike Slade (United Kingdom), Stefan Priebe (United Kingdom)

OP18.1 The Therapeutic Relationship Model - a guide for clinicians in the least restrictive practices to support recovery

Ian Dawe, Sanaz Riahi (Canada)

OP18.2 Winning hearts and minds: communicating a strategy to bring about recovery orientation in a mental health trust

Gabrielle Richards, David Blazey (United Kingdom)

OP18.3 Is there an association between continuity of patient care and clinical outcomes in the community care of patients with psychosis?

Stephen Puntis, Tom Burns, Jorun Rugkasa (United Kingdom)

OP18.4 Young people using the Internet for mental health information and advice: the French case of www.filsantejeunes.com

Ilaria Montagni, Isabelle Parizot (Italy)

OP18.5 Courses of helping alliance in the treatment of people with severe mental illness in Europe: A latent class analytic approach

Sabine Loos (Germany), Mike Slade (United Kingdom), Bernd Puschner (Germany) and the CEDAR study group

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Posters Sessions

Guided Poster Session I – Thursday, October 3 – 13.00-14.00		
Poster ID	First Author	Title
PS1.01	<i>Urban Markström</i>	Towards Hybridization? The relations between public and non-governmental organizations in the community mental health field in Sweden
PS1.02	<i>Sherrill Evans</i>	Promoting Recovery and Social Inclusion: Using systems thinking to change community mental health services in North Wales
PS1.03	<i>D. Duin</i>	Quality Assessment of Regional Treatment System for Schizophrenia (QUARTS), A study on the implementation of evidence based in the Netherlands
PS1.04	<i>Matthias Schützwohl</i>	The MEMENTA-Study. A multi-site study assessing the mental health status and needs for care in adults with mild to moderate intellectual disabilities
PS1.05	<i>Daniel Poremski</i>	Experiencing evidence-based supported employment services: Qualitative findings of a mixed-methods study
PS1.06	<i>Clément Nestrigue</i>	How depression is cared for in mental health hospital? Overview of care and determinants of the variability in use of mental health service in France
PS1.07	<i>Jed Boardman</i>	Implementing Recovery in Organisations: The ImROC project
PS1.09	<i>Giovanni de Girolamo</i>	Is discharge from residential facilities likely and possible? A longitudinal study in Italy
PS1.10	<i>Amelie Felx</i>	Patients to be discharged from hospitals to community-based residential facilities in Montreal: profiles and residential orientations
PS1.11	<i>Amanda Lundvik Gyllensten</i>	Physical Activity guidelines for persons with schizophrenia
PS1.12	<i>Vanessa Pinfold</i>	Social network development for people with severe mental illness – is it important for recovery and whose role is it anyway?
PS1.13	<i>Giovanni de Girolamo</i>	Pathways to first-ever contacts with child and adolescent mental health services: an Italian study
PS1.14	<i>Giovanni de Girolamo</i>	Age of onset of mental disorders and use of mental health services: is there any correlation?
PS1.15	<i>Emma Motrico Martínez</i>	Regional financing systems and financial incentives for mental health care in Spain. comparison of andalucia, catalonia and basque country

Guided Poster Session I – Thursday, October 3 – 13.00-14.00		
Poster ID	First Author	Title
PS1.16	<i>Michael Clark</i>	Developing the evidence base for social care in mental health – the NIHR School for Social Care Research in England
PS1.17	<i>T.E. Verrijp</i>	The influence of moving to better quality supported housing on long-term care-dependent psychiatric patients
PS1.18	<i>T.E. Verrijp</i>	Experiences and stigma of people living in the proximity of a supported housing facility for people with severe mental illness.
PS1.19	<i>Helen-Maria Vasiliadis</i>	The economic impact and benefits associated with implementing suicide prevention programs at the population level
PS1.20	<i>Margareta Östman</i>	Low satisfaction with sex life among people with severe mental illness living in a community
PS1.21	<i>Peter Huxley</i>	Social work intervention in self-harm (SWISH); a feasibility study for the replication in Wales of an intervention developed in Australia
PS1.22	<i>Gianfranco Zuaboni</i>	“ORIENT” - Pilot Study: A Recovery-Oriented Mental Health Nursing Intervention Pilot study
PS1.23	<i>Vesna Švab</i>	Barriers and errors in implementation of community psychiatry in Slovenia
PS1.24	<i>David Brunt</i>	Satisfaction with housing and housing support for persons with psychiatric disabilities
PS1.25	<i>Trond Nergaard Bjerke</i>	What does it mean to be recovered from drug-addiction? Preliminary results from a phenomenological study of patients experience of recovery
PS1.26	<i>Kristina Klein</i>	The effectiveness of interventions for adults with intellectual disabilities and mental illness: a systematic review
PS1.27	<i>Catherine Briand</i>	Implementing evidence-based practices in rehabilitation and mental health in the Quebec public health system
PS1.28	<i>Andrzej Cechnicki</i>	The effect of two predictors’ interaction on short- and long-term treatment outcomes in schizophrenia
PS1.29	<i>Aneta Kalisz</i>	The significance of persisting negative symptoms as a prognostic factor for the course of schizophrenic psychoses
PS1.30	<i>Andrzej Cechnicki</i>	Recovery in schizophrenia

Posters Sessions

Guided Poster Session I – Thursday, October 3 – 13.00-14.00		
Poster ID	First Author	Title
PS1.31	<i>Agneta Öjehagen</i>	Hazardous alcohol and drug use among people with psychiatric disabilities visiting day centres
PS1.32	<i>Simon Riches</i>	Differences in perception of well-being between staff and service users with psychosis
PS1.33	<i>Yolanda Nijssen</i>	Recovery oriented care on closed admission wards in the Netherlands
PS1.34	<i>Naomi Clewett</i>	A qualitative exploration of the impact of mental health personalised social care in England
PS1.35	<i>Terry Safits</i>	A psychological treatment programme for traumatised ex-military personnel in the UK
PS1.36	<i>Naomi Boycott</i>	‘Working Well!’: A Pilot Work-Focussed Psychotherapy Programme in Addition to Individual Placement and Support (IPS) – Six Months On
PS1.37	<i>François Wyngaerden</i>	Networks of social support and continuity of care for psychiatric users
PS1.38	<i>Chantal Van Audenhove</i>	User and family members’ involvement in the mental health care reform in Belgium: a pilot-study
PS1.39	<i>Sandra Saldivia</i>	Prevalence and treatment of depression in a sample of adults attending Primary Care facilities in Chile
PS1.40	<i>Hanneke Van Gestel</i>	Routine Outcome Monitoring (ROM) in an intensive community-based care program for severely marginalized persons that are hard to reach: An implementation study

Posters Sessions

Guided Posters Session II – Friday, October 4 – 13.00-14.00		
Poster ID	First Author	Title
PS2.01	<i>Rumina Taylor</i>	Promoting Recovery: Social Cognition and Interaction Training (SCIT) for Forensic Inpatients
PS2.02	<i>Magnus Bergmark</i>	Implementing methods that support Recovery- Analysis of policy and practice in Sweden
PS2.03	<i>Rossana Riolo</i>	Mothers without depression: A screening program, treatment and study of affective disorders in the post-partum period
PS2.04	<i>Gabriella Tirone</i>	A rehabilitation program based on sporting activities in people with severe mental disorders: an example from Trieste, Italy
PS2.05	<i>Aglaé Sousa</i>	Needs and profile of a sample of patients with mental disorders living in residential facilities in São Paulo city, Brazil
PS2.06	<i>Cindy Noben</i>	Comparative cost-effectiveness of two interventions for improving work functioning among nurses: pragmatic cluster randomised trial
PS2.07	<i>Francis Vergunst</i>	Does coercive mental health care affect long-term social outcomes in psychosis patients?
PS2.08	<i>Daniela Pucci</i>	Forensic Psychiatric Hospitals closure in Italy: new perspectives in the Lazio Region after the 2008 DPCM act
PS2.09	<i>Amelie Felx</i>	Take a glimpse! Using concept mapping to develop a visual representation of housing and community-based residential settings
PS2.10	<i>Richard Byng</i>	Contribution of service design to four fold variation in access to psychological therapies: a systems level, mixed method study
PS2.11	<i>Liv Zetterberg</i>	The introduction of compulsory community care – for the best of the patient or managing political risk?
PS2.12	<i>Hans Kroon</i>	Fidelity to Flexible Assertive Community Treatment in the Netherlands
PS2.13	<i>Giovanni de Girolamo</i>	Psychoeducation for patients with bipolar disorder: a study of effectiveness in Italy
PS2.14	<i>Guilherme Gregório</i>	User embracement at the Psychosocial Care Center (CAPS) in Brazil: one strategy to user compliance

Posters Sessions

Guided Posters Session II – Friday, October 4 – 13.00-14.00		
Poster ID	First Author	Title
PS2.16	<i>J.R. Theunissen</i>	Social functioning and participation in society in an Amsterdam cohort of patients with severe mental illness
PS2.17	<i>Vincent Lorant</i>	Mental Healthcare Delivery System Reform: Stakeholders and Policy Priorities Compared
PS2.18	<i>Savina Rauber</i>	Multidimensional outcome after involuntary treatment from 2010 to 2013 of a consecutive cohort in a mental health centre of Trieste
PS2.19	<i>Hannah Jones</i>	A cluster randomised controlled trial of an oral health intervention for people with serious mental illness
PS2.20	<i>Denise K. Manchisi</i>	Ten years of individual placement and support in Italy
PS2.21	<i>Jean Pierre Wilken</i>	Key factors in supporting recovery processes
PS2.22	<i>Helle Høgh</i>	“Medical Pedagogy” - a national social psychiatry development project in Denmark
PS2.23	<i>Harry Michon</i>	Facts and figures on societal participation in people with severe mental illnesses in the Netherlands; First findings of a national panel
PS2.24	<i>Ian Dawe</i>	Mindfulness - a guide for clinicians in distress reduction practices to support recovery
PS2.25	<i>Sarah Tosato</i>	Can Obstetric complications predict a more severe functional and clinical outcome? Data from the 2-year follow-up of a large first episode psychosis study (PICOS)
PS2.26	<i>Sarah Tosato</i>	Association between the COMT gene and neurological abnormalities and poorer executive function in Caucasian patients with psychosis
PS2.27	<i>Elisa Ira</i>	Positive symptoms in first-episode psychosis patients experiencing low maternal care and stressful life events: the mediating role of the COMT gene
PS2.28	<i>Irene Bighelli</i>	Bridging the gap between research and practice through the development of GRADE recommendations for psychotropic drugs interventions
PS2.29	<i>Francesca Girlanda</i>	Guideline implementation strategies for specialist mental health care: a systematic review
PS2.30	<i>Kai Sabas</i>	An evaluation of REFOCUS Personal Recovery and Coaching Training

Posters Sessions

Guided Posters Session II – Friday, October 4 – 13.00-14.00		
Poster ID	First Author	Title
PS2.31	<i>Anna Kristine Waldemar</i>	Recovery-oriented practice in psychiatric wards: organizational challenges
PS2.32	<i>Lisa Tlach</i>	Decision-making and Information Needs in Mental Health Care: A Mixed-methods Study
PS2.33	<i>Sian Oram</i>	Systematic review and meta-analysis of psychiatric disorder and the perpetration of partner violence
PS2.34	<i>Toby Brandon</i>	Examining the recovery impact of emancipatory action research for service user and carer researchers in the UK
PS2.35	<i>Anna Liberadzka</i>	Trust in patient- therapist relationship
PS2.36	<i>Yonsuk Chae</i>	Communication Improvement through Narrative Therapy: Case Study on Schizophrenia in Adolescents
PS2.37	<i>Kim Jørgensen</i>	Development of employees' skills in recovery-oriented activities
PS2.38	<i>Anne Petersen</i>	The logics of everyday psychiatric work
PS2.39	<i>Tine Van Bortel</i>	Empowering service users and health professionals and improving health services through coaching interventions
PS2.40	<i>Pedro Mateus</i>	Assessing leadership profiles in Portuguese public mental health services

DRAFT

Abstract SYMPOSIUM

s01

**Implementing evidence based early interventions
for psychosis in routine practice: the road travelled, the road
ahead**

DRAFT

The feasibility and the effectiveness on objective and subjective outcomes of a multi-element psychosocial intervention for early psychosis conducted in the real world routine: Findings from the GET UP PIANO TRIAL

Mirella Ruggeri¹, Chiara Bonetto¹, Sarah Tosato¹, Katia De Santi¹, Sara Poli¹, Silvia Zoppei¹, Doriana Cristofalo¹, Giovanni de Girolamo², Angelo Fioritti³, Paola Rucci³, Paolo Santonastaso⁴, Giovanni Neri⁵, F. Pileggi³, D. Ghigi⁶, Maurizio Miceli⁷, S. Scarone⁸, Angelo Cocchi⁹, Stefano Torresani¹⁰, Carlo Faravelli¹¹, Christa Zimmermann¹², Anna Meneghelli⁹, C. Cremonese⁴, P. Scocco⁴, F. Giubilini¹³, E. Leuci¹³, F. Mazzi⁵, M. Gennarelli², Paolo Brambilla¹⁴, Michele Tansella¹, Antonio Lasalvia¹ and the GET UP GROUP (Italy)

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Background

Most multi-element research in early psychosis has been conducted in non-epidemiologically representative samples enrolled in experimental settings, thereby raising the risk of underestimating the complexities involved in treating First Episodes of Psychosis (FEP) in 'real-world' services. The GET UP PIANO (Psychosis early Intervention and Assessment of Needs and Outcome) trial has two overarching aims: 1) To compare, at 9 months, the effectiveness of a multi-component psychosocial intervention with that of treatment as usual (TAU) in a large epidemiologically based cohort of patients with FEP and their family members recruited from a 10 million-inhabitant catchment area; 2) To identify the barriers that may hinder its feasibility in real-world routine clinical settings and patient/family conditions that may render this intervention ineffective or inappropriate. Primary outcomes were considered symptom reduction, increased social functioning, lower inpatient admission rates.

Methods

Participants were recruited from community mental health centers (CMHCs) operating for the Italian National Health Service and located in two entire regions of Italy (Veneto and Emilia Romagna), and in the cities of Florence, Milan and Bolzano. The PIANO trial had a pragmatic cluster randomized controlled design, which compared the effectiveness of TAU plus a multi-element psychosocial treatment for patients with FEP and their family members, versus TAU alone. The experimental additional treatment comprised: 1) cognitive behavioral therapy for psychosis (CBTp) for patients; 2) family intervention for psychosis (FIp); and 3) case management. It was expected that an optimal number of 20–30 CBT sessions per patient would be delivered during a time frame of 9 months, with weekly sessions held during the first 3 months and fortnightly during the subsequent 6 months. Family intervention consisted of an optimal number of 10–15 sessions over 9 months with each individual family: 6 sessions in the first 3 months, and at least 1 session/month during the subsequent 6 months. Every patient/ family had a case manager who coordinated all planned interventions.

Results

A total of 338 patients participated in the study: 172 patients in control condition and 272 patients in experimental condition. At baseline, the socio demographic characteristics of the patients did not differ between groups. One hundred and 89 patients have completed 10 or more CBT sessions and had their relatives complete 2 or more FI sessions. One hundred and 38 patients have completed over 20 CBT sessions; 24 people did not participate in the CBT treatment due to various reasons that

included: withholding consent to treatment (13 patients), attrition before the start of CBT (3 patients) and others. Concerning Family Intervention, the largest group (n=121) have participated in 10-19 FI sessions; 52 patients' relatives did not participate in FI due to various reasons such as: no relatives available (17 patients), patient refusal to grant consent to contact relatives (7 patients), no consent to CBT (13 patients), relatives not giving consent (7 relatives) and others. At follow-up subjects in the experimental group had significantly lower PANSS Total Score, lower GAF and Hamilton Score (treatment effect estimates based on random effects linear regression models) and lower number of days of admission Subjective appraisal of symptoms (measured by PSYRATS) showed significant post-treatment improvements, with experimental treatment having a crucial role for total delusion score and for the items regarding cognitive and distress levels..

Conclusions

This study proves that it is possible to apply evidence based interventions for early psychosis also in routine CMHCs, with an improvement – obtained with a treatment lasting for a short time – in clinical and social outcomes, both objective and subjective. Interventions proved to be acceptable to the vast majority of patients and their families. Knowledge produced by this study is to date unique in this field and greatly contribute to bridge the gap between research and clinical practice in the area of early interventions.

DRAFT

S01.2

Building capacity in routine care professionals to provide innovative interventions for patients in the early psychosis phase in the frame of the GET UP PIANO TRIAL

Anna Meneghelli, Sara Poli, Katia De Santi, A. Alpi, L. Bislenghi, T. Bolis, F. Colnaghi, S. Fascendini, S. Grignani, C. Paglia, G. Patelli, Doriana Cristofalo, Chiara Bonetto, Mirella Ruggeri and the GET UP GROUP (Italy)

Affiliazioni

DRAFT

Meeting the needs of caregivers in psychosis- developing focused interventions

Elizabeth Kuipers¹, Juliana Onwumere¹, Paul Bebbington²

¹King's College London (United Kingdom), ²Imperial College London (United Kingdom)

Community provision for people with psychosis has left informal carers to take on a greater role. They provide key duties and can help to secure optimal outcomes for patients. However, psychological morbidity can be high in carers. Carer only interventions have a new evidence based recommendation in the UK NICE Schizophrenia 2014 guidelines.

Further development of carer interventions are likely to be influenced by the key issues facing carers of those with psychosis. One of these is aggressive behaviour, which is not uncommon in psychosis. However, few studies have explored links between patient-initiated violence in mental health caregiving relationships and carer functioning. The current study investigated caregiver reports of aggressive acts committed by their relative with psychosis and their links to carer appraisals of the caregiving relationship and carer outcomes.

Method

Carers of those with a recent relapse of psychosis, recruited to a psychological therapy trial, completed the audiotaped Camberwell Family Interview (CFI) at baseline. This semi-structured interview includes questions on the quality of the relationship between caregiver and patient, and patient history of violence. Seventy two transcripts of interviews were assessed for reports of patient-initiated violence.

Results

Half the carer sample (52.9%) reported an incident of patient-initiated violence during their interview; 62.2% of these involved violence towards themselves, and 24.3% towards property. Reports of patient violence were associated with carer ratings of hostility expressed towards patients, lower self-esteem, and emotion focused coping. Single carers were more likely to report incidents of patient violence. Younger patients, males and inpatients were more frequently identified as having a history of this kind of violence.

Conclusions

The current findings confirm that carer reports of patient-initiated violence in psychosis are not uncommon. Mental health staff need to be aware of the risks of such violence for carers of people with psychosis, and consider appropriate procedures for assessing and minimising it. Carer focused interventions that promote their safety and adaptive coping skills and early signs identification are indicated; an example of such an intervention is provided.

Life events and outcome of care in early psychosis patients participating in the GET UP PIANO TRIAL

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Objective

The aim of the present study is to evaluate the role of psychosocial stressors in a cohort of patients with first episode of psychosis, within the strategic research program Genetics Endophenotypes and Treatment: Understanding early Psychosis (GET UP).

Methods

348 early psychosis patients recruited in the GET UP PIANO Trial and 309 controls representative of the general population and matched to cases by sex, age and education were assessed for the occurrence of early and recent life events, the perception of early parenting, and the parental expressed emotions. Recent life events were evaluated by assessors not involved in the interview and blind the patient or control status. Independent events (outside the subject's control) were also evaluated. Results: The comparisons between patients and controls revealed that childhood loss events (22.2% among patients vs 10.7% among controls $\chi^2=10.96$ $p=.001$), recent life events (73.3% among patients vs 42.3% among controls $\chi^2=45.95$ $p<.001$), parental rearing (e.g. mother care $M=23.96\pm 8.22$ in patients vs $M=28.66\pm 5.82$ in controls $t=5.35$ $p<.001$) and family emotional climate ($M=29.12\pm 6.97$ in patients vs $M=10\pm 7$ in controls $t=-30.84$ $p<.001$) were all strong risk factors for early psychosis. Independent recent events were more frequent among controls (53.7 %) than among patients (23%; $\chi^2=26.70$ $p<.001$).

Conclusion

Subjects affected by psychosis undergo more stressful life events in the year prior to the onset of psychosis. However, the number of events that are independent of the subject's behavior is lower than in controls. Are there maladaptive behaviours preceding the onset? Is there an active gene-environment correlation?

Third Wave of Implementing Recovery in the City of Aarhus – Engaging Users in the Implementation Process and in Measuring Personal Outcomes

Søren Frost

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Since 2006, the City of Aarhus has strived to implement recovery orientation as the fundamental value for the delivery of services for its citizens with psycho-social disabilities. Our experience is that there is not one method or concept that can guarantee a recovery orientated services. Rather, a successful recovery implies complex interventions where detail and nuances in our professional practice matters. After the first years of focusing on establishing what would constitute a recovery oriented practice in the social psychiatry of Aarhus (our first wave of implementation) and here after systematically training all staff (second wave of implementation), we have reached the third wave of implementing recovery. This wave focus on two dimensions:

- 1) Further engagement of users in the implementation process – bringing out the knowledge of recovery to users and inviting them to participate in securing that social psychiatry in Aarhus is supporting their individual way to recovery
- 2) Documenting effectiveness of the recovery oriented practice and interventions both in individuals and in organizations

In the symposium, we will present how we reached this third wave of implementing recovery focusing on these two dimensions. Our aim is to offer researchers and practitioners rich practical insight into how they unfold. The symposium is structured as four presentations which offer a variety of perspectives from relevant stakeholders related to recovery: users, staff and leaders in the social psychiatry and our Center for Social Innovation. The presentations includes the following topics:

1. How we applied massive education and training of staff in the implementation. How we experienced that the build-ing of competences for staffs and users have to work on a recovery oriented basis in itself in order to make staff, users and cooperation partners in the regional psychiatry practice recovery orientation – e.g. training all staff in the CARE method (CARE is a systematic yet flexible method whereby a mental health worker supports the user of psy-chiatry along the way to recovery after a Dutch concept from the Storm Rehabilitatie), working with the Brake Through method, building a new diploma in psycho-social rehabilitation in cooperation with the University College of Aarhus.
2. Working with a systematic way of enhancing the dialogue between staff and users and ways of establishing a com-mon language on the objections and trajectories of recovery - e.g. creating a user friendly reformulation of the re-cove-ry values, and how it turned into the entire organizations starting point for the recovery dialog and, working with Open Dialogue inspired by Dr. Jaakko Seikkula's hospital team in Western Lapland in Finland. Users will par-ticipate in the presentation and bring in their experiences
3. Experiences of developing a tool for screening how recovery orientated our providers of social psychiatric services are on an organizational level. The first part of the screening is an evaluation of the organizational status of recov-ery orientation measured by questionnaires to users, staff and leaders, analysis of the local dialogue between users and staff and observations in the organization and of the physical environment. The second part is a systematic dia-logue with users, staff and leaders involved in order to qualify and discuss our findings ending up with recommen-dations of how to enhance the focus on recovery in the local practice. Users and staff that have had their workplace screened will participate in the presentation and bring in their experiences
4. Experiences of developing a tool for evaluating individual progress towards social or full recovery. As a way of supporting the individual plan and helping the users setting individual goals we have developed a way of measuring individual progress on dimensions pointed out by uses a being important for individual recovery. The measurement is built on a self evaluation by the user and a scoring by the staff and the dialogue around the measurement.

In the symposium, we will invite the participants to discuss our findings and what it takes to make a thorough and sys-tematic implementation of recovery orientation. Read more about the implementation of enhanced recovery orientation in Aarhus on <http://www.recoverydk.dk/>

Users take the lead – the production Dialogue cards

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Background/Objectives

We will present how we have worked with a systematic way of enhancing the dialogue between staff and users and ways of establishing a common language on the objections and trajectories of recovery. Users from the Social Psychiatry in Aarhus have created a user friendly reformulation of the recovery values on their own initiative and created the 'Dialogue cards'. Users have discussed what the purpose of the four Recovery Values is and how users themselves would like to express the values. The 'Dialogue cards' describe user's expectations to the staff.

Methods

A presentation of how users were involving in the creation of the 'Dialogue cards'. Users will participate in the presentation and bring in their experiences.

Results

Four small cards were created - one card for each value. The front of each card features a specific value formulated by users and on the back of the cards can be read in a user friendly language what consumers can expect from the professionals as a consequence of the specific value.

Discussion/Conclusion

We have strengthened the common ground and dialogue between users and staff in correlation to what Recovery orientation means to for us. We will invite participants to discuss our way of involving users in the process of distributing Recovery Orientation in our organization.

Result documentation

A tool for service users, staff and management information

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Background/Objectives

We will present our experiences with developing a tool designed to evaluate the individual's development towards recovery.

The tool is produced for all levels of the organization. It is a tool for service user and staff regarding service user. On this level the tool supports the individual plan and helps service users to establish targets and evaluate whether they are fulfilled. The tool is also supposed to visualize this. The tool is developed so data on an aggregated level can be used as a foundation for quality development in each center and to evaluate the target group, which target group the tool is best suited for etc. – to build up local based knowledge. Finally the tool can be used to provide information to the top management about what the centers achieve and the expected results for the purpose of a closer examination of extremely good results to learn from these, or a closer examination of extremely bad results to improve these.

As a way of supporting the individual plan and helping service users setting individual goals we have developed a way of measuring individual progress on dimensions pointed out by service users as being important for individual recovery. The measurement is built on a self evaluation by service users and a scoring by the staff and the dialogue around the measurement.

Methods

The measurements are built on self evaluation and listing of goals with the staff – but the service user has the final say. For each of the tool's factors the score concerns status and goal. In aggregating data the level of goal achievement is used to take the individual's situation into account.

Results

So far service users and staff are satisfied with the tool so following a successful first pilot study the tool is about to be implemented in the field of supported housing and facility housing.

Discussion/Conclusion

We want to develop the tool further and would like the participants to give us feedback.

Screenings of how Recovery orientated providers of social psychiatry are on an organizational level

Runa Bjoern¹, Peter Boldsen

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Background/Objectives

We will present our experiences with developing a tool for screening the degree of recovery orientation among our providers of social psychiatric services on an organizational level. The first part of the screening is an evaluation of the organizational status of recovery orientation measured by questionnaires to service users, staff and managers, analysis of the quality of the local dialogue between service users and staff and observations in the organization and within the physical environment. The second part is a systematic dialogue with service users, staff and managers involved in order to qualify and discuss our findings resulting in recommendations of how to enhance the focus on re-recovery in the local practice. We will present:

- Our theory of change for the recovery orientated organization and how we have operationalized the crucial points into questionnaires and other analytical tools
- How the service provider and service users experience the screening process
- How the results of the screening is used in the organization that is the object of the screening and how the screenings can provide useful information for the senior management.

So far the screening tool has been applied in 13 organizations in Denmark. The Department of Social Psychiatry of Aarhus has decided to screen all its service providers every two years in the future, and to further develop the tool to be able to screen whether the exercise of visitation authority is based on the recovery values and supports the users' road to recovery.

Methods

A presentation of the screening tool and process, followed by discussions with the participants in the symposium.

Results

Providing the participants with inspiration as to how implementation of a recovery oriented practice can be underpinned by documentation and local developmental processes in which the users of social psychiatric services play a major role.

Discussion/Conclusion

In the symposium, we will invite the participants to discuss our findings and reflect on whether this way of organizational screenings could be applied in their organizations.

About the Open Dialogue education program in Aarhus, and how to support different professionals to develop their own dialogic practices in the work with citizens with psycho-social disabilities

Astrid Eiterå

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Background/Objectives

In Denmark there is a growing interest in the Open Dialogue approach in psychiatric practice, focusing on the dialogue between patients, private network and professionals. We have been inspired by the “Open Dialogue” approach developed in Western Lapland, Finland and “Reflecting processes”, developed by professor Tom Andersen, Tromsø – Norway.

These ideas have been discussed and tried implemented in very different practice-environments, Social psychiatry, Community Services and hospital centered psychiatry for the last 10 years. A few local education programs have been established, but in 2011 Århus Municipality started a 2 year education program, which is open for participants from all over Denmark, and they come from very different practice-areas.

Right now there are 66 students, and 30 students have already graduated.

During the 2 years, the students participate in 6 courses, each lasting 3 days. However, the most important part of the education takes place in the local study-groups, where they train reflecting processes, and discuss how to implement this way of working in their own teams or workgroups.

Our aim is not to learn the students to “copy” Jaakko Seikkulas or Tom Andersens approaches or methods, but that each student develop their own reflecting practice, inspired by the different practitioners we invite to the courses, and the philosophical and other theories they read, during the education process. We try to be truthful to Tom Andersens emphasis: “Practice comes first!” – and in doing that, it seems like practice develop in different ways, we professionals are all different persons – and our patients/clients, and their network seems also difficult to put into strict method-boxes, when we start our meetings by asking them: What do you feel is important to talk about, today?

We have realized that for us, trained professional to work like this – it takes a lot of courage. We have to bring ourselves – as persons into our work, which sometimes can be risky, or painful. We meet a lot of pain and distress amongst our clients and their network, to be able to cope with this, the training process in the study-groups and to work with reflecting processes are extremely valuable.

Comorbidity of mental and physical disorders - a major challenge for medicine in the early 21st century

Norman Sartorius

*Association for the Improvement of Mental Health Programmes
14 chemin Colladon, 1209 Geneva, Switzerland*

Physical illness is more prevalent among people with mental illness, as compared to the general population. People with severe mental illness (SMI) experience a markedly increased risk of premature mortality, with life expectancy shortened by 10-20 years. The reasons for higher physical illness rates in people with mental disorders are of different nature: some pertain to the social settings and lifestyles of people with mental disorders; they frequently live in conditions of social disadvantage and are exposed to violence and abuse, and frequently abuse of alcohol or substances. A substantial part of the physical comorbidity, however, depends on patients' unhealthy lifestyle and on side effects of most psychotropic medications, mainly antipsychotic drugs: for this reason mental health services may do much to prevent and minimize physical comorbidity promoting an healthy lifestyle and appropriate medication regimes.

The first aim of this symposium is to review the current state of knowledge in this field and develop recommendations for mental health services, medical and nursing schools, policy makers, researchers, and administrators, so as to develop ways to improve the health of individuals suffering from mental as well as physical disorders. The following aspects will be highlighted:

- Appropriate organisation of health and mental health services in Europe to tackle this public health problem, and models of collaboration between the two;
- changes in health professionals' undergraduate and postgraduate training curricula;
- research recommendations and establishment of multidisciplinary research networks;
- proposals concerning the evaluation and feasibility of preventive and treatment strategies.

Mental-physical comorbidity: data from the world mental health survey initiative

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The World Mental Health (WMH) Survey Initiative was established by the World Health Organization in 2000 to provide valuable information for physicians and health policy planners. These surveys have shed light on the prevalence, correlates, burden, and treatment of mental disorders in countries throughout the world. The WMH project has also investigated the epidemiology of coexisting physical and mental illness around the world. Surveys from 18 countries on six continents have provided a large amount of information about epidemiology, risk factors, consequences, and implications for research, clinical work, and policy. Many physical and mental illnesses share a relationship with one another and often occur simultaneously. Clinicians from the disciplines of both psychiatry and medicine are increasingly faced with both challenges on a daily basis, and for this reason these information have large clinical implications.

DRAFT

Stigma and discrimination as barriers to physical health care for people with mental disorders

Graham Thornicroft

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To provide an overview of how far access to mental health care is limited by stigma and discrimination. Globally over 70% of young people and adults with mental illness receive no treatment from healthcare staff¹⁻³. The rates of non-treatment are far higher in low income countries. Evidence from some descriptive studies and epidemiological surveys suggest that potent factors increasing the likelihood of treatment avoidance, or long delays before presenting for care include: (i) lack of knowledge about the features and treatability of mental illnesses; (ii) ignorance about how to access assessment and treatment; (iii) prejudice against people who have mental illness, and (iv) expectations of discrimination against people who have a diagnosis of mental illness⁴.

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DRAFT

Meeting the challenge of physical comorbidity and unhealthy lifestyles: PHYSICO-DSM-VR study

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Background/Objectives

Excess rates of mortality and physical co-morbidity are highly prevalent among people with mental illness due to multiple causes including unhealthy lifestyles. Specific or adapted programmes to change lifestyles related to diet and/or physical activity are being developed among other corrective interventions. A systematic review and meta-analysis on weight management in psychotic patients (Bonfioli et al., 2012), showed that preventive and individual lifestyle interventions that include diet and physical activity should be taken into account in the comprehensive treatment of schizophrenic patients.

The general objective of PHYSICO-DSM-VR (Physical health promotion in patients with functional psychoses of the 4 Community Psychiatric Services of ULSS 20, Verona: a multicentre Randomised Controlled Study) is to implement preventive strategies related to dietary habits and physical exercise and to study their efficacy with a randomised controlled trial in patients with functional psychoses referred to the 4 Community Psychiatric Services (CPSs) of ULSS 20 (the local health authority) of Verona.

The main hypothesis of the study is that the intervention package will result in the improvement of physical activity and diet-related behaviours in people with functional psychoses, compared to those receiving treatment as usual.

Methods

The intervention package (6 months) consists mainly in health education sessions on physical activity and nutrition and walking groups under the guide of an expert trainer.

Subjects will be tested at baseline and after the end of treatment on: physical health status, physical activity and diet habits, number of steps during walking groups, health-related quality of life, satisfaction.

Results

Subjects with an ICD-10 diagnosis of affective and non-affective functional psychotic disorder in contact with the four CPSs were recruited, assessed and randomized. Two dieticians and two physical activity trainers were employed to provide the group interventions. Diet education and walking groups were installed and are now close to completion.

Discussion/Conclusion

Participation in the project has been excellent: subjects showed interest and curiosity in the topics covered in the educational sessions and participated actively in the walking sessions. Follow-up assessment is now being conducted: preliminary results will be available for presentation and discussion in the conference.

Exercise training in patients with dysmetabolic disorders: interrelationships between physical, metabolic and psychological issues

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Regular physical activity is considered a mainstay of the therapeutic approach to metabolic diseases. However, transferring these recommendations into clinical practice is extremely difficult for a number of reasons, including the poor attitude of patients with metabolic disorders to exercise.

Factors underlying the behavioural characteristics of these subjects are scarcely understood. Both genetic and acquired mechanisms are probably involved, and psychological issues may participate in this phenomenon.

Walking was proposed as a reliable approach for implementing the recommended programs of moderate intensity exercise in these subjects. Nevertheless, self-paced walking is inadequate to reach the exercise intensity target in patients with type 2 diabetes, as they show a propensity to walk slower than non-diabetic subjects. Whether this characteristic relies on specific metabolic or psychological issues remains unclear.

A number of data point to abnormalities in metabolic flexibility in these subjects, i.e. in the ability of the body to modify substrate oxidation according to the conditions occurring at any specific time. In particular, there is evidence that in obese individuals fat oxidation is reduced, leading to depletion of glycogen stores, with stimulation of appetite and further weight gain. Physical activity may enhance metabolic flexibility, suggesting that regular exercise could be particularly important in reverting these abnormalities.

Cognitive impairment and depression are increasingly recognized characteristics of subjects with diabetes, and they contribute to make difficult changing the lifestyle of these subjects. Several mechanisms may potentially participate in this phenomenon, including macrovascular complications and drug-induced hypoglycaemias. Interestingly, poor cognitive performance was reported in middle-aged people with mild hyperglycemia, suggesting that hyperglycemia per se could have adverse effects on this function. Adiposity and insulin resistance are potential intermediate mechanisms for these alterations. In men, metabolic alterations are associated with hypogonadism, which may have psychological consequences. Nonetheless, psychological alterations may be primitive events in these subjects, favouring unhealthy lifestyle changes and subsequent metabolic abnormalities. It was reported that exercise may favourably affect psychological disturbances in diabetic patients, and that combined aerobic/resistance exercise may produce greater benefit. However, there is a need for high-quality RCTs focusing on the effect of exercise on psychological endpoints of these patients.

Causes and consequences of comorbidity of mental and physical diseases

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The Dialogue on Diabetes and Depression (DDD) Initiative is a collaborative effort of numerous Non-Governmental Organization, institutions and individuals aiming to increase the awareness about the frequency and consequences of comorbidity of depression and diabetes and the improvement of care for people who suffer from these diseases. The initiative has already resulted in numerous meetings of experts, publications and training programmes directed at different categories of health personnel. A major collaborative study involving sites in 17 countries has also been started. The presentation will describe the initiative, its origins and future plans.

DRAFT

S04

**Financing systems and quality of mental health care.
The REFINEMENT Project**

DRAFT

Mapping the state of the art in the financing of mental health systems. The REFINEMENT project experience

David McDaid, A-La Park, Tihana Matosevic

(United Kingdom)

Much has been written about the effectiveness of specific interventions and organisation of services within mental health systems. Increasingly attention is turning towards analysis of the performance of mental health systems at the macro level. Performance is inextricably linked to the way in which services are funded and in the ways in which resources are allocated to specific services e.g. inpatient care versus primary or community based services. Financing mechanisms are also vital to the continuity of care for people with mental health needs, not only within health care systems but in other sectors such as social welfare, housing and employment. Financing mechanisms can also help or obstruct the integration of services. This presentation therefore looks at the state of the art in the financing and funding of mental health services in high income countries worldwide. It reports on the findings of a systematic mapping of literature on methods of revenue generation, pooling and allocation of resources to services to support mental health both within and external to health care systems. Evaluations of the success or failure in the implementation of these mechanisms, barriers and facilitators to their use and impacts on the efficiency and performance of mental health systems are analysed. Innovative approaches to financing that have applied to mental health systems, such as new methods of consumer directed payment mechanisms are also outlined.

DRAFT

Financial incentives and disincentives in provider payments and user charges for mental health care. The REFINEMENT project experience

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Background/Objectives

One task to be performed by the REFINEMENT project is to examine the impact of financial incentives/disincentives for providers and users/consumers in order to explore the effect on the quality of care for people with mental health needs, including the appropriateness of pathways of people with mental health problems through the specialist mental health and general health care systems.

Methods

A toolkit was developed for identifying financial incentives/disincentives in provider payment mechanisms and user charges. The participating countries (Austria, England, Finland, France, Italy, Norway, Romania and Spain) were asked to identify and describe in some detail examples of financial incentives. We focused on three types of major health services which provide mental health care and not only specialised mental health services: primary care, specialised mental health outpatient care and inpatient care for people with mental health needs.

Results

Altogether 50 examples were analysed, 46 on financial incentives/disincentives in provider payment mechanisms and four on user charges. We identified a) financial incentives/disincentives for mental health care which are implicit in routine payment mechanisms (e.g. fee-for-service tariffs which incentivise mental health activities in primary care; DRG payment systems for inpatient care which tend to shorten length of stay), and b) explicit target payments (e.g. incentivizing screening for depression in diabetes patients in primary care; incentivizing continuity of care and coordinating care between health care services) and also looked for c) unintended consequences (e.g. cream skimming; competing incentives). An astonishingly motley picture of concepts behind financial incentives for improving mental health care was found, as well as of unintended consequences.

Discussion/Conclusion

While the task was to identify incentives for a specific type of service, quite a few of the reported examples were related not to one type of these services only but to several, showing the trend to incentivize continuity of care, shared care and cooperation across service types. This is an interesting development in a financing and services landscape which has been characterized for a long time by fragmentation and difficulties for patients to move from one treatment modality (e.g. inpatient care) to another (e.g. outpatient care).

Mapping mental health services in Europe. The REFINEMENT project experience

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Background/Objectives

The REFINEMENT (REsearch on FINancing systems' Effect on the quality of MENTAL health care) project arises from the necessity to compare and standardize the different and elaborate systems of both financing and performance assessment of Mental Health care in Europe. In order to analyze the different financing and mental health care systems and their correlated outcomes, it is necessary to ensure that researchers, service planners and policy makers in different regions, countries and at the European level, compare 'like with like' and adequately use the data from different services systems. What has been missing from previous service mapping instruments to date has been a common comparison of primary care, general health and social care services that may be used to support people with Mental Health needs.

Methods

Data were collected by the Refinement MAPPING of Services toolkit (REMAST) from Workpackage of the project and composed by the ESMS-R coding instrument, a Services Inventory file, a Socio-Economic Status (SES) index and Geographical Information Systems (GIS) instruments to map and describe the psychiatric services of nine selected Study Areas of the REFINEMENT countries (Italy, Austria, Spain, England, Norway, Finland, Estonia, Romania and France). Maps were created to geolocate the services and show their distribution on the population density and statistical analyses were conducted with the data retrieved by ad hoc questionnaires and national and local databases.

Results

First maps and statistical analyses asked for a further detailed collection of the data and the creation of a new version of the REMAST toolkit. Preliminary results showed that people are spread differently and not homogeneously all over the REFINEMENT countries. Moreover they differ along many dimensions like age, gender and socio-economic status. These differences increase when comparing countries even if they all belong to the European Union. First complete database was ready by August 2012, various reviews and updates followed to create the final dataset by the end of July 2013 with a total of 748 observations for 8 countries (all but Estonia).

Discussion/Conclusion

GIS method was combined with statistical methods to explore the relationship between social disadvantage and the quantity of services available. Comparison with the SES indicator provided interesting insight of the provision of care. Better geographical organizations of the services should support high-quality and effective provision of mental health care.

Pathways of mental health care in European countries. The REFINEMENT project experience

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Background/Objectives

We describe the similarities and differences in the pathways which service users usually follow in the participating countries of the REFINEMENT project (Austria, England, Finland, France, Italy, Norway, Romania, and Spain) and try to demonstrate the relationship between typical service utilization patterns and aspects of the respective health care system.

Methods

Based on a systematic mapping of literature four major research topics were defined: (1) pathways on the interface between primary and specialized mental health care, (2) continuity of mental health care, (3) disengagement from mental health care and (4) psychiatric readmissions. A toolkit (REPATO) was developed to identify the typical and most relevant pathways of mental health care and to identify system and service related factors, which could predict differences in service utilization patterns between the REFINEMENT partner countries. Partner countries' replies to the REPATO toolkit were analysed.

Results

We found large variations in the extent, to which general practitioners treat service users with psychiatric disorders themselves or refer them to psychiatric care or, maybe, follow a "shared care paradigm". Depending on the country, up to 90 percent of service users with a mental disorder are treated exclusively by a general practitioner and do not utilize any kind of specialized psychiatric outpatient treatment. While in some countries the pathways between primary and specialized mental health care are determined by official regulations or guidelines, in other countries they more seem to be the result of historically grown care structures. Data on follow-up care after discharge from acute psychiatric hospitalization, on dropout from outpatient mental health care as well as on readmission show large differences between the REFINEMENT countries: proportions for follow-up after 30 days range from 20 to more than 60 percent, readmission rates within 30 days from 6 to 22 percent.

Discussion/Conclusion

Regarding the pathways of mental health care and possible predicting variables, we have found more differences than similarities between the REFINEMENT countries. To some extent the observed differences can be seen in connection with characteristics of the mental health care system. Nevertheless, it seems, based on experiences in some partner countries, that strategies for enhancing quality and prevent adverse effects in mental health care, can be implemented.

Quality of mental health and social care in Europe. The REFINEMENT project experience

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The presentation reports the main results of the REFINEMENT (REsearch on FINancing systems' Effect on the quality of MENTAL health care) Workpackage 8 "Quality of Mental Health care and met/unmet needs" which aims to identify indicators of performances and outcomes of mental health care and compare quality of mental health care in the REFINEMENT countries.

The Refinement QUALITY of care toolkit (Requalit) was developed to describe the various aspects of the mental health system quality within the European Union context. The measures included in the Requalit try to cover the different system phases (input, process and outcome level) and quality of care dimensions (e.g. accessibility, continuity, appropriateness, effectiveness). As mental health care takes place in a variety of settings throughout the health and social care system, Requalit takes into account different integrated and connected features - primary care, inpatient, outpatient and community services, health and social care.

A large number of possible indicators and measures resulted from a search for indicators in reports of health and mental health international organisations and in published papers on electronic databases. Selection of indicators was based on feasibility and relevance through experts' evaluations using likert scales and during meetings with REFINEMENT partners. Both statistical indicators (e.g. readmission rate) and survey based measures of quality (e.g. quality of life assessment) were considered. The first indicators was calculated by using administrative data systems, often hospital administrative databases or national/regional health/mental health registries. Instead, the second ones were described in each country on the basis of published data or stakeholder interviews (e.g. information on the presence/absence of a regulation).

The main results of statistical indicators in eight of the REFINEMENT countries are reported in the presentation. These indicators provide vital data on different dimensions of mental health system performance in European countries.

The stigma associated with mental illness: Studies on its societal context and interventions

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The ability to effectively intervene in reducing stigma and discrimination against people with mental illness depends on locating negative attitudes among specific target groups and understanding the consequences of these attitudes for people with mental health problems. In this symposium, we describe attitudes amongst influential population subgroups (i.e., families, caregivers and students), investigate the consequences and impact of stigmatizing attitudes for people with mental health problems and discuss results from initial interventions aimed at improving attitudes among families and caregivers and empowering individuals with mental illness to confront negative attitudes.

Luca Pingani will present research on the identification of predictors of stigmatizing attitudes within a population of university students in Italy and will discuss the study implications for developing programmes to reduce stigma among university populations.

Andrea Fiorillo will discuss the results of an assessment of stigma in 30 different Italian mental health centres and a follow-up intervention which aimed to improve the opinions of family members of individuals with mental illness.

Sarah Clement will present a meta-synthesis of quantitative and qualitative studies examining the impact of stigma on help-seeking for mental health problems. Findings on effect sizes; key barriers to care; and which groups may be particularly vulnerable to stigma compromising help-seeking will be discussed; together with a map of underlying processes which can be used to identify intervention strategies.

Sara Evans-Lacko will present data investigating whether the European macro-economic crisis had a greater impact on employment of people with mental health problems compared to people without mental health problems and whether the impact may be greater for people living in regions with greater public stigma towards people with mental illness. Study findings and their implications including interventions to combat economic exclusion and to promote social participation of individuals with mental health problems will be discussed.

Nicolas Rüsç will present findings from a pilot RCT to evaluate the efficacy of a peer-led group programme, Coming Out Proud (COP), among 100 participants with mental illness. COP focuses on the pros and cons of secrecy and disclosure and on appropriate disclosure strategies in different contexts. Change in self-stigma and other outcomes was measured pre, post and at three-week follow-up. Findings and their implications for interventions to reduce self-stigma will be discussed.

What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies

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Background/Objectives

Individuals often avoid or delay seeking professional help for mental health problems. Stigma may be a key deterrent to help-seeking but this has not been reviewed systematically. Our systematic review addressed the overarching question: What is the impact of mental health-related stigma on help-seeking for mental health problems? Sub-questions were (a) what is the size and direction of any association between stigma and help-seeking? (b) to what extent is stigma identified as a barrier to help-seeking? (c) what processes underlie the relationship between stigma and help-seeking? and (d) are there population groups for which stigma disproportionately deters help-seeking?

Methods

Five electronic databases were searched from 1980 - 2011 and references of reviews checked. A meta-synthesis of quantitative and qualitative studies, comprising three parallel narrative syntheses and subgroup analyses, was conducted.

Results

The review identified 143 studies meeting inclusion criteria. The median association between stigma and help-seeking will be presented, with details of the types of stigma most often associated with reduced help-seeking. We will also present the comparative ranking of stigma as a barrier compared to other barriers to help-seeking. A detailed five-theme model was derived which describes the processes contributing to, and counteracting, the deterrent effect of stigma on help-seeking. Four groups were identified who were disproportionately deterred by stigma, and these will be detailed

Discussion/Conclusion

Stigma has a negative effect on help-seeking. The conceptual model can be used to help inform the design of interventions to increase help-seeking, and the vulnerable groups identified can help us to know where to target such interventions.

The mental health consequences of the recession: economic hardship and employment of people with mental health problems in 27 European countries

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Background/Objectives

High unemployment rates among individuals with mental illness are a main contributor to the substantial societal burden associated with these disorders. Economic recessions may be particularly difficult for people with mental health problems as they may be at higher risk of losing their job, and more competitive labour conditions may make it more difficult for them to find a job. This study assesses unemployment rates among individuals with mental health problems before and after the economic recession in Europe.

Methods

Using individual and aggregate level data collected from 27 EU countries in the Eurobarometer surveys of 2006 and 2010, we examined changes in unemployment rates over this period among individuals with and without mental health problems.

Results

This study will present findings on the gap in unemployment rates between individuals with and without mental health problems before and after the onset of the financial crisis and identified subgroups of people with mental illness were especially vulnerable to unemployment. Finally, it will discuss the role of public stigma on unemployment rates.

Discussion/Conclusion

Findings from this study suggest that times of economic hardship may intensify the social exclusion of people with mental health problems. The findings also suggest that interventions to combat economic exclusion and to promote social participation of individuals with mental health problems are even more needed during times of economic crisis and should target support to the most vulnerable subgroups.

Effective strategies to fight stigma associated with mental illness: a 15-year experience

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Since 1998, the Department of Psychiatry of the University of Naples SUN has carried out several studies to fight stigma associated with schizophrenia and other severe mental disorders. In the first study, we developed and validated a self-reported questionnaire on the opinions of relatives of patients with schizophrenia on the causes and social consequences of this mental disorder (Opinions' Questionnaire about severe mental illness). The questionnaire was subsequently adapted to investigate the opinions on schizophrenia of mental health professionals, the general public, school students and users themselves.

Given the high levels of stigmatizing attitudes found in patients' relatives, since 2003 we carried out several studies to implement family psychoeducational interventions in routine practice. At the end of these studies, relatives had more positive attitudes towards patients' social competence, civil and affective rights, and possibility to recover from schizophrenia compared with data collected before the study.

As regards users' opinions, we found that the majority of them feel to be limited in their life by their mental disorder, agreeing that it is difficult for persons with schizophrenia to have a love relationship and to get married. Moreover, they think that people with a severe mental disorder can be unpredictable and suddenly act strangely. These results document that stigma is largely shared even by patients.

More recently, we promoted educational seminars with school students on major mental disorders with the double aim of reducing stigma among young people towards psychiatric patients and of preventing the onset of mental disorders by giving information, advices and support.

The Opinions' Questionnaire is a simple tool to investigate the levels of stigma among different populations and can be easily used in routine practice. Psychoeducational interventions as well as educational seminars for target populations seem to be effective means to fight stigma towards patients with mental disorders.

What predicts stigma against people with mental illness among university students?

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Background/Objectives

University students have stereotypical views about people with mental illness: that they are incurable, dangerous, unpredictable and responsible for their condition. Students also lack information about mental disorders and report desire for social distance from people with mental illness. This presentation describes the prevalence of stigmatizing attitudes in a student population and investigates factors associated with higher levels of stigma.

Methods

The Italian version of the Attribution Questionnaire-27 and a questionnaire about socio-demographic characteristics were administered to a sample of students from the Faculty of Medicine and Surgery of the University of Modena and Reggio Emilia (Italy). Cronbach's Alpha and Confirmatory factor analysis were performed to check whether the original constructs were reliable and valid for a population of Italian university students. Simple and multiple linear regression analyses were carried out to identify factor associated with stigmatizing attitudes in this population.

Results

Of the 948 students contacted, 269 (28.38%) completed the questionnaire. The I-AQ-27 has demonstrated good psychometric properties: $\alpha=.79$ and the fit indices of the models supported the factor structure and paths. The factor associated with more stigmatizing attitudes were male gender (related to unwillingness to give help and willingness of forced segregation for people with a mental disorder) and the lack of information about mental health (related to forced drugging, willingness of forced segregation and the need to maintain a physical distance from people with a mental disorder).

Discussion/Conclusion

The results of this study highlight that education and knowledge about mental health represents a good strategy to fight stigmatizing attitudes in the university student population: the participation and the involvement in educational events (such as lectures and conferences) are in fact associated to low level of stigmatizing attitudes. In literature is described another strategy adopted successfully in several anti-stigma campaign: the "contact" with people suffering from mental disorders. May be subject to further study to verify if the frequency of workshops and roundtable together with patients and their families may be an appropriate tool to fight the stigma in the context of university students.

The efficacy of Coming Out Proud, a peer-led group intervention, to reduce stigma-related distress: findings of a pilot RCT

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Background/Objectives

Due to fear of public stigma as well as due to self-stigma or shame, people with mental illness may decide to keep their condition secret or even to withdraw from social contacts altogether in order to avoid being labeled. Others opt to disclose their mental illness to their personal and/or professional social environments. Both choices, secrecy as well as disclosure, carry risks and benefits, depending on the disclosing person, the setting and the level of disclosure. Therefore persons with mental illness are often confronted with a tough choice whether or not to disclose, but interventions to support them in this domain are missing. In this randomised-controlled pilot trial, we aimed to evaluate the efficacy of Coming Out Proud (COP), a peer-led group intervention developed by Corrigan and colleagues and meant to facilitate decision making and to reduce the negative impact of stigma on people with mental illness.

Methods

One-hundred participants with mental illness were randomised to either COP or a control condition. Each COP group was facilitated by two peers for three weeks, with one group meeting each week. Self-stigma, cognitive appraisal of stigma as a stressor, perceived benefits of being out as well as secrecy and group identification were assessed by self-report at baseline, after three weeks and again at follow-up three weeks later.

Results/Discussion/Conclusions

We will present findings of this pilot trial on the efficacy of COP and discuss implications for future evaluation and development of COP as well as for interventions to reduce self-stigma and disclosure-related distress in general.

Crisis alternatives to hospital admission

Sonia Johnson

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Acute inpatient care is a costly part of mental health services and is frequently experienced as unsatisfactory by service users. Crisis alternatives to acute inpatient wards are therefore of great interest as a potential means to increase service user choice and the effectiveness and acceptability of mental health crisis care.

Sonia Johnson's research group at University College London have an ongoing programme of research into crisis alternatives. In this seminar, we will present new data, not yet publically available, from one recently completed and one ongoing research study regarding crisis residential care and crisis home treatment respectively. Sonia Johnson will provide an overview of her research and the wider literature regarding acute care systems and alternatives to admission. Sarah Fahmy will present results from two multi-site studies which sought service users' views about optimal crisis care and means to improve therapeutic alliance between staff and service users in acute services. Beth Paterson will report findings from a national survey of Crisis Resolution Team managers in England, describing patterns of service organization and delivery and managers' views on key factors influencing effective crisis home treatment. Brynmor Lloyd-Evans will present the development of a fidelity measure to assess adherence to a model of best practice for Crisis Resolution Teams and research plans to investigate the validity of the measure and the effectiveness of implementation resources to enhance model fidelity. Alyssa Milton will present the development of a peer-supported, self-management programme for people following a period of care from a Crisis Resolution Team and preliminary results from piloting the programme.

This symposium all fits into the ENMESH sub-theme of "health services research", within the "psychosocial Interventions that promote better outcomes and recovery" theme. It also includes presentations relevant to the ENMESH themes of "effectiveness evaluation of complex recovery orientated interventions in routine mental health services" and "improving communication skills for better mental health services".

Optimal mental health acute care systems: what do we know?

Sonia Johnson

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Background/Objectives

Acute hospital admission is both costly and often not favoured by service users in crisis. As a result, the quest for effective alternatives to acute admission has been and remains been one of the central projects in mental health service delivery and research in Europe. A consensus is however yet to emerge on the best ways of planning acute care systems to optimise both service user experiences and effectiveness and cost effectiveness.

Methods

An overview will be presented both of the presenter's group's work on alternatives to acute admission and on other key work. Potential future directions for service development and research will be described.

Results

The body of evidence on acute care in mental health is surprisingly insubstantial considering the importance of this area from both service user and service planner perspective. Nonetheless, crisis resolution and home treatment teams, crisis houses and acute day programmes all have some supporting evidence as models that avert some (but not all) admissions, and improve service user satisfaction and choice. They may not, however, prevent compulsory admissions, at least unless enhanced by additional interventions.

While admission alternatives are potentially effective, challenges in implementation remain substantial. Pitfalls include failing to focus on those who are most acutely at risk, and providing care that is limited in strength of therapeutic relationships or in the range of interventions available. Particular challenges in systems with multiple forms of acute care are to ensure all service users enter care pathways that are appropriate to their needs, and to avoid excessive discontinuities in care.

Discussion/Conclusion

The current challenges in research and service delivery in acute care systems and potential future directions will be outlined. The main challenges relate to achieving high quality implementation of potentially effective models and designing effective acute care pathways that result in good outcomes, low readmission rates and service user choice whenever feasible.

Service users' perspectives on acute care: findings from qualitative interviews in acute wards, crisis houses and home treatment teams

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Background/Objectives:

Alternatives to hospital admission – both residential crisis houses and home treatment – have been shown to increase service users' satisfaction with mental health acute care. Good relationships with staff and feeling safe have been identified as important, but little is known about how to optimise service users' experience of acute care.

In one study (TAS2), we explored service users' experience of admission to hospital wards and residential crisis houses, aspects of their relationships with service staff, and factors which facilitate or impede good staff-service user relationships. In a second study (CORE), we interviewed service users of Crisis Resolution Teams (CRTs) to understand their experience of acute home treatment and views on best practice in CRTs.

Methods:

TAS 2: Semi-structured interviews were conducted with service users at 4 crisis houses and 4 acute wards in London. Participants were purposively sampled to reflect the socio-demographic characteristics and service use history of all users of the service. Interviews focused on participants' views on therapeutic alliance between staff and patients including: expectations of, characteristics of, preferences for, barriers to, facilitators of and recommendations for therapeutic alliance.

CORE: Semi-structured interviews were conducted with service users from 10 CRTs in urban and rural settings in England. Participants were asked for their views on the most important aspects of CRT services and on best practice regarding CRT service organisation and delivery.

For both studies, interviews were transcribed and analysed thematically by multiple coders using Nvivo software. Interview schedules and coding frames were developed collaboratively with involvement from researchers and stakeholder groups. Service user researchers conducted interviews wherever possible.

Results

Results will be presented from interviews with service users of Crisis houses (n=14), acute hospital wards (n=15) and CRT services (n=40).

Discussion

The implications from both studies will be discussed for how to optimise service users' experience of acute care and relationships between staff and service users. Implications for involvement of service users in research will also be considered.

Results from National Survey of innovative practice in Crisis Resolution Teams in England

Bethan Paterson, Sonia Johnson, Brynmor Lloyd-Evans

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Background/Objectives

Crisis Resolution Teams (CRTs) aim to provide rapid assessment in a mental health crisis followed by intensive home treatment. The aim of the national survey was to contribute towards an evidence base on how to optimise the functioning of CRTs in real-world clinical settings. The survey was one source of evidence to be combined to other sources to formulate a model of best practice in CRTs and a fidelity measure to assess best practice to be tested in later stages of the CORE Study, a nationally-funded UK research study.

Methods

218 CRTs were identified in 65 NHS Trusts in England. The manager of each CRT was contacted and invited to complete an electronic survey on team characteristics, services provided, initiatives used to improve CRT practice and initiatives to improve service user and carer experiences.

Results

192 teams (88% of total) responded and completed at least part of the survey. 84.4% of teams completed all or at least two thirds of the survey. Most key elements of previous UK government guidance were delivered by some CRTs, but few CRTs met them all. Similarly to a previous survey in 2005 we found considerable variation between CRTs regarding: referral criteria and processes, location and service structure, staffing mix and numbers, arrangements for working with other services, gatekeeping and types of interventions provided.

Discussion/Conclusion

Our survey provides a description of current service organisation and delivery in Crisis Resolution Teams in England. It identifies what can be feasibly delivered in CRTs and the views of a key stakeholder group about important elements of the CRT model. Although most services have been developed within the last dozen years in response to a national mandate and implementation guidance, we found considerable variation in service delivery and organisation. Clear specification of a CRT model is required, as are resources to assess and facilitate model implementation.

Optimising service organization and delivery in Crisis Resolution Teams: the development of a CRT fidelity measure

Brynmor Lloyd-Evans, Sonia Johnson

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Background

Crisis Resolution Teams (CRTs) providing acute home treatment can reduce mental health hospital admissions and increase users' satisfaction with acute care. However the CRT model is not highly specified. Critical ingredients have not been established empirically and there is substantial variation in CRT services' organization and practice.

Objectives

Following methods established by the US Evidence Based Practices Program, we developed a fidelity measure for CRTs, designed to assess services' adherence to a model of CRT good practice and aid service improvement.

Methods

72 statements about aspects of good practice in CRTs were generated from development work for the CORE study (a systematic review of literature and CRT guidelines; a national survey of managers of CRT services in England; and interviews and focus groups with CRT stakeholders (n=105)). 68 CRT stakeholders took part in concept mapping meetings in the UK and Norway. Participants grouped statements thematically and rated their importance. Concept mapping data were analysed using Ariadne software and used to inform development a CRT fidelity measure. The fidelity measure was refined through further stakeholder consultation and piloting of one-day fidelity reviews in four CRTs. A fidelity survey of 75 UK CRTs will be conducted in July-December 2013.

Results

A 39-item fidelity measure was generated, with each item scored on a scale of 1-5. The measure included items rated by stakeholders as of high-importance, which represented four thematic elements of CRTs: referrals and access; content and delivery of care; staffing and team procedures; timing and location of care. Procedures were developed for using the measure to assess CRT fidelity during one-day fidelity reviews. Preliminary results from a 75-team survey of CRT fidelity will be presented.

Discussion

The CRT fidelity measure defines a model of CRT good practice. It can feasibly be used to assess model fidelity in CRT services and promote service improvement. Plans to investigate the psychometric properties of the measure and develop implementation resources to help CRTs achieve high model fidelity will be discussed.

Development and design of a peer-support self-management programme for people following mental health crisis

Alyssa Milton, Sonia Johnson

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Background/Objectives

Crisis Resolution Teams (CRTs) have been widely established across the United Kingdom as an alternative to acute inpatient care for mental health consumers in crisis. CRTs have been reported to have positive impacts on inpatient admissions, healthcare costs and service user satisfaction. Continuity of care between services during and following a period of CRT support has been identified by service users as areas of service provision that could be improved. These reports suggest that CRT support can end abruptly and insufficient attention is placed on promoting self management strategies that help to maintain well being and avoid future crises or relapse. Peer-facilitated self-management programs may have scope address these service gaps; however, there have been no known evaluations of peer-support self-management interventions for people leaving CRT care in the research literature. Therefore, as part of the ongoing CORE project we are comprehensively developing and evaluating a peer facilitated self management programme in a large scale multistage mixed methods RCT.

Methods

In the development phase of the project systematic reviews of Randomised Controlled Trials were initially conducted for both peer facilitated support and for self-management programmes. Multi-stage interview and focus group consultation were held with stakeholders including service-users, clinicians and carers to inform programme acceptability, feasibility and design. A subsequent pre-pilot, facilitated by trained peers (n=4), was conducted with service-users post discharge (n=10) so as to gain an understanding of the feasibility of the programme in a real world setting. Interviews with participants and a focus group with peer support workers were conducted post-preliminary pilot to understand stakeholders' experience of the programme and triangulate views on how to enhance the intervention. From this, a randomised controlled pilot was established and is currently being trialled (n=40).

Results

Design features and results from all completed stages of the project will be presented and discussed.

Discussion/Conclusions

A multi-stage mixed methods approach that combines systematic review, multiple stakeholder qualitative consultations and rigorous programme piloting has proved a useful tool to assist design and development of real-world research.

Experiences in the use of the CORE-Outcome Measure to improve communications skills and outpatient service quality

Vidje Hansen

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The CORE-OM is a self-administered outcome measure of mental distress and risk of suicide and harm to self or others, and if scored at least twice, it yields a score for change during therapy. It has been used extensively and for many years in the UK, the Netherlands, and Scandinavia. The results that will be shown in this symposium come from many different services and thousands of patients. We will focus on results that inform the therapist about the course of the therapy, and make it possible to change the form and content of the patient-therapist communication. This is especially true if session-by-session scoring is applied.

DRAFT

How to engage practitioners in collecting high quality data – Swedish experiences

Rolf Holmqvist

Norway

Background

Knowledge about effects of psychological treatment in ordinary clinical practice is surprisingly limited in a number of important respects, such as therapist effects, number of sessions needed, and differences between treatment methods. Practice-based (PB) studies may in addition to such findings increase knowledge about basic questions like the alliance-outcome issue.

Purpose and results

Results from an on-going Swedish PB study on effects of psychological treatment in primary care and psychiatry will be presented with emphasis on treatment outcome and alliance findings.

Conclusion

PB studies offer an important alternative to randomized trials and may be used to build large data bases for comprehensive analyses of major questions in psychotherapy research. Challenges and possibilities with this type of design will be discussed.

DRAFT

Implementation of routine measurement of individual progress and outcomes in outpatient services - Experiences with CORE in treatment teams

Anders Hovland, Audun Røren

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Background/Objectives

Routine assessment and evaluation of the clinical progress during treatment as well as the efficacy of the treatment are important both from the patient's perspective as well as from a societal perspective. Challenges with the implementation of such routine evaluation pertain both to the individual clinician's appraisal and the practical solutions related to administration and interpretation of scores and outcomes.

Methods

CORE OM and CORE-10 have been used as measures of clinical efficacy and clinical progress, respectively. Implementation within the current department has been conducted through pilot use within a newly developed treatment offer, with a 'champion' working on the treatment team to facilitate implementation.

Results

The experiences with the CORE measures within the pilot treatment offer have been positive, and the team has reported that these measures provide important clinical feedback and affirmation on their clinical efficacy. The team's positive feedback regarding the use of these measures has generated interest from the other treatment teams, and CORE is now used for all treatment offers in the department. The team's experiences with the use of CORE will be described in more detail by the 'champion' from the team.

Discussion/Conclusion

As a result of the successful implementation of CORE within the pilot treatment, further implementation of these measures could be performed from the bottom-up within the rest of the department. Other factors deemed important for successful implementation of routine evaluation based on the current experiences are discussed.

Introducing Practice-Based Evidence in Psychological Therapies Services: An Organisational Change Perspective

John Mellor-Clark, Simone Cross

CORE IMS

Practice-based evidence has been described as an important complement to evidence-based practice, enabling practitioner researchers to address questions of maximum relevance to their service. IT systems are now capable of scoring, organising and displaying client questionnaire data to enable tracking of client progress and to facilitate problem solving when cases are 'off-track'. In spite of the fact that quality improvement systems of this kind have been shown to improve client outcomes, there is evidence to suggest that clinicians are often resistant to using practice-based evidence and in some recent studies the positive effects of feedback appear to be mediated by clinician attitudes towards the use of questionnaire feedback from clients. In this paper, we outline a new strategy to the implementation of practice based evidence in psychological therapies services. This strategy involves recognition of the major organisational change involved in using practice-based evidence. Each step in the journey towards implementation of the practice based evidence system is specified and proceduralised. Emphasis is placed on the dissemination of on-line training in both the rationale and practical use of the system. In addition to this, progress is monitored via a changing sequence of 'on-track' targets with associated 'off-track actions' that have been agreed by the service in advance. This work is currently being piloted in a group of five services in the UK. Success or failure of these projects will be demonstrated by data quality reports in the first instance, followed by clinical targets (such as evidence of reflection relating to 'off-track flags') in later stages of the project.

DRAFT

How to engage practitioners in routine outcome measurement by Tracking Responses to Items in Measures (TRIM)

Simone Cross, John Mellor-Clark

CORE IMS

This paper presents a novel clinical application of questionnaire feedback, which focuses on change at the item, rather than summary score, level. The approach, termed Tracking the Responses to Items in Measures (TRIM), was influenced by solution-focused therapy (Berg & de Shazer 1993) and the personal questionnaire (Elliot, Mack & Shapiro 1999). TRIM aims to 1) provide client and therapist with feedback on areas of positive change which may be masked by more global feedback, 2) reinforce client strengths and self-efficacy, 3) aid identification of extra-therapeutic factors which may be helpful or harmful, and 4) establish a collaborative dialogue relating client problems to client goals and means of treatment. The origins and development of TRIM is summarised. The heart of TRIM – clear, user-friendly display of item change across sessions using colour codes – is shown and the process illustrated by three different clinical examples. Whilst in this paper the TRIM method has been shown using the CORE-OM, the method could easily be used with other “broad spread” and disorder specific measures. TRIM is a useful complement to existing feedback systems, especially in work with clients who are less likely to show change on overall, summed symptom measure scores.

DRAFT

Research on recovery for recovery-oriented services

Alessandro Svettoni

Service for Early Psychiatric Rehabilitation and Recovery "Gelmini", Via F. Schiller, 2 Salorno (BZ) – Italy

In these last years the concept of “recovery” has become more and more popular among professionals in mental health, but it is necessary to avoid it to become the buzz word of the moment and have it instead translated in successful outcomes for individuals disabled by severe mental illness. It is therefore necessary to get to a more comprehensive understanding of this complex phenomenon, which can be possible only considering subjective and objective perspectives, qualitative and quantitative approaches, the different stakeholders' points of view.

This symposium, after offering an updated framework where “recovery” can be defined, will present the results of the Italian Study on Recovery 2, a multicentric, quantitative and qualitative research conducted among several mental health services in Italy in which the Italian translation of the “Recovery Assessment Scale” was validated, the relationships between recovery, empowerment, self-esteem and quality of life were explored and first person accounts of subjects in recovery and their key-relatives were analyzed, in order to identify factors that facilitate or hinder the person's recovery process.

The results of this research, integrated with the already existing literature on the subject, are then presented translated in the practice of orienting and delivering recovery oriented services in mental health.

DRAFT

S09.1

Is “Recovery” just the new buzz word?

Alessandro Svettoni

Service for Early Psychiatric Rehabilitation and Recovery “Gelmini”, Via F. Schiller, 2 Salorno (BZ) – Italy

DRAFT

The Italian Study on Recovery 2: quantitative results

Ileana Boggian

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Background/Objectives

Mental Health Services in Italy in the last years are increasing approach on recovery. However, there are varying meanings for recovery and few measures that specifically target recovery outcome. The Italian Study on Recovery, at first, aimed to assess construct and concurrent validity of patients self-report measure, the Recovery Assessment Scale (RAS).

Methods

Participants were 219 individuals with severe and persistent psychiatric disability who were participants in the Italian Study on Recovery. They completed self-report recovery and other mental health measures such as Self-Esteem, Empowerment, Quality of life and their case workers completed the Health of the Nation Outcome Scales. Exploratory and confirmatory factor analyses were carried out to examine the factor structure of the RAS and correlations with others main factors involved in personal recovery process.

Results

Exploratory factor analysis of the RAS confirmed five factors that were replicated using confirmatory techniques, as found by Corrigan et al., 2004. The factors displayed convergent validity with positive and significant correlations with other recovery measures. Concurrent validity was demonstrated with significant relationships with empowerment, self esteem and quality of life.

Discussion/Conclusion

The factors of the RAS are consistent with the consumer literature on recovery. Correlations with other variable suggest that the RAS is measuring something different from traditional symptom or functional mental health measures.

Further research is needed to clarify the extent to which the RAS is able to capture the range of recovery experiences that have been described by patients.

The Italian Study on Recovery 2: qualitative results

Dario Lamonaca

Centro Salute Mentale AULSS 21 Legnago, VR

Background/Objectives

The recovery is a concept that has gained increasing attention in recent years and has been described as a process of management of mental illness that moves beyond its devastating effects and seeks to achieve a meaningful life in the community. This is the most recent Italian study on factors related to recovery from severe mental illness

Methods

This work deals with the qualitative analysis of interviews sent by the service operators, within the research SIR 2, a participatory research, bottom-up, which aims to give relief to the experiences and values of service users and their families, it comes to 82 users and 45 family members; was used the semi-structured interview is from “The Recovery Work Book” by Spaniol

Results

The mental health services, particularly rehabilitation, aim to help people to reconnect again to the complex set of activities and relationships that make up everyday life

Discussion/Conclusion

The interventions provided by the services should be made according to individual needs and personal accounts of users can provide valuable information for a correct definition of personal needs.

Recovery oriented intervention in recovery oriented mental health services

Silvia Merlin

Dipartimento Salute Mentale AULSS 21 Legnago, Centro Diurno "Il Girasole"

The report seeks to propose methods and practices of intervention recovery oriented and developable within the mental health services in the Italian context. It starts by analyzing the basic principles of recovery and trying to turn them in rehabilitative actions that operators can put in place to encourage the process of recovery with patients.

DRAFT

Managing everyday life with psychosis: psychiatry, poverty, people and pills

Alain Topor

Social Work, University of Stockholm, Sweden

The living conditions for persons with severe mental illness has changed dramatically in recent decades, mainly due to the closure of mental institutions and construction of health care and support services in municipal management. The effects of the closures have been debated. Critics argue deteriorating living conditions in the form of crime, homelessness and loneliness, proponents argue that the change has created an opportunity to regain citizenship in the community. A lack of robust knowledge concerning the living conditions for persons with severe mental illness in Sweden in the beginning of the 21st century, resulted in the “Stockholm Follow-up study”. This study involves 1501 users with a psychosis diagnosis. Data was collected from seven local and national registers (interventions & social situation) and from interviews with a structured sample of 19 users. The interviews were conducted several times a year during a three year period, with a total of 97 interviews. The focus of the interviews was the challenges and social consequences in daily living and the experiences of psychiatry and social services.

This presentation takes its point of departure in results from the interviews, emphasizing four areas of everyday life and the experiences of dealing with the financial situation, medication, social relationships and psychiatry.

DRAFT

Psychosis and poverty

Alain Topor

University of Stockholm, Sweden

Background/Objectives

Persons with severe mental illness (SMI) are now living outside psychiatric institutions, many of them facing problems with poverty. The connection between SMI and poverty is well-known. The direction of the relation between them is still under discussion. Does poverty lead to psychiatric illness or is it the contrary? Traditional psychiatry defines persons with SMI in terms of lack of reality testing and other symptoms. However we lack studies about how people with SMI manage their double troubles in everyday life. How do they manage to live with the double burden of psychosis and poverty?

Methods

1355 persons with a psychosis diagnosis were followed for a period of four years. 19 of them were interviewed 2-3 times a year about their everyday life. The presentation is based on 97 interviews with these persons. The transcriptions were analyzed in accordance with Grounded Theory.

Results

Persons with SMI developed different rational ways of coping with economic strain: reducing their expenses, increasing their incomes or borrowing money and acquiring debts. Living under poverty negatively affects their possibility to acquire and maintain a social network and their sense of the self. Behaviors and emotions that are usually interpreted as symptoms of psychosis could be understood as reaction to a life in poverty. In contrast to traditional criterions related to psychosis, the persons described a number of rational ways to manage with economic strain. Even irrational ways got rational when put in their social life context.

Discussion/Conclusion

Research based on the experiences of persons with SMI in their context put the traditional psychiatric knowledge, based on the institutionalized patient, in question. This contextual knowledge may affect the way services should meet persons with SMI and the psychiatric knowledge about the social sources of what is defined as symptoms of illness. The problem of poverty affecting people with SMI should be part of the evaluation of the psychiatric illness and of the possible interventions.

Coping with psychiatry

Anne Denhov¹, Gunnel Andersson, Per Bülow, Alain Topor

University of Stockholm, Sweden

Background/Objectives

Literature reviews suggests that the alliance between user and professionals is important for the treatment outcome not only in psychotherapy but also among patients with severe mental illness and in everyday practice in psychiatry.

Regarding psychosis a literature review showed that there is a scarcity of studies focusing specifically on patients with psychosis and found that “there is some, but not overwhelming, evidence that the TR (therapeutic relationship) predicts outcomes of complex psychiatric treatment programs in patients with psychosis”.

Given the indications supporting the importance of the relationship quality it is vital to explore the components and the circumstances which promotes or hinders a helping relationship to thrive. In this study we focus on users experiences of psychiatry.

Methods

This study builds on the qualitative part of The Stockholm follow-up study of persons diagnosed with psychosis (SUPP). 19 persons were interviewed in open interviews during three year. The interviewees were chosen by strategic selection. For this study all excerpts regarding contact with psychiatry were analysed using Grounded Theory

Results

We found three different managing types: The authority of the white coat, The care-smart and The Protesting. We also found that the respondents could change the type of managing over time.

Discussion/Conclusion We found that the respondents were far from passive recipients of psychiatric care. They were actively managing their contacts with psychiatry in order to receive what they regarded as optimal for them.

Psychotropic drugs and everyday life

Per Bülow, Gunnel Andersson, Anne Denhov, Alain Topor

University of Stockholm, Sweden

Background/Objectives

Antipsychotic is a cornerstone in the treatment of people with psychosis. However, treatment with these drugs is not without problems, and there are gaps in knowledge about choice of drugs, dose levels, treatment duration and combinations with other drugs. Guidelines exist in many countries, but research shows that adherence to these is regularly poor. A common clinical problem is non-compliance, that patients do not follow doctors' orders, which is interpreted as a lack of insight and is seen as a primary symptom resulting directly from an illness process.

Methods

Nineteen people with experience of psychosis were interviewed recurrent for 3 years. A total of 97 interviews were conducted. The interviews were open and focused on different aspects of everyday life. The interviews were analyzed according to qualitative methods.

Results

Some of the respondents are in favour of drug treatment and feel experience a positive effect. Others are more hesitant and feel that the medicine is not effective, create serious side effects and only provide confirmation that the person has a mental illness. The interviewees differ in their own involvement in the treatment. Some are very active while others have confidence in the profession and that the treatment is adequate. Some interviewees developed their own medical practice to manage drug therapy by choosing not to follow doctors' orders. The most common ways were a) to raise or lower the dose over periods from a few days to several months, b) to temporarily refrain from taking drugs in specific circumstances, such as when to take a drink, and c) to stop taking their drugs completely for three consecutive days or more. This private medical practice was kept secret to all staff since the initiative was disapproved, especially by the psychiatrists.

Discussion/Conclusion

Treatment with psychoactive drugs affects everyday life and relationship to health care but the manner in which varies greatly among the respondents.

Everyday life and social relationships

Gunnel Andersson, Alain Topor, Anne Denhov, Per Bülow

University of Stockholm, Sweden

Background/Objectives

The living conditions for persons with severe mental illness has changed dramatically in recent decades, mainly due to the closure of mental institutions and construction of health care and support services in municipal management. A lack of robust knowledge concerning the living conditions for persons with severe mental illness in Sweden in the beginning of the 21st century, resulted in the “Stockholm Follow-up study”. This study involves 1501 users with a psychosis diagnosis. Data was collected from seven local and national registers (interventions & social situation) and from interviews with a structured sample of 19 users. The follow-up period is 2004-2008.

This presentation takes its point of departure in the results from the interviews with the 19 respondents. The focus of the interviews were the challenges and the social consequences in daily living and the experiences of psychiatry and social services. This presentation emphasizes everyday life and social relationships.

Methods

The main purpose in the interview study was to follow the respondents everyday life as close in time to the life events as possible. The 19 respondents were interviewed between four and nine times during a period of three years. The interviews were recorded and transcribed. In all, 97 interviews were conducted.

Results

Results show that persons diagnosed with psychosis have a wide range of different everyday life stiles. Based on the participation and presence in the “community organized” sphere (psychiatry and social services) on one hand and “individually organized” (the social context outside the mental health system) on the other, four types of everyday life emerges.

Discussion/Conclusion

Four different types of everyday life can be seen with different amount of involvement in the community organized and the individually organized sphere respectively. In spite of how everyday life is organized, the respondents are to be considered as socially active, participating in decreasing or increasing their social networks.

From Theory to Practice: Implementing Recovery into Mental Health Services in Quebec, Canada

Myra Piat

McGill University, Douglas Mental Health University Institute, 6875 Lasalle Blvd, Montreal H4H 1R3

Implementing recovery is the priority of the Canadian Mental Health Strategy, and the guiding principle for mental health reform in Quebec. While mental health recovery is grounded in over 20 years of international research and is the driving force behind policy, little is known about how recovery is being implemented at the level of mental health services and practices in Canada. In this symposium we will present the current work being undertaken to make recovery a reality in the Quebec public health system. The overall objective is to present concrete examples (both in research and in practice) of the different strategies being used to implement recovery into mental health services. This symposium is timely and important because recovery has emerged as the new paradigm for mental health policy on the world stage, occupying a central focus in policies in Canada, New Zealand, England, Australia, the United States and numerous European countries. Recovery-oriented services go beyond traditional clinical care by helping people to achieve a better quality of life, to become integrated into their communities, and to access stable housing and employment. This presentation will focus on how recovery as a national policy and vision is being implemented into services. The perspective of users, peers, administrators and researchers will be offered.

Presentation #1: will focus on the perspective of mental health administrators and the challenges they face in implementing recovery into a complex health and social service system (Catherine Briand, Researcher and Lise Labonté, Administrator, Community Health and Social Service Centre).

Presentation #2: will focus on the perspective of mental health users of services and illustrate the important role users play in creating a vision of hope beyond the formal mental health system (Annie Bossé, Peer Worker, User)

Presentation #3 will focus on mental health service providers and the processes used to develop ownership of the recovery concept among service providers. Different initiatives including: developing a community of practice, translating documents, implementing innovative practices (feelingbetter.com) will be discussed (Lise Labonté, Administrator and Annie Bossé, Peer Worker, User).

Presentation #4 will focus on a participatory action research project aimed at exploring local health and social service networks that are currently transforming their mental health services to a recovery orientation (Myra Piat, researcher and Catherine Briand, researcher).

Understanding the Issues: The Challenges of Implementing Recovery Within a Complex Health and Social Service System

Catherine Briand, Lise Labonté, Myra Piat, Annie Bossé

McGill University, Douglas Mental Health University Institute

Background/Objectives

The living conditions for persons with severe mental illness has changed dramatically in recent decades, mainly due to the closure of mental institutions and construction of health care and support services in municipal management. A lack of robust knowledge concerning the living conditions for persons with severe mental illness in Sweden in the beginning of the 21st century, resulted in the “Stockholm Follow-up study”. This study involves 1501 users with a psychosis diagnosis. Data was collected from seven local and national registers (interventions & social situation) and from interviews with a structured sample of 19 users. The follow-up period is 2004-2008.

This presentation takes its point of departure in the results from the interviews with the 19 respondents. The focus of the interviews were the challenges and the social consequences in daily living and the experiences of psychiatry and social services. This presentation emphasizes everyday life and social relationships.

Methods

The main purpose in the interview study was to follow the respondents everyday life as close in time to the life events as possible. The 19 respondents were interviewed between four and nine times during a period of three years. The interviews were recorded and transcribed. In all, 97 interviews were conducted.

Results

Results show that persons diagnosed with psychosis have a wide range of different everyday life stiles. Based on the participation and presence in the “community organized” sphere (psychiatry and social services) on one hand and “individually organized” (the social context outside the mental health system) on the other, four types of everyday life emerges.

Discussion/Conclusion

Four different types of everyday life can be seen with different amount of involvement in the community organized and the individually organized sphere respectively. In spite of how everyday life is organized, the respondents are to be considered as socially active, participating in decreasing or increasing their social networks.

Creating Hope: Recovery Stories of People with Mental Health Challenges

Annie Bossé, Myra Piat, Catherine Briand, Lise Labonté

McGill University, Douglas Mental Health University Institute

Background/Objectives

Recovery-oriented mental health services should promote hope, self-mastery, a meaningful life, and belonging in the community for individuals with mental health challenges. This second presentation will focus on the perspective of mental health service users and the important role users play in creating a vision of hope beyond the formal mental health system. Hope is a fundamental element of recovery and is often the trigger that enables people to embark on their recovery journey.

Methods

In this presentation we will focus on the recovery stories of people with mental health problems. Each recovery story is different and offers us the opportunity to gain insight into what helps people recover such as choice, building a social network, caring for a pet, being involved in meaningful activities. This presentation will be moderated by a peer worker (service user) involved in Quebec. She will describe first hand her experience both as a service user and peer work the different ingredients required to sustain recovery.

Results

Recovery stories (video) will be used as a spring board to facilitate the conversation on what is important for people to recover, how services fit in and what lessons can be learned.

Discussion/Conclusion

This presentation will encourage participants to reflect upon the uniqueness of each person's recovery journey and the importance of sustaining hope and allowing each person to be at the centre of decisions and make choices based on their own interests and values.

Agreeing on a Common Vision- Moving from Discourse to Action: Innovative Practices & Initiatives in Services

Lise Labonté, Annie Bossé, Myra Piat, Catherine Briand

McGill University, Douglas Mental Health University Institute

Background/Objectives

Traditional mental health services tend to foster dependency, discouragement, and even stigmatization. Recovery-oriented services go beyond traditional clinical models by helping people to actively participate in developing and implementing services that enable them to achieve a better quality of life and thus to become truly integrated into their communities. In Quebec (Canada), we are in the initial stages of this process of exploring the challenges and strategies required to transition our mental health system to a recovery oriented system. In this presentation we will focus on mental health service providers and the strategies used to develop ownership of the recovery approach and how this is being integrated into practice.

Methods

A series of meetings were held in Montreal over a 24 month period (2011-2012) at approximately four to six month intervals, each 1.5 days in duration (CHIR Grant, Piat et al.). The objective of these meetings was to: 1) discuss and validate the translation of two British monographs detailing the recovery approach, its origin and definition, and the strategies used to implement this approach. 2) develop an action plan to promote the dissemination of these documents in Quebec in order to facilitate knowledge translation and adapted to the Quebec context, 3) discuss barriers and facilitators to the implementation of recovery-oriented mental health services in Quebec and 4) establish a community of practice to support development and implementation of the recovery process into mental health services in Quebec. These 2 documents are: “Making Recovery a Reality” and “Implementing Recovery: A Methodology for Organisational Change” (Shepherd & al. Sainsbury Centre, UK).

Results

In Quebec we are confronted with an additional challenge of limited evidence-based practices detailing recovery-oriented services in the language of a primarily French speaking population. To meet these challenges a community of practice was established in September 2013 in Quebec and a coalition for change has gradually emerged stressing on knowledge exchange, support and collaboration among partners.

Discussion/Conclusion

This project represents a concrete step in moving the recovery perspective into practice. The project will provide as a unique networking and knowledge translation experience seldom undertaken in Quebec.

Sustaining Innovation: Translating the Evidence for Mental Health Recovery into Concrete Practice: A Participatory Research Project

Myra Piat, Catherine Briand, Lise Labonté, Annie Bossé

McGill University, Douglas Mental Health University Institute

Background/Objectives

Recovery is understood as a unique process of personal change leading to a more satisfying, hopeful, and productive life, even within the limitations caused by mental illness. Recovery oriented services go beyond traditional clinical care by helping people to achieve a better quality of life, to become integrated into their communities, and to access stable housing and employment. Implementing recovery is the priority of the Canadian Mental Health Strategy, and it is also the guiding principle for mental health reform in Quebec and New Brunswick. This fourth presentation will focus on a participatory action research project aimed at exploring local health and social service networks that are currently transforming their mental health services to a recovery orientation.

Methods

Twenty decision makers from Quebec and New Brunswick met numerous times with the research team to develop this proposal over the past year and a half. The need to integrate recovery from policy to practice emerged in these meetings as a priority. Our principal decision makers include five Directors Mental Health Services, the Director of the Mental Health Strategy for Canada, and two provincial Mental Health Directors and three decision makers from user and family organizations.

Results

Six case studies will be included in the study: 4 Community Health and Social Service Centres in Quebec and 2 community mental health centres in New Brunswick. Within each case, 5 respondent groups will participate: service users, family members, service providers, managers, and psychiatrists. Both qualitative and quantitative data will be collected. The research questions guiding this study are: 1- How is mental health recovery being implemented into ambulatory mental health services? 2- What factors facilitate/hinder the implementation of recovery into mental health services? What solutions can be identified to address these barriers? 3- What is the service user's perspective? 4- How does this compare with the perspectives of families, service providers, managers, and psychiatrists? 5- How can this information be used to help decision makers improve mental health services?

Discussion/Conclusion

The outcome of this participatory research project will impact service users, providers and family members. The study should help us better understand system transformation and what is required to move recovery as a policy into practice.

Transition from Child to Adult Mental Health Care in Europe: Barriers and Opportunities

Swaran P. Singh

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Transition to adulthood is the period of onset of all the potentially serious mental disorders that disable or kill in adult life. Three quarters of adult mental disorders have an onset before the age of 25 years; 50% before the age of 16. However very few young people with mental disorders access services or receive appropriate care. Across the EU, mental health services follow a paediatric-adult split, with distinct Child and Adolescent Mental Health (CAMHS) and Adult Mental Health Services (AMHS), and a transition cut off ranging from 16-21 years. There are profound conceptual, clinical, and ideological differences between CAMHS and AMHS, which create impediments to continuity of care for young people, especially those who make a transition from one system to another. Transition is critically importance, given the recognized importance of early interventions and the age of onset of most mental disorders; yet it is poorly researched. Only one study in Europe (the TRACK study) has carefully evaluated the characteristics and outcomes of such transitions.

The purpose and objectives of the symposium are:

- 1) To present the current state of transition from CAMHS to AMHS, and the unmet needs of young people who fall through the current transitional pathway;
- 2) To suggest the development of integrated models of care and functioning of CAMHS and AMHS, with a specific focus on strategies and procedures to improve transitional care from CAMHS to AMHS; and
- 3) To propose a research agenda for the field.

Age of onset of adult mental disorders and the problem of transition

Giovanni de Girolamo, Jessica Dagani

IRCCS Fatebenefratelli, Brescia (Italy)

The studies which will be reviewed confirm previous reports on the Age Of Onset (AOO) of the major mental disorders. Although the behaviour disorders and specific anxiety disorders emerge during childhood, most of the high-prevalence disorders (mood, anxiety and substance use) emerge during adolescence and early adulthood, as do the psychotic disorders. Early AOO has been shown to be associated with a longer duration of untreated illness, and poorer clinical and functional outcomes. Summary. Although the onset of most mental disorders usually occurs during the first three decades of life, effective treatment is typically not initiated until a number of years later. There is increasing evidence that intervention during the early stages of disorder may help reduce the severity and/or the persistence of the initial or primary disorder, and prevent secondary disorders. However, additional research is needed on effective interventions in early-stage cases, as well as on the long-term effects of early intervention, and for an appropriate service design for those with emerging mental disorders. This will mean not only the strengthening and re-engineering of existing systems, but is also crucial the construction of new streams of care for young people in transition to adulthood.

DRAFT

Transition process, outcomes and experience: Findings from the TRACK study

Swaran Singh

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Birmingham and Solihull Mental Health Foundation Trust
Hub Lead, Mental Health Research Network (MHRN) Heart of England Hub*

Background

The conceptual, clinical and organisational differences between Child and adult mental health services can create barriers to continuity of care for those who reach the transition age for child services. However little is known about the outcomes and experiences of those who reach this boundary

Aims: TRACK was a multisite, mixed-methods study that explored the process, outcome and experience of transition from Child and Adolescent Mental Health Services (CAMHS) to adult (AMHS) care in six healthcare Trusts in London and West Midlands, UK.

Methods

We mapped existing transition protocols, tracked transition pathways and outcomes of all users who crossed transition boundary in the preceding year, conducted qualitative analysis of clinicians', managers' and voluntary sector perspective on transition with in-depth interviews with a sub-sample of service-users, carers and their clinicians

Results

There were 14 active protocols in the study areas, which differed on practical aspects. Transition boundary varied from 16–21 years. Three-quarters of protocols had no provision for ensuring continuity of care for cases not accepted by AMHS. Of the 154 cases who crossed the transition boundary, 90 made a transition to AMHS and 64 were either not referred or not accepted by AMHS. Almost 50% fell through the care gap and very few experienced an optimal transition. Those with a severe and enduring mental illness, a hospital admission and on medication were most likely to make a transition. Those with neurodevelopmental disorders, emotional disorder or emerging personality disorder were most likely to fall through the gap. A fifth of cases accepted by AMHS were discharged without being seen. Following transition to AMHS, most users stayed engaged and reported improvement in their mental health.

Conclusions

The journey from CAMHS to adult mental health care is fraught with barriers and pitfalls. Since late adolescence is the maximum risk period for the emergence of serious psychiatric morbidity, this weakness in the pathway where it should be most robust must be a priority for service commissioners, providers and policy makers.

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Can transitional care be improved: Findings from the BRIDGE Project

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Background

The need to improve the rate of transfer and quality of transitional care for young people at the transitional boundary between Child and Adolescent (CAMHS) and Adult (AMHS) Mental Health Services has been highlighted in government policy, practice-orientated guidance and research. There is, however, a paucity of good quality research comparing different models of transitional care. The aim of the Bridge Project was to compare two models of transitional care between CAMHS and AMHS in two demographically similar areas of the West Midlands, UK: a protocol driven model and a protocol and transition worker driven model. Today we will report on the establishment of a national transition workers network.

Aims

To compare and contrast transition worker posts across England and Wales.

Methods: An initial group of transition worker posts were identified from a guide for commissioners produced by the National Mental Health Development Unit and a practice enquiry undertaken for the Social Care Institute for Excellence (SCIE). A snowballing technique and consultation with experts added to the group of identifies transition workers. Six-monthly network meetings were held and the group remained in touch with each other and the Bridge Team by email. Qualitative and quantitative data on posts were collected through comparison of job descriptions and other transition post/service-related documentation and facilitated discussions at network meetings.

Results

Over 20 transition workers were in regular contact with the Bridge team and around 10 regularly attended the five network meetings held by the end of the Project. Whilst there were significant variations in how transition worker roles or services worked, some of the most common features of the work included responsibilities to develop transition protocols and pathways; to offer training and consultation to other staff; to develop inter-agency links and to undertake awareness-raising type work around young people's needs when in transition from CAMHS.

Common problems included worker isolation, ambiguity and confusion over the role and facing increasing demands for their service, often from young people in crisis, and frequently accompanied by a loss of services elsewhere, which thus limited the choices available to young people. In a number of the network meetings, the problems caused by cultural and practical differences between CAMHS and AMHS were raised. Poor or inconsistent paperwork and blockages in information sharing between CAMHS and AMHS were noted, sometimes as a result of child protection concerns or because of incompatible IT systems. Members of the network also identified similar groups of young people for whom transfer seems especially hard to achieve, notably young people with ADHD/ASD. Many were struggling to address and described difficulties they experienced getting feedback from young people on their experiences of transitional care.

Conclusions

Transition worker roles and services vary but have a number of common features. Post holders faced common systemic challenges, including cultural and practical differences between CAMHS and AMHS and difficulty gaining feedback from service users.

The experience of transition, user and carer perspectives: Findings from the BRIDGE Project

Cathy Street

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Background

The need to improve transitional care for young people at the boundary between Child and Adolescent (CAMHS) and Adult (AMHS) Mental Health Services has been highlighted in government policy, practice-orientated guidance and research. In the Bridge Project, where the aim was to compare two models of transitional care between CAMHS and AMHS, the study sought the views of young people and their parents or carers regarding their experiences of transition, and their suggestions for how this period of care might be improved.

Aims

To further understanding of the experience of transition from the perspective of young people leaving CAMHS and their parents and carers.

Methods: Comprehensive research packs were prepared for the two Bridge Project sites; these contained information for young people and consent forms and also a pack of information for them to pass to their parent or carer if they were happy for them to also be involved in the Project. All young people passing the CAMHS transition boundary over an agreed period of time received a pack by post, with follow-up reminders by telephone as required. Young people were identified by their date of birth via the respective service databases. Individual interviews and/or small group meetings were offered. These were scheduled as flexibly as possible and were undertaken at either the young person's home or at the offices of their local CAMHS.

Results

8 young people and 3 parents/carers contributed to the study. Despite this small number of interviews, the Bridge Project gathered valuable insights about how young people view their transition from CAMHS. Of particular note, many appear to feel that at this point, they wish to get on with their lives independently without professional support. This is both highly understandable, but also, indicates the challenge of maintaining their involvement with mental health services, and achieving a transition into AMHS if this is thought necessary. Echoing other research studies, both young people and parents and carers also talked of transition planning often starting too late, and of receiving inadequate information about possible options and about what to expect in AMHS. Suggestions for improving transition included: services working more flexibly and staffed with professionals experienced in working with the multiple needs (practical and clinical) often presented by young people. The need to provide all young people with information about different sources of support that might be available post-CAMHS was also highlighted.

Conclusions

The experience of transition remains unsatisfactory for many young people. Despite national guidance and reports setting out good practice, problems with planning, information transfer between services and involving young people and their families or carers in the process continue.

S12.5

A research agenda for transitions

Swaran Singh, Giovanni de Girolamo

DRAFT

Towards a European Roadmap for Mental Health and Well-being (ROAMER): Identifying priorities for social inclusion and economic research

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The ROAMER (A roadmap for mental health research in Europe) project aims to develop a comprehensive and integrated mental health research roadmap. One work package in ROAMER focuses on two issues: social inclusion and the use of economics. The aim is to map advances in research related to these issues, identify gaps in our current knowledge and then set priorities for future research. These issues are a major public health concern. For instance, poor mental health is associated with increased risks of poor physical health and reduced participation in education or employment. Social exclusion is damaging to people with mental health problems and associated with substantial societal burden. These challenges may be compounded by rapid societal change, including the consequences of the current economic downturn.

It is critical therefore to improve our knowledge of what works, in what context and at what cost. Can for instance we improve what is known about the cost effectiveness of measures to promote social inclusion of people with mental health problems. Understanding the state of the art in these areas of research is vital to the effective implementation of genuinely whole of government approaches to mental health.

This symposium will present results from an innovative approach to the mapping of research literature related to social inclusion and economic research, highlighting temporal trends in research themes, research methods used and the distribution of research capacity across Europe. Methods adopted and findings from a two stage Delphi process involving the participation of European experts in both fields to identify research gaps and key research priorities will be presented.

S13.1

Overview of ROAMER (roadmap for mental health research in Europe) and the role of social and economic research in a fragmented and fast changing European landscape

David McDaid

DRAFT

Result of a systematic mapping of the state of the art in European research on promoting social inclusion, addressing social exclusion and stigma

**Emilie Courtin, Andrea Fiorillo, Mario Luciano, A-La Park,
Graham Thornicroft**

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Background and objectives

Social exclusion and stigma of people with mental health problems are associated with significant societal costs. Available evidence shows that suffering from mental illness has a substantial impact on social inclusion, including in the areas of employment, housing, education and access to health and social care. Against this background, the aim of the mapping exercise is to describe the current state of the art of research on social exclusion and stigma in Europe. The mapping is guided by the following overarching research question: Where (i.e., in which countries and European centres) is research on social exclusion in relation to mental health being performed? Sub-research questions include: What is the nature of the research on social exclusion in relation to mental health in Europe (i.e., methodology, type of disorder, age groups)? What are the main topics in relation to research on social exclusion and mental health in Europe?

Method

Building on a previous systematic review which covered the years 1948-2003, Medline and PsycINFO databases were searched from 2007 to 2013. Only empirical, peer-reviewed and English language articles reporting research conducted in a European Union country were included in the mapping. Included articles had to focus on mental illness and social exclusion or stigma. Two reviewers independently assessed each abstract against the inclusion criteria.

Results

Of the 20,122 references that emerged from the initial search, 5,000 were randomly selected for review and data extraction. 320 articles (17%) met the inclusion criteria. Findings will be reported for: (1) geographic region; (2) type and nature of research performed (including representation of gender and age groups in the selected studies, type of mental health problem and type of study); and (3) topics covered and gaps identified in the evidence base.

Conclusion

This mapping exercise describes the type of research which has been conducted on social exclusion, stigma and mental health in the past years across Europe. By mapping out the available and the gaps in knowledge, it contributes to: (1) set priorities in future research; and (2) inform policy and practice in that area of mental health research in Europe.

S13.3

**Result of a systematic mapping of the state of the art
in European research on the use of economics
in mental health and wellbeing research**

A-La Park
United Kingdom

DRAFT

Results of DELPHI exercises to identify research gaps and priorities areas for future funding

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Background and objectives

One of the six areas of the ROAMER (Roadmap for Mental Health Research in Europe) project focuses on social and economic issues in relation to mental health and well-being. One aim of this project is to identify knowledge and implementation gaps and the main priorities for future research across Europe including what is known about the economic costs and social consequences of stigma and discrimination, as well as risk of co-morbid physical and mental health problems.

Methods

A two round modified Delphi exercise, supplemented by 2 scientific workshops was used to identify research knowledge and implementation gaps and priorities. For the Delphi survey, we used a snowball sampling technique in addition to targeted sampling of participants, as we aimed to include at least one expert from each EU country. Delphi participants were invited based on: recommendations from ROAMER work package experts, participation from relevant research networks (i.e., European Network for Mental Health Services Research [ENMESH] and Mental Health: European Economic Network [MHEEN]).

Results Discussion/Conclusion

We will present findings on (i) the top 8-10 research priorities in Europe for social inclusion and economics research in relation to mental illness and well-being in Europe and (ii) the highest ranked 3 priorities for each research area (i.e., social inclusion and economics).

Case management or treatment approaches for neglected or marginalised patient groups

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Given the strong association between social disadvantages and mental disorder, research on and service provision for socially marginalized or neglected groups suffering from mental disorders needs to be strengthened. However, community mental health care systems in most countries do primarily focus on a core clientele of chronic patients that are well integrated into the system, whereas persons in need from marginalized societal groups very often experience high barriers to treatment or care. These groups include ethnic minorities, emigrants or persons living in precarious financial or instable housing conditions etc.

This symposium summarizes recent findings on the association to and effects of these conditions on mental disorders and present case management approaches for persons at risk from various European countries. Conclusions are drawn for an appropriate provision of mental health care

DRAFT

Migration, social adversity and psychosis - recent findings and implications for mental health services research

Ulrich Reininghaus

United Kingdom

Several studies have reported higher rates of affective and non-affective psychoses in Black and Minority Ethnic (BME) groups. This talk will report recent findings on markers of childhood and adult adversity as potential explanatory factors for the increased rates of psychosis in minority ethnic groups. Overall, evidence on factors that may explain the higher rates of psychosis in BME groups is limited. However, the evidence that there is suggests social adversity in childhood and adulthood may be relevant. Specifically, findings suggest childhood separation from parents, social disadvantage and isolation in adulthood, discrimination, ethnic density, and ethnic identity are factors that may account for the elevated rates. Recent evidence further suggests that the impact of early adverse experiences on psychosis may be mediated by social adversity in adulthood and that the greater prevalence of social adversity across the life course in BME groups may account for the higher rates of psychosis in these groups. There are also a number of plausible biological and psychological mechanisms through which exposure to social adverse experiences may increase risk for psychosis. The implications of these findings for mental health services research will be discussed in the context of new challenges in the field and directions for future research.

DRAFT

Illness perceptions and personality traits of patients with mental disorders: the impact of ethnicity

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Background

To identify differences and similarities between immigrants of Turkish origin and native-German patients in therapeutically relevant dimensions such as subjective illness perceptions and personality traits.

Method

Turkish and native-German mentally disordered inpatients were interviewed in three psychiatric clinics in Hessen, Germany. The Revised Illness Perception Questionnaire (IPQ-Revised) and the Neuroticism-Extraversion-Openness Five-Factor Inventory (NEO-FFI) were used. Differences of scales and similarities by k-means cluster analyses were estimated.

Results

Of the 362 total patients, 227 (123 immigrants, 104 native Germans) were included. Neither demographic nor clinical differences were detected. Socioeconomic gradients were identified and differences on IPQ-R scales. For each ethnicity, the cluster analysis identified four different patient types based on NEO-FFI and IPQ-R scales. The patient types of each ethnicity appeared to be very similar in their structure, but they differed solely in the magnitude of the cluster means on included subscales according to ethnicity.

Conclusion

When subjective illness perceptions and personality traits are considered together, basic patient types emerge independent of the ethnicity. Thus, the ethnical impact on patient types diminishes and a convergence was detected. Further research is needed to determine the role of socioeconomic gradients, cultural acculturation processes and therapeutic results.

Outcome relevance of illness perceptions and personality trait profiles of German and Turkish inpatients

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Background

Franz et al. (2013) identified four similar patient profiles for German and Turkish patients based on subjective illness perceptions and personality traits. Outcome relevance of profiles should be examined.

Method

Data on the Revised Illness Perception Questionnaire (IPQ-Revised) and the Neuroticism-Extraversion-Openness Five-Factor Inventory (NEO-FFI) were collected for Turkish and native-German mentally disordered inpatients in three psychiatric clinics in Hessen, Germany. Prior results of cluster analyses provided the empirical defined patient profiles which were analysed by ANOVA models adjusted for potential confounders. Different outcomes were examined.

Results

Of the 362 total patients, 227 (123 immigrants, 104 native Germans) were included. Samples were roughly balanced. Multivariate ANOVA results yield inconsistent evidence across subjective and objective outcomes.

Conclusion

Patient profiles based on subjective illness perceptions and personality traits show evidence for clinical relevance. However, results are restricted to inpatient treatments and a comparatively short time interval. Hence, achieved results are promising for further research in order to gain more insights into cross-cultural health services research and related health economics.

Treatment initiation in mentally disordered people on the edge of homelessness - the MOTIWOHN-Study

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Many studies have confirmed the close association between homelessness and mental disorders. However, studies on mental ill-health of persons who are living in unstable housing conditions and having a high risk in getting homeless are scarce. Lacking evidence on the psychiatric prevalence of this high-risk group prevents from addressing possible psychopathological problems underlying the adverse social or financial circumstances and disregards opportunities for preventing a further social decline.

On the basis of earlier findings from the catchment area of Mannheim, Germany, which confirmed the high untreated psychiatric prevalence among persons under immediate threat to loose accommodation (Salize et al 2006), we conducted a prospective intervention-study on persons living in instable housing conditions and suspected to suffer from an untreated mental disorder.

We recruited persons at risk in job centers and social welfare agencies, where they were screened for a possible mental disorder and - in case of a positive screening - asked for inclusion into the study.

After inclusion a regular psychiatric assessment was done and during 6-8 motivational oriented sessions insight into the need for a regular psychiatric treatment was raised.

In case the persons consented to be treated according to their individual diagnosis, treatment in a routine mental health care service was initiated. In order to maintain compliance and treatment continuation, patients were supported by study staff with additional motivational sessions during the treatment phase.

After 6 and 12 months, treatment continuation, symptom severity, quality of life and housing conditions were assessed to analyse effects of treatment initiation and continuity on these factors.

Out of 130 persons at risk identified by job centers and social welfare agencies, 59 agreed to be included into the study. Seventeen dropped out, 7 were stabilised without a regular psychiatric treatment and 27 started treatment in a mental health care service.

Treatment initiation and continuity was associated with an increase in quality of life and other endpoints.

Women's Mental Health

Louise M. Howard

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There is growing evidence that investigation of gender differences in mental health can help us understand the aetiological determinants of mental disorders and lead to more tailored treatments for men and women. Therefore, this symposium on women's mental health will explore evidence on the health care experiences of women with severe mental illness and current responses of mental health services.

The topics in this symposium cover three of the four conference themes and include:

- 1) An examination of the use of antipsychotic medication during pregnancy (conference theme 3: "changing patterns of psychotropic drug interventions in mental health systems")
- 2) A meta-synthesis of qualitative research on the experiences of mental health services for women and mothers with severe mental illness, from pre-conception considerations of pregnancy to parenting (conference theme 4: "improving communication skills for better mental health services")
- 3) An examination of mental health services' response to human trafficking (conference theme 1: "reducing socio-economic inequalities of places, individuals and services for better patient recovery")
- 4) A meta-synthesis of qualitative research on mental health service users' experiences of disclosing domestic violence in mental health settings (conference theme 4: "improving communication skills for better mental health services")

DRAFT

An examination of the use of antipsychotic medication during pregnancy

Clare Taylor¹, Matthew Broadbent, Ann Greenough, Simon Hannam, Richard Hayes, Richard Holt, Mizanur Khondoker, Dharmindra Pasupathy, Robert Stewart, Louise Howard

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Background/Objectives

There is a very limited evidence-base on the risks and benefits of psychotropic medication in pregnancy for women with serious mental illness. This study aims to investigate the risk of, and time to, relapse of psychiatric illness during pregnancy and in the postpartum after stopping psychotropic medication compared with continuing.

Methods

Design: Retrospective cohort study using secondary mental healthcare data from the South London and Maudsley (SLaM) Case Register Interactive Search (CRIS) system and maternity Hospital Episode Statistics. Study population: Women with serious mental illness (schizophrenia and related disorders, bipolar disorder and previous puerperal psychosis and other affective psychoses). Measures: Exposure – psychotropic medication use from three months before pregnancy through each trimester to 1 year post partum, Outcome – relapse of mental disorder through pregnancy to 1 year post partum, Covariates – Sociodemographics, mental disorder history and severity, drug use in pregnancy.

Results

A cohort of 460 women who gave birth in hospitals from 2007-2011 has been identified, 241 were diagnosed with non-affective psychoses, 219 with affective disorder (166 with bipolar affective disorder, 46 with depressive psychosis and 7 with a history of puerperal psychosis). The mean age at first index delivery was 32 (SD 6.2), the median Townsend (2007) deprivation score for the cohort was 34.92 (range 3.81-77.17 out of a potential range of 0.37-85.46; higher score indicating more severe deprivation); 221 (48%) were from African Caribbean or other Black background, 155 (34%) White, 37 (8%) Asian, and 47 (10%) other; median contact time with SLaM before the index delivery was 799 days. Data on medication exposure and maternal mental health outcomes will also be presented.

Discussion/Conclusion

We will discuss the service implications of preliminary analyses and how this work will be extended to compare maternal physical outcomes and neonatal outcomes in women taking medication or not in pregnancy. Challenges of using electronic health records obtain evidence for this type research will also be discussed.

A meta-synthesis of qualitative research on the experiences of mental health services for women with severe mental illness, from pre-conception to parenting

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Background/Objectives

The majority of women with a severe mental illness (SMI) become pregnant and have children. The aim of this systematic review and meta-synthesis was to examine qualitative research on the experiences of motherhood in women with SMI, from preconception decision making to being a mother. The experiences of the health professionals treating women with SMI were also reviewed.

Methods

Eleven biomedical and social science databases were searched from their respective start dates to 25th April 2012, using keywords and mesh headings. A total of 23 studies were identified that met the inclusion criteria on the views of women with SMI, eight reported the views of health professionals including one which reported both.

Results

The meta-synthesis of the 23 studies on women's views produced two overarching themes: (1) Experiences of Motherhood, and (2) Experiences of Services. Sub-themes included: (1) Guilt, (2) Coping with Dual Identities, (3) Stigma, and (4) Centrality of Motherhood. Four themes emerged from the synthesis of the eight papers reporting the views of health professionals: (1) Discomfort, (2) Stigma, (3) Need for Education, and (4) Integration of Services.

Discussion/Conclusion

The results of this meta-synthesis emphasize the central importance women with SMI assign to motherhood and the level of anxiety health professionals experience when caring for women with SMI in the perinatal period. An understanding of the experiences of pregnancy and motherhood for women with SMI can inform service development and provision to ensure the needs of women and their families are met.

Pathways into care among victims of human trafficking in contact with a large inner city Mental Health Service

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Background/Objectives

Research suggests a high prevalence of mental disorder among trafficked people but there are no rigorous data on how trafficked people come into contact with mental health services. We aimed to describe pathways into care among trafficked people in contact with a large inner city mental health service compared with a non-trafficked cohort. We hypothesised that, compared with a matched non-trafficked cohort, trafficked people would be significantly more likely to have adverse pathways into care including detention under the Mental Health Act and contact with police for first contact with mental health services.

Methods

Study design: Cohort study. Study population: mental health service users who had been trafficked for exploitation and a non-trafficked service user cohort matched for gender, age (+/- 2 years) and primary diagnosis. Data collection: Free text searches of South London and Maudsley NHS Trust (SLaM) Biomedical Research Centre Case Register Interactive Search (CRIS) database were used to identify a cohort of trafficked and non-trafficked service users. The CRIS database allows the search and retrieval of anonymised full patient records for mental health service users in contact with SLaM services between 2006 and 2012. Data were extracted on socio-demographic and clinical characteristics, functioning (using Health of the Nation Outcome Scale) and on episodes of care.

Results

Case records of 135 people who had been trafficked for sex work, domestic servitude and exploitation in other labour sectors were identified. 77% (n=104) of the sample was female. Age at first SLaM contact ranged from 8 to 49 years (mean 23.6, SD 8.0). Depression (28.1%, n=38), PTSD (19.3%, n=26), and schizophrenia and related disorders (12.6%, n=17) were the most common diagnoses recorded. Trafficked adult service users were significantly more likely than matched non-trafficked adult service users to be admitted as a psychiatric inpatient under the Mental Health Act and be subject to a police section.

Discussion/Conclusion

Trafficked people who use mental health services in London appear to suffer from a multiplicity of psychiatric disorders and have adverse pathways into care. Services that work with victims of trafficking should recognise the breadth of potential diagnoses and treatments required.

Mental Health Service Users' Experiences of Disclosing Domestic Violence in Mental Health Settings: a qualitative meta-synthesis

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Background/Objectives

Little is known about mental health service users' experience of the response of psychiatric services to domestic violence. This study synthesised evidence on the healthcare experiences and expectations of mental health service users experiencing domestic violence.

Methods

Data sources: 23 biomedical, social science, and grey literature databases and websites were searched from their respective start dates to March 31st 2011; supplemented by hand-searches, reference list screening, citation tracking, and expert recommendations. Inclusion criteria: qualitative study designs, with a study population of mental health service users (aged ≥ 16 years) with experience of domestic violence. Data extraction and appraisal: Data were extracted and independently assessed for quality by two reviewers. Data analysis: Findings from primary studies were synthesised using meta-synthesis techniques.

Results

Ten studies provided data on 125 mental health service users. First- and second-order constructs were generally consistent across studies and were not seen to vary by study quality; constructs included professionals' facilitation of disclosures of domestic violence, the prioritisation of service users' safety and the limitations of the biomedical model of mental illness. Third-order constructs included the preparedness of professionals to respond to domestic violence and the adoption of abuse-informed care.

Discussion/Conclusion

Mental health service users who experience domestic violence have complex needs that are not being adequately addressed by their services. This meta-synthesis highlights the need for mental health professionals to receive specific training on how to appropriately identify and respond to domestic violence to ensure the safety and optimal care of this vulnerable population.

Specialization, integration care and continuity of care: how important are they for patients' outcomes?

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Throughout Europe, mental health care is undergoing major changes. Services are re-organized to improve outcomes and reduce costs. Yet, the direction of changes is inconsistent across countries, some emphasize the importance of specialization, whilst others try to strengthen the integration of care with a focus on continuity of care. These re-organizations absorb high levels of resources and are currently driven by only very poor and, at best, partial research evidence. The debate needs to be informed by research evidence as far as possible, and the symposium will consider what the existing evidence can and cannot show.

In this symposium we will present the existing evidence on the effectiveness of more specialized and more integrated systems of mental health services, and explore the association between continuity of care, coercive measures and outcomes.

The symposium will have four presentations that will: 1) report findings on the impact of continuity of care on clinical outcomes of severely mentally ill patients (Dr. Puntis); 2) illustrate the association between covert coercion and continuity of care (Dr. Yeeles); 3) summarise the available evidence on the effectiveness and cost-effectiveness of the two systems based on a systematic review of the literature (Dr. Giacco); 4) present rationale and methodology of the first large scale European study comparing functional and integrated systems of mental health care (Prof. Priebe).

The symposium can be chaired by Prof Tom Burns (Oxford) and Prof Stefan Priebe (London).

DRAFT

Is there an association between continuity of patient care and clinical outcomes in the community care of patients with psychosis?

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Background/Objectives

Continuity of Care (CoC) is a multi-dimensional construct that can broadly be defined as the long-term delivery of care that is coordinated between services and is appropriate to the patient's current needs. CoC is recognised as vital in managing long-term illnesses. Within mental health care, maintaining CoC is difficult as those with severe mental illness can have poor adherence with treatments and are less likely to maintain contact with services (Nose et al., 2003). CoC is valued by both patients and professionals and discontinuities of care have been cited as a major source of patient dissatisfaction and disengagement (Waibel et al., 2011)

Despite this, there has been little CoC research in mental health and its impact on clinical outcomes. Freeman (2002) outlined a seven-axial model of CoC, which Burns et al. (2009) operationalised, allowing aspects of CoC to be assessed through routinely collected clinical data. This study will utilize this operationalisation to investigate CoC and its relation to clinical outcomes.

Aims

1. Can patterns of continuity and discontinuity of care be identified that are associated with differences in outcome?
2. Is the duration of legal compulsion associated with a patient's long term engagement with services?

Methods

Design

The study has a prospective observational design. Data from clinical records will be collected at 36 months. Variables identified through the operationalisation of CoC in the ECHO study (Burns et al., 2009) will be collected. The two outcome variables are: time to readmission; and total readmission length.

Sample

333 patients with a diagnosis of schizophrenia and related disorders who participated in the OCTET trial (Burns et al., 2013).

Analysis

Regression models will be used to analyse the data. Data will be analysed separately for the two outcome variables. For time to readmission, CoC data only up to the readmission will be entered for analysis. For total readmission length, all CoC data will be included in analysis.

Time schedule

Participants on the OCTET trial were recruited between November 2008 - February 2011. As data for this study will be collected at a participant's 36-month follow-up, data collection will continue until February 2014.

Coercion, therapeutic relationship and continuity of care

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Background/Objectives

Clinicians and family members employ varying types of formal and informal coercion to avoid relapses and frequent hospital admissions of patients who have failed to adhere to treatment or engage with services. Many voluntary patients feel coerced or experience themselves constrained from making free treatment decisions. Current evidence suggests that use of informal (covert coercion, 'leverage') is common in psychiatric practice.

Therapeutic relationships are considered central to the quality of psychiatric care. Strong trusting therapeutic relationship allows clinicians to use therapeutic leverage within the constraints of the therapeutic relationship. Patient perception of experienced coercion may be affected by relationships with the clinicians (or family members) who apply pressure. Continuity of care has an important role allowing the building of the therapeutic relationship and trust. Knowing a patient can make a clinician feel easier about using coercion. Associations of the use of covert coercion with continuity of care and the therapeutic relationship have not been tested yet.

Methods

Psychosis patients in integrated and functional systems of psychiatric care across England were interviewed at baseline and at 12 months. Data on the experience of formal and informal coercion, the therapeutic relationship and continuity of care was collected through interviews with patients and from medical records.

Results

More than 200 patients from 130 community mental health teams and 30 local mental health authorities with diagnosis of psychosis were interviewed for the study. Associations of reported informal coercion with continuity of care and the therapeutic relationship in integrated and functional systems will be reported.

Discussion/Conclusion

Social interaction involved in engaging and maintaining patients in services remain understudied. Clinicians are combining pressure and support in assertive therapeutic care. How is the use of treatment pressures related to the continuity of care and the role of the therapeutic relationship in the context of integrated and functional systems will be discussed.

Effectiveness of functional and integrated systems: what do we know?

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Background/Objectives

Currently, different countries adopt different strategies in their organisation of the mental health system. Such contrasting mental health service transformations are taking place throughout the world and are based on little, if any, research evidence. This study aims to conduct a systematic review to search for and synthesize the literature evaluating outcomes of integrated versus functional systems of mental health care. A synopsis of such information could guide future research on the evaluation of integrated and functional systems in mental health and inform policy makers.

Methods

We included in our review studies with data on: 1) clinical outcomes (rates of re-hospitalizations, symptom levels etc.) of the two systems; 2) social outcomes (quality of life, social functioning etc.) of the two systems; 3) cost-effectiveness of the two systems; 4) Experiences and opinions of patients and clinicians regarding the two systems. All study designs were considered: randomized control designs, controlled before and after studies, uncontrolled before and after studies, time series analysis, observational studies, qualitative studies etc.

Results

Few non-European and even fewer European studies (mostly from the United Kingdom and Germany) were found. All of them were of a small size and commonly compared a new model service with the usual care system in the given country. Different outcomes were considered in different studies. Integrated systems, ensuring coordination of different interventions, might be better suited to treating patients who are affected by severely disabling mental health conditions (e.g. schizophrenia) and comorbid physical illnesses, and for those who have complex psychosocial needs (older patients, patients with a low socio-economic status, migrants). On the other hand, functional systems may allow greater autonomy and choice, and provide easier access to specialised staff with higher adherence to treatment guidelines.

Discussion/Conclusion

The evidence on relative effectiveness and cost-effectiveness of the functional and integrated systems is still mixed and contradictory, probably because of the small sample sizes of the studies, the different and very specific settings in which they were conducted, and the different mental health systems and outcomes they compared.

Comparing policy framework, structure, effectiveness and cost-effectiveness of Functional and Integrated systems of mental health care (COFI project): rationale and methodology of a pan European study

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Background/Objectives

Mental disorders are a leading cause of disability in Europe and determine high health-care costs and loss of productivity. Optimal service organization is required to maximize the effects of mental health care and reduce this burden. Throughout Europe, countries are seeking to improve the organization of mental health care. Yet, the reforms are inconsistent, and all policies are currently made in the absence of any sound scientific evidence.

The overall aim of COFI is to compare the effectiveness and cost-effectiveness of the functional and integrated systems of mental health care in Europe. The comparison will consider clinical and social outcomes (re-hospitalization rates, symptom levels, social functioning) as key performance indicators (KPIs), as well as patients' quality of life, health and social needs, safety and cost-effectiveness of care. Different patients subgroups defined by diagnosis, age, gender, socio-economic and migrant status, and physical comorbidities will be investigated.

Methods

A large multicentre study, with a sufficient sample size, i.e. more than 5000 patients followed up for nine months, will establish which of the two systems is more effective, and to control for the various confounding factors, at patient and country level. The study will be conducted in five countries (Belgium, Germany, Italy, Poland, United Kingdom) in which functional and integrated systems of mental health care co-exist so that comparisons can be made within a similar context.

(Expected) results:

COFI represents a new approach of high quality research on mental health care systems. It will provide, for the first time, sound and systematic research evidence for mental health care organization that has been generated across several European countries. It will produce clear indications for policy decision-making on mental health care and guide the re-organization of services on the basis of empirical data.

Discussion/Conclusions

COFI project will represent a step change in mental health service organization and, for the first time, will ensure that organization of mental health services is informed by high-quality research evidence. Its impact on mental health policies at a European level and at national levels will be maximized by the development of guidelines for policy decision-making based on study findings.

Research into mental health supported accommodation services: international perspectives and comparisons

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The symposium focuses on research into specialist supported accommodation for people with mental health problems. This is an area that has attracted very little attention in the way of research, despite the fact that these services account for a large proportion of health and social care budgets. The symposium will include presentations on national studies in this area from Australia, Italy, Canada and England, focusing on investigations of the quality and effectiveness of supported housing of various types. Comparison of the results of these international studies will be included, along with discussion of their implications for service planning and areas for future research.

DRAFT

How different types of supported accommodation contribute to recovery: Findings from the second Australian national survey of psychosis

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Background/Objectives

Access to adequate housing consistent with personal preferences and needs supports recovery from psychosis. We aimed to: (1) describe people with psychosis living in different housing types, their preferences and needs; and (2) compare two subgroups – participants living in supported group accommodation and supported housing – on key demographic, functional, clinical and social inclusion variables.

Methods

Current housing, preferences, needs and assistance, and housing-related social inclusion variables were assessed in a two-phase psychosis prevalence survey conducted within seven catchment areas across Australia in 2010. Residents in two supported housing models were compared: supported group accommodation and supported housing (rental accommodation with in-reach support). Descriptive statistics were used.

Results

Of the total participants (n=1825), one half were living in public or private rented housing (48.6%). 414 participants (22.7%) were on a waiting list for public independent housing. Despite being the preferred form of housing, only 13.1% were living in their own home. One in twenty participants (5.2%) was currently homeless. Of 636 participants who had a psychiatric inpatient admission in the year prior to interview, 7.5% reported that they had not been given any help and had nowhere to live on discharge. Supported group accommodation was the current housing for 11.0% but the preferred housing for 2.8%. Compared with supported housing residents (n=98), those living in supported group accommodation (n=100) were significantly more likely to be single men with less family contact and greater difficulties with functioning. Residents of supported group accommodation felt safer in their locality than those in supported housing, but experienced less privacy and choice.

Discussion/Conclusion

Access to public housing is restricted compared with identified need. Although fewer participants were homeless compared with the first Australian psychosis survey, the proportion remains high and responses should include better attention to the housing needs of inpatients as well as wider availability of supported housing. Each supported housing model may offer different advantages to people with psychosis, and contribute to services that support and maintain recovery. These findings suggest a need for diversity of housing types and support as well as more affordable and well located housing for people with psychoses.

The Italian 'dream' of community psychiatry without residential facilities: lessons for European non-dreamers

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After legislative changes in 1978, Italian psychiatry underwent a thorough overhaul, with the gradual closure of all Mental Hospitals. A nation-wide network of Departments of Mental Health now deliver outpatient and inpatient care, but also run semi-residential and Residential Facilities (RFs). Hospital care is delivered through small psychiatric units (with no more than 15 beds). There is marked quantitative and qualitative variation in the provision of out- and inpatient care throughout the country, and service utilization patterns are similarly uneven. The Progetto Residenze (PROGRES) residential care project surveyed the main characteristics of all Italian RFs. On 31 May 2000 there were 1,370 RFs with 17,138 beds; an average of 12.5 beds each 10,000 population and a rate of 2.98 beds per 10,000 inhabitants. Residential provision varied ten-fold between regions and discharge rates were very low. Most had 24-hour staffing with 1.42 patients per full-time worker. In the second phase of the project 2,962 patients living in the sampled facilities were individually assessed; most were males. A substantial proportion (39.8 %) had never worked and very few were currently employed (2.5 %); 45 % of the sample was totally inactive, not even assisting with domestic activities in the facility. Two-thirds had a diagnosis of schizophrenia; co-morbid or primary substance abuse were uncommon. Twenty-one per cent had a history of severe interpersonal violence, but violent episodes in the RFs were infrequent. The managers judged almost three-quarters appropriately placed in their facilities and considered that very few had short-term prospects of discharge. Also recent studies on RFs conducted in Italy will be presented. There are data showing that the number of beds in RFs has increased since the end of the PROGRES project; moreover, a well designed longitudinal study on a cohort of 403 residential patients shows that discharge from these facilities is very unlikely. The Italian 'dream' of a mental health care system with no long-term beds has been shown to be totally unrealistic. RFs will be necessary for patients needing long-term care for many years (or decades) to come, until more effective treatments for severe mental disorders, and their associated disabilities, will become available.

Developing quality measurement for residential services with key stakeholders perspectives in Canada

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Background/Objectives

Since the 1960s over two dozen standardized environmental evaluation instruments have been used to describe features of community-based residential facilities for adults with mental illness. However, there are methodological and conceptual challenges involved in developing such instruments. This presentation will address those challenges and present the findings from a research project conducted in Canada in which an instrument designed to describe structural and procedural attributes of community based-residential facilities was developed.

Methods

Phase I: A participatory approach as well as a purposeful sampling strategy designed to gather a mixture of relevant viewpoints and lived experiences covering the spectrum of housing were used. Participants (n = 722) included service users, family members, staff and operators of residential facilities, mental health workers and managers. As part of a group concept mapping process, participants brainstormed, rated and sorted into categories housing attributes. Of these, 12 participants were involved in the interpretation of the conceptual maps produced using multidimensional scaling and hierarchical cluster analysis. Principal component analyses were conducted to refine the conceptualization. Phase II: An instrument was designed and used to describe 270 facilities ranging from 24-hour staffed congregated settings to apartment with no onsite support (validation process). The instrument took the format of a fidelity scale scored by a trained interviewer during an audio-taped semi-structured telephone interview.

Results

The instrument includes four domains and 86 attributes rated using 5-level ordinal scales (anchored criteria). Attributes are thought to represent key distinguishing aspects of housing. It also includes 34 nominal or numerical attributes (e.g. housing demographics). Interview duration was 130 minutes in average. The instrument successfully described the spectrum of facilities. Results highlight the diversity of facilities in relation to style of provision and content of care.

Conclusion/Discussion

The instrument provides a multidimensional and multilevel profile of a facility. It was designed with stakeholders based on conceptual and statistical considerations. It covers several elements of healthcare quality assessment starting from the assumptions that there is no ideal setting for all and not enough evidences to demonstrate which housing types or attributes are beneficial for whom. Further steps in the validation process include identifying variation in outcomes for groups of consumers.

The QEST study - Quality and Effectiveness of Supported Tenancies for people with mental health problems; a national study of supported accommodation in England

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Background/Objectives

Many people with mental health problems live in supported accommodation in England at a cost of millions of pounds to the NHS and Local Authorities. However, there is little empirical research in this area to guide clinicians and service planners. The QEST study is a five year programme of research that started in 2012 that aims to survey current provision, quality, clinical and cost-effectiveness of these services in England.

Methods

WP1: Adapt an existing quality assessment tool, the Quality Indicator for Rehabilitative Care (QuIRC), for supported accommodation services. We will review its content through focus groups with staff and service users of the three main types of supported accommodation in England (residential care, supported housing and floating outreach) and expert panels and assess inter-rater reliability.

WP2: National survey of supported accommodation services and cohort study. We will describe and assess quality of care and costs of a representative sample of 90 supported accommodation services using the adapted QuIRC. We will interview 450 service users about their experiences of care and assess outcomes over 30 months including whether they have moved on successfully. We will compare costs and effectiveness of different approaches, taking account of service user characteristics.

WP3: Qualitative interviews with service users and staff to identify aspects of care that are most valued. We will incorporate these into the models of supported housing that we will compare in WP4.

WP4: Feasibility trial comparing two models of supported housing - temporary tenancies with staff on-site ("Train and Place") and outreach support to people living in their own homes ("Place and Train").

Results

The programme has just started. WP1 will be completed by the end of 2013. Discussion/Conclusion
The QEST study will deliver:

- i) the first standardised, comprehensive quality assessment tool for supported accommodation services in England
- ii) a detailed description of these services and those who use them
- iii) evidence on their clinical and cost-effectiveness
- iv) information about the feasibility of a large scale trial to assess the clinical and cost-effectiveness of two models of supported housing

Tackling stigma and discrimination in people with major depression: findings from the international ASPEN/INDIGO study

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Background

Depression is today the third most important cause of disability in the world, and the third leading contributor to the global burden of disease. By the year 2020, depression is projected to reach second place of the ranking of causes of morbidity (disability adjusted life years) for all ages worldwide. Despite its high prevalence and burden, depression remains one of the most under-diagnosed and undertreated health conditions within the primary care setting. One of the main barriers to effective care is stigma and discrimination associated with mental disorders.

Methods:

The ASPEN (Anti Stigma Programme European Network) and the INDIGO-Depression (International study of Discrimination and Stigma Outcomes) multisite research networks were established in order to assess discrimination reported by people with major depression. Overall, 19 sites located in 18 ASPEN EU-funded countries were included, along with another 20 sites across 17 countries in the wider INDIGO research network. This research aimed to investigate the nature and extent of experienced and anticipated discrimination of people suffering from major depression, and to contribute towards the reduction of stigma and discrimination of people suffering from this condition. Our methodology consisted of a mixed methods approach, incorporating cross-sectional surveys and face-to-face interviews by using the Discrimination and Stigma Scale (DISC-12) with 1087 participants. Results: Main results will be presented at the conference.

Discussion/Conclusions

Discussion will focus on how ASPEN/INDIGO data can contribute to improving practice, legislation and policies in order to reduce stigma and discrimination of people with depression

Evidence for Reducing Discrimination In Mental Health

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Summary of presentation

Stigma and discrimination against people with mental illness are common and severe wherever they have been studied (1-3). One surprising aspect of this is that many consumers report that they feel discriminated against by health and social care staff, even though these are precisely the staff who are trained and experienced in offer assistance to people with mental illnesses. Furthermore, the 'social contact' hypothesis suggests that those with more contact with people with a diagnosis of mental illness will have more favourable and less stigmatising views(4). This paper will review evidence about discrimination and evidence of what is effective (at the local and national levels) to reduce stigma and discrimination (5-8;8-10).

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Global pattern and cross-cultural variations in reported discrimination among people with major depression. Findings from the ASPEN/INDIGO study

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Background/Objectives

The nature and severity of experienced and anticipated discrimination reported by adults with major depressive disorder (MDD) worldwide was assessed. Moreover, it was investigated whether experienced and anticipated discrimination were related to individual socio-demographic and clinical characteristics (i.e., psychiatric history, provision of health care, episodes of depression, psychiatric hospitalizations). Finally, levels of experienced and anticipated discrimination were compared across the participating countries.

Methods

In a cross-sectional survey (the ASPEN/INDIGO study), people with a diagnosis of MDD were interviewed in 39 sites (35 countries) worldwide with the Discrimination and Stigma Scale (DISC-12). Results - Overall, 1082 people with MDD completed the DISC-12. Of these, 79% reported experiencing discrimination in at least one life domain. The main source of perceived discrimination was represented by the family and marriage context. Higher levels of experienced discrimination were associated with several lifetime depressive episodes, at least one lifetime psychiatric hospital admission, poorer levels of social functioning. Both experienced and anticipated discrimination widely differed across countries. Those countries with higher score on Human Development Index (a summary measure of human development, produced by the UN and which combines life expectancy at birth, mean years of schooling and gross national income per capita) also displayed higher levels of both experienced and anticipated discrimination.

Discussion/Conclusion

Discrimination related to depression acts as a barrier to full social participation. Besides some individual clinical characteristics, the socio-cultural environment seems to play a crucial role in determining levels of perceived discrimination in people with MDD.

Personal experiences of discrimination in various areas of life; formulating solutions through civil society engagement in mental health policy making

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Background/Objectives

The overall aim of ASPEN/INDIGO is to contribute towards the eradication of stigma and discrimination of people with mental health problems and to better understand and tackle mental ill health stigma and discrimination as a significant barrier towards recovery. A large EU survey on experienced and anticipated stigma and discrimination by people with a diagnosis of major depressive disorder looked at prevalence and individual experiences in various areas of life. Research into mental health policy making & legislation in Europe uncovered the levels of civil society involvement into these processes and its importance as well as understanding the significance of legal and social barriers to employment. EU Best Practice Anti Stigma Campaigns were identified and shared across Europe.

Methods

Personal experiences were elicited through a structured questionnaire on experienced and anticipated stigma and discrimination of depression in various areas of life.

Data on experiences of civic society involvement in mental health policy making and legal and social barriers to employment in Europe were gathered through telephone and face-to-face interviews and focus group discussions with policy makers, NGOs, people with lived experiences and wider civil society.

Best Practice regarding EU Anti-Stigma Campaigns was gathered via comprehensive literature reviews in all participating sites.

Results/Discussion/Conclusion

All across Europe, people with a diagnosis of major depression reported high levels of stigma and discrimination in all areas of life - particularly in the workplace – and reported to actively conceal their condition. People also reported that depression is little understood (by family, employers, and also by health professionals) and that stigma and discrimination is often a significant barrier to help-seeking and recovery. Furthermore, civil society is not enough (and sometimes not at all) involved in the mental health policy making and legislation process often resulting into policies, legislation and protocols that are not properly needs-based or congruent with grassroots reality and work disempowering and counterproductive. Much more needs to be done to engage civil society as active and equal stakeholder in the entire mental health policy making and legislation process at local, national and international levels as well as in awareness campaigns as social contact and role models have positive influences on understanding conditions and changing minds. Additionally, more general as well as targeted campaigns (specific age groups and conditions) are needed.

Predictors of reported discrimination in obtaining and keeping employment among people with major depression. Findings from the ASPEN/INDIGO study

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Background/Objectives

Employment is one of the key sources of discrimination reported by people with mental illness. This research aimed to investigate the person-related predictors of experienced and anticipated discrimination of people suffering from major depression in obtaining and keeping employment. We hope that the findings will contribute towards the reduction of stigma and discrimination of people suffering from this condition in the workplace .

Methods

The ASPEN (Anti Stigma Programme European Network) and the INDIGO-Depression (International study of Discrimination and Stigma Outcomes) multisite research networks were established in order to assess discrimination reported by people with major depression. Overall, 19 sites located in 18 ASPEN EU-funded countries were included, along with another 20 sites across 17 countries in the wider INDIGO research network. The methodology consisted of a mixed methods approach, incorporating cross-sectional surveys and face-to-face interviews by using the Discrimination and Stigma Scale (DISC-12) with 1087 participants. Multivariate analyses was conducted, introducing experienced and anticipated discrimination as dependent variables.

Results

The results will be presented at the conference.

Discussion/Conclusion

Discussion will focus on how these ASPEN/INDIGO data can contribute to improving practice and policies in order to reduce stigma and discrimination of people with depression on the labor market and in the workplace.

Discrimination of people with major depression, social capital and European policy options: the way forward

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Background/Objectives

Modern mental health policies aim at social inclusion of people with mental disorders. Mental illness stigma, i.e. discriminatory and negative attitudes towards people with mental disorders, is a main obstacle to social inclusion. Indeed, the ASPEN Project shows that four of five people with major depressive disorder experience discrimination. Self-reported discrimination is linked to non-disclosure of depression, which creates a barrier in making contacts and seeking help. Individual and collective social capital, i.e. social networks, social support and mutual trust, is closely linked to people's mental and physical health. A high level of social capital even reduces mortality.

Methods

Survey conducted within the framework of ASPEN Project

Results

In Europe, ASPEN results show that a high level of individual social capital is linked to lower levels of experienced discrimination among people with major depression. Higher levels of interpersonal and institutional trust as well as perceived social support are linked to non-discrimination of people with depression.

Discussion/Conclusion

These findings indicate that promoting social capital will reduce discrimination of people with mental disorders. As even large-scale and expensive anti-stigma campaigns have not shown much promise in achieving changes in public attitudes, the next step might be interventions that promote social capital. This will require collaboration across public policy arenas, and should include social structures and a fabric of community that promote natural encounters between people with different backgrounds. Investing in social capital will pay off not only as reduced discrimination, as research also links social capital to economic development and prosperity

Inpatient treatment in acute wards: patterns of functioning in Europe and future trends

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Recent data from the WHO Atlas of Mental Health show that in 13 countries of the 'old' European Union the median value of acute hospital beds per 10,000 inhabitants is 2.25 per 10,000 (WHO, 2005); General Hospital Psychiatric Units (GHPUs) can be found everywhere and represent an important component of the overall network of services, although in England the recent trend has been for small freestanding units outside the general hospital (in Italy, with the only exception of Sicily, there are 0.78 beds in public GHPUs per 10,000 inhabitants, whereas the total number of acute, public and private, beds is 1.72). Hospital care, in the often idealized context of community care, has come to represent what Paul Lelliott has called a 'default option': an option to be used when everything else has failed, or when nobody knows what to do. But this position is anachronistic: indeed "There is no evidence that a balanced system of mental health care can be provided without acute beds" (Thornicroft & Tansella, 2004). Therefore it is urgently required to plan rigorous projects of research-intervention which can, on the one hand, shed light on many problematic facets of acute care in GHPUs, and on the other hand can rapidly translate into continuous quality improvement projects, extremely needed in this area of care. It is necessary to abandon the outdated model of acute inpatient facilities functioning as a 'black box' (expression suggested by Lelliott) and accurately take apart the ingredients which constitute and make possible the functioning of inpatient units, in order to identify effective models of care, capable to be generalized across the entire mental health system in the different European contexts. This symposium will present contributions from authors who have led large research projects on different aspects of GHPU care, and will propose a number of recommendations to improve the care delivered in GHPUs and to strengthen research in this area.

General Hospital Psychiatric Wards: An evidence-based overview of the Italian situation

Giovanni de Girolamo, Viola Bulgari, Jessica Dagani, Giulia Signorini

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Background

In Italy, although all mental hospitals have gradually been replaced by general hospital psychiatric units (GHPUs), detailed data on acute inpatient facilities were scarce.

Aims: The 'PROGRES-Acute' project consisted of 2 phases: Phase 1 aimed to survey the main characteristics of all Italian (public and private) acute inpatient facilities. In Phase 2 a representative sample of facilities and inpatients was assessed in detail.

Methods

Structured interviews were conducted with each facility's head psychiatrist. All Italian regions participated, except Sicily.

Results

Italy (except Sicily) has a total of 4,108 public inpatient beds in 319 facilities, with 0.78 beds for every 10,000 inhabitants, and 4,862 beds in 54 private inpatient facilities, with 0.94 beds per 10,000 inhabitants. In the year 2001, in those facilities which provided data, 139,140 acute admissions were recorded, for a total of 93,159 patients admitted, with rates of psychiatric admissions and admitted patients per 10,000 inhabitants of 26.7 and 17.8, respectively. The percentage of compulsory admissions was at 12.9%. Many facilities suffer from significant logistic and architectural limitations. Staffing showed a great variability among facilities, with a much smaller staff/patient ratio in private facilities. Facilities differ in working style, as suggested by the presence of sharp differences in patients' exclusion criteria for admission and length of stay. Public and private facilities differ in case-mix, with no evidence of clear definition of different missions between the two systems.

Conclusions

In Italy there are two parallel systems of inpatient care, a public and a private one, which are not fully interchangeable. Despite the crucial role of acute inpatient care, many features of hospital care are unsatisfactory, and many problems still await appropriate solutions.

Crisis resolution teams as an alternative to inpatient acute treatment in Norway

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Background/Objectives

Crisis resolution teams have been introduced and established in Norway during the last decade as an alternative to acute inpatient treatment for many persons with mental crisis. One of the objectives for the observational Multicenter study of Acute Psychiatry (MAP) in 2005-2006 was to know what type of persons who were served by such teams and wards, respectively.

Methods

Data on all 680 patients included by 8 of the 9 first mobile crisis resolution teams and 3506 patients admitted to 19 acute psychiatric wards during three months were collected by the services as a joint project coordinated by a network.

Results

The inpatients in the ward had significantly more severe mental disorders and problems than the outpatients seen by the mobile teams, had more previous hospitalizations, had a higher suicidal risk, and had more co-occurring substance use disorders. But there also were some similarities an overlap in severity.

Discussion/Conclusion

The first crisis resolution teams in Norway seemed to be an alternative to inpatient acute treatment mostly for less severe mental health problems. Extended opening hours were associated with more severe patients been treated by the team. Later crisis resolution teams have been established at most community mental health centers with the aim also to give alternative treatment to persons with more severe mental crisis.

Prevention of involuntary treatment in general psychiatric care in Germany - lessons for other European countries

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Reducing the number and rate of involuntary placement or treatment of mentally ill is crucial for mental health care systems in general and persons concerned in particular. The issue has a very high human rights and health policy relevance.

As evidence on strategies to reduce involuntary admission to psychiatric wards or hospitals is poor, we conducted a randomised controlled study testing a specific intervention.

Patients treated for schizophrenia or affective disorders with a high risk for involuntary placements in 4 hospitals in the Rhine-Neckar-region of Germany were included into the study followed up for 2 years after discharge.

Patients in the intervention group received training for raising awareness for their individual risks for relapsing. At discharge each patient received an individual crisis card which listed these risks. Patients were contacted regularly by members of the study team each third week after discharge for monitoring and checking their individual relapse and re-admission risks. In case of a threatening relapse they were advised to contact their regular psychiatrist or other mental health care service for preventing a voluntary or involuntary re-admission. Patients in the control group did not receive this intervention and were treated by regular community mental health care services („treatment as usual“).

Major endpoints were the number and average length of voluntary and involuntary psychiatric hospital readmissions during 24 months of follow-up. 204 patients were included. The drop-out rate was 37.4 % in the intervention group and 28.4 % in the control group. During the first 12 months of the follow-up the proportion of patients with at least one re-admission to psychiatric inpatient treatment was higher in the control-group (56,6 %) than in the intervention group (47,9 %). Mean length of stay was 57 days in the control group and 44 days in the intervention group. However, differences were not statistically significant. When analyzing involuntary and voluntary re-admissions, the same trends were detected. Similarly, there was a clear but not statistically different tendency towards earlier re-admissions in the control-group (“survival time”). There were hints towards significant differences when analysing specific patients groups, e.g. patients with severe psychotic symptoms at baseline, who had a higher length of (voluntary) inpatient stay during the follow-up. Results suggest that the intervention may be too unspecific for the analysed patient group as a whole. Further analyses must aim to confirm the effectiveness in specific sub-groups.

S19.4

A comparison between acute psychiatric services in North-west Russia and Northern Norway: clinical profiles, involuntary admissions and differences in treatment

Knut Sørgaard

Norway

DRAFT

Acute care in England: challenges and initiatives for improvement

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Background

Considerable progress has been made in developing networks of integrated community services in the UK, but as elsewhere acute hospital services remain central to management of psychiatric crises. Unfortunately acute wards have been identified as both expensive and unsatisfactory to service users and clinical staff. Quality improvement in hospital and the development of alternatives to acute admission have therefore remained high on the NHS agenda.

Objectives/Methods

This presentation will give an overview of the recent history of acute service delivery in England, summarizing our current situation and the challenges arising from it. Some recent initiatives for service improvement and their evaluations will be outlined, and conclusions drawn regarding the more promising directions for future research-led developments.

Results/Conclusion

England has departed from trends elsewhere in Europe in that most acute hospital care is provided in specialist psychiatric units than in general hospital settings. This appears to reflect both a disillusionment with the extent to which stigma is effectively challenged through locating acute units in general hospitals, and policy making which has tended to result in a wide gulf between physical and mental health care. The units in which acute care is now delivered tend to be smaller and more central to catchment areas than the old asylums, but nonetheless often very separate from the life of their communities.

Adverse service user experience, limited therapeutic relationships and treatment programmes which focus too exclusively on medication have been identified as major limitations of NHS acute care. A series of initiatives has addressed these problems, but often with little evaluative evidence supporting them. This in part probably reflects the difficulties in carrying out research in acute psychiatric crises. Enhancing therapeutic relationships and enriching the provision of psychosocial interventions in hospital are directions which may alleviate current difficulties.

The future of inpatient care for people with mental disorders

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After nearly 60 years of recommendations concerning inpatient care for people with mental disorders and numerous efforts to reduce the numbers of beds in psychiatric institutions in order to render the care for the mentally ill better and more effective it is necessary to sum up the experience and the evidence about the success of this strategy so as to decide whether it needs revision or not. The environment in which the treatment of mental illness takes place has changed and so have a number of other factors influencing the provision of services for the mentally ill. Among them is the comorbidity of mental and physical illness (finally recognized as a major problem whose solution will require changes of service strategies), the continuing and increasing stigmatization of mental illness, the continuing fragmentation of medicine into ever more specialized services and a number of others. The presentation will examine some of these factors and present educated guesses about the possible changes of inpatient care for mental illness which seem inevitable.

DRAFT

Outcome monitoring as a tool to improve patient-clinician communication: studies from the northern Netherlands mental health network

Sjoerd Sytema

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Selfmanagement, shared-decision making and empowerment will become increasingly important in mental health care in the coming decades. New web-based and e-health tools will become available supporting this process. In the northern part of the Netherlands all mental health facilities and the University of Groningen cooperate in an outcome monitoring project, including the development of a web-based tool called RoQua (www.roqua.nl). RoQua enables patients and practitioners to complete questionnaires and it has a feedback module to presents outcomes (tables; graphics; statistics). RoQua is integrated in electronic patient files of each participating service. Therefore feedback from questionnaires (or registrations) is real time available in electronic patient files to be used in patient-practitioner communication. The main aim of feedback of outcome data is to inform patient and practitioner about the progress made in treatment ('on-track' or 'not on-track').

1. In the first presentation the RoQua project will be outlined and some general principles, guidelines, examples and future perspectives of feedback systems in mental health will be given.
2. A specific outcome protocol for SMI patients (Phamous), including somatic screening, will be outlined in more detail in the second presentation, including outcomes of a number of ongoing studies on the data.
3. In an additional research project, a tools is developed for SMI patients to improve shared-decision making based on advices linked to specific outcomes from Phamous. A RCT had been done to study its effectiveness. The tool will be outlined and the results will be presented.
4. The Groningen psychiatric case register originates from 1974 and since 2000 it includes the catchment area of the northern Netherlands mental health network (population: 1.7 million). By connecting the case-register service consumption data with the outcome monitoring data, cost-effectiveness studies are now possible. Some details of the register will be given and data will be presented.
5. With reducing costs of mental health care as the main incentive, the Dutch government wants to move large categories of patients living in sheltered homes to independent living arrangements. To study the positive and negative effects of this policy, we started a research project to follow a cohort of these patients using outcome monitoring. The study started in the beginning of 2013. The design of the study and preliminary data will be presented.

The importance of this symposium lies in:

1. the high relevance of the topic, which fits within one of the congress theme's
2. the integration of large datasets from a described catchment area
3. RoQua as an innovative monitoring tool in clinical practice

RoQua - a large scale Dutch project to improve patient-practitioner communication using outcome monitoring

Sjoerd Sytema

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Selfmanagement, shared-decision making and empowerment will become increasingly important in mental health care in the coming decades. New web-based and e-health tools will become available supporting this process. In the northern part of the Netherlands all mental health facilities and the University of Groningen cooperate in an outcome monitoring project, including the development of a web-based tool called RoQua (www.roqua.nl). RoQua enables patients and practitioners to complete questionnaires and it has a feedback module to presents outcomes (tables; graphics; statistics). RoQua is integrated in electronic patient files of each participating service. Therefore feedback from questionnaires (or registrations) is real time available in electronic patient files to be used in patient-practitioner communication. The main aim of feedback of outcome data is to inform patient and practitioner about the progress made in treatment ('on-track' or 'not on-track'). A second aim is to use the data for research projects. A number of ongoing research projects will be presented in this symposium. In this presentation the RoQua project will be outlined, the ROM tool will be demonstrated and future perspectives will be discussed.

DRAFT

PHAMOUS – Pharmacotherapy and outcome survey

Agna Bartels-Velthuis

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Patients with a severe psychosis are at increased risk of developing comorbid physical and mental disorders. Early detection of physical and mental problems will facilitate adequate treatment timely. Thus, physical and psychological health screening programs will benefit this patient group when they are offered systematically and periodically. In order to improve care as usual, in the north of the Netherlands annual screening for patients with psychotic disorders was rolled out through the regular routine outcome monitoring (ROM) program of mental health care institutions in the catchment area. As a result, a report - to be discussed by patient and therapist together - and a letter for the physician are generated. Besides, data collected by this screening program enables investigation of the long-term effects of antipsychotic treatment longitudinally. Moreover, the screening program offers opportunities to incorporate some extra questionnaires or interviews temporarily in order to answer additional research questions. Contents and implementation of the ROM-PHAMOUS program will be described; demographic, physical and mental health characteristics of the participants are given; and study outcomes are presented.

DRAFT

An e-health tool to support shared decision making between practitioners and patients with psychosis

Lian van der Krieke

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Since 2007, Routine Outcome Monitoring (ROM) assessments have been a regular element in care for people with psychotic disorders in the northern provinces of the Netherlands. However, a large percentage of service users do not receive adequate feedback concerning their ROM-results, as not all clinicians are accustomed to discussing ROM results with service users. In an attempt to improve ROM practice and to increase potential for service user empowerment, we developed a prototype of a web-based support system called 'Wegweis'. This support system provides service users with an overview of their ROM results, and with personalized information and advice based on these ROM results. In this presentation, we will present the web-based support system and discuss research results and future perspectives.

DRAFT

The Groningen psychiatric case register, connecting service use and outcome data to enable cost-effectiveness studies

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The Groningen psychiatric case register with the catchment area of the northern Netherlands mental health network (population: 1.7 million) includes service use data of the four largest mental health care institutions in the area. Twelve years of service use data and diagnostic and sociodemographic characteristics of patients are now available (2000-2011). Since 2006, a growing number of patients are monitored while being treated for their mental illness. The institutions that participate in the case register also participate in RoQua, a web-based tool to monitor patient outcomes. Herewith, case-register service consumption data can be connected with outcome monitoring data. For example, in an ongoing 'Pharmacotherapy Monitoring and Outcome Survey' (PHAMOUS), patients with a psychotic disorder are yearly screened on symptomatology, level of psychosocial functioning, and physical parameters. PHAMOUS aims to improve mental and physical health of patients with a psychotic disorder. To study whether PHAMOUS is successful, we compared outcome data of two successive screenings (the first and the second screening of PHAMOUS-participants), and, in addition, we also examined the association with service use between these screenings. Although no specific data is available about treatments and interventions that patients underwent between screenings, the study describes the PHAMOUS-population and the intensity of care they receive which may help design care pathways that avoid insufficient or unnecessary use of care.

DRAFT

Monitoring 'the move': from psychiatric sheltered housing programs to independent living arrangements

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In the next seven years, cuts in mental health care budgets obligate Dutch residential care facilities to decrease their available places with 30%. As a consequence, some of their service users will have to move to an independent living situation. However, it is unclear which service users are willing and/or able to make such a transition, and if this move is cost-effective. In the current study we aim to investigate the wishes of service users regarding a transition to an independent living situation, and their ability to fulfill these wishes successfully. In addition we study the cost-effectiveness of transitions to independent living. A two year follow-up study is currently conducted in six Dutch regional institutes for residential care and one provincial mental health center. This study was preceded by two focus group meetings with service users and staff of participating organizations discussing and identifying important aspects of moving from a residential facility to your own home. Preliminary results reveal that part of service users in residential facilities do have wishes to become independent. Professional and social support are indicated by professionals and service users to be crucial to the success of such a transition. However, the current cuts in mental health care cause uncertainty about this service provision in the nearby future. This is in itself experienced by service users as an important impediment to aspirations regarding housing.

DRAFT

Using Outcome monitoring data to start and evaluate lifestyle interventions in severe mentally ill patients

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Since 2007 the somatic and psychosocial health of severe mentally ill (SMI) patients in the Northern part of the Netherlands is monitored. This revealed that 50% of SMI patients living in residential facilities fulfilled the criteria of the Metabolic Syndrome, a condition that gives a three- to tenfold increased risk of cardiovascular disease. A cluster randomized trial was performed to investigate the effectiveness of a lifestyle intervention aimed at creating a healthier environment. Lifestyle coaches encouraged staff to offer more physical activities and healthier food products. Routine outcome monitoring data were used to measure changes in cardio-metabolic risk, depression and quality of life. The routine outcome monitoring database yielded baseline and follow-up measurements of 463 patients. A reduction in waist circumference and other components of the metabolic syndrome was found, as well as an increase in physical fitness and healthy food choices. Trends were found in depression and quality of life. To conclude, lifestyle interventions increase cardio-metabolic health in SMI patients and using routine outcome monitoring data enables the investigation of large samples of patients across various mental health facilities. Last, the design of the next trial will be presented, in which a web tool will support patient- nurse communication in setting and reaching goals in healthier lifestyle behavior.

DRAFT

Outcomes in times of recovery-orientation

Michaela Amering

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The idea that in order for recovery-orientation to survive and gain impact research evidence is essential is quite prevalent among professionals thinking about policy change and system transformation. Consequently, outcome variables in line with recovery values have been suggested and developed. This symposium will explore a range of pertinent concepts and their scientific and political relevance. Beate Schrank/UK will present review data on different academic phases of well-being conceptualisation and measurement and their respective implications. Ingrid Sibitz/A will present the concept of stigma resistance with quantitative and qualitative data and a discussion of its possible therapeutic and scientific relevance. Michaela Amering/A will highlight recent new human rights legislation and their place in recovery-oriented mental health practice and research. Finally, Stefan Priebe will review social outcomes in psychiatry and discuss the state of the art of concepts and measurements.

DRAFT

From objectivity to subjectivity: conceptualisation and measurement of well-being in mental health

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Background/Objectives

Well-being has become a prominent term in the political arena and in recent years. However, in academic research the concept and use of well-being has been unclear. This paper aims to provide an overview of the different conceptualisations and measurement approaches that have been proposed for well-being over time.

Methods

We conducted a literature review on measurement tools for well-being across the scientific literature and identified the concepts underlying the individual measures. Concepts were grouped according to similarities in their assessment and their main fields of application.

Results

We identified four academic strands of well-being conceptualisation and measurement: economic, medical, psychological, and integrative. Over the last century, well-being has shifted from being conceived as a collectivist concept with objective measures, e.g. of national wealth and general quality of life, to being conceived in individualistic terms, with subjective measures and a focus on positive psychology and recovery research. While this transition may have led to well-being becoming a key concept in mental health there are limitations to its usefulness.

Discussion/Conclusion

Considerations for future research are proposed.

Factors contributing to stigma resistance

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Background/Objectives

Stigma resistance is a new and until now poorly studied concept. It might be of crucial importance to successfully confront prejudices and discrimination, which is an essential goal in the therapy of people with schizophrenia. The aim of the study was to shed more light on the genesis, importance and impact of stigma resistance.

Methods

Qualitative interviews with 32 people with schizophrenia spectrum disorder were conducted. Transcripts were coded and analyzed thematically following a modified grounded theory approach.

Results

Stigma resistance is absolutely necessary. To develop stigma resistance is hard work and a process as long as you live. Premorbid personality, course of illness and social network have an influence on the amount of stigma resistance. A repertoire of strategies such as selective openness, ignoring, relativizing, humor and informing others can be helpful to manage stigma in different situations. Encouraging relationships, person centered and integrative care, possibility to work and specific anti-stigma interventions were mentioned to further stigma resistance on an individual level. Relating to the societal level promoting resilience in kindergarten and school, public action/policy efforts for diversity and respect, information about mental illness involving people with experience in mental illness were mentioned.

Discussion/Conclusion

Stigma resistance is a highly relevant concept which should be studied further.

Recovery – a human right?

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Context

English-speaking countries, such as USA, UK, Ireland, Australia, New Zealand, and Canada have embraced Recovery-orientation as a guiding principle of their mental health policy.

Objectives

Data and concepts illustrating the meaning of Recovery under different and sometimes competing perspectives will be presented and discussed.

Key messages

Recovery has meaning in terms of evidence-based medicine as well as within the framework of health economics. Recovery can be understood in terms of mental health system transformation as well as a human rights movement. The recent UN-Convention on the Rights of Persons with Disabilities (CRPD) - www.un.org/disabilities - explicitly includes persons with psychosocial disabilities.

Conclusions

The recent changes in international law warrant special attention with regard to defining and advancing the Recovery movement.

DRAFT

Social outcomes in psychiatry

Stefan Priebe

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Background/Objectives

Social outcomes are central to the evaluation of treatment in psychiatry both in routine care and research.

Methods

Non-systematic literature review and introspection

Results

Although social outcomes are widely accepted as important, there is no consensus on their precise relevance as primary and secondary outcomes of psychiatric treatment. Various concepts have been introduced, and numerous instruments have been developed for assessing social outcomes. They commonly address simple characteristics of the social situation of patients and do not distinguish well between objectively assessed characteristics and the patient's appraisal of their situation.

Conclusion

Given the importance of social outcomes in psychiatry, there has been little conceptual and methodological work on their role and assessment, and the current "state-of-the-art" of assessing social outcomes may be seen as very poor. Developing better concepts and assessments methods of social outcomes is a promising area for further systematic research with potential implications for evaluation studies and for the practice of mental health care.

DRAFT

Clinical Decision Making and Outcome in Routine Care for People with Severe Mental Illness: CEDAR

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The implementation of effective interventions hinges upon clinical decisions made between patients and mental health professionals. Clinical decision making (CDM) in persistent conditions such as severe mental illness is characterised by a focus on long-term disease management, a high number of decisions arrived at frequently, and patients being highly knowledgeable about their illness. While it has been shown that people with mental illness do want to be informed about and have a say in their care, practitioners so far have largely failed to adopt principles of shared decision making including adequate patient information in their daily routine. There is a lack of knowledge on CDM and its outcome in long-term illnesses, especially in the treatment of people with severe mental illness. Balancing autonomy and dependence, mental health services research should focus on what level of participation patients want in their care, and whether a good match between desired and experienced level of participation has an impact on treatment outcome.

Four papers will tackle these tasks using data from the CEDAR study, which, between Nov 09 and Dec 12, followed-up for one year 588 people with severe mental illness and their key workers (N = 213) in six European countries.

First, Arlette Bär (Zürich/Switzerland), will report on patients' desire for autonomy in CDM. Second, Eleanor Clarke (London/UK) will put forth a detailed analysis of CDM style (passive vs. shared vs. active) from patient and staff perspectives, with a special focus on preferences, agreement, and satisfaction. Third, Malene Krogsgaard Bording (Aalborg/Denmark) will report on patient involvement in CDM and professional context. Finally, Marietta Nagy (Debrecen/Hungary) will focus on quality of life as an important outcome of CDM. Using the "Manchester Short Assessment of Quality of Life" (MANSA), she will comprehensively analyse predictors and moderators of quality of life in people with severe mental illness.

Desire for autonomy in clinical decision making

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Background/Objectives

In the last two decades, the term “patient autonomy” has appeared more and more frequently in medical literature. The aim of this study was to examine patients’ desire for autonomy.

Methods

The Autonomy Preference Index has been modified to the Clinical Decision Making Style Questionnaire (CDMS). The CDMS has been developed in the CEDAR study, a European multicenter study, and has three parts: Part A, “desire to make medical decisions”, Part B, “Decision Making Preference Scale” and Part C, “desire to be informed”. The instrument has two versions (patient and staff). The CDMS data was collected at two assessment points: at baseline and follow-up after one year.

Results

588 patients assessments and 574 staff assessments were collected in the CEDAR study. Regarding the CDMS questionnaire, only 512 patients assessments and 416 staff assessments were suitable for analysis. Essential condition was the participation in the first and last assessment of the study.

Patients’ results: Generally, patients do not have the desire to take medical decisions themselves but they want to be informed. Nevertheless, in Part A of the CDMS (desire to make medical decisions) we found significant cross culture differences (between south, east and central/north Europe).

Staff results: Generally, patients should not take medical decisions themselves but they should be informed. In Part A (desire to make medical decisions) and Part C (desire to be informed) we found significant cross culture differences.

Discussion/Conclusion

We found that, in general, patient’s preferences for decision-making were weakly distinct. Patients wanted their keyworker to be the principal decision-makers; nevertheless, patients wanted to be informed. The aspect “desire to be informed” proved to be essential for patients. It appears to be the central topic of autonomy.

Clinical decision making style: preferences, agreement and satisfaction

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Background/Objectives

Clinicians and mental health service users (SU) make decisions throughout care. Clinical decision making (CDM) can be defined through the level of involvement of the SU from active CDM to shared to passive. This paper aims to test two hypotheses. Preference: SUs will be more satisfied with a specific decision if it is made using their pre-stated preferred decision making style and Agreement: SUs will be more satisfied with decisions they make with a clinician with the same pre-stated decision making style preference.

Methods

445 SUs with severe mental illness from six European countries were recruited as part of the CEDAR study. This naturalistic observational study used specifically developed CDM measures of decision style and decision specific satisfaction rating. The variable Preference was calculated by merging SU rated desired and experienced CDM style giving categories of Disempowered (SU received less active CDM than desired); Received (SU received desired CDM style) and Empowered (SU received more active CDM than desired). The variable Agreement was the difference between clinician and service user rated desired CDM style with categories of Clinician Empowers (desires more active decision making than the SU); Agreement (both SU and clinician desire same CDM) and Clinician Disempowers (clinician desires less active decision making than does the SU). Two ordinal logistic regression analyses were conducted with a random effect for clustering by staff of Satisfaction on Preference and Agreement.

Results

Ordinal logistic regression results showed that SUs who were Empowered were significantly more likely to have a higher satisfaction rating than those who were Disempowered (OR 2.53, $p=0.003$, 95% CI 1.37-4.70). SUs were significantly more likely to have a higher satisfaction rating if they were in the Clinician Empowers compared to the Clinician Disempowers group (OR 3.02, $p=0.004$, 95% CI 1.42-6.39).

Discussion/Conclusion

In CDM decision satisfaction is improved by meeting or exceeding SUs desires for decision involvement. It is also higher when the clinician desires more active CDM than the SU. This study highlights the need for more research into active CDM and SU preferences. The results show the importance of clinicians values around CDM.

Patient involvement in clinical decision making

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Background/Objectives

The patient-clinician encounter is an important aspect of the psychiatric mental health care, and the quality of this encounter has often been proposed as an essential factor for involving patients in treatment and positive outcome.

The aim was to investigate patients' and clinicians' assessments of involvement (passive, shared, active) in clinical decision-making (CDM) during a 12-month observation period, and to explore any differences in the ratings of involvement in various staff professions.

Methods

Data was collected as part of the study entitled "Clinical decision making and outcome in routine care for people with severe mental illness" (the CEDAR study ISRCTN75841675). The study was a longitudinal observational study with bimonthly assessments collected during a 1-year observation period. The CEDAR study recruited 588 mental health outpatients and corresponding staff (n=213) from six European sites.

Results

Results indicate that the majority of staff professions investigated in this study (psychiatrists, psychologists, nurses, other) are more prone to assess patient involvement in CDM as being more active than patients rate involvement in CDM ($p < 0.001$). One staff profession differs, and clinicians in this category (general practitioners/medical doctors) assess patient involvement significantly more passive compared with other staff professions in mental health outpatient treatment ($p < 0.001$, OR 0.17).

Comparing prescribing clinicians and non-prescribing clinicians the results indicate that the prescribing clinicians rate the level of involvement significantly more passive ($p < 0.001$, OR 0.22).

Discussion/Conclusion

CDM is a rather complex and dynamic social interaction, perhaps especially complex within psychiatry and the course of an outpatient long-term treatment. Awareness of the complexities of clinical decision making in outpatient mental health treatment may be of assistance to the clinicians when treating patients. The results of this study will make it possible to further define patient involvement in CDM when taking clinicians' profession into account, and it can also contribute to strengthening the patient perspective in outpatient mental health care.

Understanding the predictors and process moderators of change in quality of life in people with severe mental illness

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Background/Objectives

The maintenance of good quality of life plays an important role in the treatment of the chronic mentally ill patients. Previous research on the effect of quality of life suggests that it highly depends on various factors, such as clinical features of the illness, patient's social background, and their view on the altered state of health. In other words, the bio-psycho-social environment influences a psychiatric patient's life greatly. Our research aims were to find main influencing factors and to assess their impact as part of the European multicentre study CEDAR, (ISRCTN75841675).

Methods

We have measured patient's subjective quality of life with the Manchester Short Assessment of Quality of Life (MANSA). The elements of a bio-psycho-social health model have been assessed with various questionnaires such as Client Sociodemographic and Service Receipt Inventory (CSSRI-EU) measuring sociodemographic data, the Outcome Questionnaire (OQ-45) measuring outcome, the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) used to assess patient needs, therapeutic relationship measured by the Helping Alliance Scale (HAS), as well as duration and severity of the illness, measured by the Threshold Assessment Grid (TAG). Correlations were calculated using SPSS statistic programme.

Results

Six countries have taken part in the study with a total enrolment of 588 patients treated by 213 health workers. After the 12 months data collection phase we included 317 patients diagnosed with psychotic and affective spectrum disorders as well as anxiety disorders in the analysis. Our findings suggest that patient's quality of life is mainly influenced by the type and severity of their illness, patient age, clinical outcome, patient needs as well as the quality of therapeutic relationship.

Discussion/Conclusion

Of all the aspects considered in our study, a chronic mentally ill patient's quality of life depends just as heavily on subjective themes such as therapeutic alliance as it does on simple biological features; an important message to clinicians working in outpatient care.

Prevalence, nature and prevention of victimization amongst persons with (severe) mental health problems: findings from a national research programme in The Netherlands

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Background:

For decades, researchers have investigated violence perpetrated by persons with (severe) mental health problems. This research has, in part, been driven by the common perception that persons with mental illness are dangerous. However, the fact that many of these persons become victims of violence and other crimes themselves, has been underestimated. Recent research in the United States shows that the risk to become victimized is eleven times higher amongst psychiatric patients than in the general population.

In Europe little research has been conducted into this phenomenon. Until recently, nationwide studies on violence against persons with mental health problems were missing in European countries. In 2010 The Netherlands Organization for Scientific Research (NWO) started a programme aimed at research into the prevalence, nature, risk factors and prevention of violence against persons with mental health problems. One aspect of this program comprises research into the relationships between stigmatization, discrimination and violence against persons with mental health problems should be investigated. In this symposium we will present the results of all four studies selected for the first round of this programme.

Methods:

1. The first research project was a nationwide study examining the 12-month prevalence, incidence and risk factors of victimization in a random sample of service users with severe mental health problems (N=956) by administering structured questionnaires. The sample was drawn from six large mental healthcare organizations located in both rural and urban regions. Prevalence and incidence rates were compared to a matched sample from the general population (N=38,227), derived from the nationwide research monitor on safety and victimization.
2. The second research project aimed to investigate the prevalence rates of victimization in Amsterdam amongst service users with a) depression, b) addiction, c) severe mental illness, and d) dual diagnosis. Also correlations with a number of risk factors were examined, e.g. appearance, behavior, criminal record, and living environment. Like in the first study, victimization of 13 specific crimes was assessed in an interview using the core questionnaire of the Dutch Safety Survey. This instrument is conducted annually amongst a large sample size of the general population.
3. To date, most studies into the victimization of persons with severe mental health problems have been of a quantitative nature. Qualitative studies are needed to learn more about the nature, contexts, circumstances and processes leading to victimization. For this reason one research project in this program comprised a multiple case study in which 23 complete cases were reconstructed and analyzed. Every case consists of the victim, a person from his or her social network and a mental healthcare professional (i.e. case manager or therapist).
4. The fourth study aimed to assess the prevalence of violence against service users with psychosis with a screening instrument imbedded in routine outcome monitoring (ROM) and hereby try to validate the other field studies. With ROM large samples of service users can be reached with less effort than in a specially targeted study, and a database becomes available with rich information and great potential. Furthermore, a ROM instrument addressing victimization could offer information on an individual base that can be used in clinical practice.

Results:

The main results of these studies will be presented at the conference. The results of the nationwide multi-site research (study 1) indicated that almost half of the outpatients with severe mental health problems had been victims of a crime in the past year. Prevalence rates were significantly higher in these outpatients compared to the general population. Risk factors for victimization included violent perpetration, physical and sexual abuse in early childhood, and substance abuse. In Amsterdam (study 2) victimization rates for violent crimes were highest in service users with an addiction (on average 5,2 times higher than in the general population) followed by service users with a depression (4,2 times) and service users with a dual diagnosis (3,8 times), and were lowest in service users with severe mental illness (2,4 times). The qualitative research (study 3) made clear that in anticipation of and responding to violent incidents, the perception of the persons directly involved plays a crucial role: the experiences of persons with severe mental health problems were often contested by significant others. This study also shed some light on the processes of victimization, which are often complex, being related to ongoing victimization throughout life, problematic relationships and living in deprived conditions. In the ROM research project (study 4) data on more than 600 service users with psychosis also showed that there is a high risk of victimization for these persons compared to the general population. Persons with psychosis in outpatient care reported more incidents than persons who were hospitalized or living in sheltered housing. In two out of three cases, the responsible mental health practitioners were not aware of the more serious incidents.

Discussion/Conclusions:

In conclusion, the victimization of persons with (severe) mental health problems constitutes a serious public health problem in the Netherlands, and probably also in other European countries. Mental healthcare organizations and clinicians should become aware of the victimization risks of their service users. The discussion will focus on how these findings can contribute to developing effective interventions against victimization for mental healthcare practice, which is the objective in the current second round of the national research programme on victimization in the Netherlands.

Victimization of Psychiatric Patients: Results of a Nationwide Multi-Site Study

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Background/Objectives

In the US, the risk to become victimized among psychiatric patients is 11 times higher than in the general population. Until today, nationwide studies in Europe are missing. This Dutch nationwide study examines the 12 month prevalence, incidence and risk factors of victimization in a random sample patient with severe mental illness (N=956) via structured questionnaires.

Methods

The sample was drawn from 6 large MHC institutes located in rural and urban regions. Inclusion criteria were being 1) aged 18-65 year, 2) diagnosed with mood disorder or psychotic disorder, and 3) outpatient at one of the MHC institutions specialized in the treatment of chronic psychiatric patients. Exclusion criteria were related to the inability to give reliable responses, e.g. 1) cognitive or neurological problems 2) insufficient command of Dutch language 3) overt psychotic symptoms, or 4) aggressive behaviour towards the interviewer. Prevalence and incidence rates were weighted on sex, age, ethnicity and SES, and compared to a matched sample from the general population (N=38,227). Comparison data was derived from the nationwide IVM (Integrale Veiligheidsmonitor) research on safety and victimization. Our research instrument included the IVM questionnaire on 12-month prevalence and incidence of crime victimization, the Conflict Tactics Scale-2, measures on stigmatization and discrimination, and risk factors, e.g. symptom severity, substance abuse, anger management, violent perpetration, early childhood trauma, and social-demographic characteristics.

Results

Almost half of the SMI outpatient had been victims to a crime in the past year. After controlling for demographic differences, prevalence rates of overall and specific victimization measures are significantly higher in SMI outpatients compared to the general population. Relative rates are especially high for personal crimes e.g. violent threats, physical assaults and sexual harassments and assaults. Car related crimes are less common among SMI outpatients than the general population. Crime incidence rates show a similar pattern. Except sexual crimes, being more prevalent among women, no differences between male and female SMI outpatients were observed.

Most often, the perpetrator was someone close to the victim, and most incidents took place in the patient's private environment. In 15% of incidents a fellow patient was the perpetrator. Risk factors for victimisation included violent perpetration, physical and sexual abuse in early childhood, and substance abuse.

Discussion/Conclusion

Among Dutch severely mentally ill patients crime victimization is a serious public health problem. MHC institutions and clinicians should become aware of the victimization risk of their patients, and structural measures to prevent (recurring) victimization should be implemented.

S23.2

Prevalence of victimization in Amsterdam amongst service users with depression, addiction, severe mental illness and dual diagnosis

Martijn Kikkert

The Netherlands

DRAFT

In-depth insight into the victimization of persons with severe mental health problems; a qualitative study

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Background/Objectives

Very little is known about interrelated factors associated with and meanings persons with severe mental health problems (SMHP) attach to victimization.

Methods

Multiple case-study with 23 victims and 46 significant others, using 5 data collection waves. Data were analyzed thematically and with constant comparison.

Results

Various manifestations of victimization were reported, ranging from bullying and name calling to serious physical violence. The results make clear that in anticipation of and responding to incidents, personal perceptions of the situation play a crucial role; these idiosyncratic experiences of persons with SMHP is often contested by significant others. This is a consequence of complex processes of victimization, related to ongoing victimization throughout life, problematic relationships and living in deprived conditions.

Discussion/Conclusion

The results are complementary to previous insights gained in quantitative research. Victimization is the result of a complicated interrelation between (the perception of) victimization, problematic life experiences and possible exacerbating contribution of SMHP symptoms.

DRAFT

Monitoring incidents with violence against clients in treatment for psychosis: prevalence, context, awareness, potential preventive interventions

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Background/Objectives

In this relatively small pilot we aimed to assess the prevalence of violence against clients with psychosis with a screenings instrument imbedded in routine outcome monitoring (ROM) and hereby try to validate the other field studies. With ROM large samples of clients can be reached with small effort and adequate potential to overcome or control for bias caused by structural non response. Also, a ROM instrument can offer information on an individual base that can be used in clinical practice. This can help to find effective ways of support and prevention.

Methods

As part of the PHAMOUS- screen (pharmacotherapy monitoring and outcome survey), a yearly interview aimed at the evaluation of care administered by mental health nurses in four mental health institutions, clients with psychoses where screened with an instrument used to monitor the exposure to violent incidents in the general population. Response was 66% (N=600) with higher response (78%) for clients in supported housing.

Results

For clients with psychotic disorder the risk of becoming a victim of severe violence is two to three times higher than for their healthy peers. Between 30 and 50 % of clients experienced more than one incident. Clients in outpatient care have a higher risk of severe victimization then clients in hospital or supported living. In 17-20% cases the perpetrator is a fellow client, in 16-25% it is someone unfamiliar. One out of four clients in outpatient care does not discuss incidents with friends, family, nurses or psychiatrist. Reports of clients and psychiatrist on incidents of severe violence only match for 25%: implying a need for more dialogue.

Discussion/Conclusion

Screening on victimization using routine outcome monitoring is possible. When both clients and professionals are 'screened', information can be matched with positive implications for mutual understanding and proper service provision. However, to help professionals adequately handle this, more insight is needed on the effectiveness of interventions for this group of vulnerable patients. At this moment a new intervention is developed targeted at preventing victimization by offering patients an assertiveness training that integrates martial arts practices and principles of social cognitive learning.

Quality and effectiveness of mental health services for people with complex needs

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The symposium focuses on an under researched area – services for people with long term and complex mental health problems. This group often experience severe impairment in day to day functioning, necessitating lengthy hospital admissions and/or high support needs in the community. Though relatively small in number they require a large proportion of mental health and social care resources. They are often socially excluded and, historically, have been somewhat overlooked by mental health researchers. This is changing. This symposium includes presentations of the results from two national programmes of research from England and Portugal investigating the quality and effectiveness of inpatient and community based mental health rehabilitation services that focus on this group. There are also two presentations from studies in Australia on the subgroup of people with severe mental illnesses living in the community who have the highest support needs. These include data from the 2010 Australian national survey of psychosis and an in-depth study investigating service user views of what community participation and support means to them.

DRAFT

The Rehabilitation Effectiveness for Activities for Life (REAL) study; a national programme of research into inpatient mental health rehabilitation services in England

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Background/Objectives

Mental health rehabilitation services focus on service users with complex needs. Despite representing a relatively small proportion of all mental health service users, this group account for around 25% of the national mental health budget in England due to their need for lengthy admissions and high levels of support in the community. Despite this there is a paucity of evidence to guide clinicians and service planners. The REAL study is a five year, national programme of research that aims to investigate the provision, quality and effectiveness of inpatient mental health rehabilitation services in England.

Methods

WP1: National survey of NHS inpatient mental health rehabilitation services

WP2: Development of a staff training programme to enhance service users' engagement in activities

WP3: Evaluation of the staff training programme through a cluster randomized controlled trial

WP4: Naturalistic cohort study to investigate service and service user factors associated with better clinical outcomes.

Results

WP1: There was a high (87%) response to the national survey with 133 individual inpatient units and over 750 service users taking part. Positive associations between service quality and service users' experiences of care and autonomy were found.

WP2 and WP3: 40 units are participating in the cluster randomised controlled trial. The intervention comprises a 5 week hands-on programme delivered within each unit by a senior occupational therapist, activity worker and service user consultant. Primary outcome (service users' engagement in activities) is assessed 12 months after randomisation. Results will be available around December 2013.

WP4: 50 units are participating in the cohort study. Service users are followed for 12 months and factors associated with the primary outcomes (successful community discharge and social functioning) are investigated through multilevel modeling. Results will be available around March 2014.

Discussion/Conclusion

Results from the REAL study have already shown the positive association between improving quality of care and better outcomes. Later stages will help to identify:

- a) whether a specific staff training programme that aims to enhance service user engagement in activities is clinically and cost-effective
- b) the service and service user factors associated with better outcomes.

Taken together these results will inform future investment and clinical practice in inpatient mental health rehabilitation services.

The “GetREAL” intervention; development and evaluation of a hands on staff training intervention to increase service user engagement in activities in rehabilitation units

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Background/Objectives

- 1) To develop GetREAL, a staff training programme aimed at equipping mostly unqualified nursing and other ward staff with the understanding, skills and behaviours to improve service user engagement in activities both on rehabilitation wards and in their local community.
- 2) To prepare an intervention manual and induction programme for the staff teams employed to deliver this training intervention to 20 psychiatric rehabilitation wards across England within the study.
- 3) To prepare a fidelity measure to assess the delivery of the training intervention during the study.

Methods

The development process involved building on existing evidence and theory, consulting with clinical experts and service users, and piloting the intervention in practice. Consultation events were held with service users, practicing occupational therapists, members of the REAL study Steering Group, and staff teams in 5 rehabilitation units. The draft intervention manual was further refined and training materials created by the new intervention teams during their induction week and by piloting the GetREAL intervention in two NHS units. Fidelity criteria were developed by the authors and the REAL study steering group and GetREAL was formally endorsed by The College of Occupational Therapists.

Results

The GetREAL training was underpinned by theories from organisational change and from occupational therapy including a three-stage model of change. Senior psychiatrists visited senior staff in each health care service provider during the ‘Predisposing stage’ to engage their commitment to change. A senior occupational therapist and activity worker, with input from a service user consultant, worked alongside ward staff for five weeks during the ‘Enabling phase’. This included two training events with all ward staff, goal setting and action planning and intensive, hands on support for staff to gain confidence in the implementation of the specific techniques learned to engage seemingly unmotivated service users in activities of their choice. An appreciative enquiry approach was taken which focuses on good practice. The ‘Reinforcing stage’ involved long term action plans and continued offers of support in order to maintain sustainable change.

Discussion/Conclusion

The GetREAL manual, training materials, induction programme and fidelity criteria were developed through successive phases that consulted many different people with a variety of expertise. The novel features of GetREAL are that it targeted management and senior staff as well as the staff working on the ground and that the trainers worked closely together with ward staff teams for a full five weeks to bring about change in practice.

The PromQual study: a national study of mental health rehabilitation services in Portugal

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Background/Objectives

- a. Assessing the quality of care, living conditions, and rehabilitation of people in long-term psychiatric and social institutions;
- b. Developing a new training intervention for professionals working in these institutions, designed to improve the quality of care and rehabilitation of its users;
- c. Evaluating the effectiveness of the intervention.

Methods

A randomized controlled trial is being carried out. All the existing units in Portugal were assessed at baseline with the Quality Instrument for Rehabilitative Care (QuIRC) filled online by the manager, and face-to-face interviews with the Service User Interview Schedule with a random sample of service users.

The intervention consisted of workshops attended by the managers and the staff of the residential units in the intervention arm; and of a 4-week local intervention delivered by one occupational therapist and one activity worker to help local professionals integrate the knowledge and skills gained from the workshops into their everyday work with residents.

Units are being reassessed at 4 and 8-months after training completion using the baseline instruments. All managers and users gave their informed consent

Results

The majority of the residential units assessed (n=42) were in Lisbon and surrounding districts (59.5%), 50% were in hospital surroundings and 50% in the community, and had a mean number of 11.5±6.9 beds [5-31]. The QuIRC mean score was 52.5% [26.6-78.8%]. The units interviewed users (n=278) were mainly men (66.2%), had a mean age of 49.4±10.6 years [23-83], and had on average studied for 9.1±4.9 years [0-30].

Discussion/Conclusion

The baseline assessment showed significant problems in several areas of the quality of care provided by the residential units. The training intervention was already carried out in half of the units without major problems, proving its feasibility.

Meeting complex needs through community mental health service delivery: findings from the 2010 Australian national survey of psychosis

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Background/Objectives

Within Australia, clinical mental health services and mental health NGOs, either alone or in combination, provide rehabilitation and support for people with psychoses to manage mental illness-related functional needs in the community. The NGO sector is specifically funded to provide rehabilitation and support, but little is known about consumer and service characteristics. This study aimed to: (1) describe people with psychoses in receipt of: NGO services only; public community mental health (CMH) services only; and, both of these services; and (2) examine whether people with psychoses in receipt of both NGO and public CMH services were those in greatest need of mental health care.

Methods

The 2010 Australian survey of psychosis was a two-phase prevalence survey conducted within seven catchment areas, covering the equivalent of 10% of the adult population. 1825 survey participants were asked about their use of mental health services, including those provided by NGOs, in the previous year.

Results

One hundred and thirty five participants were in receipt of NGO services only ('NGO'); 876 were receiving public community mental health (CMH) services only ('CMH'); 405 received both NGO and public CMH services ('NGO/CMH'). There were significantly more people with non-affective psychoses in the NGO/CMH group (75.5%) compared with the NGO (48.1%) group (and 69.4% in the CMH group). Significantly more participants were never married (71.6%) and currently unemployed (86.2%) in the NGO/CMH subgroup compared with CMH participants (57.9% and 78.3%, respectively). The NGO/CMH group was more likely to experience a continuous chronic course of illness (42.7%) compared with CMH participants (28.9%) and Personal and Social Performance scale ratings were lower ($M = 53.60$, $SD = 12.92$) than the NGO ($M=58.01$, $SD=13.53$) and CMH ($M=56.96$, $SD=15.03$) groups. There were few differences between the NGO/CMH and CMH only group regarding receipt of different forms of care supporting rehabilitation and recovery.

Discussion/Conclusion

Although the demographic and functional profile of people with psychoses receiving both public community mental health and NGO services suggests that they have the most complex needs, greater consideration should be given to better targeting of specific forms of mental health care to address these needs.

Process evaluation of an intervention to promote recovery and related outcomes

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A recovery orientation is mental health policy in most Anglophone countries, with countries such as New Zealand, Australia and the United States use recovery as a guiding principle for mental health practitioners (Ramon et al., 2007).

In this symposium we will discuss some of the challenges of implementing and evaluating a recovery intervention in community based mental health teams in the United Kingdom.

Specifically we will:

- i) describe the REFOCUS intervention which has been designed to improve recovery and related outcomes for people with psychosis,
- ii) present the findings from the process evaluation, embedded within the trial, which examine the views of participants towards delivering and receiving the intervention, explores factors impacting upon the implementation of the intervention and lessons learnt, and
- iii) discuss the relationship between personal recovery support and related outcomes

Ramon S, Healy B, Renouf N (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. Int J Soc Psychiatry, 53:108–122.

DRAFT

Process evaluation of REFOCUS (recovery) intervention evaluated in cluster Randomised Controlled Trial

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Purpose

The purpose of this paper is to describe the REFOCUS intervention, underlying model and present an overview of the process evaluation, embedded within the REFOCUS trial.

The process evaluation was designed to explore the implementation, receipt, and setting of the intervention and help in the interpretation of the trial outcome results.

Method

This study took place in two NHS mental health trusts in England, UK: South London and Maudsley NHS trust and 2gether NHS trust (Gloucestershire), from July 2012 to June 2013.

A purposive sample of senior managers (N=10), team leaders and mental health professionals (N=30) and service users (N=30) was selected for individual interviews, representing range of seniority, professional backgrounds, teams and research sites. Focus group participants included staff and team leaders (N=32) and service users (N=24).

- Individual, semi-structured interviews with senior managers, clinicians and service users
- Focus groups with mental health teams (N=4) and service users (N=3)
- Thematic analysis of written entries in clinical records of working practices of intervention
- Interrupted Time Series analysis of care plan entries
- Trainer's reports and interviews, participant evaluation forms, attendance registers

Results

The REFOCUS model was developed as an underpinning theoretical explanation of the intervention, process and outcome evaluation of the trial.

Intervention

i) Intervention components: Relationships: staff values, knowledge, coaching skills and partnership and Working practices: understanding values and treatment preferences, strengths assessment and supporting goal-striving

Process evaluation

ii) Practice change Team and individual staff values, knowledge, skills, behavioural intent and behaviour
iii) Experience of service users: increased experience of personal recovery support, including coaching, increased focus upon strengths, values and personal goals

Outcome evaluation

iv) Outcomes: Increased personal recovery, including hope, empowerment, quality of life and wellbeing.

This paper will give an overview of the validation the model, highlighting the practice change and implementation issues.

Discussion

A general interpretation of study

Staff experiences of implementing a recovery intervention

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Background

Embedded within the REFOCUS Randomised Controlled Trial is a process evaluation. The staff aspect of the process evaluation will help us to understand staff perceptions of the intervention. Specifically how successful the implementation strategies were; the staff experiences of delivering the intervention; the barriers and enablers to implementation and the wider context of the trial.

Methods

Participants were 30 staff, team leader and senior manager interviews from REFOCUS intervention teams in two NHS trusts in the UK. A purposive sample of staff was identified of staff able to discuss using the intervention with service users or had attended the training. Transcripts were analysed in NVivo 9 using thematic analysis as described by Braun and Clarke (2006).

Results

The main themes from the final analysis will be explained and illustrated with relevant quotes. Preliminary analysis has shown that by using the intervention staff are finding out more about the lives and motivations of the service users they work with. Using the intervention increases trust between service users and staff. However staff report facing many barriers including working in a large organisation within a context of financial pressure and stress, pressures on time, practical barriers and negative attitudes to the intervention or to the concept of recovery. Enablers include staff using strategies to incorporate the intervention into everyday practice and seeing the positive effects of the intervention reinforces future use.

Conclusion

Implementing recovery interventions successfully requires a detailed understanding of localised contextual factors. Some of the barriers described by staff could be reduced if they are taken into account when developing future recovery promoting interventions and implementation strategies. Clinicians who implemented the Refocus intervention had to overcome many barriers in implementing the intervention, highlighting some of the obstacles clinicians face to working in a recovery orientated way. Clinicians using the intervention were surprised by what they discovered about their service users lives and motivations and the improved relationships. This indicates that working in a recovery orientated way is humanising and improves therapeutic relationships.

Service user experience of a recovery-focused intervention

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Background/ Objectives

The experience of individuals using community mental health services is of vital importance to any intervention aiming to provide recovery-orientated care. To assess the experience of service users in receipt of the REFOCUS intervention, a process evaluation has been embedded within the randomised controlled trial. The service user component focuses on obtaining examples of the different intervention elements and the impact of these on the individual's recovery. This talk will present the initial framework of how service users experienced the REFOCUS intervention.

Methods

Interviews (n=20) and focus groups (n=3) were conducted with individuals receiving care from intervention teams within the REFOCUS trial. We identified a purposive sample of people who had received, and were able to discuss different elements of the REFOCUS intervention. Thematic analysis was used to identify the main themes within the data and to develop a coding framework.

Results

The main themes from the analysis will be discussed alongside illustrative examples of the three working practices contained within the intervention. Seven higher-order categories were identified: "Defining recovery", "Existing experiences of services - treatment as usual", "Experience of the different elements of REFOCUS", "Impact of REFOCUS on recovery outcomes", "Alternative ways to support personal recovery", "Personal qualities of staff" and "Working relationship with staff". Within each category, sub-themes explored the diverse and rich experience of individuals. Many service users were able to discuss changes in the relationship and conversations had with staff. Additionally, service users identified areas of existing practice which they felt supported their recovery.

Conclusions

The experience of the REFOCUS intervention was generally positive, with individual's reporting that staff "got to know them better" or "saw the person not the illness". Service users saw the relationship between themselves and staff as key to a positive experience of care - regardless of whether or not they noticed any intervention-specific changes. Working relationships which promoted the service user as an individual with unique strengths, preferences and goals were vital to the experience of recovery. Understanding which features of the intervention were successful from a service user perspective will not only enable the evaluation of the REFOCUS intervention but may help clinicians to translate elements of the intervention into routine practice.

Using INSPIRE to assess staff support for recovery: preliminary analysis from the REFOCUS trial

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Background

It is important to understand how mental health services can support personal recovery. INSPIRE has been developed as a measure of staff support for personal recovery. It has been used as part of the evaluation of the REFOCUS Randomised Controlled Trial (RCT) which aims to increase support for personal recovery and improve service user experience of this. The intervention in the REFOCUS RCT is based on the REFOCUS Model that identifies the intended effects of the intervention. One assumption behind the model is that if the person's experience of receiving support for recovery changes then this will have an impact on the outcomes they experience. This presentation will analyse the association between the experience of support for recovery and an increase in personal recovery.

Methods

The results from baseline data collection with service users in the trial (n=402) were analysed to examine the relationship between staff support for recovery, personal recovery and related aspects of life such as well-being. Measures were completed by 15 service users randomly selected in each of the 27 teams in the REFOCUS RCT. These measures assessed constructs such as support for recovery, personal recovery, hope, empowerment, quality of life, well-being, needs and symptoms. Demographic information was also collected. The relationship between staff support for recovery, demographic factors and related constructs were analysed using regression models.

Results

The main associations and correlations between staff support for recovery and related constructs will be examined and discussed and any implications for supporting recovery by staff will be discussed. The results will be evaluated to provide some preliminary ideas on how staff support translates into the increase in personal recovery for service users.

Conclusions

This research will be able to provide initial ideas on how staff support is received and experienced and how it impacts on personal recovery and related aspects of life such as well-being. Any link between support for recovery and increased recovery will be discussed, along with any implications for clinical practice or future research.

Access to health services for persons with mental health problems and mental disorders in Málaga (Spain)

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The Carlos Haya Hospital Mental Health Service is comprehensive, well integrated and delivers health care for a defined population located in Málaga (southern Spain). This service is organised according to the principles of the psychiatric reform that emphasized the need to focus on community care. It includes a wide spectrum of out-patient, day-patient and general hospital inpatient facilities, as well as staffed and un-staffed residential facilities. It ensures easy access of patients to any of its components, straightforward clinical assessment, continuity of care, as well as social support and close liaison to other community medical and social services, in particular with GPs.

This symposium summarizes the results of some evaluative studies conducted in Málaga. The five presentations report different aspects of care provided by comprehensive community-based service including primary care, mental health services and emergency both hospital and out of hospital department. We analyse variables such as sociodemographic, economic and clinical factors that can influence the use of services. Our primary focus is on the severely mentally ill but also on all other residents in the catchment area who need mental health care (including suicide behaviour). We use mainly large clinical data bases as for example the Málaga Schizophrenia Case Register (RESMA).

In conclusion, developing community-based mental health care requires a series of coordinated actions and service evaluation is an important part of this exercise. We believe that routine clinical assessment covering all health services of a defined catchment area represent a 'new generation' of research tools. These studies are mainly developed by the research group named "GAP" which focus is to identify gaps of mental health service delivery.

DRAFT

Prevalence and use of services in persons with schizophrenia and related disorders in Málaga (Spain)

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Background/ Objectives

Very few studies have examined schizophrenia morbidity in Spain, using multiple sources of information. We performed a 1-year prevalence study of schizophrenia and related disorders in Málaga and the use of services in a population aged 14 years or older living in the mental health catchment area of Carlos Haya hospital (Málaga, Spain).

Methods

Data were obtained from multiple sources of information mainly clinical databases. We selected more than 4000 persons as “possible cases” and we consult case notes and key informant (general practice and psychiatrists) to confirm schizophrenic diagnoses and place of living.

Results

A total of 1808 patients, 1169 men and 639 women were included as cases in the study. The one year ICD-10 prevalence rate was 6,8 (6,5-7,1) per 1000 adult population. Almost 80% of cases were in contact with public mental health services and 37% had contact with primary care as well but only 39 out of 1808 were solely in contact with their GP. Responsibility for schizophrenic patients is mainly carried by mental health services.

Discussion/Conclusion

Health planning should be based on local data about prevalence and use of services. Multiple sources of information are essential for accurate estimation of prevalence of schizophrenia disorders.

Relationship between readmissions, social needs and functioning among severe mental psychiatric patients in an urban area of Málaga (Spain)

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Background/ Objectives

Readmissions is one of the most consistent measure of outcome reported in mental health . Factors associated to recidivism remain controversial. The aim of this study is to analyse the relationship between needs and social functioning and readmissions of people with severe mental disorders (SMD) in an urban area of Malaga.

Methods

Prospective controlled observational study. Readmission is defined as one hospitalization episode during a period of time of 12 months of been discharged. Subjects: 100 patients with SMD admitted in aMental Health Unit for a period of 18 months. Variables: Social Needs: Camberwell Assessment Needs Schedule (CAN), Clinical Symptoms Brief Psychiatric Scale (BPRS), Personal and Social Performance Scale (PSP), Clinical Diagnosis (CIE-10) and sociodemographic characteristics. A survival bivariate and multivariate analysis was conducted.

Results

The overall of readmissions within 30 days, 90 days and 1 year after discharge were 21.21%, 40.40 % and 61.61%, respectively. Only 11.11% did not have history of previous admissions, of those only 18% were readmitted at one year follow up. A 74.7% keep the appointment with community mental health unit after discharge. The mean in PSP was 39.75 ± 19.259 and in BPRS was 43.83 ± 14.094 . The median of length of stay was 14. In multivariate analysis (cox regression) remained in the model the number of previous readmissions 2-8 (Hazard Ratio; HR=3.735; CI= 1.438-9.704; p=0.007), and > 8 (HR=3.793; CI=1.535-; p=9.376) and PSP <30 (HR=1.799; CI=1.039-3.113; p=0.036). CAN items that were significant, controlled by the number of readmissions and level of functioning, were in CAN performed by the professional: receive help from family for anguish (HR=0.410; CI=0.194-0.867; p=0.020) and receive information from social service about treatment and medication (HR=0.431; CI=0.232-0.802; p=0.008); and one item of user-made CAN: Receive adequate support for their psychotic symptoms (HR=3.625; CI=1.435-9.154; p=0.006).

Discussion/Conclusion

Factors related to family and social support and functioning on the one hand, and those related to disorder chronicity on the other (specially the previous readmissions), are higher predictive factors with respect to the likelihood of hospital readmission. Instead, psychopathology and diagnosis have not influence on the phenomenon of repeated readmissions in this sample.

Demands for prehospital emergency medical services: factors associated with psychiatric problems

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Background/ Objectives

In the 90's the Prehospital Emergency Medical Services were created in Spain, in order to establish a coordination mechanism through the creation of a single telephone number (061) available to patients. The present study aims to analyse the epidemiology of psychiatric and suicide-related demands for Prehospital Emergency Medical Services in the province of Malaga, Spain. In addition, it compares the characteristics of these demands with non-psychiatric demands.

Methods

We carried out a cross-sectional study for the Prehospital Emergency Medical Services utilization in 2008. A computerized database of the "Centro Coordinador de Urgencias y Emergencias" (Prehospital Emergency Coordination Center) which coordinates all requests for emergency services in Malaga (1,528,851 population) was used. We applied a two-step logistic regression analysis. In the analysis, psychiatric demands were the dependent variable. We used the χ^2 test and Student's t test for bivariate analysis. Subsequently, we distinguished among four groups of attendance according to the number of demands per user/year, and analysed the percentage of requests classified as psychiatric in each group. We also analysed a number of repeater patients with suicide-related demands.

Results

A total of 241.101 demands have been analysed, with a daily average of 658. Psychiatric demands accounted for 4.9% and suicide-related for 0.5%. Among the psychiatric demands, 48.4% have been classified as "nervousness". The variables associated with psychiatric demands include age between 18 and 44 (OR = 5.036) and 44 to 64 (OR = 2.605), requests coming from the police or fire department (OR = 1.904), and negatively associated with male gender (OR = 0.715). The percentage of psychiatric demands has been highest in the group whose members made more than 20 demands per year (14.5%). 16 people (2.04%) made 3 or more suicide-related demands throughout the year.

Discussion/Conclusion

In this study, psychiatric demands represents a figure slightly higher than that found in other studies of our environment. Compared with the total of demands, both psychiatric and suicide-related demands have a rising trend line along the year. In conclusion, there are some significant differences between psychiatric and non-psychiatric demands for Prehospital Emergency Medical Services.

Frequent users of a psychiatric emergency department in Spain and Portugal

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Background/ Objectives

In developed countries, the use of emergency services has increased considerably in the previous years. Patients with mental health problems (e.g. schizophrenia) belong to the frequent users of emergency services. Repeated visits are problematic due to economical reasons and due to probable under-treatment. So far, there is a lack of studies that analyses the relationship between specific clinical mental health problems and (frequent) emergency service use. The aim of this study was to determine the factors associated with multiple frequent users of psychiatric emergency departments in Portugal and Spain.

Methods

Patient data were collected during one year in emergency services of hospitals delivering health care for catchment area in Malaga (year 2008) and Lisbon (year 2009). We conducted a logistic regression analysis by using 1 vs. more than 1 visit as the dependent variable and country, age, sex and mental health problems (diagnoses) as probable predictors.

Results

A total of 4129 patients visited the respective emergency services for mental health problems, 53.7% in Malaga and 46.3% in Lisbon. The mean age of considered patients was 43 years (SD: 15.5) and 57% were female. The most frequent diagnoses were mood-affective disorders (28,8%) and neurotic, stress-related and somatoform disorders (25.8%) (codes F3 and F4 of ICD-10 respectively). The mean of visits was 3.48 (SD=6.96) and the range 1 to 47. Of the total patients, 19% visited the emergency service more than once. The results reveal a particularly high risk for frequent visits in patients with psychotic, affective problems and patients with a personality disorder.

Discussion/Conclusion

Knowing the clinical predictors of frequent emergency visits is important to improve outpatient services and to reduce costs. Our study showed that particularly patients with severe mental health problems belong to the frequent users.

Space-time suicide clustering in rural area of Málaga

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Background/ Objectives

Approximately 4,000 people commit suicide every year in Spain and almost 200 occurs in Malaga. The major aim of this study is to explore if a spatial and temporal clustering of suicide exists at the north of Malaga province (Spain) in the county of Antequera.

Methods

Sample and procedure: All suicides from January 1, 2004 through December 31, 2008 were identified using data from the Forensic Pathology Department of the Institute of Legal Medicine, Malaga (Spain). Geolocalisation: Google Earth was used to calculate the coordinates of each suicide decedent's address. Statistical Analysis: A space-time permutation scan statistic and the Ripley's K function were used to explore space-time clustering. Contingency tables were generated for combinations of 4 critical time periods (1-4 weeks) and distances (0-2,5 km; 2,5-5 km; 5-10 km; and 10-15 km). Pearson's chi-square test was used to determine whether differences existed between suicide cases inside and outside the spatiotemporal clusters.

Results

A total of 120 individuals committed suicide, of which 96 (80%) were included in our analyses. The median age of suicide completers was 54.1 (\pm 20.3) years. Hanging was the most frequent method (79.2%). Statistically significant evidence for seven spatiotemporal suicide clusters emerged within critical limits of 0-2,5 km and the first and second weeks ($p < 0.05$ in both cases) after a suicide. Suicide cases within these clusters tended to be more likely diagnosed with a personality disorder than cases outside of these clusters (52.9% vs. 45.6%; $X^2 = 0.30$; $df = 1$; $p = 0.60$).

Conclusions

There are spatiotemporal suicide clusters in the area surrounding Antequera, (Malaga, Spain). Preventive measures are advisable within 2,5 km and during the first two weeks in the aftermath of an index suicide in this region. Subjects diagnosed with personality disorders appear to be more vulnerable to suicide after an index suicide.

Residential facilities: are they promoting recovery or are they ‘homes for life’?

Giovanni de Girolamo

IRCCS Fatebenefratelli, Brescia (Italy)

The closure of mental hospitals in Europe has seen the parallel growth of a large network of Residential Facilities (RFs) for patients needing medium- or long-term mental health care. Yet there are a number of unsolved controversies about the role and the functions of such facilities. Probably the main point of controversy is to clearly define whether they should be conceptualized as intensive treatment programmes, or merely as ordinary homes or living settings for people who participate fully in treatment and psychosocial programmes provided by local mental health services. These contrasting objectives may actually lead to different characteristics of their functioning and to diverse typologies of care processes, although the scientific literature usually refers to RFs as a unitary concept. Related to this point, there is the need to develop a clear taxonomy of residential facilities, based on specific operational criteria. This taxonomy should spell out acceptable ranges of available RFs, staffing levels, optimal size, satisfactory environmental features and activities needed to fill residents’ weekly time, and in particular weekends, evenings, and so on. Precise patients’ inclusion criteria should be developed; all patients that are candidates for residential facility admission should receive careful, multidimensional assessments, highlighting not only clinical characteristics but also impairments in social and vocational roles. Management plans and related organizational frameworks should match residents’ typologies and their various needs and requests. Patients’ rehabilitation plans should be carefully monitored with appropriate instruments. Avoiding an indistinct case mix (i.e. aged patients mixed up with young, treatment-resistant patients) in residential facilities is a prerequisite for the development of tailored treatment plans and for transforming residential facilities into effective rehabilitation settings for those patients with realistic prospects of rehabilitation. This strategy also implies the selection of staff with specific characteristics, and a reasonable staff turnover should be foreseen to prevent burnout. This symposium will discuss all these unsolved issues and will propose a set of possible solutions and an agenda for further research.

Residential facilities: an update of the italian situation and the findings of recent research in this area

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In Italy, where all mental hospitals have been phased out, psychiatric patients requiring long-term care are being treated in Residential Facilities (RFs). The National Residential Project (PROGRES) surveyed the main characteristics of all Italian RFs. On 31 May 2000 there were 1,370 RFs with 17,138 beds; an average of 12.5 beds each 10,000 population and a rate of 2.98 beds per 10,000 inhabitants. Residential provision varied ten-fold between regions and discharge rates were very low. Most had 24-hour staffing with 1.42 patients per full-time worker. In the second phase of the project 2,962 patients living in the sampled facilities were individually assessed; most were males. A substantial proportion (39.8 %) had never worked and very few were currently employed (2.5 %); 45 % of the sample was totally inactive, not even assisting with domestic activities in the facility. Two-thirds had a diagnosis of schizophrenia; co-morbid or primary substance abuse were uncommon. Twenty-one per cent had a history of severe interpersonal violence, but violent episodes in the RFs were infrequent. The managers judged almost three-quarters appropriately placed in their facilities and considered that very few had short-term prospects of discharge. A very recent cohort study that we conducted on a sample of 403 residential patients from 23 RFs has indeed confirmed this (de Girolamo et al., 2013). Very few patients were discharged to independent accommodations after 1 year. The main variables associated with a higher HD likelihood were: illness duration of >15 years and effective social support during the previous year. Lower severity of psychopathology and higher working skill levels were also associated with a significantly greater HD likelihood.

Count and financing of residential facilities for severely mentally ill in balanced publicly funded health and social services systems

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Context/Objectives

In a balanced publicly managed mental health care system, supervised residential facilities including long-term hospital settings may represent 60 % of the budget for less than 10% of severely mentally ill (Amaddeo et al., 2007). In Canada, the sources of financing include the ministries of health and social services, the federal/provincial/municipal housing agencies, the ministry of Justice (prisons and halfway-houses), transfer payment to individuals, public and private disability insurances, private donations and individual contribution.

Methods

Using Province of Quebec's administrative data, the presentation counts the population-based array of supervised residential places and costs.

Results

About 30 % of the budget goes for supervised residential services, whilst another 25% is for short and long-term hospitalisation. The array of publicly funded supervised residential settings from the health, social, justice and housing sectors offer about 176 places for severely mentally ill per 100k inhabitants.

Conclusion/Discussion

Further downsizing of psychiatric hospital, or downright closure, have been hampered by the availability of suitable supervised residential settings and failure or slowness of social housing to develop enough places, leaving the health and social services sector develop and run housing facilities in addition to provide clinical and social support.

How should community-based residential settings be conceptualized: findings from a research project in Canada

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Background/ Objectives

Despite decades of evolution and researches in housing field it is still a challenge to identify attributes that differentiate between the various housing types and to systematically describe housing and community-based residential facilities. This presentation will address the following questions based on the findings from a research project conducted in Canada: How should housing and community-based residential facilities be conceptualised and operationalized? According to whom? What common attributes, dimensions and domains should be used?

Methods

Group concept mapping was used to identify key attributes and conceptualized housing and residential facilities. Participants included service users, family members, staff working in residential facilities, mental health workers and managers. During the concept mapping process, 221 participants generated 1382 statements describing housing attributes, 416 participants rated 140 selected statements, 73 sorted the statements into categories and 12 participants were involved in the interpretation of the results. Multidimensional scaling and hierarchical cluster analysis were used to produce conceptual maps. These maps and the rating data obtained from a subgroup of participants (n=228) were used to conduct principal components analyses (PCAs) and further operationalize community-based residential facilities.

Results

The refinement of the conceptualization produced by the concept mapping process lead to the identification of four domains, 11 components and over 80 attributes. The four domains are: 1) the geo-physical environment (2 components); 2) the provision of services and support (3 components); 3) the milieu atmosphere and functioning (3 components); 4) the organizational and managerial practices to ensure quality of care (3 components). Examples of components include: proximity to community and services, privacy and architectural features, occupational lifestyle and participation, support and interventions for personal development and skills building, housing agency organizational practices. Examples of attributes comprised in domain 2 (the provision of services and support) include: Provide information on citizenship and rights; Assist/teach the person how to budget and make it through the month.

Conclusion/Discussion

The research project integrated the perceptions of multiple stakeholders as well as statistical and conceptual considerations. The final conceptualization portrays housing and community-based residential facilities as a complex multifaceted, multi-person and multilevel system.

Residential facilities in Germany: a challenge for practice and research

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In spite of substantial change in German mental health care in recent decades (Salize et al. 2007) there is widespread concern that the issue of long-term residential care has not been resolved. There is a lack of full community integration and specific rehabilitation practice. There is a range of residential services for people with mental illness with a variety of levels of staffing and intensity of supervision. Kallert et al. (2006) surveyed a number of German dehospitalisation studies, and they suggest that there are a few modest predictors of successful deinstitutionalisation (e.g. younger age, shorter illness duration, shorter length of stay). There are estimates, in Germany, of about 250 residential places per 100,000 inhabitants required for institutional outpatient care (and 30 patients for day clinic and full-time in-patient treatment and 40 places for residential home care) (Bartusch et al. 2007). There is a debate in Germany on the pros and cons of closed residential homes for people with long-term mental illness. Regional surveys and 'grey' sources on residential homes in Germany report on excessive institutional focus, limited social integration of residents and limited choice of residential services, e.g. in Swabia. Studies on care needs and programs planning individualized regional residential care networks are under way. Key recommendations on residential care of a new evidence-based (S3) guideline on psychosocial interventions in severe mental illness of the German Association of Psychiatry, Psychotherapy and Nervous Diseases (DGPPN) will be outlined (DGPPN 2013).

Bartusch SM et al. (2007) Hannover study on long-stay hospitalization – part II: Characteristics and care conditions of long-stay hospitalization in cases of chronic mental illness. Clinical Practice and Epidemiology in Mental Health 3: 1-9

DGPPN (2013) S3-Leitlinie Psychosoziale Therapien bei schweren psychischen Erkrankungen. S3-Praxisleitlinien in Psychiatrie & Psychotherapie. Springer, Berlin Heidelberg

Kallert T et al. (2006) The process of deinstitutionalization in German state mental hospitals. Critical overview of empirical research studies. Fortschr Neurol Psychiat 74: 309-328

Salize HJ et al. (2007) Mental health care in Germany: current state and trends. Eur Arch Psychiatry Clin Neurosci 257: 92-103

Is this an era of re-institutionalisation in Europe? An analysis of drivers of institutionalised care

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Major reforms have changed psychiatric care in Europe since the 1950s. As part of 'de-institutionalisation' large asylums were abolished or downsized, and services in the community have been established. Yet, it has been suggested that the process of 'de-institutionalisation' has ended or been even superseded by 're-institutionalisation'. The latter is characterised by an increase of care provided by new institutions. At the centre of the argument are forms of residential care and supported housing, the provision of which has been increasing substantially in most European countries. Research on this process and the potential drivers behind it is complicated because of various conceptual and methodological problems, including poor quality of available data. First, a brief overview will be provided on the understandings of the term 'institutional care' in the psychiatric literature. Available figures on how different types of institutionalised psychiatric care, ie care provided by institutions that are defined by bricks and mortar, have changed in several European countries since 1990 will be presented. Potential drivers for the changes will be explained. These include a hypothesized increase of morbidity, a changed attitude to risk, economic interests of provider organisations, less social support in traditional families, and a shift in funding priorities. Expert opinions on these drivers will be reported, the existing evidence, and implications for research and policies be discussed.

DRAFT

DRAFT

Abstract
ORAL
PRESENTATIONS

Payment by Results, recovery and equalities: what is happening in England?

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Background/Objectives

Mental health care in England is gradually moving from a 'block grant' mode of commissioning services to one of 'payment by results'. The policy is evolving as it is implemented. As we are part way through this it is timely to review intentions and progress to date and consider the potential impact of this development on supporting recovery-oriented care and addressing (in)equalities. This presentation will examine the development of PbR so far, and provide some thoughts on its potential impact on recovery and equalities and the continuing evolution of the policy.

Methods

A critical review of related policy documents, policy implementation and developments to date to assess progress in terms of supporting recovery and greater equalities.

Results

There are good intentions towards encouraging better recovery-oriented services and greater equity of care and outcomes, but there is considerable way to go. The policy is still evolving and presently there is a strong focus on devolved, local operationalization and payment tariffs.

Discussion/Conclusion

Reasoned arguments exist for why PbR will/not support better recovery for people using services in England. The case has yet to be fully tested. Local variation in implementation potentially provides a means of testing different models of, but could equally lead to greater inequalities. A more explicit focus on recovery and equity would be helpful in the evolution of the operation of PbR.

Recovery and older people's mental health services: What is different and and what are the issues in changing service delivery?

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Background/Objectives:

Mental health policy is increasingly framed in terms of recovery, however equivalent developments and research in older people's mental health services have not yet taken place. A qualitative study was undertaken with 28 service users and 10 carers, using grounded theory techniques to produce a conceptual framework of recovery for older people with mental health problems (Daley et al, Int J Geriatr Psychiatr, in press). This framework highlighted similarities and differences in the experience of recovery for older people, and was used to develop the RECOPE model comprising an intervention (a 3-day team-based recovery training package and implementation support for staff working within older people's mental health services) and intended effects. The main aim of this study is to evaluate the impact of the RECOPE intervention upon users and staff within older people's mental health services.

Methods:

The RECOPE intervention was delivered to 203 staff working in 15 clinical teams in South London, UK. The hypotheses were that the RECOPE intervention would improve recovery and quality of life for service users.

Outcome evaluation used a controlled pre/post design, with service user participants (n=65) across three time points, using the Illness Management and Recovery Scales (Mueser et al, 2004) and two quality of life measures. Fidelity was assessed. Process evaluation comprised: qualitative interviews with staff (n=19), pre-post staff ratings (n=176) of recovery knowledge and attitudes using the Recovery Attitudes Questionnaire (Borkin, 2007) and the Recovery Knowledge Inventory (Bedregal et al, 2006), and review of longitudinal care plan data (n=250) over seven time points.

Results:

The results from the outcome evaluation will be presented. The process evaluation highlighted that the fit between trainer and team, and team organisational culture and professional group membership were significant mediators in the successful delivery of training and transfer of learning into practice.

Discussion/Conclusion:

Recovery measures suitable for use with older people are needed. Pre and post strategies to implement the intervention in the local team context and with different professional groups are required.

Norway versus USA: How is ACT working? Results from fidelity assessment of 12 Norwegian ACT teams with the American fidelity measure TMACT

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Background/Objectives

During the last few years Assertive Community Treatment (ACT) has been implemented throughout 14 sites in Norway. Preliminary results show a significant decrease in hospitalisations during the first year of ACT-treatment compared to the previous year. The implementation of ACT is followed by a national research-based evaluation, which includes assessment of the ACT-teams fidelity to the model. To what extent are the Norwegian teams working as specified in the ACT model?

What can the fidelity measures tell us about the specific challenges and advantages in implementing ACT in Norway?

How does Norwegian ACT-teams work compared to American teams as measured by TMACT?

Methods

The newly developed instrument Tool for Measurement of Assertive Community Treatment (TMACT) has been used to measure the fidelity to the ACT model by 12 Norwegian teams one year after they started. The TMACT as a fidelity tool demands time and resources but provides rich and relevant information on fidelity towards the ACT-model. The Norwegian teams express that the TMACT feedback gives a good reflection of their practice and that it is useful in further development and implementation of the ACT-model

Results

Results from the fidelity assessment of 12 Norwegian ACT-teams show that the Norwegian teams reach high fidelity for structure and organisation and moderate fidelity for core team and core practices. Person-centered planning, evidence-based practices and specialist roles have low fidelity. Even though these findings can be explained by national factors such as education of health professionals and organisation of mental health care in Norway, an American pilot study on TMACT reveals a similar pattern for American ACT-teams (Monroe-De Vita M et al., 2011). Thus, suggesting additional cross-cultural explanations for lower fidelity scores on scales focusing on recovery and evidence-based practices.

Discussion/Conclusion

After 12 months the Norwegian teams have implemented the core features of the ACT-model with moderate to high fidelity. Elements focusing on recovery and evidence-based practices are less well implemented. These findings are in line with TMACT evaluations of American ACT-teams and suggest explanations beyond national conditions.

The role of caregiver characteristics in mental health service use by young people aged 9-18 years

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Background/Objectives

Studies have highlighted the need for an increased understanding of factors underlying young peoples' mental health service utilisation. Caregivers hold a key role in processes associated with youths' help-seeking and service access, and parent stigma-related characteristics might be critical in determining youths' service contact. This study aimed to advance the understanding regarding youths' caregiver-related service use determinants through examining to which extent caregivers' stigma-related characteristics, help-seeking attitudes, and personal service use predicted youths' likelihood of service use. These influences were considered in relation to services obtained via the health care sector and/or within education settings.

Methods

The study used a cross-sectional design nested within an ongoing prospective investigation. Participants were 407 caregivers of youth aged 9-18 years recruited from Greater London. Youths' caregiver-reported service use during the past year was assessed using the "Service Assessment for Children and Adolescents", and caregivers reported on their intended stigma-related behaviours, help-seeking attitudes, and personal service use. Youths' clinical profile was determined via the "Strengths and Difficulties Questionnaire". Logistic regression analyses examined the relationship between caregiver characteristics and youths' service use, controlling for youth clinical and socio-demographic factors. Models tested for interaction terms and confounding effects..

Results

Findings will be presented on the extent to which caregiver characteristics predicted youths' likelihood of service use. In particular, findings will describe the influence of caregivers' stigma-related characteristics on youths' service use in different settings.

Discussion/Conclusion

This study highlights the key influence caregiver characteristics exert on youths' service use. Efforts targeting stigma in caregivers appear useful to reduce barriers to youths' service contact. The study extends the literature on youths' service use determinants through considering the role of caregiver characteristics on a general level, beyond thoughts and attitudes directly related to young people's health. It overcomes limitations of past research through considering a community sample and a range of service settings, not restricting the exploration to a clinical sample. Future studies should continue to explore the complex manner in which stigma-related influences can constitute barriers for youths' service utilisation, and how such influences can be reduced, to bridge the gap between youths' service need and utilisation.

Recovery-Oriented mental health projects in Wales: The BIG Lottery 'Mental Health Matters' (MHM) Investment Programme

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Background/Objectives

The BIG Lottery Fund in Wales is investing £15 million pounds in innovative community mental health projects delivered by non-statutory (independent third sector) services (2009-2014). Funding was granted for four or five years. Eighteen projects were funded, most involved the delivery of services, others were educational projects; most were aiming to improve social inclusion and promote recovery. This paper reports on the overall programme evaluation.

Methods

Documentary analysis of grant applications and most recent project reports; thematic analysis of transcribed telephone interviews with all project managers; consultation with nominated respondents and site visits.

Results

More project outcome targets were hit than missed with extensive benefits to the consumers of services. Projects varied from those which aimed for sustainability from the outset to those which always regarded the project as a 'task and finish' exercise. Where the statutory services were consulted about the initial application and bidding process, the operation and sustainability of the project was more likely to proceed well.

There has been a clear impact on some aspects of policy and on practice. The recovery and person centred approach adopted by some projects has been taken up by planners and commissioners and built into future plans for community services. There was very little participation in local development plans, but operational engagement with all the projects was very good on the ground in all parts of Wales. The respondents were clear that projects filled important gaps in provision, and were complementary to existing provision. There were already examples among the projects of successful cloning of projects in neighbouring areas.

Discussion/Conclusion

Third sector organisations are somewhat distant from mental health and NHS strategy, development and planning groups, and find it hard to exert any influence. . New commissioning arrangements in the mixed economy of welfare mean that there are opportunities for projects to bid to continue to provide services. There were indications that projects were looking closely at the development of payment by results (PbR). In the end these quasi-market arrangements may prove to be fertile ground for the future. This could lead to a lasting legacy for BIG MHM investments.

Days out of role due to common mental disorders in Bulgaria: Public health and individual consequences

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Background/Objectives

The objective of the presentation is to explore the days out of role due to health problems of somatic and mental origin in Bulgaria and their consequences for the individual and the society. Data from national representative epidemiological study EPIBUL 2003-2007 for Bulgaria (Harvard and Michigan University), show the share of common somatic and psychiatric disorders in the total days out of role in Bulgaria

Methods

The study covered 5318 respondents over 18. The instrument was the fully structured World Mental Health Initiative version of the Composite International Diagnostic Interview (CIDI-3). A presence of ten chronic somatic disorders and nine psychiatric disorders for each respondent, is investigated along with information about the number of days out of role in the last month before the interview in which respondents were not able to work or perform their other normal daily activities due to problems of physical or mental origin. Multiple regression analysis to assess the multivariate associations of somatic and psychiatric disorders controlling age, gender, employment and education was applied

Results

About half of respondents (48.1%) had a psychiatric or somatic disorder of the 19 disorders included in this analysis. Those who reported at least one somatic disorder (44.3%) are significantly more than those who reported any mental disorder (10.7%). People with neurological disorders have the highest average number of days out of role (77.5 days), followed by those with social phobia (50.5 days), headache and/or migraine (44.6 days) and insomnia (40.6 days). Neurological diseases had also the largest individual effect followed by headaches and/or migraine, insomnia and alcohol abuse. On the social level, however, a strong effect (population attributable risk - PAR) had conditions associated with chronic pain, cardiovascular diseases, headaches and/or migraine.

Discussion/Conclusion

Days out of role due to health problems are a major reason for loss of human capital. The study of the causes leading to the loss of days has a value on a personal as well on population level. Increasing productivity and increasing social capital is directly related to reduction of the leading causes for days out of role. In Bulgaria, unlike other countries, a shift of the leading causes of lost days in the direction of somatic diseases, which is taken as an indirect indicator of the high level of stigmatization of mental health services.

Extended freedom attained? – A case study of the design and construction of a free choice system in community mental health

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Background/Objectives

Systems for freedom of choice within mental health has been implemented in several western countries to increase citizens' freedom of choice, conduce diversification in service and providers of service, reduce inequalities by providing equitable choice to all users while contribute higher quality of service and facilitate efficient use of public funds. In Sweden "Act of Free Choice Systems" (2008:962) was introduced in 2009, and optional for municipalities to use. Community mental health is organized within the municipalities. The aim of this study is to describe the process of designing and constructing a market of free choice within community mental health, and analyse what kind of freedom of choice the citizen in need of community mental health have, in the example of Daily occupation.

Methods

A case study was conducted in Stockholm, the capital of Sweden, where free choice was implemented in January 2010. The study consists of semi-structured interviews with twenty-eight actors' involved in the process, complemented with political documents. Interviews were conducted 2009 and 2012. To analyse the material direct content analysis was used, and theories regarding quasi-markets, market design and regulation of markets were applied.

Results

The design and construction of the market of community mental health have determined the degree of clients' freedom of choice. The volume of the market was regulated by national legislation, but sometimes influenced by the local political budget, and users sometimes appealed their decisions in court to have their rights assessed by law. Admission rules set by authorities concerning management and staff qualifications, financial stability and technical documentation equipment, determined which providers could enter the market. Many user-led organisations were not able to enter due to the admission rules. Quality regulation was developed by authorities to examine providers within the system. The client should be provided neutral and rich information, though full information was hard to access.

Discussion/Conclusion

Freedom of choice seems to have been both extended and reduced by the design and construction of the new system. All users theoretically had the same possibilities to choose providers in the system. However the construction limited the actual client choice significantly.

Results of a randomised controlled trial of evidence based supported employment for people who have recently been homeless and have a mental illness

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Objectives

The Individual Placement and Support (IPS) model of supported employment is the most effective at helping people with mental illness in general attain their goal of employment. This randomized controlled trial is the first to investigate the efficacy of IPS services in a population with mental illness and recent experiences of homelessness.

Methods

Ninety participants were recruited from a larger housing first randomized controlled trial in which they received housing and clinical supports. Participants expressing a desire to work were randomized to receive IPS services (n=45) or treatment as usual (n=45). Both groups were followed for a minimum of 12 months. Days in competitive employment, earnings, and hours worked were measured every three months using structured interviews and a self-report questionnaire. Baseline data across groups were compared using parametric or non-parametric methods according to the distributions of the variables. Employment outcomes were compared on an intent-to-treat basis; mixed effects models will be used to compare outcomes across groups.

Results

No baseline differences were observed between groups. The average length of follow-up was 628 days. During this period, 42% of the experimental group and 27% of the control group gained some employment in a competitive job. Once randomized, participants receiving IPS services worked more days in regular jobs, with regular paychecks, in the competitive labour market (26.4 days vs 9.6 days, $p=0.028$), and relied less on pan handling as a source of income (\$152.85 vs. \$1104.83 per month, $p<0.00001$). Hours worked in casual work, usually paid under the table, were identical between groups (7 hours per week). Receiving IPS services did not diminish the income received from welfare and social assistance which was identical for both groups (\$718.94 per month). The evaluation of IPS intervention fidelity improved with time and, in the final year of the study, reached a high level.

Conclusion

IPS appears effective among people with mental illness who were recently homeless, though less so than typically reported among the general population of people with mental illness. Initial implementation difficulties may have contributed to this. Further research with a longer follow-up period is needed.

The barriers and facilitators to implementing a supported employment service (Individual Placement & Support) within a London catchment area

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Background/Objectives

The study set out to gain a better understanding of the usefulness of the Individual Placement & Support model as a means of increasing employment and reducing social exclusion among people with severe mental health problems, to highlight any inequalities in its uptake, and the factors that promote or impede its successful implementation.

Methods

A service evaluation over two years collected demographic, clinical, and employment data for an entire cohort of service users in a London catchment area, comparing outcomes for those with access to IPS services versus those without. Qualitative interviews with service users, clinicians, employment workers, and employers highlighted the multiple challenges involved with implementing this model of employment support, and indicated some of the reasons for low employment rates found in this group.

Results

Access to the employment service did not increase the likelihood of service users finding paid work, and overall employment rates for the investigated cohort remained below 10% over the 2 year study period. Predictors of finding paid work included having had employment since referral to mental health services, being in contact with services for a shorter length of time and without co-morbid substance misuse difficulties. Qualitative interviews highlight the ambivalence experienced by service users around finding paid work, the disincentives of finding work due to the current welfare system, the lack of awareness of the IPS service by clinical staff, and the difficulties of implementing a high-fidelity IPS model.

Discussion/Conclusion

The IPS model was not successfully implemented in this catchment area, with difficulties apparent at an individual and a service level. Poor fidelity to the model in delivery of the service undoubtedly impacted its success, but qualitative data highlights the complexity of this issue and points to areas in need of further consideration to improve employment rates for this group. Investigations of preferences for voluntary work, and an exploration of alternative models such as social enterprises are also warranted.

Anti-psychiatry sentiments among the general population; explaining unequal access to mental health care services

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Background/Objectives

This study questions why particular subgroups of people are less likely to access mental health care services. Help seeking is a social process in which the norms and values held by the people in your social network influence your personal attitudes towards psychiatric care. Therefore, we seek the explanation for unequal access to mental health care services in studying the network content of people with different levels of socio-economic status. We hypothesize that people with a lower socio-economic status and less network social capital will report more anti-psychiatry sentiments.

Methods

The survey 'Stigma in a Global Context – Belgian Mental Health Study' (2009) conducted face-to-face interviews among a representative sample of the general Belgian population, supplemented by a drop-off questionnaire (weighted N=783). The socio-economic status of the respondent refers to years of education attained and to the socio-economic index of their occupation (ISEI). Network social capital is assessed by means of the position generator. We calculated the volume of social capital and the average occupational prestige of the accessed occupations. Anti-psychiatry sentiments are on the one hand addressed by a 5-item scale addressing stigmatizing attitudes towards psychiatric care in general. On the other, stigmatizing attitudes towards institutional care are addressed by means of the open-ended question what to expect from help provided in a psychiatric hospital. After content analysis, this resulted in four categories: negative, neutral, or positive attitudes towards institutional psychiatric care and a 'don't know'-category. Negative attitudes refer to anti-psychiatry sentiments in this case. Linear and multinomial logistic regression models are estimated in SPSS.

Results

People with less years of education and those with a lower volume of social capital report more anti-psychiatry sentiments towards psychiatric care in general. Those respondents with a lower volume of social capital are also more likely to report negative rather than neutral attitudes towards institutional care.

Discussion/Conclusion

People with lower education and less network social capital report more anti-psychiatry sentiments. So to tackle the unequal access to mental health care services, the image of psychiatric care has to be improved among those particular subgroups.

Needs of people with severe mental disorders treated in community psychosocial centers in São Paulo, Brazil

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Background/Objectives:

Few studies in Brazil tried to assess the needs of people with severe mental disorders although these studies could be very useful for service planning and for the establishment of treatment goals. The aim of this study was to identify the needs of people with severe mental disorders in intensive treatment regime in community psychosocial centers in Sao Paulo city, Brazil.

Methods

We performed a cross-sectional study with 373 patients who were attending psychosocial care activities at least three times per week in community psychosocial centers in São Paulo, Brazil, during 2007-2008. Needs were assessed using the "Camberwell Assessment of Need" (CAN). Psychotic symptoms were assessed using the "Positive and Negative Symptom Schedule" (PANSS). One-way ANOVA was performed to examine association between patients' characteristics and total number of needs.

Results

Mean age of patients was 40.0 years (standard deviation, SD = 12.6 years); 57.6% were male, 57.9% had fundamental education, 40.5% had schizophrenia, 15.9% had worked during last 12 months, 14.7% were living alone and 21.9% had no previous psychiatric hospitalizations. Mean scores of PANSS positive, negative and general scales were 13.4 (SD = 4.8), 14.9 (SD = 5.7) and 29.0 (SD = 8.7), respectively. Median time attending in community psychosocial centers was two years and mean number of weekly therapeutic activities was 3.6 (SD = 2.3). The mean score for the total number of needs was 7.1 (SD = 2.8), with a range of 0 to 15. Daytime activities (91.4%), company (88.5%) and transport (67.6%) were the most frequent needs. Women showed higher number of needs than men ($p = 0.02$) and people that had studied less than 8 years also showed more needs ($p = 0.02$). We did not observe associations between weekly activities, unemployment, age, diagnosis and number of needs. Patients with higher PANSS scores showed more needs ($p < 0.001$).

Discussion/Conclusion

We observed higher number of needs than in studies conducted in Europe. The needs of many patients went beyond the care provided by community psychosocial centers, such as education, employment and welfare.

Development and psychometric properties of the Costs of Discrimination Assessment (CODA)

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Background/Objectives

Stigma and discrimination are faced by many with mental health problems and this may affect the uptake of services and engagement in leisure and recreational activities. The aim of this study was to develop a measure of the impact of stigma and discrimination on service use, employment and leisure activities and to estimate the value of such reductions.

Methods

A questionnaire, the Cost of Discrimination Assessment (CODA) was developed and piloted in a sample people with mental health problems. Costs were calculated and test-retest reliability assessed.

Results

Test-retest reliability was good for most items. A substantial proportion of the sample had experienced negative impacts on employment as a result of stigma and discrimination. Around one-fifth had reduced contacts with general practitioners (GPs) in the previous six months due to stigma and discrimination (Mean value in 2010/11 £ 15, SD 50) and the leisure activity most affected was visiting pubs/restaurants/cafes ((Mean value in 2010/11 £ 21, SD 74).

Discussion/Conclusion

Stigma and discrimination result in reduced use of services and reduced engagement in leisure activities. This represents a welfare loss to individuals.

Offender mental health: Individual and relational initiatives can initiate, but not sustain, healthcare equity, a case-study

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Background/Objectives

The principle of equity of access to the NHS has been extended, in the last decade, to include the incarcerated. National policy and local service initiatives have also begun to embrace the idea that greater health needs require higher inputs to achieve equity of healthcare, particularly in relation to offenders. A case-study of an urban local-authority area, in southwest England, examined how health and criminal justice services worked together and how this could enhance offender health.

Methods

Data included semi-structured, recorded, interviews with health and criminal justice practitioners (15) and local service documents (20), supplemented by data from longitudinal interviews with offenders from the case-study area.

Analysis began with tabulation of national policy prescriptions against local service delivery. A narrative case study was constructed providing exploratory 'thick description' of healthcare for this socially disadvantaged group. Diagrammatic representations were then produced to consider the various perspectives, and the contribution of inter-relational factors, to facilitating healthcare for offenders.

Results

The most prevalent unmet needs were common mental health problems. Offenders struggled with 'access hoops', such as registering with a GP and having a postal address for appointments. Offenders often didn't meet implicit and explicit access criteria, such as turning up sober and in clean clothes or had co-morbidities which excluded them from services.

Health and criminal justice practitioners regularly exceeded their prescribed roles to overcome social and economic healthcare inequalities for offenders. These 'heroic initiatives' faced two limitations. Firstly, they weren't sustainable if the practitioner was no longer in position. Secondly, they were only possible if there was a suitable service to send someone to; the lack of 'wet hostels' was particularly challenging.

Discussion/Conclusion

Practitioner initiative and individual relationships built up across organisations over time were significant contributors to overcoming the socio-economic inequalities that offenders faced, particularly in addressing their mental health needs. These relationships were not addressed by national policy, are challenging to protocolise and are highly vulnerable to change. In order to promote, these seemingly effective, ways of improving offender mental health we need to understand how these individual examples of excellence can be more widely applied.

Analyzing schizophrenia care variability: an exploratory care pathway typology

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Background/Objectives

Schizophrenia is the most widespread of adult psychoses. Between 1 and 2% of the French population, i.e. 400 000 persons would be concerned. The various steps of the illness, as well as its several symptomatic forms, require a large range of mental health services, from inpatient to outpatient care. By using hospital database (Rim-P), this communication aims to identify several care patterns for people having received a schizophrenic diagnosis.

Methods

The Rim-P allows us to describe precisely all the contacts of a mental health user within the hospital: kind, length and intensity of care, professionals involved.

In 2010 more than 130 000 patients admitted in a mental health service have received a schizophrenic diagnosis. For 87% of them we were able to observe a 6 month-period of care. We carried out a typology of care pathways by combining a principal component analysis with a hierarchical ascendant clustering.

Results

Five main clusters of care can be distinguished. With 37% of the patients, the first group is composed by patients having a punctual contact (inpatient or outpatient care) with the mental health system, while for the other groups contacts are regular. 10% of the patients have a long term admission or day care. 4% of the patients can be characterized as “difficult” with frequent involuntary treatment or emergency service use. The last two groups concern patients with regular ambulatory care: 5% receive very frequent and varied outpatient care, while 44% have a more moderate follow-up.

Discussion/Conclusion

Frequency of these clusters of care strongly varies between areas. That questions the equity of access to care, and to care of quality, for people with schizophrenic disorders in France.

Predictors of quality of life among patients suffering from schizophrenia living in Residential Facilities: A longitudinal study using a structural equation model approach

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Background/Objectives

Quality of life (QOL) has been considered an important outcome measure in psychiatric research and determinants of QOL have been widely investigated in many cross-sectional studies. On the other hand, only few studies have tried to identify factors which influence QOL in patients with schizophrenia by using a longitudinal design. In this study we focused on two additional factors so far rather neglected: satisfaction with mental health services and spiritual and religious well-being. The aim of the present study was twofold: to determine to what extent clinical factors, socio-demographic variables, spirituality and satisfaction with services affect the QOL of patients with schizophrenia; to identify clinical predictors associated with QOL at 1-year follow-up.

Methods

Data were collected in the framework of the PERDOVE study (Epidemiological Project on Discharge from Residential Facilities and Outcome Assessment). Logistic regression models were adopted to evaluate the association between QOL, as measured with WHOQoL-Bref scores, and potential determinants of QOL. Furthermore, a final model was examined including all variables which were significant for each QOL domain. Finally, all variables significantly associated to four facets of QOL in the final logistic regression model were tested by Structural Equation Modeling (SEM).

Results

The study included 139 patients with a primary diagnosis of schizophrenia. Level of activity, social support, age at first hospitalization, services' satisfaction, spiritual well-being and symptoms' severity were determined as predictors of baseline different QOL facets, in the final logistic regression model. SEM model confirmed that satisfaction with services and social support were effective predictors of QOL at baseline. Weak relationships were observed for other variables, such as spiritual well-being, activity level and age. Longitudinal analysis carried out by SEM showed that 40% of QOL variability at follow-up was explained by QOL at baseline; and significant indirect effects toward QOL at follow-up were found for satisfaction with services ($r=0.23$, $p<0.001$) and for social support ($r=0.15$, $p<0.05$).

Discussion/Conclusions

Findings appear to be consistent with previous studies done in this area. Rehabilitation plans for people with schizophrenia living in RFs should pay attention to mediators of change in subjective QOL, such as satisfaction with services and social support.

Epidemiology and Health Economics of Depressive Symptoms in Old Age – Results of the Leipzig Longitudinal Study of the Aged (LEILA 75+) and the German Study on Ageing, Cognition and Dementia in Primary Care Patients (AgeCoDe)

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Background/Objectives

Depressive symptoms are common in old age and associated with substantial economic consequences. In order to assess future needs of the health care system for prevention and treatment, information on occurrence of and costs associated with depressive symptoms among the highest age groups is required.

Methods

A population-based sample and a primary care sample aged 75 years and older were investigated face-to-face regarding depressive symptoms (Center of Epidemiologic Studies Depression Scale and Geriatric Depression Scale), risk factors, resource utilisation and costs (cost diary). Resource utilisation was monetarily valued using 2004/2005 prices.

Results

Incidence rates were 34 and 43 per 1,000 person-years, 95% confidence interval 31-37 and 38-48). Depressive symptoms were significantly associated with marital and educational status, functional impairment and mild cognitive impairment. The mean annual direct costs per patient were € 5,241 for depressive and € 3,648 for non-depressive individuals at baseline, and € 6,491 for depressive and € 4,537 for non-depressive at follow-up. Mean annual total costs at baseline were highest for individuals with chronic depressive symptoms followed by individuals with remittent, no and incident depressive symptoms (see figure 2). At follow-up, mean annual direct costs were also highest for individuals with chronic depressive symptoms, prior to individuals with remittent, no and incident depressive symptoms. Significant differences were found between individuals with no and with chronic depressive symptoms at baseline.

Discussion/Conclusion

Since depressive symptoms are common in oldest age, associated with broad categories of risk factors, and with a significant increase in direct costs, late-life depression represents an important public health issue. Employment of comprehensive geriatric assessment to ascertain depressive symptoms and its concomitants could help to improve treatment effectiveness.

Landlords experiences of tenants suffering from severe mental illness

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Background/Objectives

Persons suffering from severe mental illness (SMI) live – and prefer to live – independently, in either private or public apartment blocks without on-site services. Living in own apartments increase feelings of safety and well-being and function as a robust social status marker. Landlords are important actors in gaining stability and sustainability and it has been found that landlords have a plethora of preconceptions, attitudes, emotions as well as ethical dilemmas in offering apartments to this group of persons. Today there is a lack systematic knowledge about the role landlords have come play in providing sustainable housing for these persons. The main aim of this qualitative study was to describe landlords' experiences of having tenant suffering from SMI

Methods

Sixteen landlords in various parts of Sweden participated in open in-depth interviews three years after the government proclaimed a vision zero regarding homelessness among individuals with SMI. Data was subjected to thematic latent content analysis.

Results

Landlords experienced being confronted with difficult circumstances such as mismanagement of apartments, sensitivity and provocative behaviors in relation to both tenants with SMI and neighbors. In acute situations landlords tried to collaborate with the community based psychiatric service system but were neglected. As a result and without the knowledge of how to best help they started to provide support to tenants with SMI involving going beyond professional borders.

Discussion/Conclusion

The findings give reasons to conclude that community-based psychiatric services need to be more pro-active in their collaboration with landlords. Also education interventions with a focus on how to best help tenants with SMI need to be developed and implemented.

Examining Help-seeking for Depressive Symptoms - Mental Health Care services Satisfaction and Perceived Treatment Benefits in a Norwegian Study

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Background/Objectives

Depressive disorders are one of today's major public health challenges in the Western world, with population prevalence upwards of 10 %. Yet only 10 % of people suffering from depressive symptoms seek professional help. Some are not in need of treatment, but many would benefit from professional help. There is an apparent incongruity between the need for and the use of specialist mental health services. The objective of this paper was to examine patterns of help-seeking. Specifically associations between mental health care services satisfaction, perceived treatment benefits and depressive symptoms. Analyses were conditioned on age, gender, rural vs. urban, SES, social network and somatic disease.

Methods

Data were from 1300 men and women, aged 18 and above, participating in the OsLof (Oslo and Lofoten) study. Data were collected at baseline and after ten years. The study included questions of service use, attitudes towards and perceptions of mental health care services. Depressive symptoms were measured by the HSCL-25 (≤ 1.54 not case, 1.55 – 1.74 sub-case, ≥ 1.75 case). Two indicators of SES were used; education and income. Social network was measured by an index developed from the questionnaire.

Results

Having sought help within 12 months was positively associated with mental health care service satisfaction, however, no association was found with perceived treatment benefits. There is a significant association between case-level HSCL-25 and having sought specialist treatment, and received desired help. However, no association can be found between HSCL-25 score and perceived likelihood of seeking specialist treatment in the future. Help-seeking was associated with gender, but not with SES, age or urban/ rural. We found a significant, negative association between education level and mental health care services satisfaction. Mental health care services satisfaction was non-significantly associated with perceived treatment benefits.

Discussion/Conclusion

It may be construed that in order to combat depression as a public health challenge, early intervention and effective treatment is requisite. Case-level HSCL-25 is associated with seeking help. There is however little evidence suggesting that specialist treatment causes improvement in depressive symptoms. To optimize individual patient recovery, more work is needed to conclude on the most beneficial strategy.

Equity in mental health care provision to immigrants and natives in Italy

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Background/Objectives

The aim of this study is compare mental health care provision in Bologna, Italy between immigrants and natives.

Methods

Records of prevalent cases on 1/1/2011 with at least one contact with the community mental health services of the Department of Mental Health (Local Health Trust of Bologna, Italy) in the year 2011 were extracted from the information system. Data on admissions were retrieved from the hospital discharge records database.

Results

The study population includes 11434 patients, of whom 4.6% were immigrants; of these, the largest groups were from Morocco (19.8%), Romania (10.7%) and Albania (9.0%). The 1-day prevalence of psychiatric disorders on 1/1/2011, standardized by age and gender, was 159.88/10.000 among Italians and 65.21/10.000 among immigrants. Italians and immigrants differed significantly on demographic characteristics (except for gender) and age at first contact with mental health services (MHS). Overall, the number of interventions provided in the year 2011 was significantly higher in Italians compared with immigrants (median: 11 vs. 8, M-W test, $p < 0.001$).

The percentage of patients hospitalized at least once in acute or long-term residential facilities, and receiving social rehabilitation was similar between the two groups (acute admission: 8.4% among Italians vs. 8.2% among immigrants; long-term admission 3.9% vs. 2.9%; rehabilitation: 16.0% vs. 15.1%). However, when rehabilitation interventions were examined separately, those carried out in day center were significantly more frequent among Italian patients ($p < 0.05$).

Hospitalizations for acute episodes were significantly longer for Italian patients in each acute in-patient facility and the median duration of admission was 30 days for Italians and 18 days for immigrants. When differences between groups in the length of stay in acute in-patient facilities were examined using Poisson regression to adjust for demographic and clinical covariates, hospitalizations were significantly longer for Italian patients in private clinics (CDC) and intensive treatment units (RTI), but not in general hospital psychiatric units (SPDC).

Hospitalizations in sheltered residential units (RTP) were also significantly longer in Italian patients.

Discussion/Conclusion

The determinants of integrated therapeutic-rehabilitation treatments include social and clinical variables that delineate severity and chronicity profiles. After adjusting for these characteristics, immigrant patients received fewer interventions and shorter hospitalizations.

Modelling the quality and technical efficiency of the mental health system in Catalonia (Spain)

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Background/Objectives: There is an increasing interest in methods to improve the assessment of efficiency in mental health care. At present, the tools that have been developed are useful to detect and to monitor efficiency. Nevertheless, it is not clear to what extent they are equally functional to assess different types of inefficiency that emerge from different combinations of inputs and outputs, and thus that are difficult to understand in absence of expert knowledge that explain these complex systems. This study is aimed to analyze the relative technical efficiency of 74 small health areas to improve the assessment of effectiveness and quality in mental health care system in Catalonia.

Methods: An Expert-based Cooperative Analysis (EbCA) is used to develop a hybrid qualitative and quantitative operational model of basic mental health community care (B-MHCC). This model combines different indicators of residential, outpatient and day care that were previously defined by the experts (service type, availability, professionals, and service utilization). This initial model fit the rules and parameters that are used to perform a Data Envelopment Analysis (BCC-DEA) that is aimed to identify and assess the relative technical efficiency of the areas to be analyzed through different possible scenarios composed for specific Inputs/Outputs (I/O) combinations. Finally, hierarchical cluster analysis techniques are utilized to describe differences between efficient and (totally or partially) inefficient scenarios.

Results: The EbCA approach identifies efficient and inefficient scenarios depending on the different I/O combinations. Benchmark areas are generally well identified through this hybrid approach. The analysis coincide with experts' opinions, and thus experts give support to the validity of these findings, but some problems have been found to characterize inefficient health areas that generally are difficult to define.

Discussion/Conclusion: Inefficiency is far more complex than the simple lack of efficiency, and in order to assess these findings additional indicators and expert collaboration may be needed to understand the final model. On the other hand, despite the usefulness of this approach future studies should address the problems of communication between experts and analyst, that is, the difficulties of understanding from both sides.

Use of the european classification of services ‘DESDE-LTC 2.0’ for mapping and planning mental care in two areas of Spain (Gipuzkoa and Bizkaia)

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Background/Objectives

PSICOST in cooperation with the Mental Health Departments of Gipuzkoa and Bizkaia produced the first Mental Health Atlas in these areas based on the DESDE-LTC 2.0 classification system. The toolkit allowed for the collection of exhaustive and standardized information on the typology and functioning of services based on the territory. This information is essential for the evaluation and planning of mental health care based on evidence-informed knowledge and useful for national and international comparisons.

Methods

DESDE-LTC 2.0 together with geographical techniques have been used to assess availability, accessibility, adequacy of provision and use of mental health care services for all age groups (child/adolescents, adults, elderly) provided by different departments (Health, Social, Justice, Education). Information was gathered through a template to be filled by services and available health databases.

Results

The Atlas includes a standardized service inventory with 152 entries for Bizkaia and 139 for Gipuzkoa mainly focused on community care. Furthermore, it has been possible to identify other units of analysis that lack organization stability such as long term or short term programs that were not included in previous versions of the classification system and provide useful information about the organization of the services in the area. A set of maps with services distribution and zoning, utilization of mental health centres and hospital services, and accessibility has also been included. Results show a tendency of services clustering in high density areas in Bizkaia, unlike Gipuzkoa that shows a more spread out provision. Finally, comparisons with other territories in Spain have been carried out reflecting an adequate availability of different types of care except for an excess of long term hospitalization care.

Discussion/Conclusion

DESDE-LTC 2.0 was useful for the development of an integral Mental Health Atlas in Gipuzkoa and Bizkaia, as it was possible to assess mental care services offered by different providers and not only by the health system. There was an identification of standardized types of care independently of the official name of the service. It was also possible to identify different units of analysis not assessed previously. The Atlas provides useful information for decision making in health policy based on evidence-informed.

A comparison of mental health services in Verona and northern Norway

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Background/objectives

The Italian psychiatric reform that started in 1978 has been regarded as an ideal in Norway, largely because of the radical closing of mental hospitals and the resulting low hospital bed-rate. However, the reasons for this have been mostly ideological, no empirical comparisons of the mental health service systems in the two countries have been performed. The present study aims to provide a comparison of the services in the two countries, by mapping one of the best known services in Italy, and the services in northern Norway, which is fairly representative of Norwegian psychiatric services.

Methods

Both services were classified with the European Service Mapping Schedule, and the International Classification of Mental Health Care. The case register of the Verona service, and data from two community mental health services in northern Norway were used to compare the diagnostic distribution of the one-year treated prevalence in both places. Prevalence rates per 1000 inhabitant 18 years and older were calculated for all main diagnostic groups.

Results

Several differences between the services were identified, both regarding structure and content. The number of psychiatrists per inhabitant was very similar, but northern Norway had 10 times more clinical psychologists than Verona. The two services had largely the same organisation, but the bed-rate in northern Norway was 1.4 times higher than in Verona (21.0 vs. 14.9 per 100 000). The one-year treated prevalence was 2.3 times higher in northern Norway than in Verona. Anxiety-disorder was the most common condition treated in both services. In northern Norway, the second most treated condition was mood disorder, and the third was alcohol/drug disorder. In Verona, the rate of the population treated with mood disorder and psychotic disorder was largely the same, occupying second and third place.

Discussion/conclusion

One important context for the differences between the two services is the economical situation in the two countries, Norway being a very affluent welfare state. This allows for treating a high percentage of the population. The socio-economic differences between the two study-areas do not indicate a higher need for service in northern Norway than in Verona. The high number of psychologists in northern Norway is connected to the Norwegian emphasis on psychotherapy for non-psychotic disorder. Verona, on the other hand, seems to give more priority to medical treatment of the most seriously ill.

Changes in hospitalization in mental health services among users in Norwegian Assertive Community Treatment teams

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Background

From 2007 until 2011 Assertive Community Treatment teams have been set up in 14 different sites throughout Norway. The teams offer services to people with severe mental illness, often with co-occurring substance use disorder and an impaired level of functioning. Many have not received adequate services or did not benefit from ordinary mental health services. They have often had frequent or long admissions in mental health hospitals. In international studies on Assertive Community Treatment, a primary aim has been to reduce hospitalization in mental health services. However, recent RCT studies, especially from Europe, have not reported significant reduction.

Objectives

The primary aim of this study is to investigate if there is a reduction of hospitalization in Norwegian mental health services during the first 12 months in an ACT team, compared to the last 12 months prior to inclusion. We will explore and compare the characteristics of three groups divided in 1) patients not being admitted, 2) patients with an increase in hospitalization and 3) patients with a reduction.

Methodology

Our study has an observational design. 186 patients from 12 ACT teams were assessed at intake and gave written informed consent to participate in the study. The teams collected data on socio-demographic variables (Questionnaire about life situation and health), level and severity of psychiatric symptoms (Brief Psychiatric Rating Scale/BPRS-E), level of psychiatric symptoms and functioning (Global Assessment of Symptom and Functional Scale – split scale), and substance use (Alcohol Use Identification Test/AUDIT, Drug Use Identification Test/DUDIT). Data on hospitalizations in mental health services during the last 12 months prior to and the first 12 months after inclusion in ACT teams were collected from local electronic medical record systems.

Reducing self-stigma in people with schizophrenia spectrum disorders

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Background/Objectives

Self-stigma, i.e. the subjective experience of stigma resulting from applying stigmatizing attitudes and stereotypes to oneself, is a complicating feature in schizophrenia treatment and considerably hinders the recovery process. Day clinic treatment might contribute to a reduction in self-stigma. The purpose of the present study was to evaluate the effectiveness of our empowerment- and recovery-oriented day clinic program on self-stigma.

Methods

Two groups of patients were compared, the experimental group attending the day clinic program (N=40) and the control group waiting for the day clinic program (N=40). Patients were assessed twice, at baseline and after five weeks. Measures of self-stigma, quality of life and psychopathology were collected. T-test and general linear model were conducted to analyze longitudinal data.

Results

Patients in day clinic treatment showed a reduction in self-stigma while the control group showed a minimal increase (Cohen's $d=0.446$). Compared with the control group the experimental group also showed a greater improvement in psychological quality of life (Cohen's $d=0.6$) and in overall psychopathology (Cohen's $d=0.452$). Interestingly, changes in self-stigma did not correlate with changes in psychopathology.

Discussion/Conclusion

Intensive empowerment- and recovery-oriented day clinic treatment appears promising in improving not only psychopathology, an established outcome variable, but also levels of self-stigma and quality of life, which are important outcome variables nowadays.

WELLFOCUS: Positive Psychotherapy for people with psychosis

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Background/Objectives

Well-being is considered to be an important outcome in the context of recovery from severe mental illness. Up until now there are no evidence based interventions that specifically aim to increase well-being within this client group. Positive Psychotherapy (PPT) is an existing intervention to increase well-being in people with mild common mental health problems and healthy participants. This study aimed to adapt PPT specifically for people with psychosis and test the feasibility and usefulness of the adapted intervention in a pilot randomised controlled trial.

Methods

A mixed methods study combining qualitative and quantitative components was conducted. The adaptation of PPT involved a systematic literature review, semi-structured interviews with service users (N=23) with psychosis and staff (N=14), and expert consultation. The pilot randomised controlled trial (ISRCTN04199273) of the adapted intervention is currently under way.

Results

Interviews with service users and staff suggested a number of adaptations to the original intervention. Adapted PPT is provided as a 12-session weekly group therapy. Initial results of the qualitative process evaluation will be presented to describe the intervention's feasibility and potential usefulness.

Discussion/Conclusion

Key components, challenges, and potential implications of Positive Psychotherapy to increase well-being in people with psychosis will be presented.

The Illness Management and Recovery program as a pathway to a recovery-oriented mental health service? A qualitative study

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Background/Objectives

The Illness Management and Recovery (IMR) program is being implemented in various settings in the USA, Asia and Europe. IMR is a recovery-oriented program consisting of weekly sessions for people who experience symptoms of severe mental illness. The role of the mental health professional is to facilitate a defined 11-unit IMR curriculum to support the patient's own recovery process. Little is known about mental health professionals' experience facilitating the IMR program, specifically whether or not their experience at supporting recovery in this manner has influenced other parts of their job. This study examined the experiences of the facilitating mental health care professionals to detect possible areas of changes in their professional role.

Methods

In-depth interviews were carried out with 16 practitioners and managers from USA and Denmark with experience in teaching the IMR program. The analysis was conducted using the principles of grounded theory.

Results

The analysis indicates a shift from the medical model towards the recovery model for mental health care due to the IMR program. The structured approach and the constant focus on recovery, which are core principles of the IMR program, have changed the mental health professionals' role. The analysis shows that the recovery-oriented approach of IMR changed both attitudes as well as specific practices of the mental health care professional. The attitude of the professionals was changed towards a more hopeful and individualized approach, while the changes in practice are reflected in a more person-centered and goal oriented approach.

Discussion/Conclusion

This article shows that IMR has an impact in changing the attitude and practice of mental health care professionals towards a recovery-oriented model of mental health care. This suggests that an IMR program can influence mental health care professionals and may be a way of creating a more recovery-oriented mental health care system.

Quality of care for severe mental illness in Lombardy (Italy)

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Objective

To evaluate routinely quality of care addressed to patients with severe mental illness through a set of clinical indicators. These indicators are related to the process of care, are specific for each disorder and can be totally drawn from current health information systems.

Method

41 clinical indicators for schizophrenia, 33 for bipolar disorders and 14 for depression have been identified by experts of the Italian Society of Psychiatric Epidemiology (SIEP) through Delphi rounds. These indicators cover both main quality domains (accessibility, continuity of care, appropriateness, safety) and phases of care (first episode, acute care, maintenance and promotion of recovery). Indicators have been subsequently applied to health databases of Region Lombardy containing data on mental health activities, hospital admissions, specialist health treatments and pharmaceutical prescriptions. The sample is composed by 28,191 patients with schizophrenic disorder (ICD 10 F2 category), 7,752 with bipolar disorder (ICD 10 F30-31 categories) and 19,271 with depressive disorders (ICD 10 F32-33 categories) that during 2009 were cared by the Departments of Mental Health (DMHs) of the Region. Benchmarking has been adopted to evaluate DMHs.

Results

Indicators have been analyzed by axis of the quality (i.e. accessibility, continuity, appropriateness, safety, sentinel events) and by phase of care (onset, acute phase, maintenance), showing strengths and weaknesses of the mental health system in Lombardy.

Conclusions

Clinical indicators are useful for evaluating quality of care in the mental health system and quality assessment could be done routinely using current information system data.

Transplanting Recovery - Research and practice in the Nordic countries

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Background/Objectives

The conceptual framework which describes recovery from mental illness is based primarily on studies conducted in English-speaking countries. Knowledge and development of a recovery orientation within other cultures and mental health systems is still limited, and few studies have discussed the impact of varied national contexts on the development and implementation of recovery-oriented services. The aim of this study was to compile, describe and discuss the research on personal recovery and recovery oriented practice within the psychiatric and social fields in the Nordic countries.

Methods

A systematic literature review of Nordic research on recovery from mental illness was conducted which included studies that clearly focused on Recovery as a knowledge base in psychiatric and social services.

Results

Twenty one studies were reviewed, summarized and analyzed with regard to their findings regarding the recovery process, descriptions of interventions which promote recovery and factors which might be specific to the Nordic context and mental health system. The majority of the studies were qualitative and stressed the importance of social relations, environmental factors and peer support. The identified research literature was limited and primarily replicated designs and confirmed findings first presented in North American and British studies. Few studies referred to aspects of welfare system, mental health service structures or cultural factors that might impact the recovery process.

Discussion/Conclusion

There is a need to identify and describe factors in Nordic mental health systems that may influence the recovery process. If research does not attend to cultural and organizational differences that may impact the development and implementation of recovery services there is a risk that users will not gain access to these interventions in a manner relevant to their needs. A corresponding challenge will be to translate and further develop outcome indicators that can promote a recovery oriented health system.

The effect of an early supported employment intervention for patients with anxiety or an affective disorder - a randomised clinical trial

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Background

Anxiety and affective disorders can be disabling and significantly impact peoples' ability to work. In Denmark people with a mental disorder, and mainly non-psychotic disorders, represent a substantial and increasing part of those receiving disability pensions. Previous studies have indicated that Individual Placement and Support (IPS) has a positive effect on employment, when provided to people with severe mental illness. The Sherpa method is a modified IPS intervention, aimed at supporting people with recently diagnosed anxiety or affective disorders in regaining their ability to work and their return to work or education, without pre-vocational training. The Sherpa method consists of individualized mentor support; coordination of activities; career counselling; help clarifying personal finances; and support in obtaining jobs, and keeping them.

Aim

To investigate whether the Sherpa method has an effect on employment or education, when provided to people with recently diagnosed anxiety or affective disorders.

Methods

The trial is a randomised, assessor-blinded, clinical trial of the Sherpa method in addition to treatment as usual compared to solely treatment as usual for 434 participants diagnosed with anxiety or an affective disorder, living in the Capitol Region of Denmark. Primary outcome is competitive employment or education at 24 months. A measurement based care approach has been used (short valid Hamilton scales) at baseline to evaluate the symptoms often identified to be the source of treatment resistant (work predictive scale). The WHO-5 quality of life scale will be used to give a proxy measure of the general social functioning. Participants are followed-up 12 and 24 months after baseline.

Results

The trial is ongoing and so far 225 participants have been included. Preliminary results of the participants who have been measured at the 12 months follow-up will be presented. Final results are expected 2016

Perspectives

If the Sherpa method is shown to be superior to treatment as usual, a large number of disability pensions could probably be avoided and long-term sickness absences reduced; with major benefits to society and patients. This trial will add to the evidence of how best to support people's return to employment or education after a psychiatric disorder.

The development and evaluation of a smoking cessation intervention for people with schizophrenia

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Background/Objectives

Disproportionate high rates of smoking are a major contributing factor towards the health and social inequalities experienced by people with schizophrenia. Clinical and cost effective interventions to help people stop smoking are embedded within primary care services in the UK, however smoking cessation interventions tailored to meet the biopsychosocial challenges faced by people with schizophrenia who want to stop smoking are underdeveloped within mental health settings.

Methods

A tailored smoking cessation intervention was developed from a synthesis of the literature and influenced by effective interventions for smokers in the general population. The feasibility, acceptability and potential effect of a 'cut down to quit' intervention was evaluated in 30 people with schizophrenia living in South London. Embedded within the feasibility study, an Interpretive Phenomenological Analysis was used to prospectively explore the process of stopping smoking.

Results

Smoking cessation rates at 6 months follow up were comparable to quit rates of general population smokers using local NHS Stop Smoking Services and mental health symptoms remained stable during and after the intervention. The difference between smokers who successfully quit and maintained abstinence for up to 6 months appeared to be influenced by their ability to tolerate nicotine withdrawal symptoms, better adherence to nicotine replacement therapy and people's capacity to renegotiate boundaries of existing relationships. Participants reported many benefits of stopping smoking, including improved physical and mental health, a sense of mastery and control in their lives and a feeling of empowerment.

Discussion/Conclusion

Smoking is integral to the lives of many services users, yet many would prefer to choose a life without cigarettes. A cut down to quit intervention proved feasible and acceptable to a small group of smokers with schizophrenia. Providing opportunities to stop smoking has the potential to have a positive impact on the recovery of people who use mental health services.

Participation in IPS enhances empowerment and engagement in community life among service users, as compared to traditional vocational approaches

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Background/Objectives

Traditional vocational approaches for persons with serious mental health problems concern symptom reduction and involve a caring perspective, where professionals emphasize on the expert role. On the contrary, the Individual Placement and Support (IPS) approach gives prominence to the choice and control of the person. Here the professional encourages the participant to take the leading role according to his or her working goals in the community. Accordingly, we argue that IPS may involve an empowerment process and support community life to a greater extent, as compared to traditional vocational services. This study is aimed at investigating whether there was a difference in self-assessed empowerment and engagement in community life between the group of participants in traditional vocational services and in IPS after six and 18 month. We also studied within group changes.

Methods

The Empowerment Scale (ES) and Profiles of Occupational Engagement Scale (POES) were administered to 120 persons, who were randomised to either traditional vocational services (n=60) or IPS (n=60), at baseline, after six and 18 months. Non-parametric statistics were used.

Results

The persons participating in IPS assessed their empowerment higher as compared to those in traditional services at 18 months ($p=0.047$, $r=0.29$). A close to significant difference was also found with regard to engagement in community life ($p=0.058$), in favor of IPS. Within the group of IPS-participants, a close to significant positive change was found in their empowerment scores between six and 18 months ($p=0.053$), as compared to those participating in traditional services ($p=0.659$). Moreover, the engagement in community life increased among the IPS-participants, especially between the start and six-months ($p=0.003$).

Discussion/Conclusion

This study advocates the importance of providing choice and control for persons with mental health problems participating in vocational services. It also highlights the impact that participating in IPS has on engagement in activities in the community. The findings emphasize on having an empowering role, instead of one that is professionally controlled, when supporting persons with mental health problems in their endeavours to work.

Key elements in community-based programs over different target groups: a systematic literature review

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Background/Objectives

A trend of deinstitutionalisation characterizes different care sectors in Western countries, which has created new approaches in care. This systematic review set out to compare effective multidisciplinary community-based methods in order to define key elements that determine the quality of care.

Methods

Relevant randomised controlled trials (RCT's) were selected from the period of 1997-2012, and were included according to predetermined criteria. Studies had to compare different multidisciplinary outreach services or community care programs with each other or with standard care. If an intervention was found to be effective, the different elements of the program were extracted. An element was considered a key element when present in at least 80% of the different effective programs. For this review, we included articles targeting persons with a mental health disorder, an intellectual disability, or dementia.

Twenty-six RCT's were included. Of these, 19 articles described an effective intervention, accounting for 6 different programs. Effective programs in adults with a severe mental illness comprise (a) Assertive Community Treatment (n=13), (b) community teams (n=2), (c) self-help and community mental health agencies (n=1), and (d) integrated care (n=1). For both adults with an intellectual disability and dementia, only one outreach program was found effective, an outreach program for persons with an intellectual disability (n=1) and a dementia guideline-based program (n=1) respectively.

Results

A total of 30 elements were detected, of which eight are considered key elements: team-based (100%), shared decision making (100%), providing social support (100%), outreaching (83%), unlimited (83%), pharmacological support (83%), and training of social (83%) and practical skills (83%). Furthermore, three other elements are considered important, based on arguments in literature: a low participant-to-staff ratio, 24 hours continual care, and providing support with practical issues.

Discussion/Conclusion

Common key elements include an approach which is team-based, outreaching, unlimited, has a low participant-to-staff ratio, includes training of practical and social skills, is 24h a day accessible, and provides support with social environment, medication, and other practical issues. In the next step of this research, the presence of these key elements will be evaluated in current practices in the different sectors in community care in Flanders.

Mental health first aid in Sweden: a randomized controlled trial

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Background/Objectives

Mental health literacy in the general population is limited. Lack of knowledge about mental health problems lead to insecurity in contacts with and to stigmatizing attitudes and discrimination of people with mental illness. Mental health first aid is an educational program for public use, developed and tested in Australia. Earlier studies have shown that participants improve their ability to recognize a mental disorder, change beliefs about treatment in a positive direction, decrease their social distance and increase confidence in providing help to someone with a mental illness.

Methods

The trial was carried out in two different regions of Sweden. An RCT was performed in one of the regions and a quasi experimental study in the other. Baseline data and six month follow-up data was collected. Six focus group interviews were performed at six-month follow-up.

Results

The RCT included 135 participants in the experimental group and 142 in the control group, the quasi experimental study 465 participants. Results showed a positive change for those who participated in the course with regard to: confidence in helping a person with a mental health disorder, how to behave and act in contact with such a person, social distance to persons with mental health disorders. There was also a tendency to an increase of the amount of help provided to others. Focus group interviews showed a high satisfaction with the course and that it provided useful hands-on knowledge.

Discussion/Conclusion

The results from this first RCT performed outside Australia were in line with earlier studies. The participants in the present study mainly came from public service agencies already serving people with mental illness, and the majority were middle-aged women with higher education. It could be presumed that participants before the course already had more knowledge about mental health problems than the population in general, which might have decreased the differences between the experiment and control group in the RCT.

A Randomised Controlled Trial of Individual Placement and Support (IPS) on People with Severe Mental Health Problems in Nottingham: An Implementation Approach

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Background/Objectives

The aim of the current study was to increase employment and related vocational outcomes (education and voluntary work) for people with severe mental health problems in Nottinghamshire. An employment support approach called individual placement and support (IPS) was used in addition to work-focussed psychological support. Key to IPS was the integration of employment support workers within mental health services.

Methods

A randomised controlled trial comparing two interventions: IPS alone with IPS + Work-focussed psychological support. Primary outcome: number of job starts and vocational related activities achieved. Secondary outcome: changes in self-esteem, stigma, fear of negative evaluation (FNE), physical and mental health, number of GP visits and use of mental health services over 18 months. In addition to this 30 participant qualitative interviews were carried out to investigate the experience of using IPS.

Results

Seventy four individuals were randomised. Preliminary analyses have shown that 24 individuals found paid work, 12 were in voluntary work and 8 were studying for a long-term professional qualification. Initial results indicate mean number of GP visits, mental health related outpatient visits and care coordinator visits have dropped between baseline, 3 and 6 months. Key themes emerging from the qualitative interviews include: Participants report IPS has encouraged them to apply for paid jobs and vocational related activities they would not otherwise pursue. Participants report employment specialists understand their needs, act as a confidant and a strong source of support.

Discussion/Conclusion

One year follow-up results will be reported. Preliminary (6 month) findings are that 60% of the sample had achieved a vocational outcome. It is expected that differences between baseline, 6 month and 12 months in scores for self-esteem, stigma, FNE, physical and mental health will be found.

Cost-effectiveness of psychotherapy for the treatment of depression in the UK compared to pharmacotherapy and combination treatment

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Background/Objectives

Individual psychotherapy is an effective treatment for major depressive disorder that is increasingly used in the UK. However, its economic value compared to pharmacotherapy, both singly and in combination has not been investigated to date. This study aims to update, augment and refine a previous economic evaluation which informs clinical guidelines for the treatment of moderate to severe depression.

Methods

We developed a decision analytic model comparing the three alternative treatments over a 15-month horizon. Benefits were quantified using quality adjusted-life years (QALYs) and costs were assessed from a health care sector perspective. We conducted a systematic review of the literature and combined evidence from randomized clinical trials in a meta-analysis. Parameter uncertainty was represented by probabilistic sensitivity analysis, whereas structural uncertainty of the model was assessed using deterministic sensitivity analyses.

Results

Preliminary results of the model suggest that, on average, psychotherapy is more effective than pharmacotherapy but these additional benefits may not outweigh its costs compared to treatment using antidepressants alone. The analysis of the comparative cost-effectiveness of combination therapy in depression is ongoing.

Discussion/Conclusion

Based on current evidence, treatment of depression with individual therapy alone should be considered carefully in light of long waiting lists for psychological therapies and the limits in budget for mental health treatment. This finding is particularly relevant in context of the Improving Access to Psychological Therapies (IAPT) initiative to expand the access to psychotherapy in the UK.

Caregivers role in social inclusion and recovery of people with mental disorders living in residential services: The experience in Sao Paulo city, Brazil

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Background/Objectives

Carers in residential services have been considered the main actor for social inclusion and recovery of people deinstitutionalized from psychiatric hospitals according to the Brazilian Ministry of Health guidance. However, the main principles for the role of these carers were not specified nor standardized in residential services. The aim of this study was to explore how the carers were involved in the promotion of recovery and social inclusion of such people in daily routine in eight residential services in Sao Paulo city.

Methods

This qualitative study was conducted through ethnographic approach and open interviews with 19 carers between 2011 and 2012. We developed a structured scheduled script covering the following areas: role in daily activities and self-care, money, transport and food management, work and social activities, health appointments, promotion of resident empowerment and stigma coping.

Results

We observed a great commitment and affection of carers with residents as a whole. All of them were lay people with no previous professional experience with health care. There was a lack of some essential components for their effective practices: a) they didn't receive any training for understanding mental illness and for coping with difficult situations (such as aggressive behavior), b) they didn't have any idea about the strategies and possibilities for recovery and social inclusion, especially for those people with severe symptoms, c) their actions were based on beliefs and background and they used to improvise solutions as problems emerged, d) their affective behaviors with residents were similar to those they established in their family relationships, announcing lack of professional approach, e) they established rigid rules for daily activities similar to those in hospital institutions, restricting residents spontaneity and freedom, f) although residents went sporadically to rehabilitation centers, carers didn't receive any guidance to how to cope with residents' needs from teams' rehabilitation teams.

Discussion/Conclusion

Altruism, commitment and dedication were positive characteristics of residents' carers in this study. However, carers should be trained on the main strategies for achieving recovery and social inclusion of residents and should be integrated with other specialized professionals involved in psychosocial rehabilitation as well.

Predictors of personal recovery in people with severe mental illness receiving supported housing services

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Background/Objectives

People with severe mental illnesses (SMI) often have a small social network, a lack of resources and a limited number of social roles. Nowadays mental health care organizations provide care that aims not only the remission of symptoms but also supports personal recovery. Personal recovery can be defined as a 'deeply personal, unique process of changing one's attitudes, values, feelings, goals and roles; a way of living a satisfying, hopeful and contributing life even with the limitations caused by an illness'. Recovery is often related to hope and optimism, empowerment, participation and self-esteem. However research on which factors can be related to recovery is still limited.

This study aims to investigate whether personal recovery can be predicted by societal participation, hope, quality of life, empowerment and fulfilment of needs in clients with long-term severe mental illness receiving supported housing services. Furthermore differences between these clients according to their demographics and received care will be investigated.

Methods

This study is part of a currently running Randomized Controlled Trial (RCT) on the Comprehensive Approach to Rehabilitation (CARE) method carried out in Three Regional Institutes for Residential Care in the Netherlands. 280 clients with long-term severe mental illness participate in this study. Outcome measures are (a) personal recovery, (b) rehabilitation and societal participation, (c) empowerment, (d) fulfilment of needs for care, and (e) quality of life. Besides that, knowledge of recovery of care providers and the quality of care will be measured.

Results

The results of the baseline measure will be presented. Regression analysis will be performed to analyze the relations between the different outcome measures and participant characteristics.

Discussion/Conclusion

In this presentation we will illuminate whether and how the personal recovery of the participants is related to societal participation, hope, quality of life, empowerment, care use and fulfilment of needs. The implications of our study findings for mental health care practice will be discussed.

Improving public attitudes toward depression and help-seeking in four European countries: results of the OSPI-Europe intervention

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Background/Objectives

Stigmatizing attitudes toward depression and toward help-seeking are important barriers for people with mental health problems to obtain adequate professional help. In the context of a large European multilevel research project (OSPI-Europe) a public media campaign about depression and its treatment was conducted in four regions in Europe. The aim of the campaign was to raise awareness about depression and to enhance the willingness and the perceived helpfulness of people to search for professional help.

Methods

The awareness campaign was rolled-out in Leipzig (Germany), Limerick (Ireland), Miskolc (Hungary), and Amadora (Portugal) and lasted for 18 months. In each country a comparable control region was selected. Before and after the intervention a large scale population survey was conducted in each region assessing attitudes toward depression and toward help-seeking.

Results

At baseline respondents showed a moderate degree of personal stigma toward depression and a strikingly higher degree of perceived stigma. Although a substantial majority showed openness to seek professional help, only half of the people perceived professional help as valuable. More negative attitudes were found in Hungary and were associated with male gender, older age, lower educational level and living alone.

After the campaign, the respondents reported improved mental health and a more positive attitude toward depression. Also, attitudes toward help-seeking were more positive, though this effect emerged in both the intervention and the control region. The intention to seek help remained unchanged. Finally, the campaign had strong effects in Germany but yielded only minor changes in Hungary and Portugal.

Discussion/Conclusion

The OSPI public campaign was able to change stigmatizing attitudes toward depression and had a positive effect on mental health. Effects on attitudes toward and intention to seek help were less convincing. In future research, one should (1) be attentive to spill-over effects of external events and (2) keep an eye on the intensity of the public campaign. The content of each campaign is best tailored to the cultural norms of the country in which it will be launched as well as to the attitudes and beliefs of specific population groups for which it is intended.

A comparison of a traditional acute inpatient admission system and a novel triage admission system

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Background

There has been a steady reduction in the number of hospital beds for people suffering from mental health problems. With this reduction there is an imperative to keep admissions as short as possible. In England, efforts to shorten admission have included the introduction of 'triage' wards to which all patients requiring hospital treatment are initially admitted. These wards are run by senior and experienced staff and strive to keep hospitalisation to around 7 days. Reports of these services have been encouraging, but seldom encompass the entire in-patient journey (ie. including patients who are transferred to other wards after the 7 day period).

Objectives

To compare the effects of a triage system to standard care on total lengths of stay, readmission rates and patient satisfaction.

Methods

The sample comprises all consecutive hospital admissions to the inpatient areas of two Borough based mental health services, both operated by one mental health Trust but only one of which provides a triage model of care. Data was collected on patient and staffing characteristics and on the total length of stay in hospital and readmission rates.

Results

Similar numbers of patients were admitted in each system (Triage 935; comparison 899) and the patient populations were similar in terms of diagnosis (60% had a diagnosis of schizophrenia spectrum or bipolar disorder), the numbers detained involuntarily (Triage 401[43%]; comparison 364 [39%]), number and length of previous hospitalisations. Although admissions to the triage ward were short, many of these patients were transferred to other wards in the system so that the average total length of stay in hospital did not differ significantly between triage and non-triage systems. Significant predictors of length of stay were whether the patient was compulsorily detained and their housing status on admission.

Discussion

The triage system is championed in terms of reduced inpatient costs, but has not demonstrated a clear advantage in terms of length of stay in this evaluation. For those patients who can respond to a short admission, it may be more acceptable than an admission to wards in which there are also severely disabled patients who have had very lengthy stays in hospital.

Effect on empowerment of “Recognition of acquired competences” for vulnerable volunteers: a randomised controlled trial

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Background/Objectives

Recognition of Acquired Competencies for volunteers (RAC), is an intervention tool designed for people with a ‘large distance’ to the labour market because of serious mental health problems and/or psychological vulnerabilities. RAC is a strengths-based self-help approach that aims for enforcing self-esteem and empowerment in people in these groups. To realise this, RAC facilitates those persons to determine and describe their skills and talents in a personal, certified port-folio. Rehabilitation professionals offer support, while participants have the lead. Although first implementation projects were welcomed with enthusiasm, little is known about the effectiveness of this rehabilitation approach.

Methods

A mixed methods pragmatic randomised controlled trial (RCT) was designed to study effectiveness of RAC in real-world practice. After baseline measurements using validated, standardised self-report questionnaires, participants were randomised to either guidance as usual (GAU) or GAU plus RAC-support. Follow-up assessments were conducted at 6 and 12 months. Primary outcome was assessed using three indicators: feelings of empowerment, mental health confidence and hope. A qualitative study was designed parallel to the quantitative part, to explore in-depth how RAC potentially results in positive outcomes as experienced by consumers and observed by professionals.

Results

257 clients (126 RAC; 131 GAU) were recruited in 26 institutes (a mix of psychiatric rehabilitation agencies and agencies offering community support). At T6 a positive significant effect was found on mental health confidence and insight in competences (secondary outcome) in RAC-participants. At 12 months no significant effects were detected. (follow-up rate: 76%).

For the qualitative study-part semi-structured interviews were conducted with 21 participants and 12 professionals. Findings ‘confirm’ that participating in RAC enhances awareness of one’s personal strengths, and increases self-confidence, in particular in taking part in occupational activities. Repeatedly receiving positive feedback from others and actively working on a personalised portfolio seem key elements that explain experienced effectiveness.

Discussion/Conclusion

This study indicates that RAC effectively helps helping people with vulnerabilities gain a more positive self-image. Discussed is whether RAC could support people in realising more tangible occupational outcomes, e.g. finding employment. Discussed are implementation and other implications for a recovery oriented (community) mental health practice.

Evaluation of follow-on support for people being discharged from recovery houses: Recovery Star and Personal Goal Scoring

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Background/Objectives

Recovery houses provide people experiencing a variety of mental illness diagnoses with short term (average approximately 5 days) residential accommodation following referral from the community or step down from a psychiatric ward. Discharge from a recovery house can be a difficult and vulnerable time. To assist in this transition the Stone Foundation provides funding for 12 weeks of follow-on support for people leaving four of Rethink Mental Illness recovery houses. The support seeks to build people's resilience and facilitate recovery. The follow-on support is able to complement NHS teams' focus on medication and clinical treatment through offering more social and practical support.

Methods

To engage with people to facilitate effective support two tools are employed: Recovery Star and Personal Goal Scoring. Using the Recovery Star the staff member and person together score, on a one to ten scale, general life and recovery focused domains in ten areas including: self-care, living skills, social networks and relationships. Personal goals are identified and rated on a one and ten to scale to indicate how close a person is to achieving the goal. These two measures are scored at baseline (entry to the service) and follow-up (exit from the service).

Results

For the 104 people with baseline and follow-up data all areas of the Recovery Star showed an improvement from entry to exit. The largest areas of improvement were: 'Social networks' (1.14), 'Living skills' (1.10) and 'Managing mental health' (1.07). For the 28 people with at least one matching goal at both time points, there was an average of a 1.53 (out of ten) point increase. At entry to the outreach service, 10% of people (n=3) had either completed or were close to completing their goals (scoring 8, 9 or 10). On exit from the outreach support, 43% of people (n=12) had either completed or were close to completing their goals.

Discussion/Conclusion

The follow-on service has facilitated improvements on both the Recovery Star and Personal Goal Scoring tools which indicates the value of one to one social and practical support in the period following discharge from a recovery house.

Football metaphor, gender and mental health: An Evaluation of the It's a Goal! Programme

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Background/Objectives

Previous research suggests that men often do not access psychotherapeutic services and that masculinities influence and complicate the experience of mental health problems and help-seeking behaviour. Indeed these factors are seen to contribute to a high male suicide rate. In this context, the idea of using football to aid engagement in mental health programmes has recently gained ground. This is because football is seen as a language that men understand and relate to. The It's a Goal! programme utilises football metaphor and football venues as a means to frame and deliver a psycho-social, non-clinical, group-based therapeutic intervention. It specifically targets men with mental health needs who are often seen as 'hard to engage'. A pilot in the North West of England was hosted by seven professional football clubs in partnership with local Primary Care Trusts. We evaluated the impact of the intervention and explored the value and key components of the approach, from the perspective of participants.

Methods

We analysed the impact of the programme through before and after well-being scores measured on a modified version of the Warwick-Edinburgh Mental Well-being Scale. Focus groups with participants and facilitators provided additional qualitative data which was analysed thematically.

Results

Findings suggest that the It's a Goal! programme had a significant impact upon participants well-being. In addition, participants report a range of positive benefits especially in relation to confidence, self-esteem and developing better coping mechanisms. Participants related these benefits to a number of key components, not least the therapeutic value of football metaphor, the focus on goal-setting and, mutual support.

Discussion/Conclusion

Using football metaphor to deliver a group therapeutic programme aimed at men appears to be an effective means of facilitating mental health benefits. Moreover, the non-clinical approach was highly valued by participants. The football framing was a unique aspect of the programme, providing a fruitful area of further research, and an approach which has potential wider application to different services areas.

Lifestyle interventions for enhancing mental health

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Background/Objectives

Lifestyle interventions are interesting alternatives for many health problems, and our research group has developed activity-based interventions to enhance mental health. Theoretically, this type of intervention is based in occupational science and occupational therapy. A basic assumption is that meaningful everyday activities, as well as a balance between different types of activities, are essential for people's well-being. Another source of inspiration comes from research on recovery from mental illness.

Methods

A two-step procedure has been used in developing these interventions; the first being descriptive studies to explore everyday life in the target group and identify main problems and needs. The second step has been to devise and evaluate the intervention.

Our first lifestyle intervention – Redesigning Daily Occupations (ReDO) – was for people with stress-related disorders and was evaluated in a matched-control study of women on sick-leave for depression or adjustment disorder.

In an on-going project, with a cluster RCT design, we are evaluating an activity-based lifestyle intervention for people with severe mental illness – Everyday Life in Balance (E-LiB).

Results

The result from the ReDO study showed that the women in the intervention group were more often working at a one-year follow-up and were on sick-leave to a lesser extent than a matched comparison group. Also secondary outcomes, in terms of quality of life and self-mastery, showed positive trends. In contrast to expectations, however, changes in perceptions of everyday activities did not differ between the groups.

The presentation will include a description of the E-LiB intervention. It is a 12-week, group-based programme with standardized exercises, and homework is performed between sessions. The RCT study evaluating E-LiB and the current status of the project will be described.

Discussion/Conclusion

The pattern of results from the ReDO study will be problematized and the potentials of both interventions, but particularly the E-LiB, will be discussed in relation to recovery from mental illness.

The Recovery-Orientation of Community-Based Structured Housing: Resident and Housing Provider Perspectives

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Background/Objectives

Over the past decade recovery has become a key concept influencing mental health policy, systems and services around the world. Housing is a fundamental right and a key element of mental health recovery. There is little research about the recovery-orientation of services provided in community structured housing for individuals with serious mental illness (SMI). This study explored resident and housing provider (proprietor) perspectives of the recovery orientation of services provided in these homes.

Methods

In all 188 residents living in 112 homes and 96 housing providers were randomly selected and completed the Recovery Assessment Questionnaire (RSA). The RSA is a 32 item questionnaire designed to evaluate the consumer and service provider perceptions of the recovery orientation of services.

Results

Residents perceive a greater need for improvement in the recovery orientation of services provided in their homes than their housing providers. Residents' mean scores are significantly lower than the mean scores for housing providers. The mean global score reported by the residents is almost 14% lower than the mean global score reported by the housing providers. Findings indicate that residents and proprietors agree that there needs to be a greater focus on the core elements of recovery. These elements involve allowing the resident to take charge of his or her life and treatment, and recognizing the individual as a valued member of society.

Discussion/Conclusion

There has been little international research to date exploring the recovery practices provided to residents in community structured housing. This is the first known study to evaluate the recovery-orientation of services provided in community structured housing. The overall finding that residents convey a greater need for improvement in the recovery orientation in their homes suggests that the recovery needs of persons with SMI have been overlooked. These findings are important since residents have unmet recovery needs and housing providers lack training in providing recovery oriented services. It is incorrect to assume that residents do not report an accurate description of the recovery orientation of services provided in their homes. Residents probably have the most realistic view of which services in their housing need improvement.

The length and breadth of community-based mental health services across 29 European countries (EuroPoPP-MH project - European Profile of Prevention and Promotion and Mental Health Systems)

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Background

Implementing and advancing the development of community-based mental health services across European Member States has been the subject of attention at EU policy level for some time. Access to mental health services for people with long-term mental health conditions is considered better with community-based services; which can better protect the human rights of people with mental illness, produce better outcomes (for example in adherence to treatment, and quality of life), and more cost effective compared to traditional psychiatric hospitals (Caldas de Almedia & Killaspy, 2011). Recent debates have also considered an appropriate balance between hospital and community-based services; and long-stay psychiatric hospitals do not feature in the proposed models for low, middle and high income countries (Thornicroft & Tansella, 2013; 2004).

Aims

In a project profiling mental health systems across 29 European countries, including all 27 Member States, up-to-date information was gathered on both hospital and community-based mental health services. As part of its aims the EuroPoPP-MH project produced 29 country profiles providing an overview mental health services in each country.

Methods

Using a multi-method approach we:

- a) conducted a review of the literature using many techniques of a systematic review
- b) used a structured template to collect, via 25 country collaborators, information/data from secondary sources on 29 countries, including all 27 Member States, Croatia and Norway
- c) searched EU and WHO databases for European statistics on mental health indicators

Results/Conclusions: The project is described, including the challenges of collecting cross-national/comparable data and the analysis of country profiles presented where possible.

Project funders

The Executive Agency for Health and Consumers (a related agency of the European Commission)

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Exploring collaborative psychiatric medication management in the UK. Presentation of findings from a Ph.D Study

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Background/Objectives

This Ph.D study has explored how mental health service users are involved in decisions about their psychiatric medication. Often people who are prescribed psychiatric medication do not take it systematically and do not share this information with their doctor. Furthermore, even those who do take medication sometimes complain of serious side effects that prevent them from leading an ordinary life and of difficulties in communicating their experience to their doctor. This highlights difficulties in sharing knowledge, both scientific and experiential, in a way that is constructive for all. This Ph.D contributes to our knowledge about views and experiences of collaboration in the decision making process for psychiatric medication.

Methods

The study took place in a community mental health service in the UK. A participatory methodology was employed. Service users and a carer were involved in all phases of the research process. 30 qualitative interviews were undertaken with different stakeholder groups: Psychiatrist's, CPNs and service users. Thematic analysis was employed. In addition, four outpatient medication related meetings were recorded. An applied conversation analysis was undertaken.

Results

There were similarities and differences in emergent themes from research interviews across the stakeholder groups. Enablers and barriers to shared decision making were found at three levels of analysis: the interaction, the relationship and the system level. Even though the recorded meetings were undertaken with the same psychiatrist, a wide spectrum of power claiming strategies were found by service users, from a very paternalistic passive stance through to highly assertive strategies being employed. Another striking finding from this data was that hidden forms of power acted as a key obstacle to a fully shared and informed decision making process.

Discussion/Conclusion

Psychiatric medication management is a dynamic process over time and is part of the recovery journey. The findings shed light on the interplay between structure and agency in shared decision making in psychiatric medication management and highlights how power is enacted in the context of shared decisions in a community setting. The important buffering role of a strong therapeutic relationship, where trust is formed, knowing the service user and 'walking the journey together' is at the fore.

QTc-Interval prolongation in psychiatric inpatients: the role of psychotropic drugs

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Background/Objectives

Sudden unexplained death in psychiatric patient may be due to drug induced arrhythmia, of which lengthening of the rate-corrected QT interval (QTc) on the electrocardiogram is a predictive marker. This study aims to estimate the prevalence of QTc lengthening in a large and representative population of psychiatric inpatients exposed to psychotropic drugs.

Methods

In a consecutive sample of psychiatric patients who were admitted to hospital during a period of three years the occurrence of QTc lengthening was calculated. QTc interval was defined as abnormally lengthened if greater than 450 milliseconds. Factors associated with QTc-interval prolongation, including exposure to antipsychotics, antidepressants, polypharmacy and excessive dosing, were analyzed by means of logistic regression analysis.

Results

A total sample of 700 consecutive inpatients were included so far. A preliminary analysis yielded an overall prevalence of QTc prolongation of 9%. Exposure to antipsychotics, antidepressants, polypharmacy and excessive dosing were risk factors for QTc-interval prolongation.

Discussion/Conclusion

Our results confirm that psychotropic drugs confer a risk of prolonged QTc interval in a dose-dependent manner and related not only to the drug category but also to characteristics of the drug used. A link between QTc prolongation and psychotropic drugs suggests that routine monitoring is needed in patients continuously exposed to these medicines, particularly if other risk factors are present.

Epidemiology of clinical trials published in the last 30 years: the case of antidepressants

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Background/Objectives

Recently, some literature reviews have demonstrated that trial design factors - such as patient population, methods, sponsorship and reporting of results - may influence randomized controlled trials (RCTs) results. In psychiatry, there are examples of studies examining the role of these factors for antipsychotic drugs in schizophrenia, but evidence on antidepressants is scant. This work aims to describe the epidemiology of RCTs on antidepressive agents conducted in the last 30 years with respect to methodology and content features, and to investigate the influence of these characteristics on trials results.

Methods

We extracted data from all RCTs included in two ongoing Cochrane systematic reviews comparing paroxetine or fluoxetine with all other antidepressant agents in the acute-phase treatment of unipolar major depression. The following information was collected using an electronic spreadsheet: year and country of publication, length of treatment, diagnosis, age, setting, average dose of drug, number of patients randomized, efficacy and acceptability data and methodological quality according to the Cochrane risk of bias tool. Finally, we recorded whether fluoxetine or paroxetine was the experimental or reference drug according to the authors' stated aims of the study. Using meta-regression techniques, we investigated whether these trial-level factors acted as moderators of treatment effect.

Results

We included a total of 280 published and unpublished RCTs from 1984 to 2012 (more than 45,000 participants). A meta-regression analysis indicated that, after adjusting for possible confounders, studies where fluoxetine or paroxetine were the experimental agent were positively associated with treatment effect.

Discussion/Conclusion

The evidence that the outcome of fluoxetine and paroxetine trials varied according to whether this drug was used as a new compound or a reference one suggests the presence of investigator or "wish" bias.

The economic impact of antipsychotics polypharmacy on the health care costs of deinstitutionalized people with psychotic disorders in São Paulo city, Brazil

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Background/Objectives

Best practices in patterns of antipsychotic prescription are supposed to be based on scientific evidence-based, on cost-effectiveness, on lowering adverse effects and on feasibility for health care budget. Contrary to such principles, antipsychotic polypharmacy prescriptions –APP (combination of two or more antipsychotics) has been widely used for the treatment of psychotic disorders, up to 50 % in some settings. The aims of this study were to estimate the costs of APP and its impact on direct costs of health care package in a sample of deinstitutionalized people with psychotic disorders in São Paulo city.

Methods

We used a bottom-up approach for the estimation of direct costs according to public health service provider perspective, Direct costs included costs with inpatient, outpatient and emergency health services and treatment received in the previous month, in 147 subjects with mental disorders living in twenty residential services during the year 2011. We evaluated residents profile (quality of life, social behaviour problems, psychiatric diagnosis, severity of symptoms, sociodemographics characteristics) and pattern of health service use. Linear regression analysis was employed to verify the effect of APP on direct health care costs.

Results

APP was found in 38% of the sample, and among them, the number of antipsychotics varied from 2 to 5 per person. Other associations with antipsychotics were also common: 43% with biperiden, 28% with prometazin and 39.2% with benzodiazepine. Atypical antipsychotics monotherapy costs were 167.4 times higher than typical antipsychotic monotherapy costs. APP monthly mean costs per person varied with the type of association between antipsychotics: typical-atypical associations costs were U\$257.5± U\$228.5, while mean costs between two typical antipsychotics were U\$4.36 ± U\$4.02. APP added U\$200.00 per person per month to direct costs of health care while olanzapine added U\$513.00 per person per month. Both explained 25.5% of the variance of health care costs and they were not associated with better quality of life or with severe psychiatric symptoms.

Discussion/Conclusion

APP, especially with atypical antipsychotic added substantial costs to health care and was not associated with better quality of life. This could be taken into account in resource allocation in public policies, especially in low-resources settings.

Cost-effectiveness of a community pharmacist intervention in patients with depression: a randomized controlled trial (PRODEFAR study)

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Background/Objectives

Depression generates a high burden and costs for patients and society. Non-adherence to antidepressants is common, preventing depressed patients to fully benefit from treatment. Pharmacist's interventions improve adherence to antidepressants but further evidence is needed about the cost-effectiveness of such interventions. The study aimed to evaluate the cost-effectiveness of a community pharmacist intervention in comparison with usual care in depressed patients initiating treatment with antidepressants in primary care.

Methods

The economic evaluation was conducted alongside a randomized controlled trial with 6 months follow-up. Patients were recruited by general practitioners and randomized to community pharmacist intervention (educational intervention) and usual care. Adherence to antidepressants, clinical symptoms, Quality-Adjusted Life-Years (QALYs), use of healthcare services and productivity losses were measured at baseline, 3 and 6 months.

Results

A total of 179 patients were randomized to usual care (92) and pharmacist intervention (87). There were no significant differences between groups in costs or effects although overall costs were higher in the intervention group than in usual care patients. From a societal perspective, the incremental cost-effectiveness ratio (ICER) for the community pharmacist intervention compared with usual care was €1,866 for extra adherent patient and €9,872 per extra QALY. In terms of remission of depressive symptoms, the usual care dominated the community pharmacist intervention. If willingness to pay (WTP) is €30,000 per extra adherent patient, remission of symptoms or QALYs, the probability of the community pharmacist intervention being cost-effective was 0.71, 0.46 and 0.75, respectively (societal perspective). From a healthcare perspective, the probability of the community pharmacist intervention being cost-effective in terms of adherence, QALYs and remission was of 0.71, 0.76 and 0.46, respectively, if WTP is €30,000.

Discussion/Conclusion

A low intensity community pharmacist intervention addressed to depressed patients initiating antidepressant treatment showed a probability of being cost-effective of 0.71 and 0.75 in terms of improvement of adherence and QALYs, respectively, when compared to usual care. Regular implementation of the community pharmacist intervention is not recommended.

Exploring the efficacy effectiveness gap

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Background/Objectives

There is broad consensus, that there is a gap between the “efficacy” of a drug, proven in a randomised controlled trial, and the “effectiveness” of this drug in everyday clinical practice. This consensus is based on anecdotal and observations, and has not been evaluated systematically. This study will systematically review and compare evidence from RCTs and nonrandomized and uncontrolled trials examining the effectiveness of venlafaxine and duloxetine in the treatment of depression.

Methods

This systematic review used pre-post effect sizes to compare treatment effects from RCTs and non-RCTs examining the effects of duloxetine, venlafaxine and placebo in the treatment of depression. Data was aggregated in random effects models and meta-regressions were used to explore factors influencing the effect sizes.

Results

Effect sizes for 114 acute phase studies were calculated, all interventions, including placebo, showed a statistical significant pre-post effect of more than two standard deviations. However, there were no significant differences of effect sizes from RCTs and non-RCTs.

Discussion/Conclusion

The analyses could not confirm the presence of an efficacy-effectiveness-gap. It is unclear if the impression of such a gap is due to a publication bias or if treatment outcomes are better independently from trial design.

DRAFT

Association between neighborhood material and social deprivation and exposition to antidepressants in depression

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Background/Objectives

Drug treatment is indicated for many people suffering from depression. There are concerns that inequities could exist in terms of access to this treatment.

Methods

Among individuals suffering from depression, to assess the association between material and social deprivation and exposure to an antidepressant drug (AD).

Results

Out of 100,485 individuals included, 65,479 (65%) were exposed to an AD in the year following diagnosis. Compared to individuals who are the less deprived materially, the most deprived had a 5% higher probability to be exposed (PR=1.05, IC=1.03–1.05). On the other hand, in terms of social deprivation, compared to individuals in the less deprived group, those in the most deprived one had a 4% lower probability to be exposed (PR=0.96, IC=0.94–0.97).

Discussion/Conclusion

Results suggest that among individuals enrolled in the Quebec public drug plan, material deprivation is not a limit to AD access.

Antidepressant prescribing in Primary and Mental Health Care: is it possible to address appropriateness and keep a curb on costs?

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Background/Objectives

Antidepressant prescriptions have considerably increased all over the world in the last decade. The increasing use of the most expensive agents plays a part in the rising cost of treatments. The Local Health Authority (LHA) of Bologna has implemented an audit process aimed at improving the appropriateness of outpatient prescriptions focusing on the two branded antidepressants. Escitalopram and Duloxetine.

Methods

The Primary Care and the Mental Health Care Departments, as well as the Pharmaceutical Department and the Clinical Governance Unit, were involved in the planning phase of the audit. The audit group, mainly composed of general practitioners (GPs) and psychiatrists, collected and analyzed scientific evidence on effectiveness and safety of antidepressants. Data on prescriptions were extracted from the Outpatient Pharmaceutical Database. Primary Care Units (PCU, n=41) and Community Mental Health Centers (CMHC, n=11) of the LHA (866.294 inhabitants) were compared on consumption rates of Escitalopram and Duloxetine. The audit group defined the standards to be addressed, the indicators to be evaluated and the actions aimed at reaching the defined goals. NICE guidelines on depression were chosen as reference.

Results

The pre-audit retrospective report (January-April 2012) showed that outpatient antidepressant treatments were mainly prescribed by GPs (95%). Escitalopram and Duloxetine represented 22% of prescriptions and 45% of the whole expenditure for antidepressant drugs in outpatient practice. The mean consumption rate, as measured by DDD/1000inhabitants/day, was 7.6 for Escitalopram and 2.8 for Duloxetine. A marked distribution variability across PCUs and CMHCs was displayed. Audit actions were implemented between October 2012 and May 2013. The feedback report is expected in September 2013.

Discussion/Conclusion

Some relevant actions have been integrated with the audit review, such as small-scale educational meetings with GPs and psychiatrists, outreach visits of the LHA prescribing adviser to GPs and CMHCs, leaflets for professionals with information extracted from NICE clinical guidelines, implementation of a web consultation service for GPs about evidence on antidepressants. The first upshot of this process has consisted in further integration between Primary and Mental Health Care, thus enabling the LHA to put the change into practice.

Service User Research Panel – “they pay me because of what I know from being a patient!”

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Background/Objectives

Background: The concept of patient-centeredness is being increasingly incorporated into the psychiatric and social psychiatric services. User Research Panel is an effort to develop user-oriented principles in research.

Objectives: To utilize the experiences and views of service users in the whole research process.

Methods

20 persons with own experience of psychiatric illness or experiences as a relatives were invited to a 40 hour course in basic theory of science, research methodology and ethics. The curriculum was inspired from SURE, London. The members of the panel are paid for their work with a salary of 1.4 Euro per hour, and they have monthly meetings which also are paid for. Panel members were asked to describe their personal reasons for participating in a focus group discussion.

Results

After three years 12 persons remain in the panel. Further education has been offered at a regular basis to develop their skills in qualitative and quantitative methods. The panel has contributed by designing interview questions for the evolution of training programs for staff members, recruited informants and performed interviews. They have applied for research grants (unsuccessfully) and have been consulted by several researchers in their planning of projects. The panel has carried out user led audits of supported housing facilities. The members of the panel are paid for their contributions (15 Euro per hour), and they have monthly meetings. Several and various reasons for participating were mentioned as important. For some taking part in the meetings was the main reason, for others contributing to body of knowledge was prioritized.

Discussion/Conclusion

Service user research panels probably are valuable resources for social psychiatric research in all stages in the research process. Panel can also be useful for the development of quality of services. There are challenges for the future; the financing of the activities of the panel means difficulties, and it is also important to find the adequate level of requirement of tasks to match the different qualifications and aspirations of the members of the panel.

“What would you do in my shoes?” Information exchange among patient and psychiatrist in early psychosis.

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Background/Objectives

Addressing appropriately patients' informative needs is a core competency in psychiatry. Previous studies suggest that patients at early psychosis onset seek information about their disease, treatment and prognosis. The aim of this study is to explore information exchange among patient and psychiatrist, focusing in particular on patients' questions and clinician responses.

Methods

This study is part of a larger RCT (Get-up) and involved 61 Mental Health Public Services in Northern Italy. A convenience sample of 70 patients at early psychosis onset have been selected. For each patient, one of the first consultation with the referring psychiatrist, was audio-taped and transcribed. A qualitative content analysis was performed on the text and a coding system derived in order to encode the type of questions asked by patients and answers given by psychiatrists.

Results

Patients (43 male), mean age of 29 (range 12-54), asked in each consultation on average 6 questions (range 0-29, s.d 6.2), mainly about treatment (43%), administrative procedures (32%), diagnosis (15%). Less frequently questions deserved coping strategies (4%), etiology (3%) and prognosis (3%). Most of the informative needs regarding treatment, referred to posology, duration of treatment and side effects (i.e. “I'm afraid of the drug ... can side effects cause serious problems?”). Generally, psychiatrists' answers are consistent with what was asked by the patient, with the exception of challenging emotional or existential questions. In these cases doctors tend to ignore the implicit concern, offering answers too articulated and poorly straightforward. For instance, when patient asked: “In my shoes what would you do?”, the psychiatrist responded: “is a question a bit 'difficult, but I would try to trust, how you are doing at the moment, is a difficult question because I am a bit' influenced to my work almost all of us doctors are hypochondriacs, that we try to exaggerate the symptoms ... that on the one hand can be an advantage but sometimes is a weakness”.

Discussion/Conclusion

Therapeutic alliance is fostered by doctors ability to facilitate patient's questions and provide consistent information.

The family and the therapist in patient's eyes

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The first crisis takes everybody by surprise. The world of psychosis, depression and mania is inaccessible, incomprehensible for the family. The ill person withdraws into their own world, full of symbolic meanings, intelligible only to them. Psychosis has its own logic. And the family needs an interpreter, who can not only explain what is going on with their relative, but also suggest how to behave and help. The family does not accept the change, they do not want to understand and prefer to follow the known, beaten track. Maybe they are afraid of the burden of guilt. It takes a lot of work to make them realize that it is not about finding the guilty but about assistance and cooperation. The family is helpless, because encouraging, persuading and explaining does not work. The illness is stronger. Psychiatry was like adult life with a safety net and the psychiatric community took over the role of the family. The world of psychiatry was unknown to the parents. They were glad, though, that we have company. When eventually we find a therapist we can trust, then begins laborious establishing of therapeutic relationship, our joint work. The therapist becomes an interpreter of our feelings. Over time we may even become dependent on our therapist. The therapist comes to be an important person, who knows more about us than we do and our family does. Trust in the therapist develops slowly. The feeling of liking is important, as it is easier to open yourself to somebody we like and respect. Sometimes the therapist becomes the only person we are able to get in contact with except for our family. The next stage is distancing yourself from the therapist by small measures – gaining autonomy. Inherent in this learning process is a period of rebellion, which may take on various forms. At the end the therapist becomes a friend. A kind of “make-believe” friend, because this friendship exists only in patient-therapist relationship. However, let us not be afraid of the intimacy of this relation, basing on which we, patients, attempt to develop safe relationships with other people.

Is UK care coordination recovery led? Exploring the perspectives of different stakeholder groups.

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Background/Objectives

In the UK the quality and delivery of care coordination has been questioned and it is unclear to many what good practice in this area means. Mental health recovery is also a contested term which has only been in part owned by service users and professionals. This paper is based on a National Institute for Health Research funded 3 year study exploring whether there is a pathway to mental health recovery through care coordination.

Methods

The project is emancipatory by design utilising a high level of service user and carer collaboration in designing the project, collecting and analysing the data along with the dissemination of findings. The study has three phases the first to be reported here being a Delphi questionnaire sent out to a sample of local mental health service users, carers and professionals along with national experts on recovery and care coordination. The Delphi explores comparative definitions of recovery and good practice in care coordination.

Results

The qualitative and quantitative data generated from this Delphi highlights the similarities and differences between the views of mental health professionals, carers and service users around key constructs for both recovery and care coordination. The works collaborative approach has been chosen to enhance the communication of multi stakeholder perspectives within the analysis of data.

Discussion/Conclusion

If the design and purpose of care coordination is to be recovery focused does it need to be considered as a unified concept which encompasses the views of all stakeholder groups? This paper will finish by exploring this question and other issues arising from the Delphi findings presented.

The relation between content of clinical decisions with outcome

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Background/Objectives

Existing research in clinical decision making (CDM) focuses on decision support and patient participation, but less on content of clinical decisions in routine mental health care. This work examines how number of unmet needs and stages of recovery affect the content of clinical decisions and to what extends this effect is susceptible to change over time.

Methods

588 people with severe mental illness gave informed consent to participate in the European multicenter study “Clinical Decision-Making and Outcome in Routine Care for people with Severe Mental Illness” (CEDAR). Participants were recruited from caseloads of outpatient/community mental health services from six European countries (Germany, UK, Italy Hungary, Denmark and Switzerland). Content of clinical decisions was examined using the “Clinical Decision Making in Routine Care Scale” (CDRC). Outcome was measured using the “Stages of Recovery Instrument” (STORI-30) and the Camberwell Assessment of Needs Short Appraisal Schedule” (CANSAS). Hierarchic linear models will examine relationships between content of CDM and outcome, following the hypothesis: Less unmet needs/higher stage of recovery lead to a change in content of clinical decisions Covariates included in the model to control for cofounding effects are age of patients, duration of illness, clinical diagnosis, and study centre.

Results

At baseline patient participants mean age was 41.7 years (SD 10.7). The majority was diagnosed with a psychotic disorder (DSM IV) and average of duration of illness was 12.51 years (SD 9.27). At baseline assessment, patients and staff quoted four main content categories for CDM (“General health status”, “Medication treatment”, “Non-medication treatment” and “Social issues”). Participant’s average on unmet needs at baseline was M=3.45 (SD 3.09) and the majority was at stage 3 of the STORI (Rebuilding & Growth n=321; 55.25%). Results will be presented concerning the relationship between content of CDM and outcome variables.

Discussion/Conclusion

Results will be discussed in order to demonstrate whether content of CDM is affected by number of unmet needs and stages of recovery. Also covariates may play a role and will therefore be taken into account.

Increased competence in community treatment for severe mental illness: results of a national two year training program for the frontline workforce

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Background/Objectives

Present a national two-year multidisciplinary onsite training program for frontline workforce in the community treatment of people with severe mental illness. Report implementation and dissemination of local programs. Report a prospective study of increased competence experienced by the participants in relation to the goals of the training

Methods

The participants' experience of their competence in relation to goals of the training program was measured with a questionnaire at baseline and after one and two years. Multilevel analysis was used to analyze changes in experienced competence, as well as the contributions of individual and program-level variables.

Results

There was a significant increase in experienced individual competence for all training goals, with a fairly high increase for understanding of psychosis and for relationship building, and lower increase for awareness of own reactions, multidisciplinary work, teamwork, and family support. The increase was highest among those with lower competence at baseline. There was no significant variance at the program level, which may indicate that local training programs have been implemented in a consistent way.

Discussion/Conclusion

The training program seems to be successful in increasing competence in key areas for frontline workforce providing treatment for people with severe mental illness in the community. Part-time training, including supervision of ongoing clinical work, has created the possibility to implement new competences in practice, and training staff from different service levels together has likely contributed to better collaboration. The training model has continued in Norway, and is also recommended for use in other countries.

Variation in Duration of Untreated Psychosis in an 18-year perspective

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Background/Objectives

The Scandinavian TIPS study engineered an early detection of psychosis program that sought to reduce the duration of untreated psychosis (DUP) through early detection teams and extensive information campaigns. In 1997-2000, DUP was reduced from 26 to 4.5 weeks median. Patients enrolled during this time had 2.5 higher odds of being recovered after ten years than control area patients¹. The program was continued beyond the initial project in modified forms for over 13 years. This study tracked the vicissitudes of DUP over a 18 year period (1993-2010) with differing early detection efforts in a defined catchment area.

Methods

The DUP of all patients meeting criteria for first episode psychosis (FEP) was measured 1993-1994 (pilot phase) and from 1997 through 2010 in a naturalistic long-term study. The study was divided into TIPS1 (1997-2000; detection teams plus information campaigns), TIPS2 (2002-2004; detection teams only), TIPS3 (2005-2006; detection teams plus information campaigns) and TIPS4 (2007-2010; detection teams plus information campaigns, now also addressing substance induced psychosis). DUP values of all patients were included (N=602), irrespective of patients' participation in the clinical follow-up study, yielding a highly representative sample.

Results

The distributions of DUP indicate that early detection manages to prevent mid- and long-range DUP by recruiting more patients very early. However, the low median DUP that was achieved in 1997-2000 was not re-achieved until 2009. Shorter DUP was nonetheless associated with the presence of information campaigns.

Discussion/Conclusion

The DUP curve as a whole has been moved towards the shorter (left) end of the continuum. However, for patients who have already been ill for some time, there is room for improvement. Perhaps denial and stigma, along with doubts as to the more insidious symptoms, need to be addressed more explicitly. Furthermore, early detection information campaigns should have a stable focus and high intensity level. Future research should further elucidate pathways to care in order to establish principal targets for information campaigns.

Cost effective analysis of a program of primary prevention for depression in primary care. The PredictD-Spain CCRT study

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Background/Objectives

The 'predictD algorithm' provides an estimate of the level and profile of risk of the onset of major depression in primary care attendees. This gives us the opportunity to develop interventions to prevent depression in a personalized way. We aim to evaluate the cost-effectiveness of a new intervention to prevent the onset of episodes of major depression.

Methods

Multicenter randomized controlled trial (RCT), with cluster assignment by health center and two parallel arms. Two interventions are applied by Family Physicians (FPs), usual care versus the new intervention predictD-CCRT, that has 2 main components: communicating the level and profile of risk of depression and building up a tailored bio-psycho-family-social intervention by FPs to prevent depression. We recruit a systematic random sample of 3326 non-depressed adult patients (1663 in each trial arm), nested in 140 FPs and 70 health centers from 7 Spanish cities. All patients were evaluated at baseline, 6, 12 and 18 months. We undertake an intention-to-treat effectiveness analysis and handle missing data using multiple imputations. The economic evaluation is approached from two perspectives, societal and health system. The time frame of this study is 18 months. We discount both costs and effects at 3.5% following NICE recommendations. All costs are expressed in euros (€) for the year 2012. We calculate incremental cost-effectiveness ratios (ICER). The incremental costs and incremental health effects are modeled by generalized linear models (GLM). Bootstrapping with 5000 replications were performed on each imputed dataset. Bootstrapped cost effect pairs are plotted on cost effectiveness planes are used to estimate cost effectiveness acceptability curves (CEACs).

Results

The main ICER analysis from a Societal point of view was -2,414 € per avoided depression. From a Health System perspective ICER was 394€ per avoided depression. The probability that the PREDICTD intervention was cost effective was 95% at a cost effectiveness threshold of 30,000€ from a societal point of view and 96.27% from a Health System point of view. Sensitivity analysis suggested that these results are robust

Discussion/Conclusion

This intervention based on the level and profile of risk for depression improved effects without generating more costs. The intervention is cost-effective.

Predicting psychiatric inpatient costs

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Background/Objectives

Inpatient care accounts for a large proportion of mental health costs but little is known about the variation in costs between patients. The aim of this study is to measure costs of staff contacts and activities on inpatient wards and to identify predictors of these costs.

Methods

Patients on inpatient wards were interviewed and staff contacts and use of activities recorded. Costs were calculated and regression analyses used to identify predictors of costs.

Results

Of 334 participants, 78% had used activities during the prior week and 90% had contacts with staff members. However, 41% reported no contact with nursing staff. Mean staff contact and activity costs were £197 and £30 per week respectively. Staff contact costs were inversely related to age and activity costs were higher for patients with higher levels of education. Patient satisfaction was positively associated with both costs.

Discussion/Conclusion

Patients on inpatient wards have low levels of staff contacts and low use of activities. Costs of these account for a small amount of total inpatient costs. Patients with higher costs are more likely to have higher levels of satisfaction.

DRAFT

Replacement of a psychiatrist centered bio-medical model by a user-centered on recovery oriented social model in mental healthcare

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Background/Objectives

Out of a user/survivor perspective plea for a model in which the user plays the most important subject role because we think that that is more effective

Methods

Power point presentation

Results

A more effective perspective on mental health care and the role of a professional worker as well as the user

DRAFT

Exploring the impact of legislative reform regarding compulsory treatment on professionals' relationship with service users and their carers

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Background/Objectives

In 2005, Scotland introduced new legislation to promote recovery and increase social wellbeing – the Mental Health (Care & Treatment) (Scotland) Act, 2003 (MHCT Act). The study aimed to evaluate early implementation of the MHCT Act, exploring experiences and perceptions of service users, carers, health and social care professionals and advocacy workers, offering rare insight into direct experiences of compulsion in an under researched area with a 'hard to reach' population.

Methods

This was a qualitative study involving interviews and focus groups as the main tools to articulate different viewpoints and explore individual experiences of compulsion. In summary, 15 national professional or interest groups, 23 health and social care practitioners and advocates, 49 individual service users, and 33 carers participated. The study was in two stages – interviews with service users and carers were conducted at two time intervals 12 months apart. This paper will focus primarily on findings from semi-structured interviews with service users, focus groups and interviews with carers/relatives to reflect on the challenges for communication and changing professional relationships.

Results

Although some positive change had occurred, many carers remained isolated and unsupported, and were critical of the lack of consultation and involvement at both individual and collective levels. Despite increased opportunities for service user and carer voices to be heard - for example, under a new style of Tribunal, the right to an Advance Statement or access to independent advocacy - this was not matched by having increased influence over professional decision-making, especially in relation to drug treatments.

Discussion/Conclusion

While the legislative reform provided a foundation for improving the process of compulsion, the findings suggest that fundamental shifts in practice are needed both in terms of the nature of therapeutic relationships, and in embracing more holistic and recovery perspectives, recognition for carers, and promotion of more community-based mental health services. Service users demanded improvements in the way mental health professionals relate to, and treat them, as well as access to alternative forms of treatment and a variety of service options.

Discursive spaces: factors influencing the contribution of independent advocacy to improving communication with mental health professionals

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Background/Objectives

This paper presents the findings, relevant to improving communication, from the first large scale study of Independent Mental Health Advocacy (IMHA) services in England. IMHA is a form of statutory advocacy introduced under mental health legislation to safeguard rights and enable them to be exercised. Commissioned by the Department of Health, this study contributes to an area where evaluative research is sparse.

Methods

This was a multi-method study, involving focus groups; shadow visits to IMHA services and 8 case study sites of mental health providers to understand the experience of people eligible to use this form of statutory advocacy and the commissioning and delivery of IMHA services, including the relationship with mental health services. Nearly 300 people participated in the study including 90 mental health service users, as well as a range of mental health professionals and advocates. The research team involved 10 mental health service users, including people with experience of being sectioned.

Results

Advocacy can lead to a different kind of conversation between mental health professionals and service users who are compulsorily detained, and therefore influence the care and treatment that they receive. Whether or not this is realised reflects the understanding of advocacy in relation to the role of mental health professionals and their disposition towards advocacy. Factors identified that influence this were:

- training of MH professionals regarding IMHA and role
- organisational culture and service policies
- inter-relationships between nursing staff and psychiatrists
- wider measures to promote service user empowerment and communication
- understanding of diversity and equality, particularly in relation to BME specific issues
- the organisation and approach of IMHA services.

Discussion/Conclusion

The IMHA role was highly valued by service users, although its full potential may not be realised. Advocacy can contribute to improving communication. However, the emancipatory and transformative potential of advocacy depends upon the willingness of mental health services relating constructively to the challenges posed and factors that influence this were identified. From this, a typology was developed to enable mental health professionals to critically reflect on their own practice and the organisational context within which they work, as well as indicating areas for future research.

Intimate partner homicide and mental illness: a descriptive population-based study

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Background/objectives

Intimate partner homicide accounts for a substantial proportion of homicides in high-income countries. In England and Wales around 10% of perpetrators of homicide are mentally ill at the time of offence, but the role of mental illness in intimate partner homicide is not clear. This study aimed to (1) To examine the prevalence of mental illness and contact with mental health services among convicted perpetrators of intimate partner homicide; (2) to investigate the distribution of characteristics associated with intimate partner homicide with and without mental illness at the time of offence.

Methods

A consecutive case series of all convicted intimate partner homicide perpetrators in England and Wales (1997-2008). Information on socio-demographic, clinical and offence characteristics was gathered from the Home Office, the Police National Computer, psychiatric court reports and, for psychiatric patients, questionnaires completed by supervising clinicians. Descriptive statistics were calculated for the socio-demographic, behavioural, clinical, service use and offence characteristics of intimate partner homicide perpetrators. Pearson's chi-squared tests were used to compare characteristics between perpetrators with and without mental illness at the time of offence.

Results

Between 1997 and 2008, 1180 perpetrators were convicted of intimate partner homicide in England and Wales. 19% of perpetrators had mental illness at the time of offence. 14% of all intimate partner homicide perpetrators, and 30% of intimate partner homicide perpetrators with mental illness at the time of offence, were in contact with mental health services in the year prior to homicide. Perpetrators with mental illness at the time of offence were less likely than perpetrators without mental disorder to have previous violence convictions or a history of alcohol abuse.

Discussion/Conclusion

Clinicians are likely to face considerable challenges in identifying the risk of, or preventing, domestic homicide. A significant minority of intimate partner homicide perpetrators had mental illness at the time of homicide, but most were not in contact with mental health services in the year prior to offence. Risk-reduction could be achieved through closer interagency working, including mental health services, police, social services and domestic violence services.

Mental Health Recovery: Evaluation of a Recovery-Oriented Training Program in the Netherlands. Effects on mental health professionals and mental health consumers outcomes

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Background/Objectives

Recovery is focused on personal growth, hope and autonomy and learning to live with the negative consequences of the disease. The question is how professionals can support the recovery process of individual clients. The aim of this study was to investigate the effectiveness of an educational program about recovery for professionals.

Methods

By using a two group multiple intervention interrupted time –series design, 210 professionals and 142 clients filled out questionnaires five times within two years. The professionals filled out the Dutch version of the Recovery Attitudes Questionnaire (RAQ) and the Recovery Knowledge Inventory (RKI). The clients filled out the Dutch version of the Mental Health Recovery Measure (MHRM) and the Recovery Promoting Relationship Scale (RPRS). Differences between the means of the RKI and the RAQ, pre- and post intervention were analysed by using a random intercept multilevel regression model with time periods nested within individuals. Differences between means of the MHRM and the RPRS were tested by two series of analyses. The first series tried to ascertain whether Gender and Age have a significant effect on the MHRM and the RPRS, whereas the second series aimed at detecting a systematic trend in the average scale response of the MHRM and RPRS.

Results

Results showed a positive change in attitudes and knowledge of professionals after two years of education. Furthermore, significant effects were found for gender on two subscales of the MHRM. Men scored higher than women on the subscales ‘self-empowerment’ and ‘learning & new potentials’. Age had no effect on any of the scale scores.

Discussion/Conclusion

The results support the effectiveness of a recovery training program on mental health care professional’s attitudes and knowledge about recovery and mental health consumer’s outcomes on self empowerment and learning & new potentials.

The implementation of Recovery Rounds to support culture and practice changes in a commitment towards recovery-oriented mental health care

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Background/Objectives

In the continuous commitment towards recovery-oriented, exemplary mental health care, Ontario Shores Centre for Mental Health Sciences has implemented Recovery Rounds to elevate the importance of restraint and seclusion prevention through witnessing these events. Witnessing contributes to organizational change through oversight, accountability, timely communication, and the commitment that will surround every restraint and seclusion event. It provides an opportunity to identify strengths and improvements in restraint and seclusion prevention techniques while learnings are shared, creating consistency and transparency across the organization. The objective of this initiative is to have organizational leaders heighten the urgency of restraint and seclusion use, through collaboration with patients and staff to promote the use of proactive and preventative alternatives in the advocacy for least restrictive, least intrusive philosophies towards care.

Methods

Guided by the Six Core Strategies to reduce restraint and seclusion use, leadership commitment has been demonstrated and implemented through the development of the Recovery Team, who attend Code White emergencies and perform Recovery Rounds. This team is comprised of members of Senior Management, Professional Practice, Peer Support and Ethics. Recovery Rounds visit daily, each patient care unit that have patients in restraints or seclusion. The purpose is to facilitate discussions with unit staff and management regarding the event, the plan for discontinuation of the controlled intervention and offer support to staff and patients.

Results

Since commencing Recovery Rounds in December 2012, early data has demonstrated a decrease in equivalent number of patients in mechanical restraints for 24 hours a day and a decrease in equivalent number of patients in seclusion for 24 hours a day. Qualitatively, there is greater awareness for the use of non-intrusive strategies as an alternative to restraint and seclusion. In addition, the Recovery Team has increasingly been consulted by treatment teams to provide proactive support for complex clinical situations with the intent to prevent future use of restraints or seclusion.

Discussion/Conclusion

The creation of the Recovery Team and implementation of Recovery Rounds has demonstrated organizational leadership's commitment to support culture and practice changes toward inter-professional, recovery based mental health care through the advocacy of least restrictive, least intrusive care.

Effectiveness of a psychoeducational programme for patients with bipolar disorders

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Background/Objectives

Psychoeducation is currently considered an essential intervention in the management of bipolar disorders. A psychoeducation group programme for patients with bipolar disorders named “Porta Aberta” (Open Door) was implemented since 2007 in the day-hospital of a Portuguese psychiatric department.

The objectives of the study were to assess the effectiveness of a psychoeducation programme in reducing the average number and duration of readmissions and to determine the individual characteristics that might influence these outcomes.

Methods

Review of the clinical records of a consecutive sample of patients with bipolar disorders discharged from the inpatient unit, attending at least 4 out of 8 programme sessions, and with a one-year follow-up. Variables assessed were: gender, age, marital status, subtype of bipolar disorder (I or II), and number and duration of psychiatric admissions in the year before and in the year following the programme attendance.

Results

The patients included (n=69) were mainly women (68.1%), single (47.8%), and with a mean age of 37.3±10.7 years. Only 15 patients (21.7%) were readmitted. A statistically significant reduction in the average number of readmissions (1.3 versus 0.3, p=.032) and in the average duration of readmissions (24.7 versus 17.3 days, p=.028) were found. Patient's gender and marital status, as well as disorder subtype had no influence in the outcome.

Conclusions

Group psychoeducation is an effective intervention in reducing the number and duration of readmissions in bipolar patients independently from gender, marital status and subtype of bipolar disorder.

“The ENGAGER study: Can we engage and retain prisoners with common mental health problems in treatment and research?”

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Background

Offenders have high levels of common mental health problems (anxiety, depression) but often do not accept medical labels and under-access community based services, which may also actively exclude those with co-morbid substance misuse. Prison may present an intervention opportunity, while also posing the challenge of maintaining engagement on release. This is problematic for both research and practice.

Method

Objective: To produce an effective model for engagement and retention of prison leavers with common mental health problems in treatment and research.

Design:

- 1) Identified barriers and facilitators for engagement and retention i) focused literature review, ii) 3 focus groups and iii) 3 best-practice case studies, to produce a model
- 2) Model implementation at two sites (NW & SW). Prisoners recruited 8-2 weeks before release. Those with identified common mental health problems and willing to accept help followed up 3-8 weeks after release.
- 3) Evaluation. Inductive thematic analysis of reflective interviews with researchers, research interviews and field notes.
- 4) Revision of model.

Results

185 (81%) of 243 approached 2-8 week prior to release participated. 122 (66%) met criteria for present or past common mental health disorder or likely personality disorder, would accept help and be followed up. 65% followed up 2-8 weeks following release.

Key mechanisms included: the face to face, initial approach; easy-read materials; non-stigmatising language; flexible interview format; permission for multiple contact points; strong relationships with community services; and persistence!

Of primary importance was an emphasis on including participants as part of the problem process, for example in suggesting ways in which they could be located and communicated with after release. The evaluation also concluded that to involve offenders in treatment a greater emphasis would need to be placed on maximising their motivation and capabilities.

Conclusions

The study developed ways to overcome individual and structural barriers to involving offenders in treatment and research. The potential application of the model to other ‘hard to reach’ groups should be considered.

The next stage is to build on this model to develop and deliver a trial for an intervention for prisoners with common mental health problems, bridging the prison/community gap, addressing social exclusion and taking co-morbidity into account (Engager 2).

Challenges and results of the Norwegian “JobPrescription” RCT on Individual Placement and Support for first episode psychosis patients

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Background/Objectives

As psychosis strikes mainly in late adolescence and young adulthood, it often severely disrupts developmental goals of education, work, and relationships. Between 60% and 90% of patients have no regular employment¹. The pilot project JobPrescription, in collaboration with the National Employment Services, used Individual Placement and Support (IPS) to help patients attain paid employment via internships in competitive employment settings. It ran from 2008-2012 and by December 2012, the majority of the 360 participants were in regular employment or education (72% of schizophrenia spectrum; 58% of other psychosis; and 68% substance abuse and psychosis patients). This study aims to evaluate the effectiveness of the IPS program in Stavanger using a randomised controlled design.

Methods

First episode psychosis (FEP) patients are referred by the TIPS early detection service and invited to participate. Inclusion criteria are age 16-65 years and having a first episode of non-affective psychosis including substance induced psychosis. Patients are randomised to either a wait-list treatment as usual, or to the IPS condition for 12 months. Patients refusing study participation are offered IPS within the program but outside the trial. The primary outcome measure is paid employment. Secondary outcomes are quality of life and social functioning. Ratings are single blind.

Results

Recruitment began in September 2012 and by April 2013, 11 patients had been enrolled. Patients in the treatment arm have engaged well and employers have embraced the program. Obstacles identified include: Referrers within the mental health care system, and their patients, are frustrated by the narrow inclusion criteria; and about 50% of eligible patients refuse participation due to the risk of randomisation to the wait-list condition.

Discussion/Conclusion

Our pilot study indicates favourable results from IPS. However, the refusal of eligible patients to participate poses an ethical dilemma: should patients be refused the choice of non-RCT IPS, so that they will be more likely to participate in the study? The overwhelming demand for the program indicates a long time unmet need. Preliminary results of this RCT will be discussed.

Psychiatric Advance Directives: a tool to promote therapeutic alliance, coordination of care, and autonomy of the user

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Background/Objectives

Psychiatric Advance Directives (PADs) are documents that allow users with severe and chronic mental illnesses to notify their treatment preferences for future crisis relapses and to appoint a surrogate decision-maker for a period of incompetence. PADs are supposed to reduce the resort to involuntary treatment, to reduce the length of hospitalisations, and to improve the compliance of users. However, their take-up rate has remained very low and their evaluation has given contradictory results. Our main objective was to develop a comprehensive PAD intervention process, which includes three stages (the design, the completion, and the honouring of a PAD document) to facilitate its effective use.

Methods

Firstly, a realist systematic literature review was carried out on 47 references ranging from 1996 to 2010. Three theoretical frameworks underlying the intervention were identified and the available evidence supporting or contradicting these theoretical expectations was examined. Secondly, we carried out a stakeholder analysis on policy makers, health professionals, caregivers, and users, to determine their preferences and value criteria for using PADs.

Results

The three theoretical frameworks identified were: enhancement of the autonomy of the user, improvement of the therapeutic alliance, and integration of care between health providers. Although designed in the first place with a view to sustaining the user's autonomy, the intervention was more likely to be efficient within a therapeutic alliance framework. These three theoretical frameworks and feasibility were included in the stakeholders' survey, which showed that the criteria for choosing options varied according to the stage: alliance was more important at the design and completion stages, while coordination and feasibility gained importance at the honouring stage.

Discussion/Conclusion

The support for the autonomy of the user and his/her involvement in treatment depends on the quality of the therapeutic alliance at the completion stage and of the coordination of care at the honouring stage. The clarification on expectations of PADs and value criteria in the course of the intervention may help to increase their take-up rates.

Improving the cost-effectiveness of primary mental health care by selectively investing and de-investing in interventions: a generalized health economic modeling approach

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Background/Objectives

Rising health care expenditure along with the current economic downturn have increased the need to inform policies about improving the healthcare system while keeping economic constraints in mind.

The aim of this study is to model the Dutch primary mental healthcare system to identify a mix of interventions resulting in an economically sustainable healthcare system. Modeling was done for patients presenting at their GP with feelings of anxiety, stress, feelings of depression, and for those meeting the diagnostic criteria for alcohol abuse/dependence, anxiety disorder and depressive disorder.

Methods

A health-economic steady-state model was used to synthesize clinical and economic evidence and to compute population-level costs and effects of interventions. The model is based on registration data from GPs on diagnosis, treatment and referral of patients in primary mental healthcare in the Netherlands in 2009. The model is based on generalized cost-effectiveness analysis and Monte Carlo simulation.

Results

A more cost-effective primary healthcare system can be obtained when increasing the coverage of psycho-education at the expense of pharmacotherapy for patients presenting with stress, feelings of depression, and depressive disorder. For patients presenting with feelings of anxiety, alcohol abuse/dependence or anxiety disorder, no superior healthcare system can be obtained by increasing the coverage of one intervention while de-investing in other interventions.

Discussion/Conclusion

The study has some limitations. The health economic model was based on registration data from a substantial number of GPs, but assumptions had to be made on how this could be extrapolated to the entire Dutch primary mental healthcare system. Parameters on compliance and clinical effects of the interventions were taken from meta-analyses or RCTs where possible, but were based on focus groups when not reported in the literature. The results of the model represent best choices in terms of cost-effectiveness given the assumptions made, whereas other considerations (e.g. regarding equity and medical ethics) were not taken into account. The results of our generalized health economic modeling approach should therefore be considered as the first of two stages, to be followed by a normative filter, where appropriateness, acceptability, and desirability from a broader perspective are taken into account.

Is a screening program for postpartum depression a long term sustainable and clinical-cost effectiveness strategy?

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Background

Considerable evidence shows the impact of Postpartum Depression (PPD) on mothers, her partners, families and overall babies. Less than 50% of PPD cases are detected by healthcare professionals in routine clinical practice. Screening is only one way in which recognition and management of PPD may be improved. Evidence surrounding its clinical and cost effectiveness is still lacking.

Aim

To assess after 3 years the long term impact of a regular screening and support program for our maternity population (1600/year) and the changes incorporated in the developing process or further needed to implement clinical and cost effectiveness.

Method

All postnatal women (25% migrant) of the investigated period (01.02.2010-30.11.2012) were met in maternity unit by 2 psychologists, given specific psychoeducation about postpartum mood disorders and then asked by phone, 6 weeks after, to fill 3 self-administered scales (EPDS, PDSS, PSI-SF) sent home and to participate in further clinical investigations and specific treatments.

Results 1521 women (34% of maternity population, 41% of reachable postnatal women, 4.9% migrant) participated in the screening. 314 women (20% of the sample) were positive for some emotional distress and further investigated, out of them only 24 met clinical criteria for DPP (1.5%). In the period no acute postpartum depression with psychotic features was observed and none postnatal woman admitted to our inpatients unit. Significant correlations were found between PPD and personal psychiatric positivity, especially prenatal emotional difficulties and other psychosocial struggles. Our postnatal women learned to have easy access to specific psychological or psychiatric consultations.

Conclusions

The DPP prevalence kept lower than reported in literature; the effectiveness of our project increased constantly monitoring and treating a sizeable part of maternity population, even though limited to 40% and with practical and economic efforts in sustaining the screening method. Highly appreciated were the psycho-education instruments given to postnatal women and the sensitization program among general care health centres towards the emotional needs of new-mothers. A free telephone first psychological aid met the needs of several mothers and families. A free access clinic for pre and postnatal-women with emotional-affective problems is the next step to overlap the limitation of the screening strategy in addressing the needs our main maternity population.

Source of Funding: "None Declared".

An evaluation of protected engagement time (PET) on staff and patient outcomes on acute mental health inpatient wards in England

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Background/Objectives

Patients on acute psychiatric wards in the UK have recurrently reported that they are unhappy with the ward environment, that they are bored and have little to do, that wards are intimidating, and above all, that contact between staff and patients is often identified as too limited in both quantity and quality, and as lacking therapeutic content.

Protected Engagement Time (PET) has emerged as a promising initiative for improving quantity and usefulness of staff-patient contact. During fixed periods of the day, staff are asked to focus solely on patient contact: visitors are not admitted and administrative duties and meetings not allowed. Government guidance, particularly relating to nursing, has advocated use of PET over the past decade.

Methods

The study had three components and was conducted between June 2010 and March 2013.

1. National mapping of all acute wards that implement PET and telephone interviews
2. Evaluation of the effects of PET on patients and staff by comparing 12 wards with PET and 12 wards without.
3. In-depth qualitative case studies on three wards with PET.

Results

446 acute wards were identified in England, of which 210 implemented PET. 194 participated in the telephone survey.

346 patients and 424 staff participated in the study. No significant differences were elicited between intervention and control wards in patient satisfaction, therapeutic engagement, staff morale, and experience of positive or negative events. A significant difference was found in terms of staff time spent with patients in the intervention wards however, and in patients reporting that their needs were met.

Themes from the 54 qualitative interviews will also be presented to elucidate the quantitative findings.

Discussion/Conclusion

PET has been implemented nationally and in accordance with government guidance since 2004 without an evidence base. The findings from this study indicate that it may not have an impact on staff or patient outcomes when implemented without guidance as to the content and activities that take place. Further investigation as to the therapeutic content of staff patient interactions is needed.

Needs for care among mentally disordered offenders receiving treatment in a therapeutic forensic residency. Relationship with clinical characteristics and recidivism risk factors

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Background/Objectives

The planned closure of the Italian Forensic Hospitals (Ospedali Psichiatrici Giudiziari, OPGs) – which is due to take place by April 2014 – presents a series of potential beneficial opportunities for the resident patients. The new Italian legislation prescribes that these patients should be discharged by the OPGs and followed by the public NHS community mental health services, which should provide appropriate levels of care and at the same time ensure that care process at the community level would not lead to serious reoffending. An assessment of individual and collective needs for care would be therefore a necessary step in planning the aftercare of the current Italian OPGs population. This study aims (1) to assess individual needs for care in a sample of mentally disordered offenders conditionally discharged from the OPG; (2) to explore relationships among socio-demographic, clinical and social characteristics of these patients with recidivism risk factors.

Methods

A group of 45 mentally disordered offenders conditionally discharged from OPG and currently living in a therapeutic forensic residency (Comunità Psichiatrico Forense “Gonzaga”, Castiglione delle Stiviere - MN), has been assessed with the Italian version of CANFOR (Camberwell Assessment of Needs – Forensic Version, Thomas et al., 2003) and the HCR-20 (Historical, Clinical and Risk Management, Webster et al., 1997), one the most widely used violence risk assessment tools. We have also investigated the presence of correlations between the total number of needs, met and unmet, and variations of risk factor scores of recidivism.

Results

Mentally disordered offenders assessed in this study have a number of needs requiring some intervention in the areas of information of the disease, its treatment and knowledge of the rights-leverages of their condition, social needs like relationships, marital and sexual needs, accommodation, daytime activities.

Discussion/Conclusion

Assessment of needs, central element in planning and providing efficient therapeutic interventions in general psychiatry may play an important role for the mentally disordered offenders discharged from the OPGs, living in a therapeutic safe environment.

The Therapeutic Relationship Model - a guide for clinicians in the least restrictive practices to support recovery

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Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is a teaching hospital specializing in comprehensive mental health and addiction services for those with complex serious and persistent mental illness. The facility, in Whitby Ontario, Canada has 17 specialized inpatient units and extensive outpatient and community services. The Centre is staffed by approximately 1200 employees and provides mental health treatment for 339 inpatients, with approximately 50,000 annual outpatient visits.

Our recovery-oriented model of care places direct emphasis on effective communication with patients and families in order to implement a proactive and collaborative approach towards care. One goal is the early identification of alternative interventions for patients who may be at risk for restraint and/or seclusion (R/S) use and the proactive implementation of a management plan as a preventative approach to strengthening the therapeutic alliance. Our Therapeutic Relationship Model guides clinicians in communicating with and promoting patients' strengths and well-being while ensuring the least restrictive and least intrusive practices to support recovery.

Ontario Shores current focus is on enhancing staff's knowledge, communication skills and attitude in advancing a culture of excellence and quality and safe care. The presentation will review key communication activities including:

- Therapeutic Relationship Model
- New policies and procedures
- The implementation of a fully integrated electronic health record
- Proactive and preventative tools to support clinical practice
- Debriefing
- Trauma-informed care
- Recovery rounds

Our most recent 2012/13 data indicates a reduction of 57% in our incidents of restraint and 51% decrease in seclusion use from April to August 2012. Similarly, we have reduced our total hours of restraints by 86% and seclusion by 48% since April 2012. Overall, the incidents of mechanical restraints have reduced from 3,101 in 2006 to 206 incidents in 2012/13 YTD

Reducing R/S requires multidimensional interventions influencing diverse staff in various ways to support changing attitude, practice and culture.

Winning hearts and minds: communicating a strategy to bring about recovery orientation in a mental health trust

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Background/Objectives

In 2010 South London and Maudsley NHS Foundation Trust launched a five-year Social Inclusion and Recovery (SIR) Strategy, building on the work of its original 2007 Strategy and assigning implementation roles to a number of distinct workstreams. These would collectively focus on further developing recovery-focused practice and on achieving

- executive-level ownership and leadership of change, in relation to both individual initiatives and organisational culture
- increased co-ordination of activities
- a marked increase in evaluative research, harnessing the existing mental health services research expertise within SLaM / King's Health Partners
- an increased focus on performance indicators and outcomes.

Methods

We will examine the communication methods that have been used to bring about the significant changes that were needed to implement the SIR Strategy in a rapidly changing and sometimes unstable environment. We will focus on a small number of case studies in more detail.

Results

Skilful use of targeted and personalised communication has played an important role in ensuring that key objectives of the SIR Strategy have been achieved and embedded within the organisational culture.

Discussion/Conclusion

Relating to and connecting with the concerns and preoccupations of those who need to be influenced increases chances of engaging their cooperation and inspiring their enthusiasm to embrace and support change.

Is there an association between continuity of patient care and clinical outcomes in the community care of patients with psychosis?

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Background/Objectives

Continuity of Care (CoC) is a multi-dimensional construct that can broadly be defined as the long-term delivery of care that is coordinated between services and is appropriate to the patient's current needs. CoC is recognised as vital in managing long-term illnesses. Within mental health care, maintaining CoC is difficult as those with severe mental illness can have poor adherence with treatments and are less likely to maintain contact with services (Nose et al., 2003). CoC is valued by both patients and professionals and discontinuities of care have been cited as a major source of patient dissatisfaction and disengagement (Waibel et al., 2011)

Despite this, there has been little CoC research in mental health and its impact on clinical outcomes. Freeman (2002) outlined a seven-axial model of CoC, which Burns et al. (2009) operationalised, allowing aspects of CoC to be assessed through routinely collected clinical data. This study will utilize this operationalisation to investigate CoC and its relation to clinical outcomes.

Aims

1. Can patterns of continuity and discontinuity of care be identified that are associated with differences in outcome?
2. Is the duration of legal compulsion associated with a patient's long term engagement with services?

Methods

Design

The study has a prospective observational design. Data from clinical records will be collected at 36 months. Variables identified through the operationalisation of CoC in the ECHO study (Burns et al., 2009) will be collected. The two outcome variables are: time to readmission; and total readmission length.

Sample

333 patients with psychotic disorders who had been subject to coercion in the OCTET trial (Burns et al., 2013).

Analysis

Regression models will be used to analyse the data. Data will be analysed separately for the two outcome variables. For time to readmission, CoC data only up to the readmission will be entered for analysis. For total readmission length, all CoC data will be included in analysis.

Results

Preliminary results from those patients who have reached 36 months since randomisation will be presented.

Young people using the Internet for mental health information and advice: the French case of www.filsantejeunes.com

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Background/Objectives

Mental and behavioral disorders are among the leading causes of disability in world's population aged 10-24 years. The health care system should then offer "youth-friendly services", recurring to the Internet, which is the most accessed information tool by people under 25. However, the Internet usage among young people has not been extensively analyzed so far. Questionnaires and surveys on this issue will help to provide well-planned and safe online services such as informative websites and forums.

Methods

www.filsantejeunes.com is a French website financed by the National Institute for Health Prevention and Education (INPES) attached to the French Ministry of Health. It is exclusively addressed to young people looking for information on health. On March 7th 2013 an online questionnaire was launched on www.filsantejeunes.com to investigate the usage of this website and the attitudes of French-speaking young people when looking for health information on the Internet.

Results

The first analyses on partial data will be started at the end of June 2013. They will be conducted on the internet use for both general and mental health (namely on eating disorders, depression, panic attacks, anxiety and addictions), with a specific focus on the www.filsantejeunes.com website. The socio-demographic characteristics of the users will be taken into account together with a specific insight on the trust of young people in the quality of the information provided.

Discussion/Conclusion

The results of the questionnaire will make it possible to better understand the way French young people use on the one hand the www.filsantejeunes.com website and on the other, more generally, the Internet for mental health information seeking. The example provided by this national survey could be applied to other international websites and represent a model for other countries to create official health websites dedicated to young people.

Courses of helping alliance in the treatment of people with severe mental illness in Europe: A latent class analytic approach

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Background/Objectives

Helping alliance (HA) between patient and therapist has been studied in detail in psychotherapy research, but less is known about the concept in general mental health services, especially in relation to long-term treatment. The aim of this study was to identify patterns of HA in a sample of people with severe mental illness across Europe over a measurement period of one year, and to investigate whether sociodemographic and clinical characteristics at intake can predict class membership.

Methods

Self-ratings of HA made by 588 people with severe mental illness who participated in a multicentre European study (CEDAR ISRCTN75841675) were analysed using latent class analysis.

Results

Four main patterns of alliance were revealed: (1) High and stable (45.6%), (2) High and increasing (36.9%), (3) High and decreasing (11.3%) and (4) Low and increasing (6.1%). Predictors of class membership were duration of illness, ethnicity, education, receipt of state benefit, recovery and quality of life.

Discussion/Conclusion

Results mainly support findings from psychotherapy research about course of helping alliance in patients with severe mental illness but also revealed new aspects.

Abstract POSTERS SESSIONS

Towards Hybridization? The relations between public and non-governmental organizations in the community mental health field in Sweden

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Background/Objectives

The deinstitutionalisation of mental health services has led to the development of community based methods and new ways of delivering services. NGO's, in this context, have been described as undergoing a process of hybridization, where various components such as political advocacy and service provision are combined. NGO's can also be described as hybrids in that their organisational structure begins to display both democratic and bureaucratic forms. At the same time, when roles for NGO's are renegotiated, it's reasonable to also expect changes in positions and behaviours exhibited by the organisations in the public sector. The aim of the study was to explore the roles of NGO's in a local context and to analyse what characterises the relationship between NGO's and public service providers in community mental health.

Methods

A collective case study design was used. Three different municipalities were purposely selected with consideration to geographic location, size and present organisation. Thematic interviews were conducted at location on each site with representatives of psychiatric care, community mental health, social service authorities and NGO's. In total, 40 persons were interviewed. The data were analysed through a directed content analysis guided by concepts from new institutional organisation theory.

Results

The results showed that the different organisations in the community mental health arena were extremely aware of each other's positions and actions - illustrated by strategic considerations, imitation of providers with high legitimacy and a tendency towards standardisation of available services. There were expectations from local governments on NGO's to offer "alternative" services but their autonomy was limited by a dependency on the public organisations. The NGO's were funded by local governments, often dependent on user-specific aid decisions from social service authorities and indirectly steered by managers from mental health or social psychiatry through their positions in the NGO's boards.

Discussion/Conclusion

This study illustrates how actors in a local organisational field interact and how NGO's and public actors exchanges ideas and concepts. It also shows how Swedish NGO's discretion is limited by considerations and decisions in public organisations - despite a national policy emphasizing autonomy and influence among non-profit and user organisations

Promoting Recovery and Social Inclusion: Using systems thinking to change community mental health services in North Wales

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Background/Objectives

The Local Health Board in the town of Wrexham (pop 135000) in North Wales determined to improve local mental health services. In order to assess service users priorities for service changes a quality of life survey was commissioned. Having identified the priority areas for change, task and finish groups with very wide representation were established. Service users chaired some groups and co-chaired others. Two service managers were seconded to oversee the implementation process. This paper reports on the results of the QoL survey, and the Task and Finish Groups, and draws conclusions about the resulting move to a recovery orientation. A systems thinking approach was adopted which concentrated on CHECK (identifying the issues in current practices) and FLOW (following the changes and observing the outcomes from the user perspective) (Seddon 2008).

Methods

A survey of 100 service users in contact with existing mental health teams was conducted using a modified version of the MANSA.. The areas considered most important for change were identified and task and finish groups established to steer the required changes. The key players in these groups were all interviewed, and the nature and outcomes of the changes assessed after 12 months.

Results

Changes resulted in Improved access to leisure facilities, overall inclusion ratings, job opportunities, the ability to borrow money, and significant changes in involvement in and satisfaction with care planning processes. Significant improvements were observed in the number of friends, weekly contact with friends and annual contacts with parents. The employment group arranged for out-reach sessions by the employment agency making access easier and more support available. The leisure services group made extensive access changes, and facilitated the development of a number of very successful user-determined leisure activity groups, based on peer-support.

Discussion/Conclusion

The importance of basing change on the service user perspective about desired outcomes, such as recovery and inclusion, was recognised as a key factor. A key feature of the systems approach is using what is there better. This may mean that the economic downturn may not be as big an obstacle to service improvement as people imagine.

Quality Assessment of Regional Treatment System for Schizophrenia (QUARTS), A study on the implementation of evidence based in the Netherlands

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Background/Objectives

People with schizophrenia need access to high quality care in the community, enabling them to go through life as valued citizens. This requires a comprehensive care system on a regional scale that consists of evidence based practices described in de Multidisciplinary Guideline Schizophrenia (MDGS) 2012. This study assesses the quality and availability of these practices in different regions in the Netherlands.

Methods

This study is a follow up of a large multisite qualitative study in which the quality of care for people with Schizophrenia was assessed for eight regions in the Netherlands (van Weeghel et al, 2011). A standardized interview instrument (QUARTS) was developed to assess the quality and availability of the recommendations in the MDGS (2012). These recommendations provide evidence based objectives on all aspects of good treatment: diagnostics, biological treatment (pharmacotherapy a.o.), psychosocial interventions, care and expertise by experience, social inclusion and rehabilitation, and organization of care.

For each recommendation a score for quality (1 to 5, based on the number of criteria that are met) and a score for availability (1 to 5, based on the percentage of clients that have received this type of intervention during the last 12 months).

Respondents are professionals and managers of regional mental health care and regional institutes for residential care. So far, nine regions have enrolled. The aim is to attain an overview of regions covering all parts of the country.

Results

Preliminary results show that, on the whole, quality of care is adequate. Most participating regions have a high standard of evidence based treatment options for people with schizophrenia. Especially with regard to the presence of pharmacotherapy and psychological interventions standards are met. However, in most regions improvement can be achieved in: fidelity to quality criteria, availability of recommended interventions, notably in rehabilitation, involvement of family and experts by experience, addressing social inclusion and stigma, and interagency collaboration in the regions. During the summer we plan to conduct the quantitative analyses.

Discussion/Conclusion

Especially in these times of budget restrictions, mental health service providers in a region should collaborate closely in creating good access to high quality care and improving social inclusion, for all persons with schizophrenia.

The MEMENTA-Study. A multi-site study assessing the mental health status and needs for care in adults with mild to moderate intellectual disabilities

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Background/Objectives

Quality of mental health services provision for adults with intellectual disabilities and comorbid mental illness is considered as poor and as being in urgent need of further improvement. However, empirical findings on this topic are rather scarce. Against this background, the ongoing MEMENTA-Study aims to compare adults with an intellectual disability and a comorbid psychiatric diagnosis to adults with an intellectual disability who do not suffer from a psychiatric disorder with respect to a set of clinical parameters. Quality of mental health care will be assessed and examined by open questions to mentally ill adults with an intellectual disability as well as with formal and informal caregivers.

Methods

The MEMENTA-Study is a multicentre, observational, epidemiological, cross-sectional study. The target sample is a representative sample of approximately $n = 600$ adults with a mild or moderate intellectual disability working at work centres. A number of parameters such as needs for care, quality of life (QoL), social functioning, caregiver burden, health services utilization, and costs for care will be assessed by using a set of well-established standardised instruments and by open questions. Data analyses comprise χ^2 -tests and t-tests, exploratory regression analyses as well as a content analysis.

Results

According to the study protocol, first analyses will be conducted after inclusion of $n = 417$ study participants. The first months of the MEMENTA-Study showed that the implementation of an epidemiological sound study in the field of intellectual disabilities raises various methodological issues which will be introduced and discussed. The MEMENTA-Study will provide data on the point prevalence of mental disorders among adults with a mild or moderate intellectual disability as well as data on the special needs for care. Up to now 107 study participants were included. At this stage, as the study sample has not yet been completed, results indicate an unexpected low point prevalence of mental disorders among adults with a mild or moderate intellectual disability.

Discussion/Conclusion

It is expected that findings from the MEMENTA-Study will inspire further research in the field and strengthen advocacy for the improvement of specialised and non-specialised services.

Experiencing evidence-based supported employment services: Qualitative findings of a mixed-methods study

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Objectives

Most people with mental illness (MI) are unemployed, yet desire to work. The Individual Placement and Support (IPS) model of supported employment is most effective at helping people with MI in general attain this goal. The present study investigates the way people with MI and recent experiences of homelessness experience IPS services.

Methods

Fourteen participants from a randomized controlled trial designed to evaluate the efficacy of IPS in a homeless population were invited to participate in repeated semi-structured qualitative interviews near the beginning, half-way, and near the end of their participation. The interviews were designed to explore the participants' opinions about the role mental illness and homelessness played in their employment histories as well as their experience of IPS. Thematic analysis was used to highlight recurrent themes and determine common experiences and solutions to the obstacles which impede peoples' return to work.

Results

At the final interview four of the 14 participants were competitively employed, two had just left employment, one was about to begin a new job and the remainder had suspended their search. We found that initial reticence to working with IPS specialists faded to be replaced by trust. Developing with time, trust and rapport, which figured prominently in the last interviews, facilitated conversations about strategies for 1) overcoming obstacles, such as having a criminal record, 2) disclosing sensitive information to employers, such as having been homeless, and 3) dealing with workplace stressors, such as needing to concentrate. People who found work were more likely than those who did not to mention having such conversations with their IPS specialist.

Conclusion

One mechanism through which evidence-based supported employment specialists appears to be effective among recently homeless participants of a Housing First intervention, appears to be through enabling them to trust the IPS specialists so that they can begin to adopt behaviors that enable them to obtain employment.

How depression is cared for in mental health hospital? Overview of care and determinants of the variability in use of mental health service in France

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Background/Objectives

Depression affects more than 3 million people; it is one of the most widespread psychiatric illnesses in France. According to the sources and measuring tools used, the prevalence throughout a year is estimated between 5% and 10%. Depending on the “Baromètre Santé 2005” published by INPES, 60% of people having lived an episode of depression declare they resorted to care for mental health reasons. 21% of patient resort to general practitioners, 13% to psychiatrists and 7% to psychologists. The use of health services for depressive disorders is relatively low (approximately 11% of people have consulted a mental health service, whether in community mental health center or in a hospital). However, this resort increases with the severity and the chronicity of the disorder. Depressive disorder represents the second most frequently diagnosis found among psychiatric inpatient. Until now, the care of patient was little known because there was not a hospital information system common to all mental health facilities.

Methods

Collection of psychiatric information (RIM-P) was established in 2006 in all mental health services. It is now possible to provide an overview of the care of depression and analyze its geographical variability.

Results

In 2010, more than 266,000 adult patients were monitored for depressive disorders in a mental health service, 83 000 for severe disorders. Depending on the severity of the disorder, the modalities of care may change. Thus, if the majority of patients with a diagnosis of depressive disorder were treated as outpatients (60%), this proportion falls to 39% for patient with severe disorders. Utilization rate of health services for depression and the part of hospitalized patients vary greatly throughout the country.

Discussion/Conclusion

To explain these disparities, several factors are analyzed both at patient and regional level: demographic and socio-economic, the supply of healthcare, outpatient and inpatient care. This paper provides an overview of the care of depression in mental health facilities and teaches about the determinants of the variability in use of mental health services in France.

Implementing Recovery in Organisations: The ImROC project

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The Implementing Recovery for Organisational Change (ImROC) project was designed to facilitate the development of recovery orientated mental health services in England and was supported by the Department of Health as part of their national strategy. The project involved 29 Mental Health provider organisations in England, who were provided with tailored consultation and organised into four learning sets. The project was evaluated by monitoring development of services based on a pre-designed format and by qualitative interviews with service personnel. The development of recovery-orientated services in these organisations was variable and depended on the starting point of each organisation, but was welcomed by a range of stakeholders. The learning points from the project will be outlined in the presentation.

DRAFT

Is discharge from residential facilities likely and possible? A longitudinal study in Italy

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Introduction

The per dove study (progetto epidemiologico residenze dimissione ospiti e valutazione esiti - epidemiological project on discharge from residential facilities and outcome assessment) is the first study conducted in Italy aimed at obtaining comprehensive data on the course and outcome of residential facility (rf) patients and to clarify whether discharge to independent accommodations is a real option for many patients. The present study examined patients' characteristics and their 1-year outcomes, with three main aims: (1) to describe the sociodemographic, clinical, and treatment-related characteristics of rf patients during an index period in 2010; (2) to identify discharge-associated predictors and characteristics at 1-year follow-up; and (3) to evaluate clinicians' predictions as to each patient's likelihood of home discharge (hd).

Methods

All psychiatric patients of 23 medium-long term residential facilities (rfs) of the St John of God order, staying in September 2010 and younger than 65 years, received a set of standardized assessment instruments, including a "patient schedule", Brief Psychiatric Rating Scale (BPRS), Honos, Psp, phi, and Slof. Detailed socio-demographic and clinical data were also collected. Logistic regression analyses were run to identify independent discharge predictors. Results: the study involved 403 patients. Sixty-seven percent were of male gender, the mean age was 49 (sd=10); 70.7% were unmarried. The average duration of illness of these patients was 23 years, and the primary diagnosis was schizophrenia in 2/3 of the sample. At 1-year follow-up, 104 patients (25.8%) were discharged: 13.6% to home, 8.2% to other rfs, 2.2% to supported housing, and 1.5% to prison.

Conclusions

Very few patients were discharged to independent accommodations after one year. These data are similar to those observed in other studies, and provide support to the notion that for many patients living in rfs discharge is an unlikely option, at least at medium term. In our study the main variables associated with a higher likelihood of being discharged home were: to have an illness duration of less than 15 years and to have an available and effective social support. Lower severity of psychopathology, and higher working skills were also associated with a significantly higher likelihood to be home discharged.

Patients to be discharged from hospitals to community-based residential facilities in Montreal: profiles and residential orientations

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Background/Objectives

In Montreal, Canada, limited inpatient beds, reduced length of stay, growing waiting lists for residential facilities and a difficult housing market have created an increased pressure on mental health services. In order to take actions to help reduce the congestion, the regional health authority requested an evaluation of patients to be discharged from hospitals to community-based residential facilities. This poster presentation objective is twofold: 1) to describe the demographic and clinical characteristics of those patients; 2) to compare preferred housing options (patient, staff and evaluators).

Methods

The cross sectional survey targeted two psychiatric hospitals, 10 general hospitals and one forensic mental health hospital located in Montreal (n ≈ 250). Inclusion criteria included: adults with mental illness waiting for a place/bed in a residential facility or likely to be referred to a residential facility at discharge. Patients in acute stabilization phase were excluded. For each patient, the hospital staff had to complete a questionnaire adapted from four existing instruments (Canadian PSR Toolkit, NABUS, Level of Care Survey (NYSOMH), Riverview Psychiatric Inventory, Consumer Housing Preference Survey). After completion, one or two staff members met with two evaluators. Evaluators systematically reviewed the questionnaire answers with staff member(s) and asked questions on the patient's strengths, interests, rehabilitation readiness and social network. For each patient, the final question explored staff perception of « ideal services ». Data were collected by 15 experienced clinicians (evaluators) between March and April 2013.

*Data analysis/Results **

Descriptive statistics were computed for patients' demographic (gender, age, civil and legal status, etc.) and clinical characteristics (diagnosis, physical health, medications, violent behaviors, etc.). Residential orientations include former place of residence, patient housing preference, staff housing preference and evaluators' residential orientation. Patients' profiles were extracted using cluster analysis.

Discussion/Conclusion

The findings highlight the need for treatment and rehabilitation services to be provided to adults discharged from hospitals. Moreover, there seem to be a need for specialized residential facilities for specific sub-groups and for more community mental health teams. The survey also suggests that admission to residential facilities should be based on multidisciplinary and careful multidimensional assessments.

Physical Activity guidelines for persons with schizophrenia

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Background/Objectives

There is a substantial inequality concerning somatic health in patients with schizophrenia. It is reported that people with schizophrenia have a two and a half times greater rate of mortality, after excluding deaths from unnatural causes, often in cardiovascular diseases. This has in recent years led to a growing concern about how to promote physical activity in the group of people with schizophrenia.

Methods

The available literature on national and international clinical practice guidelines and recommendations on Physical Activity for schizophrenia was reviewed, and discussed in different international forum with experts in the area.

Results

The International Organization for Physiotherapists in Mental health, a subgroup to the World Physiotherapy organization, has develop a consensus on the best available evidence on current Physical Activity guidelines in order to minimizing cardio-metabolic risk in patients with schizophrenia? Recovery- oriented factors and barriers to increased physical activity were also identified.

Discussion/Conclusion

Physical Activity guidelines for persons with Schizophrenia were formulated and other recommendations important to minimize barriers and aid the process of recovery were identified and published.

Social network development for people with severe mental illness – is it important for recovery and whose role is it anyway?

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Background/Objectives

Recovery and social inclusion are important aspects of mental health care delivery in modern services across Europe. Increasing interest is also paid to social capital and the assets within people's own lives to build and sustain recovery from severe mental illness. Social network analysis offers a methodological approach to understanding people's lives. This paper aims to assess the potential impact of social network development strategies on recovery practices.

Methods

Data has been collected from 150 people severe mental illness to map networks of connections to people places and activities. This is an innovative approach, extending name generating social network methods. In addition semi-structured interviews with 40 practitioners and 40 in depth follow up interviews with service users were carried out. Data synthesis by the research team, and feedback events in project sites, was used to analyze and interpret these data. We will compare networks by place – rural Devon and Inner city London.

Results

We are currently analyzing the data and this will be presented in the poster. Our practitioner data shows that there is role confusion over who is responsible for network development and variation in views on recovery from severe mental illness between primary care practitioners, secondary care mental health professionals and the voluntary sector. The network data shows great diversity in structures (which we are exploring in detail) and the methodology could itself become a useful therapeutic recovery approach.

Discussion/Conclusion

It is important for social network development to be more explicitly discussed within mental health support teams. Understanding the therapeutic value of place and activities as well as people within networks may aid recovery strategies for people with severe mental illness.

Pathways to first-ever contacts with child and adolescent mental health services: an Italian study

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Background/Objectives

The precise knowledge of pathways to specialist care for young people suffering from emotional and behavioural problems is crucial to improve health policies. However, few studies have assessed clinical samples, and none has ever been conducted in Italy. The present contribution is aimed at shedding light on who, why, and how asks for a consultation at Child and Adolescents Mental Health Services (CAMHS).

Methods

The study took place in 12 Italian CAMHS with a catchment area of about 640,000 youths. During a 6-month index period, parents of 399 patients aged 6-18 years at their first-ever contact were enrolled. For all enrolled patients, an ad hoc-devised questionnaire – including the “Parent Schedule” and the “Clinician Schedule” – was administered. In addition, parents and clinicians filled in the following standardized instruments: Child Behavior Checklist/6–18, Health of the Nation Outcome scale for Children and Adolescent Mental Health, Clinical Global Impression Severity Index.

Results

The mean (SD) age of the sample was 10.5 (+3.2) years old, males (N=227; 56.9%) were slightly more frequent than females (N=172; 43.1%). Learning disorders was the most frequent diagnosis (N=84; 21.1%), followed by “Neurotic, stress-related, somatoform disorders” (N=68; 17.0%) and “Emotional disorders with childhood onset” (N=67; 16.8%); one in every ten patients (N=46) did not satisfy criteria for any mental disorders. Most parents reported to have been referred by school teachers (36%) or health professionals (32%); 17% did ask help by themselves. School (50%) and emotional (17%) problems were the most frequent reasons for contact. One-third of patients had already undergone treatment with private practitioners or other health professionals.

Families with a non-traditional structure were more likely to consult CAMHS without any intermediate referral; foreign young people were more often referred by teachers. Patients with externalizing problems were more frequently referred by parents themselves, while youths with emotional problems were more often referred through an health professional. The proportion of subjects without any mental disorders was not different by source of referral.

Discussion/Conclusion

The pathways to CAMHS care of young people is associated with patients’ sociodemographic and clinical characteristics. Interventions to improve problem recognition and referral will be discussed: informational interventions specifically addressed to immigrants to let them know the functioning and the mission of CAMHS, education to parents and teachers about emotional problems, and training on child psychiatry issues for GPs and paediatricians.

Age of onset of mental disorders and use of mental health services: is there any correlation?

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background/objectives

most mental disorders begin in adolescence and early adulthood, with these disorders now revealed as the major contributors to the burden of disease in young people. although the onset of most mental disorders usually takes place in the first three decades of life, with 70% of mental disorders starting by age 25, effective treatment usually does not begin until a number of years later. this presentation aims at analyzing the correlation between the age of onset (aoo) of mental disorders and the organization of mental health services. suggestions on how to redirect these services using an “age-appropriate” approach will be given.

methods

we will review the latest studies on aoo of mental disorders, the pathways of care of young people treated in mental health services and how these data relate to the personal profiles of patients.

results

the revised studies confirm that the onset of most serious mental disorders occurs in childhood and adolescence. in particular, behaviour disorders and anxiety disorders emerge in childhood, while most of the high prevalence disorders (mood disorders, substance abuse and eating disorders) and psychotic disorders occur during adolescence and early adulthood. an early aoo is associated with a longer duration of untreated illness and with poorer clinical and functional outcomes.

discussion/conclusion

there is growing evidence that effective interventions, if implemented in the early stages of the disorder, can reduce the severity and persistence of the disorder itself, and prevent secondary disorders. however, further research is needed to evaluate the long-term effects of early interventions. this means not only strengthening and re-engineering of existing systems of care, but especially the construction of new care pathways for young people in transition to adulthood. investment in this stage of life is essential to address the hard fact that treatment delay is much more likely to occur if the onset is in children or young people.

Regional financing systems and financial incentives for mental health care in Spain. Comparison of Andalucía, Catalonia and Basque country

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Background/Objectives

Relatively little attention has been paid to better understanding the way mental health (MH) is financed in Spain. The aim of this study is describing characteristics of the regional financing systems and financial incentives/disincentives for mental health care in Spain and comparing the results of three Autonomous Communities in Spain: Andalucía, Catalonia and Basque Country (40% of Spanish population).

Methods

This study is based on the REFINEMENT Mental Health Care Financing Toolkit. A systematic mapping of the literature and scrutiny of national datasets were followed by the development of a glossary of financing terms and a MH financing toolkit (FINCENTO) to collect information on economic context, revenue collection, pooling and allocation mechanisms and inbuilt financial incentives related to the provision of MH and social care in Spain and in the above mentioned three Autonomous Communities.

Results

In Spain, with a health care expenditure of 9,44% GDP in 2011, 74,2% of health spending was funded by public sources in 2010, and 25,8% by private sources. Spain provides a specific breakdown of funding for mental health. The Mental Health expenditure in Spain is around 0.65% of the total health budget, this percentage varies significantly across Autonomous Communities. We present the differences in financial incentives/disincentives between Autonomous Communities.

Discussion/Conclusion

The public Spanish mental health system is decentralised and its planning and management functions have been transferred to each of the Autonomous Communities. The main sources of funding for mental health services are the general tax system and out of pocket and private insurance premiums. Differences between Autonomous Communities exist in the utilization of financing incentives and also in the organization of services; there can, for instance, be different interactions with local government social services. The regional comparison allows concluding with some policy suggestions.

Developing the evidence base for social care in mental health – the NIHR School for Social Care Research in England

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Background/Objectives

Mental health care in England has a strong component of social care, and mixed modes of integration of health and social care. Social care in general in England, though, has not been as well served as health care with resources and support for the development of research evidence. The organisation of social care is very diffuse, which presents challenges for improving the evidence base. The School for Social Care Research (SSCR) is a national initiative to address these challenges, and is active in the area of mental health research. This presentation will examine the history and rationale behind SSCR and its work in mental health.

Methods

A review of the rationale behind the SSCR and its activities to date to contribute to the evidence base for improving adult social care in mental health.

Results

The research activities of SSCR in the field of mental health are described. The context of social care and the challenges it presents to developing and implementing evidence are also considered.

Discussion/Conclusion

SSCR is contributing to developing the evidence base for improved social care in mental health in England. Challenges lie ahead, but there is every expectation that the School will significantly contribute to the evidence base to help improve adult social care for people with mental health problems.

The influence of moving to better quality supported housing on long-term care-dependent psychiatric patients

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Background/Objectives

In January 2012 Mental Health Organization Yulius opened the new supported housing facility BW Volgerlanden. Building a new and better quality supported housing facility was intended to have a positive effect on the patients. However, the available literature does not solidly confirm this assumption. Objective: to investigate the influence of moving to better quality supported housing (private apartments, more space) on the quality of life, behaviour, impairment, symptoms, social functioning and care needs of long-term care-dependent psychiatric patients.

Methods

The Manchester Short Assessment of Quality of Life (MANSA), Health of the Nation Outcomes Scale (HoNOS), Camberwell Assessment of Need (CAN) scale, self-report Stigma Scale and Clinical Global Impression (CGI) were administered to forty-two patients (of whom 71% had a psychotic disorder) moving to the new facility and twenty-one control patients were measured 1-2 months prior and 1.5-2.5 months after the move. Also, before and after the move, qualitative interviews were conducted with the moving patients.

Results

Repeated measures ANOVAs showed a significant interaction ($p < 0,05$) between time and group for the MANSA and HoNOS total scores and HoNOS subscale 3 (symptoms). The MANSA score increased (better quality of life); the HoNOS scores decreased (better functioning). In the qualitative interviews conducted two months after the move, 45% of patients reported increased symptoms due to the move. Eighty percent preferred the new supported housing facility.

Discussion/Conclusion

Although moving was a burdensome experience for a substantial minority of the patients, the move to better supported quality housing had a positive effect on patients' quality of life (MANSA) and behaviour, impairment, symptoms and social functioning (HoNOS) two months after the move. More long term research is deemed important. An additional follow up moment one year after the move was planned to assess long term consequences, the results of which will be presented.

Experiences and stigma of people living in the proximity of a supported housing facility for people with severe mental illness

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Background/Objectives

Supported housing facilities for people with severe mental illness aim to position their residents into a neighbourhood as full citizens. For this to succeed, integration into the neighbourhood is essential. The perspective of the people living in close proximity is important to fully evaluate the success and possible down sides of this socialization. Objective: to investigate the positive and negative experiences and opinions of residents living in the proximity of a supported housing facility for people with severe mental illness and their possible stigmatization of people with a psychiatric illness. Furthermore, to investigate whether there is a correlation between the contact frequency or experiences with the residents of the supported housing facility and the amount of stigmatization.

Methods

In March and April of 2012, 364 questionnaires were distributed in the close proximity of two supported housing facilities of Yulius (Mental Health Organization). One of the facilities was recently closed. The questionnaires contained questions about contact and experiences with the residents of the supported housing facility and opinions about the facility and psychiatric patients. To investigate stigmatization a selection of items from the Community Attitudes toward the Mentally Ill (CAMI) and a social distance scale were used.

Results

Eighty-six people filled in the questionnaires (24%). Of the respondents 47% had had contact with the residents of the supported housing facility (42% of which was limited to greeting). 12% had had positive experiences and 22% had experienced nuisance. The average score on the CAMI items was 2.7 (1 = no stigma, 5 = much stigma). Significant ($p < 0.05$) medium to large correlations were found between the CAMI and subjective nuisance and between the social distance scale and nuisance.

Discussion/Conclusion

Probably not much contact existed between the residents of the supported housing facility and the people living in close proximity to the facility. Nuisance is regularly attributed to the residents of the supported housing facility (and bore a relationship to stigma scores). In total, these results do not suggest that the intended integration in the neighbourhood was successful.

The economic impact and benefits associated with implementing suicide prevention programs at the population level

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Objectives

The aims of this study were to (i) assess the cost of a death by suicide using a government and societal perspective and (ii) assess the incremental cost-effectiveness ratio (ICER) and cost-utility ratio (ICUR) of implementing 4 suicide prevention programs, highlighted in the Nuremberg Alliance against Depression (NAD) trial.

Methods

The prevalence of suicide, attempted suicide and depression in 2007 were ascertained from Quebec's public managed care physician billings database and Public Health Agency. The costs considered included those incurred during a hospitalization, an emergency department or ambulatory visit, physician fees paid, medication and Coroner related costs as well as those related to a police investigation and funeral costs. Indirect costs associated with loss of productivity, using the friction cost method (FCM) and human capital approach (HCA), and short term disability were also considered. Costs were discounted at 3%. The NAD suicide prevention program costs were ascertained from published reports and interviews with key decision makers. The effect of the NAD trial on the prevalence of suicidal acts was ascertained by published data. An ICER was measured and the ICUR was ascertained using a Markov cohort analysis with 9 year projected follow-up. Sensitivity analyses were also carried out.

Results

The average annual cost of a suicide reached \$31 943 (\$17 414 to \$129 060) using the FCM and \$528 310 (\$ 430 532 to \$802 481) using the HCA. The NAD program specific costs reached \$23 982 293. The incremental analyses associated with the NAD program showed (i) that the average cost for one averted suicide was \$17 412 (-\$20 009 to \$19 296) and (ii) cost savings reaching \$ 6 062 per life year saved (up to -\$15 364). The Markov analysis showed that the NAD program is dominant, i.e. it costs less and yields higher QALYs [ICUR= - \$ 3 986 854]. Probabilistic sensitivity analyses, with a willingness to pay of <50000\$, showed that the NAD program was recommended 80% of the time.

Conclusion

The NAD suicide prevention program is cost-effective and results in important cost savings due to averted suicide deaths and reduced life years lost.

Low satisfaction with sex life among people with severe mental illness living in a community

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Background/Objectives

Research on sex lives of people with severe mental illness (SMI) most often focuses on dysfunction and the side-effects of medication.

We wished to determine how people with SMI experience sex and assess satisfaction with it in a broader evaluation of quality of life.

Methods

Data was gathered using mixed methods, including a reliable psychometric quality of life instrument and in-depth interviews.

Results Sex life showed the lowest rating of all quality of life domains, with men indicating lower satisfaction with sexual life than women. Low satisfaction also correlated with lower scores on the total quality of life index. Sex life for people with SMI was seen to be of secondary importance.

Discussion/Conclusion

The area of sex showed the lowest experienced satisfaction rating of all measured domains of quality of life. Our interview-based study verified that intimate relationships and sexual experiences are considered unattainable among those suffering from SMI. Programs to increase the possibility sustaining a sex life might need to be added to existing recommendations for people with SMI living in a community.

DRAFT

Social work intervention in self-harm (SWISH); a feasibility study for the replication in Wales of an intervention developed in Australia

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Background/Objectives

The annual cost of mental ill health in Wales has been estimated at £7.5 billion (1). The cost of deliberate self-harm (DSH) in the UK has been estimated to be £56m in hospital costs alone (2). In the UK, despite NICE guidelines suggesting all DSH cases should have a psychosocial assessment (PA) (5), only 60% receive PA (6). No contact with psychiatric services is associated with having no PA in hospital (7). Evidence about the best form of help for first-episodes of DSH is limited (8). Joubert et al have reported promising results (in terms of repeated episodes and improved quality of life) for a social work intervention with young people admitted to hospital for self-harming for the first time (4). The purpose of the present study is to assess the feasibility of providing this intervention in Wales, leading to a full trial if warranted.

Methods

The intervention is for people who have no contact with psychiatric services but who have harmed themselves, most commonly by self-poisoning (10). Consented patients will be randomly allocated to treatment as usual (TAU) or the SWISH intervention. SWISH is designed specifically to address psychosocial problems and is based on PA, assertive engagement, brief client-centred psychotherapy and community linkage.

The main hypothesis is that the change scores on the BDI II will be significantly greater in the SWISH group compared to the TAU group. The study is powered to detect a ten point difference in the BDI score between the arms of the trial at three month follow-up as it has been shown to correspond to a clinically recognised moderately important difference in outcome (12). Analysis will be analysis of covariance (ANCOVA).

Results

Will be expressed as differences in the primary and secondary outcomes between the index and control groups. Measures will be taken at baseline, six weeks and three months. Primary outcome is Self-rated BDI II score; Secondary: MANSA Quality of Life Scale (13)

Discussion/Conclusion

In the event that the feasibility study is successful funding for a full trial will be sought. Anyone interested in hosting an intervention site should contact the Principal Investigator.

“ORIENT” - Pilot Study: A Recovery-Oriented Mental Health Nursing Intervention Pilotstudy

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Background/Objectives

Mental health nurses support and care in inpatient settings is often limited on the hospitalisation and the inpatient setting. Core area of nursing care is focused on the acute process of disease and safety. Less important are the users' situation and symptom management at home. Often there is a deficit in implementing and applying of personal centred concepts like recovery and social inclusion. The objectives of this pilot study are to implement and evaluate a nursing intervention in hospital based mental health acute units that focuses on personal recovery, social inclusion, achievement of goals and the use of motivational interviewing and coaching techniques.

Methods

The study is conducted between January 2013 and February 2014 in two mental health clinics in Switzerland, on 6 wards (4 intervention and 2 control wards). The research uses a mixed method design.

The quantitative part is based on a pre- and posttest design, with the following instruments: Recovery Self Assessment (O'Connell et al. 2007), Stage of Recovery Instrument (Andresen et al. 2006) and Goal Attainment Scale (Hurn et al. 2006).

The intervention contains the following: 4 half day training sessions for nurses in personal recovery, social inclusion, motivational interviewing, coaching and goal attainment and the implementation of these techniques with systematic support from peers and experts.

For the qualitative part of the study we conduct four focus groups, with users and nursing staff from the intervention and control wards at the end of the intervention.

Sample size is n=60 for mental health nurses and n=240 for services users. In each focus group 7 participants (n=14 users, n=14 nurse) are included.

The study is supervised by an expert group including professionals, users and careers.

Results

We will present our study protocol at the poster session.

Discussion/Conclusion

To our best knowledge this study is the first that focuses on implementation and evaluation of recovery and social inclusion techniques in the German speaking area. Evaluating nurses' mental health care is complex. We will discuss our experience with the study protocol and the practicability of a pre- post-test study in the natural field of acute mental health units.

Barriers and errors in implementation of community psychiatry in Slovenia

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Background/Objectives

Slovenian psychiatry is predominantly hospital based. A proposal for development general community psychiatric services was proposed to improve access, quality and comprehensiveness of psychiatric care according to the modern standards of delivery of psychiatric services.

Aims

The aim of the paper is to present the program for developing community services that was proposed to the Slovenian government and to describe the barriers encountered in its implementation, as well as the errors made by the programme authors, that contributed to the programme rejection in last year.

Discussion/Conclusion

There are historical, political, professional and service organization characteristic that impede community psychiatry development in Slovenia. These are to be addressed through coordinated action involving primary care professionals, non-government organization with service users and carers, Health Insurance Agency and politicians involved in planning of health services.

DRAFT

Satisfaction with housing and housing support for persons with psychiatric disabilities

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Background/Objectives

No scientific studies have been carried out that have focused on satisfaction with and preferences for housing and housing support for people with psychiatric disabilities in Sweden. Furthermore the Swedish municipalities commonly utilize non-validated questionnaires for gathering information about the residents' satisfaction with their housing as part of their quality assurance work, but questions about the residents' preferences do not feature at all in these questionnaires. A major project on housing satisfaction and preferences and the development of instruments to study these aspects in a Swedish context is thus under progress. The focus of this oral presentation is partly on the validation of an instrument for investigating residents' satisfaction with housing and housing support but mainly the results from the first study using the questionnaire.

The study thus has two aims – the first being the construction and testing of the reliability and validity of a new questionnaire for studying satisfaction with housing and housing support for people with psychiatric disabilities. The second aim is to investigate the level of satisfaction with housing and housing support for this group.

Methods

A new questionnaire (23 items) based on an American original containing four important factors for housing satisfaction (choice, safety, privacy and proximity) has been constructed. Items concerning aspects of housing support have been added and cultural differences adhered to. The content and construct validity (factor analysis) and reliability of the questionnaire (Cronbach's alpha och test-retest) were investigated.

Descriptive statistics, comparisons between subgroups and multiple regression analysis will be used to investigate the responses of 370 persons with psychiatric disabilities.

Results

The stability of the instrument was confirmed by the test-retest reliability analysis showing good or moderate agreement for nearly all the items. The reliability of the instrument was good and the final factor solution after item reduction to 20 items revealed five factors. The analysis of the satisfaction with housing and housing support is ongoing and no results are as yet available. These will be presented at the conference and will form the major part of the presentation

Discussion/Conclusion

Content of discussion depends on the results of the study. The construction of the questionnaire will be discussed.

What does it mean to be recovered from drug-addiction? Preliminary results from a phenomenological study of patients experience of recovery

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Background/Objectives

A common way to measure recovery from drug-addiction today is to use screening instruments like AUDIT (Saunders et al., 1993), (DUDIT) (Berman et al., 2005), HSCL-10) (Derogatis et al., 1974; Strand et al., 2003), WHO-FIVE (Bech et al., 2003) and HoNOS (Wing et al., 1998). Absence of symptoms or the fulfilment of diagnostic criteria is reliable and precise indicators of improvement. They are not, however, complementary in the light of the huge variations one finds in individual and interpersonal level of functioning among patients. In this study we explore how people, who are in recovery from drug-addiction, experience the recovery process. The main question being addressed is: What does it mean to be recovered from drug-addiction?

Methods

The study is based on qualitative methodology. 10 informants were recruited via purposive sampling. Inclusion criteria were that they had been in specialized treatment for drug-addiction, had been in after-care recovery for no less than 2 years, and defined themselves as being in recovery. An interview guide was made containing three main themes to discuss with the informants: 1) What is your experience with and how do you understand recovery? 2) History of drug-addiction and 3) Important factors for seeking help. In-depth interviews are conducted with the 10 informants and the analysis will be inspired by an interpretative phenomenological approach.

Results

The process of analysis is in a preliminary stage, but our impression from the interviews indicates that there are varying experiences and understandings of what recovery from drug-addiction implies. Their narratives differ on several areas; total abstinence or not, disease, personal choice, time, trust and more. In the next level of analysis we will focus on the relation between the informants' expressed meanings, and the socio-economic environment in which they live (lifeworld).

Discussion/Conclusion

Recovery is a ubiquitous concept. Still, it remains poorly understood and ill defined (Laudet, 2007), especially in the field of addictions. This study examines recovery from a patient perspective and based on the findings we will discuss implications for therapeutic practice. Including the need to shift from a pathological model to more focus on individual wellness and continuum.

The effectiveness of interventions for adults with intellectual disabilities and mental illness: a systematic review

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Background/Objectives

People with intellectual disabilities (ID) are at a high risk to develop mental disorders. Transfer of results of intervention studies with people with mental illness without ID to this group is questionable. Rather, evidence-based interventions tailored to the needs of this vulnerable population are called for. Therefore, this systematic review aims to examine the evidence on the effectiveness of existing interventions for adults with ID and comorbid mental illness.

Methods

Electronic databases Medline, EMBASE, PsycINFO and EBM were searched. Inclusion criteria were: age 18 to 65 years, presence of mild or moderate intellectual disability, any comorbid mental disorder. Only RCTs and controlled studies in English and German published after 1980 were included. Additionally, identified publications were cross-checked for further relevant literature. The analysis was performed by PRISMA checklist.

Results

The first search yielded 1049 hits. Nine studies were included. Of these, six evaluated psychotherapeutic treatment, and 3 examined pharmacological interventions. All studies identified took place in English speaking countries and were conducted in forensic, community or service settings. The sample size varied between 9 and 86 participants, with samples being larger in pharmacology studies. At this stage, as the literature search has not yet been completed, results indicate limited evidence for psychotherapy and pharmacological interventions.

Discussion/Conclusion

Over the last 30 years, only a few trials investigated the effectiveness of interventions for people with ID and mental illness. Quality of the studies included in this review was generally poor, including methodological limitations such as small sample sizes and lack of standardized outcome measures with questionable psychometric properties. In sum, there is a disconcerting lack of high-quality evidence on the effectiveness of interventions for people with ID and mental illness. Future research should aim at developing an evidence base through well conducted controlled trials being crucial to establish new treatments and to confirm the benefit for already existing interventions.

Implementing evidence-based practices in rehabilitation and mental health in the Quebec public health system

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Background/Objectives

Quebec (Canada) and its 16 administrative regions are equipped with a public mental health system that comprises 94 local service networks. A range of rehabilitation services are provided by public health and community organizations to help people better manage their illness and re-integrate into their social and work life. The services offered are not equal across all regions and several challenges exist. This project aims to clearly define the challenges involved in implementing Evidence Based Practices (EBPs) in 3 administrative regions in Quebec (rural, urban and mixed regions) and describe the courses of action to be taken in order to improve services.

Methods

This action research project presents a logic model of mental health services in the 3 regions and a qualitative analysis of implementation issues.

Results

The results highlight gaps between actual and ideal services and bring out the issues involved at the local, regional and provincial levels. The results also help to better understand the challenges involved in a rural context versus an urban context and enable us to identify several action strategies.

Discussion/Conclusion

This project highlights the importance of a regional and provincial perspective and the need to work in close collaboration with partners in each local services network.

The effect of two predictors' interaction on short- and long-term treatment outcomes in schizophrenia

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The study was conducted by the Cracow Schizophrenia Research Group.

Objective

The Cracow study of the prognosis, course and outcome of the treatment of schizophrenic psychoses is a prospective, real-time study. This paper focuses on: 1/ the assessment of the relationship between duration of untreated psychosis (DUP) and expressed emotion (EE) at the time of first hospitalization, 2/ the assessment of the relationship between treatment outcomes over 12 years and the interaction between DUP and EE.

Method

56 individuals diagnosed with DSM III schizophrenia (redialognosed acc. to DSM IV-TR) were assessed at index hospitalization and after 3, 7 and 12 years. CFI was used to assess EE and BPRS-SA for symptom assessment. Analysis included: the number of relapses, the number and duration of rehospitalizations and the severity of symptoms.

Results

No correlation was found between DUP and EE measured at index hospitalization. Over the 12-year period the number of rehospitalizations for individuals with short DUP and low EE did not increase, as opposed to those with short DUP and with high EE (significant differences after 3 ($p=0,041$), 7 ($p=0,023$) and 12 ($p=0,029$) years). In the group with long DUP, the number of rehospitalizations increased irrespectively of EE level. The positive syndrome in the group with short DUP and high EE was less severe than in individuals with long DUP and high EE (significant differences after index hospitalisation ($p=0,023$) and after 7 ($p=0,009$) and 12 ($p=0,050$) years). Analogous differences were found in the group with low EE after index hospitalisation ($p=0,005$) and after 3 ($p=0,038$) and 12 ($p=0,001$) years.

Conclusions

1/ No correlation was found between DUP and EE at index hospitalization. 2/ Only people with short DUP and low EE had lower number of rehospitalizations 3/ Short DUP, irrespectively of EE level, was associated with lower intensity of positive syndrome.

The significance of persisting negative symptoms as a prognostic factor for the course of schizophrenic psychoses

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The study was conducted by the Cracow Schizophrenia Research Group.

Objective

The Cracow study of the prognosis, course and outcome of the treatment of schizophrenic psychoses is a prospective, real-time study. Its general objective is long-term observation of people suffering from schizophrenia beginning at the onset of the illness. This study focuses on the occurrence of persisting negative symptoms (PNS), present after one year of treatment, and their relationship with the course of schizophrenic psychoses.

Method

Of the original group 80 people with first-episode schizophrenia (DSM-III diagnosis, DSM-IV and ICD-10 rediagnosis), 50 people were assessed after 3, 7, 12 and 20 years. The analysis included a set of demographic, clinical and social predictors, data from Catamnestic Questionnaires and results in CFI, BPRS-LA and GAF.

Results

PNS are present in 20% of the subjects after 1 year since I hospitalization and show significant associations with: worse general assessment of functioning by GAF (explaining either solely or in combination with other predictors 29-44% of variability of the results), the course of illness assessed according to Watt, Shepherd et al.'s classification after 3 and 7 years (36-38%), the severity of 24 symptoms assessed by BPRS-LA after 3, 12 and 20 years (31-48%), the severity of positive symptoms after 12 years (41%), the severity of negative symptoms after 3, 7, 12 and 20 years (41%), lower number of extra-familial social contacts after 3, 7 and 20 years (24-51%).

Conclusions

1/ Persisting negative symptoms were found in 20% of the subjects 2/ Persisting negative symptoms are a significant prognostic factor for predictions of short and long-term unfavorable general, clinical and social outcomes of treatment in schizophrenia.

Recovery in schizophrenia

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The study was conducted by the Cracow Schizophrenia Research Group.

Objective

The Cracow study of the prognosis, course and outcome of the treatment of schizophrenic psychoses is a prospective, real-time study. Its general objective is long-term observation of people suffering from schizophrenia beginning at the onset of the illness. This presentation includes: 1/ an assessment of recovery according to 3 criteria, 2/ an assessment of temporary recovery, 3/ an assessment of late recovery.

Method

Of 80 people with first-episode schizophrenia (DSM-III diagnosis, DSM-IV and ICD-10 rediagnosis), 77 were assessed after a year, 74 after 3, 71 after 7, 72 after 12 and 64 after 20 years. The analysis included results in GAF, two composite assessments of recovery, temporary recovery and late recovery (symptom remission, employment, good social contacts). Anamnestic and Catamnestic Questionnaires were used.

Results

After 20 years 11% of subjects were assessed as recovered (22% including multi-episode course with remissions). GAF (71+) indicates 31% of recovery in the same group. Temporary recovery assessed at various time points was found in 29% with one episode of psychosis and 45% including multi-episode course with remissions. Late recovery was found in 6% after one episode of psychosis and in 16% with multiple remissions.

Conclusions

1/ The strictness of the criteria used for assessment significantly affects the number of people achieving recovery status. 2/ The results of Cracow study are in agreement with the results obtained in various centers around the globe, which find a significant group of schizophrenic psychoses with symptomatic and social recovery as a possible outcome.

Hazardous alcohol and drug use among people with psychiatric disabilities visiting day centres

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Background/Objectives

Hazardous alcohol use in psychiatric patients may increase the risk of the development of a substance use disorder and negatively affect the course of the psychiatric disorder. Objectives: To describe the occurrence of hazardous alcohol and drug use in a Swedish psychiatric outpatient population, investigate relationships between hazardous use and different aspects of well-being and functioning, and explore any changes in risky use between a baseline measurement and a 15-month follow-up.

Methods

Study participants were 123 day persons with psychiatric disabilities, 59 of which participated in a follow-up. Alcohol Use Disorders Identification Test (AUDIT) and Drug Use Disorders Identification Test (DUDIT) were used to assess hazardous use, and self-report questionnaires were employed to estimate different aspects of well-being and engagement in day centre activities. Level of functioning and severity of psychiatric symptoms were assessed by the Global Assessment of Functioning (GAF) scale.

Results

Few patients were found to have scores indicating hazardous alcohol use. Analyses of levels of AUDIT and DUDIT scores will be presented in relation to socio-demographic factors, quality of life, self-rated health and psychiatric symptoms.

Discussion/Conclusion

Alcohol and drug hazardous use needs attention because of its importance for health and quality of life, and different populations' consumption patterns need to be investigated. The findings' implication for the targeted population and care context will be discussed.

Differences in perception of well-being between staff and service users with psychosis

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Background/Objectives

Well-being is both an important outcome in the context of recovery from mental illness and an everyday concept used by individuals, regardless of whether they have suffered mental health problems. The views of mental health professionals on well-being and possible ways to attain it for themselves and for their clients have not been explored, and may impact on the professional's ability to support recovery. This study aimed to explore how mental health professionals conceptualise and believe they can improve well-being for themselves compared to what they identify for people with psychosis.

Methods

Semi-structured qualitative interviews were conducted with 14 mental health service staff members who had worked with people with psychosis. The purposive sample included occupational therapists, clinical psychologists, social workers, and psychiatrists at different career stages and responsibility levels. Transcripts were analysed using thematic analysis.

Results

Staff held similar conceptualisations of well-being for themselves and for their clients. Views that stressed a distinction between "them and us" were expressed only cautiously. Differences were identified in relation to specific factors and strategies suggested to improve well-being. It was also questioned whether improving well-being should be a focus of mental health care.

Discussion/Conclusion

Staff overall held consistent views on the concept of well-being for themselves compared with their clients. They acknowledged differences in the attainment of well-being that may arise from mental illness. However, regardless of the general importance of well-being, mental health professionals did not consistently agree that the improvement of well-being should be the aim of mental health care.

Recovery oriented care on closed admission wards in the Netherlands

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Background/Objectives

In the past decade the recovery orientation in mental health care has gained influence, especially for long-term mental health. Recovery refers to the efforts that clients undertake to overcome the often devastating consequences of a serious mental illness and to give their life new meaning and purpose (Anthony, 1993). Proper treatment and rehabilitation can effectively support the recovery process of clients (Davidson e.a., 2009). It is unclear to what extent the principles of recovery are implemented in the daily practice of closed admission wards.

Clients regard their stay on closed admission wards as one of the most stressful aspects of the experience of mental health problems (Morisson e.a., 1999). Public policy aims at community care and least-restrictive services but with the reduction of hospital beds and the objective of shorter admissions professionals have to deal with a growing number of involuntary treatments. So it's a real challenge to specify the recovery orientation for the daily care practice of these wards.

Methods

Concept mapping is an empirical method for developing a conceptual framework for complex concepts which can guide evaluation or planning (Trochim, 1989). In group meetings with a cross-section of involved parties (clients, family, staff) from various institutions, who had experience with closed wards or expertise in the field of rehabilitation, quality statements were collected on the subject of recovery supporting care on closed admission wards. In the next step these statements were individually categorized according to content and priority. Subsequently the statements were processed using multidimensional scaling and cluster analysis in the form of a concept map.

Results

The focus of the concept map is on personalised care for individual clients. The experiences and wishes of clients must be taken as starting point whereby the emphasis is not on limitations due to disease but on capabilities. Actively involving relatives and ambulatory professionals in the planning of care is considered very important, as well as meaningful personal contact and autonomy within the context of seclusion

Discussion/Conclusion

This concept map will serve as basis for the development of an instrument to evaluate recovery support on closed admission wards.

A qualitative exploration of the impact of mental health personalised social care in England

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Background/Objectives

In England a policy and practice shift towards personalised care has led to the use of ‘personal budgets’, which allow eligible adults in receipt of social care services to spend individually allocated money to meet their agreed support needs. Personal budgets may be in the form of a Direct Payment – where the individual controls the money directly – or a managed budget, where the budget is controlled by the Local Authority and spent according to an agreed support plan. This paper will present findings from the PEOPLE (Personalisation: Evaluating Outcomes, Practice and Lived Experience of People using Mental Health Services) study which investigated the impact of Personal Budgets for people with a severe mental illness in four regions of England.

Methods

The study used longitudinal, in-depth qualitative interviews with 54 people with a diagnosis of severe mental illness at either 2 or 3 time points over a year. Participants at baseline were either in the process of applying for a personal budget, had previously received, or were currently receiving a personal budget to address their mental health needs. 30 professionals and 15 informal family carers were also interviewed once for their perspectives on the process and impact of personal budgets.

Results

The presentation will focus on how decisions were made relating to individuals’ goals, and the agreement of appropriate purchases and types of support. We discuss the key factors associated with effective use of Personal Budgets to meet self-identified goals and outcomes, including: service user and practitioner understandings of the purpose of personal budgets; the process and principles of decision-making and support planning; and how services and individuals manage the reduction and withdrawal of Personal Budgets.

Discussion/Conclusion

The findings have implications for developing best practice in the use of Personal Budgets and other forms of person-centred care. We discuss how such personalised packages of care may present new challenges for evidence-based service provision and the measurement of outcomes in relation to individually set goals.

A psychological treatment programme for traumatised ex-military personnel in the UK

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Background/Objectives

Home Base (HB) is a programme run by Community Housing and Therapy (CHT) in partnership with the Tavistock Trauma Service (TTS). The programme treats former members of the Armed Forces who have become homeless as a result of psychological trauma. Many are dependent on substances including alcohol and suffer the effects of institutionalization. HB is a comprehensive programme which includes accommodation, psychotherapy and rehabilitation within a therapeutic community (TC) methodology. Each year over 50 people pass through the programme.

Methods

Prior to admission potential clients undergo a thorough psychological assessment. The programme itself lasts for 12 months and is composed of three elements: (1) Immersion into the TC with its set rules and timetable aims at the stabilisation of the client's through the development of peer relationships; (2) short and long term group and individual psychoanalytic psychotherapy; and (3) rehabilitation including training for work.

Results

CHT and TPHT have commissioned Dr. Nick Maguire from Southampton University at the Centre for Social Work Research to evaluate the effectiveness of the programme. The following scales are used to measure outcomes:

PHQ9/GAD7- Anxiety and depression

WASA- Work and social adjustment

Mississippi- Trauma in military experience

AUDIT- Alcohol and drug usage

CORE- Overall well-being and social function

URICA- Clients willingness to change

PDQ4- Personality traits.

Discussion/Conclusion

At the end of the clients' treatment a reduction is expected in clients' overall symptomatology and social functioning.

‘Working Well!’: A Pilot Work-Focussed Psychotherapy Programme in Addition to Individual Placement and Support (IPS) – Six Months On

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Background/Objectives

A pilot work-focussed CBT programme offered in addition to IPS for clients aiming to return to work following severe mental illness.

Methods

Participants receiving IPS services were offered 3 - 6 sessions of work-focussed problem solving psychotherapy, delivered by psychologists. The aims were to help overcome psychological barriers to returning to work, including anxiety, self-esteem, depression, stigma, memory difficulties, and socialising. Baseline and 6 month scores were compared on measures of self-esteem, fear of negative evaluation, problem solving, and perceived executive problems. Participants' views were collected.

Results

Thirty-seven participants were randomised to the programme: 27 completed (19 men) (M= 30 years); data available for 21 at 6 months. Feedback was that the programme helped to improve confidence in interpersonal skills and empowered people to make positive and realistic life changes. Nine participants (43%) showed clinically significant improvement on a problem-solving measure. Nine (43%) improved on self-esteem, 10 (48%) on fear of negative evaluation and 11 (52%) on perceived executive problems. Only 3 participants did not improve significantly on any measure, and all were female. The majority of participants who chose the memory topic improved on a measure of perceived executive problems (7/11, 64%). Over half of those who chose the depression session improved on self-esteem and fear of negative evaluation measures (7/12, 58%).

Discussion/Conclusion

Early indications may suggest that brief work-focussed psychotherapy is a valuable adjunct to IPS for selected participants, and that this programme may improve problem solving skills, helping people to feel empowered to look for work.

Networks of social support and continuity of care for psychiatric users

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Background

Efforts to reorganize mental health services strive to improve continuity of care and patients' social integration. However, these two goals may prove incompatible. Indeed, continuity of care requires better coordination between service providers and standardization of practices. Social integration, on the other hand, supposes that the user is empowered for treatment decisions and flexibility of delivery practices.

In this study, we examined the relationship between social integration and continuity of care for patients with severe mental illnesses in their use of social support networks.

Methods

We conducted an exploratory study on 90 users. Data regarding their social support networks were collected using a hierarchical mapping technique and analyzed by Social Network Analysis. Participants' perception on continuity of care was measured by the Alberta Continuity of Services Scale For Mental Health (ACSS-MH). Social integration was measured with the scale SIX. We also used the Health of the Nation Outcome Scales (HoNOS) to assess the degree of distress of users

Results

Continuity of care appears to be associated with structural elements of patients' professional support network such as the central position of a health care provider. It is also associated with the presence of informal carers and their connections with health care provider, with reciprocity of relationships, with the diversity in social resources, "weak ties", i.e., relationships less emotionally invested, and with structural holes, i.e. parts of the network that are not connected to each other. These elements combine in different ways and are related to the degree of distress of users.

Discussion

Our preliminary findings suggest that continuity of care and social integration might not be contradictory goals. It should be possible to reach both goals by increasing coordination between services and facilitating development of weak ties between users and carers. This is a significant challenge for mental health services as patients with severe mental illnesses often have poor social support networks consisting mainly of strong ties. These results have to be completed with more in-depth analysis.

User and family members' involvement in the mental health care reform in Belgium: a pilot-study

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Background

User involvement in mental health care (MHC) can be defined as “involvement in decision making and active participation in various activities starting from the expertise by experience of the person, in collaboration with and as equal partners of professionals” (Tambuyzer et al, 2011, p. 5). Involvement of users and family members helps to improve MHC and is therefore stimulated in Belgium's MHC reform. The goal of this reform is to introduce more community care and user empowerment by reducing the number of psychiatric beds, by putting a solid outpatient alternative in place and by the development of local MHC networks (www.psy107.be).

The study aims to collect perceptions of users and family members on their participation in the MHC reform and treatment. The results are used as an input for policy recommendations.

Methods

Inspired on the research of Tambuyzer et al. (2012, 2013), the authors developed two checklists, one for -representatives of- users (19 items) and one for -representatives of- family members (18 items). Representatives, patients or family members of 12 networks in the MHC reform rated their network on two levels. First the level of participation in the own treatment was rated (involvement in decisions, information on treatment, management of crisis, communication with others, needs assessment). Next, the level of participation in the local MHC reform was rated on diverse items. Items were constructed as 5-point semantic scales.

Results

Most projects score low on overall involvement, although family members score their own level of involvement higher than users. Expert panels using the checklists as input, formed 17 recommendations considering the formation of individual treatment plans, contact with experts by experience, possibility to evaluation of the MHC, the right to look in own treatment plans...

Discussion

Checklists proved to be a useful and simple way to collect data from beneficiaries in local projects. They make it possible to give specific feedback on user and family involvement in the MHC reform. Checklists are currently being improved by constructing 4 different checklists (for users, family members and representatives). After improving readability, checklists will be distributed among all networks in the Belgium MHC reform.

Prevalence and treatment of depression in a sample of adults attending Primary Care facilities in Chile

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Background/Objectives

To know the prevalence of depression in a representative sample of adults attending 10 primary care facilities in the Province of Concepción Chile. Results of treatment and associated factors are also analyzed.

Methods

A follow-up study of 12 months on an initial random sample of 2480 patients attending primary health care centres in the Province of Concepción. Each patient was interviewed using CIDI 2.1 section for Depression. Information on clinical diagnosis and treatment was collected from clinical records. Participation in the study was voluntary; this was expressed through the patient's signature on an informed consent form.

Results

1,735 patients answered to the first step. At 12 months follow up response rate was 81%. Twelve-months prevalence of depression was 18,3%. Women and the group between medium ages presented the highest prevalence rates. The general practitioners had identified a low proportion of the patients diagnosed as depressed by CIDI. The results of treatment showed better results in severe depression.

Discussion/Conclusion

Chile has a national program to treat depression. However, prevalence of depression in primary care attendees has not decreased in this period. It would be necessary to assess the protocol adherence in the primary care teams.

Routine Outcome Monitoring (ROM) in an intensive community-based care program for severely marginalized persons that are hard to reach: An implementation study

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Background/Objectives

Systematical collection of data by ROM on the outcomes of clients in everyday clinical practice appears to be effective with respect to diagnosis, monitoring of treatment, reduction of hospital admissions, improvement of the communication between staff and clients, and the quality and transparency of healthcare. ROM is increasingly used in regular mental healthcare and addiction care, but less common in community services aiming at persons that are hard to reach. Implementing ROM in these services is challenging because of the outreaching and ad hoc characteristics of the services and the delicate relationship with these clients.

Methods

In a case study, ROM was implemented in a community-based care program aiming to reach severely marginalized persons that are not receiving services yet. The implementation process was registered systematically by fieldnotes and a diary. Furthermore, response rate, and the use of ROM data, measured with staff rated questionnaires, were assessed before and after the implementation. Descriptive analyses were performed.

Results

The implementation aims were successfully reached: i.e. a ROM instrument for this target group was developed and integrated in daily routine, ROM lists were structurally put on the agenda of team meetings, staff members were trained in using ROM, and software that provided the staff with user friendly, graphical output was designed and integrated in the existing registration system. The data were used for the annual report, the response rate was satisfactory and improved during the project, however, the use of ROM information by staff members was low at the start and hardly improved.

Discussion/Conclusion

The study showed that team members thought ROM measures provided useful information, and that they were willing to support the implementation of ROM, however, they were less willing to use the ROM data. One explanation might be that staff needed more time to adapt to the new technology, another explanation might be in the limited perceived added value of ROM by the staff. Recommended is to invest in the development of ROM training programs for staff members, and to expand the experience on ROM in this sector.

Promoting Recovery: Social Cognition and Interaction Training (SCIT) for Forensic Inpatients

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Background/Objectives

Social cognition refers to a set of cognitive processes which provide individuals with information in order to function during social interactions, follow social rules, and process social cues. Social functioning deficits are one of the diagnostic criteria for schizophrenia and tend to only be slightly improved with medication. Social Cognition and Interaction Training (SCIT) is a manual-based treatment that was designed to improve social functioning in schizophrenia by enhancing social cognition (Penn et al., 2005; 2007). SCIT groups have been carried out in both inpatient and community settings and have shown promise as an intervention for those with psychosis who wish to improve their social functioning. The aim of this study was to evaluate the efficacy, feasibility and acceptability of SCIT in the UK within a new setting; adult male inpatient forensic wards.

Methods

This study followed a wait-list control design. Four wards were selected and eligible participants (aged 18-65; with a schizophrenia spectrum diagnosis; and difficulties with social functioning) were assessed. Two wards were then randomised to take part in 16 group therapy sessions while the other 2 received treatment as usual. Following the intervention, all participants completed the assessments again. The SCIT groups were then implemented on the 2 remaining wards and again at the end of these, all participants received the assessments. The SCIT groups were conducted by a clinical psychologist and assistant psychologist. SCIT was adapted in order to work within a forensic inpatient setting.

Results

On average 5 participants attended each group. The group was positively evaluated by participants and the majority felt their social goals made at the start of therapy had been met as a result of the intervention. We are currently analysing pre and post therapy measures to evaluate whether significant improvements in social cognition as measured by theory of mind, attributional style, emotion perception and cognitive insight have been achieved.

Discussion/Conclusion

This study has showed it is possible to carry out SCIT within an inpatient forensic setting and that it is positively received by service users. We look forward to sharing further findings with a wider audience.

Implementing methods that support Recovery - Analysis of policy and practice in Sweden

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Background/Objectives

The Swedish mental health service system has, since the psychiatry reform of 1995 been characterized by the continuous development of diverse psychosocial interventions, where the trend has gone from locally developed solutions to internationally tested programs and methods. The current research project is studying 16 Swedish municipalities' implementation of methods recommended in the national guidelines for severe mental illness, published by the National Board of Health and Welfare 2011. Interviews will be conducted regarding the implementation processes and we will measure program fidelity and outcomes for individuals. Policy-makers and national strategies inevitably influence which interventions are prioritized and implemented. A policy-analysis will be conducted to get a comprehensive picture of the implementation process. The aim is to describe and analyze how the issue of community based interventions and methods are handled in Swedish policy documents and the types of strategies the government has used to steer the community mental health field.

Methods

A review of important mental health related policy documents at the national level published between 1992-2012, will be conducted. The focus will be on how the Swedish policy-makers handle issues related to interventions and methods. Methods used in the analysis will be based on Faircloughs three-dimensional framework for studying discourse. Theories about organizations, policy implementation and governance will also be used.

Results

A preliminary analysis of the data will be presented at the conference. The focus will be on how Swedish policymakers discuss concerning interventions and methods, what information they base their choices and decisions on, and what strategies for governance and management are being used.

Discussion/Conclusion

The initial analysis suggests that the Community Mental Health arena in Sweden is steered by a soft governance approach. On the one hand efforts are made to tighten control strategies in the form of national guidelines and advocacy for evidence-based practice, but it is still very much up to each municipality how they choose to organize their interventions to individuals with psychiatric disabilities.

Mothers without depression: A screening program, treatment and study of affective disorders in the post-partum period

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Background/Objectives

Postpartum depression affects 10.15% of mothers. The causes of postpartum depression are not well known, but a wide range of risk factors were studied. Our hospital in 2009, has launched a pilot project to assess the phenomenon and introduced screening for all women who give birth in the Department of Obstetrics and Gynecology. Following this experience has been operational since 2010 a dedicated Outpatient clinic at the Unit of Psychiatry Camposampiero which has the following objectives: 1.perform screening of mothers in our hospital. 2.engage in counseling and therapy, in a psychological and psychiatric outpatient clinic, available to all women in our area. 3.carrying out studies and assessments of sociodemographic characteristics, psychological and psychosocial our sample through use of diagnostic tools and a purpose-built database.

Methods

All mothers were subjected to an interview after 6-8 weeks after birth by a written summons and \ or phone for the self-administration of three tests (EDPS, PDSS, PSI-SF) and short interview with two psychologists of the project. After scoring and based on the cut-off (minimum 2 positive) women can be sent to psychiatric consultation, and then receive medication and / or psychotherapy or continue the path with psychologists with sending to a group psychotherapeutic focus.

Results

During the 2010-2012 period were invited to screening 4,000 women (give birth about 1500 women per year of which 30% of migrants) and have adhered screening about 1520 women with a adherence over the years has resulted from 34% to 42%. Of these women were positive to screening about 17%, but they received a psychiatric diagnosis about 5% with a diagnosis of DPP at around 1.9%. The data for 2012 are waiting for consolidation, but we could already assess that the screening positivity was significantly higher around 25.7%, although the elaboration of how many have received a psychiatric diagnosis is not yet consolidated figure. It is evident after three years of activity that only a clinical evaluation may confirm the diagnosis of Post-Partum Depression, resulting also in our sample, the assessment carried out solely with test overestimates the true incidence of DPP. A significant fact is that from 2009 to the present there has been no hospitalization to our department for Postpartum Depression. For 2012, it is confirmed that the dpp is about 1.15%, the socio-demographic characteristics and psychological showed that younger women with high parity do not adhere to screening. Migrant women found to have a 3 times higher risk not to join. It should be noted, moreover, the rate of voluntary abortions significantly higher among immigrants women (14,50 versus 1.47 of the Italian women).

Discussion/Conclusion

Remains also confirmed as having a psychiatric familiarity leads to greater adherence to screening and mental disorders in pregnancy and pregnancy out are considered at risk for development of dpp (as reported in the literature). To enhance the project and increase the participation of women, this year we will begin a collaboration with dispensaries of for vaccination of infants, involving health personnel in the distribution of the Edinburgh Post Natal Scale to all mothers in the hope more women can be understood and helped.

A rehabilitation program based on sporting activities in people with severe mental disorders: an example from Trieste, Italy

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Background/Objectives

The "Fuoricentro Polisportiva" is a non-profit organization of social utility founded in Trieste in 1999 and supported by the Mental Health Department, with the aim of promoting recovery in people with serious mental illness.

The aim of the present work is to verify whether a rehabilitation-program based on sporting activities can improve psychopathological conditions, coping ability, person's "social functioning", subjective and objective family burden in people with severe mental disorder.

Methods

This is a 2 years, descriptive, case-control study, led on 40 patients (20 cases and 20 controls) followed by the Trieste Mental Health Department. We compared two groups of out-patients with serious mental illness, for the following characteristics: age, diagnosis, professional condition and living situation, compliance to treatment, number and duration of admissions, main therapeutic interventions (both pharmacological and non-pharmacological).

Results

We recruited a total of 40 patients (20 cases and 20 controls). In the experimental group we found a stable improvement of the professional and living conditions, compliance to treatment and a reduction in the number and duration of admissions. Moreover, we found that this rehabilitation-program was effective in improving social interaction, self-esteem, body self-consciousness, compliance to treatment and in reducing anxiety and depression levels, admissions-rate, aggressiveness, family burden and finally stigma.

Discussion/Conclusion

Sporting rehabilitation strategy can be a useful strategy to improve the severity of symptoms and the socio-relational burden of mental disorders in people with serious mental illness.

Needs and profile of a sample of patients with mental disorders living in residential facilities in São Paulo city, Brazil

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Background/Objectives

Patients with mental disorders face limitations in their daily lives resulting in serious losses in several areas, such as, learning, economic, financial, social and legal. Their needs are complex and involve various types and levels of care and interventions besides control and remission of their psychic and physical symptoms. To establish needs and clinical and functional profiles of patients with mental disorders living in residential facilities (SRTs) in São Paulo, discharged from long-stay inpatient psychiatric hospitals.

Methods

Data were collected from 147 SRTs' residents in a cross-sectional study. Needs and profiles (quality of life, behavior problems, psychiatric diagnosis, severity of symptoms, socio-demographic characteristics) were assessed by using five scales (QLS-BR, SBS, M.I.N.I, CGI, ILSS-R) and pattern of service use (Client Sociodemographic Receipt Inventory).

Results

Residents mean age was 50.3 ± 13.2 yrs., median 52, range 19-77 yrs. It was found in the sample: females-55%, singles-81%, illiterates-20%, elementary education-53%, never worked - 67%, unemployed -29%, no income- 26,5%, receiving no benefits - 28%; mean stay in psychiatric hospitals 120 ± 113 months, median 84 months, range one to 45 yrs.; schizophrenia and other psychoses -72%, severe symptoms-45%, moderate symptoms -20%, mild symptoms-35%, cognitive problems - 40%, problems in appearance and personal hygiene- 50%; serious communication impairment -15%; social behavior impairment - 10%; use of three or more psychotropic drugs -75%; had attended an interaction community center- 15%.

Discussion/Conclusion

For reducing losses and increasing functionality in these patients several intervention needs were identified, such as, literacy and educational improvement programs, use of techniques for developing skills, improving communication and cognition, and training for assisted employment. In relation to drug therapeutic approach an important need for systematic and periodic review of prescriptions and treatment based on Evidence-Based Medicine was identified.

Comparative cost-effectiveness of two interventions for improving work functioning among nurses: pragmatic cluster randomised trial

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Background

The specific job demands of working in a hospital may place nurses at elevated risk for developing stress, anxiety disorder and depression. Screening followed by referral to early interventions may reduce the incidence of these adverse health conditions, improve wellbeing and promote work functioning.

Objectives

To evaluate the comparative cost-effectiveness of various strategies to promote work performance in nurses. Three conditions were compared: CTR, EMH and OP. The control (CTR) condition consisted of an online screening for stress and mental problems, but without any feedback about the screen results. The OP condition was the screening with feedback plus an invitation to visit the occupational physician (OP) for screen positive nurses. EMH was the screening with feedback, followed by referral to e-mental health (EMH) interventions for screen positives.

Methods The study included 617 nurses in one academic medical centre in the Netherlands. The study was designed as an economic evaluation alongside a pragmatic cluster randomised controlled trial with randomisation at ward level. Criteria for treatment response were met when a nurse manifested with an improvement on the Nurses Work Functioning Questionnaire (NWFQ) of at least 40% at follow-up. Total per-participant costs encompassed intervention costs, direct medical costs, direct non-medical costs and indirect costs stemming from lost productivity due to absenteeism and presenteeism. All costs were indexed for the year 2011.

Results

At 6-month follow-up, significant improvement in work functioning occurred in 20%, 24% and 16% of the participating nurses in CTR, OP and EMH, respectively. In these conditions the total average annualised costs were €1,752, €1,266 and €1,376 per nurse. The median incremental cost-effectiveness ratio (ICER) for OP versus CTR was -€5,049 (cost saving) per treatment responder. The ICER for EMH versus CTR was estimated as €4,054 (added costs) per treatment responder. Sensitivity analyses attested to the robustness of these findings.

Discussion/Conclusion

The OP-care intervention resulted in greater treatment responses for lesser costs relative to CTR and can therefore be recommended. In contrast, EMH produced less treatment response than CTR and cannot be recommended as an intervention to improve work functioning in nurses.

Does coercive mental health care affect long-term social outcomes in psychosis patients?

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Background/Objectives

Psychotic illnesses carry a substantial personal and societal burden in terms of disability, suffering and cost. Deficits in social functioning are a core feature of these illnesses and one of the most commonly cited burdens by patients, carers and families. Coercive treatment is common in the care of these patients with the aim of increasing adherence with medication and improving social and functional outcomes. However, it carries the risk that it may isolate and stigmatise patients, increase marginalisation and lead to poorer social outcomes. How social and functional outcomes are affected by coercion and treatment pressures has seen little empirical attention.

The Oxford Community Treatment Order Trial (OCTET) recruited 333 psychosis patients to test the effectiveness of community-based coercive treatment (Burns et al., 2013). Consistent with previous trials in the US, the trial found no reduction in relapse and readmission. The absence of any demonstrated clinical advantage raises the question of whether coercion affects social functioning and outcomes in the longer-term and justifies their use.

Methods

A subsample (n= 150) from the OCTET study is being interviewed 48-months after commencing the trial to assess whether the duration and pattern of coercive treatment affects social outcomes. Social outcomes will be assessed in three areas: social networks, social inclusion and quality-of-life.

Results

I will present the choice of instruments and the preliminary data from the first 50 patients interviewed.

Forensic Psychiatric Hospitals closure in Italy: new perspectives in the Lazio Region after the 2008 DPCM act

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Background/Objectives

In 1978 the “180 law” determined the definitive closure of mental hospitals in Italy. This widely known and appreciated project did not include, however, forensic Psychiatric Hospitals (Ospedale Psichiatrico Giudiziario: OPG). The 2008 DPCM act transferred penitentiary healthcare to the NHS, but the existing six OPGs, hosting around 1200 patients, will be definitively shut down only by April 2014. Meanwhile deinstitutionalization in OPGs became the object of a heated debate: the application of law has been beset by lack of forethought and by lack of alternative structures to OPGs for those patients with psychiatric diagnosis who had committed crimes. In 2011 a working group (involving Lazio Region, Agency for Public Health, Ministry of Justice, the 12 Departments of Mental Health, a dedicated unit in Sant’Andrea Hospital) was established to manage and ensure a convenient setting for patients undergoing a security measure.

Methods

An evaluation platform was implemented by the Agency for Public Health in order to group patients admitted to OPG in the Lazio Region and collect socio-demographic information, past psychiatric and medical history, criminological features and clinical data.

Results: 133 Patients (of which 11 females) from Lazio Region are at present inmates in OPG (over 85% of which in the 2 OPGs in the Naples area). Following the 2008 DPCM the discharge rate from OPG slowly increased: 182 patients have been already taken in charge by the Community Mental Health Centres (CMHC).

Discussion/Conclusion

CMHCs now must deal at their best with this new population. The Lazio region has made a massive effort for the taking in charge and territorial reintegration of forensic Psychiatric Hospitals’ inmates. The first goal has been the resettling of those whose security measures’ length kept being extended, and to organize treatment and rehabilitation programs. Shutting down the OPGs, In contrast with the closure of mental hospitals, must face the fact that – being the Criminal Code unchanged – there is still an incoming flow of persons receiving a custodial security measure, which is estimated at about 3 new entries per month. New structures for intensive psychotherapeutic programs, re-socialization activities, job placement and rehabilitation need to be completed before the 1st of April 2014 (D.L. 25 marzo 2013), when all the OPGs in Italy are expected to be closed.

Take a glimpse! Using concept mapping to develop a visual representation of housing and community-based residential settings

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Background/Objectives

Over the last 50 years, housing models have evolved towards models that are more conducive to consumers' empowerment and closer to their preferences. However, existing models do not provide a detailed description and conceptualization of residential environments and housing programs. This poster objective is to present the development of a pictorial conceptual model of housing and community-based residential settings for adults with mental illness as perceived by various key stakeholders.

Methods

Concept mapping is a six-step structured conceptualization process. It is a mixed methods participatory approach which incorporates group processes. Participants were selected using a purposive sampling for heterogeneity. Participants were from the public, private and nonprofit sectors and included service users, family members, staff working in residential facilities, mental health workers and managers. Participants (n = 221) generated 1382 statements describing housing and community-based residential settings attributes (99.5% saturation). Statements were analyzed using content analysis. Then participants rated (n = 416) and sorted into categories (n = 73) 140 selected statements. Multivariate statistical analyses (multidimensional scaling (MDS) and hierarchical cluster analysis) were used to produce the maps. Stakeholders (n = 12) were also involved in the interpretation of the maps. The process took place in 6 rural and urban regions of the province of Quebec (Canada).

Results

The stress value of the two-dimensional solution of the MDS is 0.2302 (10 iterations). The final conceptualization includes 12 clusters and 5 broader domains: geo-physical environment, milieu atmosphere and functioning, provision of interventions and support, organizational and managerial practices, social and organizational environment. The findings show an overall concordance between the statements perceived importance (rating) as well as statements interrelationships (sorting). The findings also illustrate the multifaceted and multilevel nature of community-based residential settings through a visual representation which facilitates comprehension.

Discussion/Conclusion

Concept mapping allowed for a rigorous and systematic exploration of the attributes (statements) of community-based residential settings and the mobilization of numerous stakeholders. The results suggest a number of domains that could be included in theory about community-based residential settings and housing, including a detailed description of the support and interventions provided.

Contribution of service design to four fold variation in access to psychological therapies: a systems level, mixed method study

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Background

The Improving Access to Psychological Therapy (IAPT) programme has trained a large number of therapists to treat depression and anxiety. Diverse pathways to care have emerged. Objective: To evaluate effect of different pathway design on access to IAPT services in the UK.

Design

Mixed methods system level study with data synthesis to make inferences about optimum design. Setting: Primary care based psychological therapy services in the Southwest of the UK. Participants: a) 11 IAPT services with equivalent investment per head population and b) 84,000 individuals referred to the services 2010-11. Intervention: New UK stepped care high volume services for psychological therapy; they need to have a central hub, supervision and collect outcome measures. Outcomes: Service by service comparisons of service design, access rates, waiting times, and outcomes for depression and anxiety (Using baseline and end of treatment PHQ-9 and GAD-7).

Results

i) Most services report self-referral and stepped care. Some have complex referral paths; others can book therapy without assessment. ii) Large variations in referral (11-36 per 1000 population per annum) and access (7-28/1000pa). PHQ-9 and GAD-7 baseline scores were equivalent in high throughput services. Mean time from referral to first clinical contact varied (27-57 days); waiting time did not increase with referral rate. Types of initial treatment varied between PCTs (eg groups: 5 - 42%; counselling: 1 - 34%). iii) Numbers achieving minimum clinically important difference (MCID) on GAD-7 and PHQ-9 ranged from 1.5-5.5 per 1000 population. One service achieving highest access and low waiting times through use of open access pathways (no triage or practitioner assessment), directly bookable appointments and groups; several services achieved high volumes, low waiting time and high recovery rates; other services performed poorly on all indicators.

Conclusion: The service with easy access routes, minimal triage and high levels of group work cope with high demand. Services with high access and low drop out after the first session are most able to achieve high numbers with MCIDs. National guidance about the need for practitioner based assessments prior to treatment (rather than patient choice) needs to be reconsidered. Further investigation is required to understand such major discrepancies in performance.

The introduction of compulsory community care – for the best of the patient or managing political risk?

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Background/Objectives

In 2008 compulsory community care (CCC) was introduced in Sweden. With CCC, patients can be treated against their will in the community. In 1999, an identical bill was rejected with the justification that such form of compulsory treatment would not be consistent with the general direction in Swedish mental health policy towards less compulsory treatment. What happened in the years between the two bills – the first one being rejected and the second one being adopted? Why did the opinion change so dramatically?

Methods

Documents from the parliamentary process, political debates, debates in mass media and in professional journals and interviews with persons with insight in the policy process are the main data sources. The policy process has been studied through a policy translation perspective to be able to analyze the introduction of CCC.

Results

- In 2003, the Swedish news media reported extensively on four fatal incidents in which men suffering from mental illness attacked people in public settings. These incidents led to an intensive public debate about mental health services. Main themes in the debate were that the mentally ill are dangerous and that de-hospitalization had failed. This resulted in a legitimacy crisis for the mental health system.
- In the debate, earlier master ideas of the mental health institutional field such as autonomy and less coercion was downplayed and new master ideas, such as control, dangerousness and risk, became central.
- When the first bill was introduced in the 1990s, CCC was described as a step backwards in the development. The second time it was instead described as a reform and a new form of care (even though the bill itself was identical). The new bill was presented as a part of a bigger investment in the mental health system.

Discussion/Conclusion

CCC came in 2008 to be seen as a solution to a problem with dangerous mental health patients. The new bill landed in the field in the “right” time – mental health suffered from a legitimacy crisis and new master ideas, such as control and risk, had entered the field – and CCC was used to create legitimacy. Studying mental health from a policy analysis perspective can help us to see how political risk management, rather than the patient’s best, sometimes is the objective behind interventions and policies.

Fidelity to Flexible Assertive Community Treatment in the Netherlands

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Background/Objectives

Flexible Assertive Community Treatment (FACT) is a Dutch adaptation of assertive community treatment. For more stable long-term patients FACT provides coordinated multidisciplinary treatment and care by individual case management. Unstable patients at risk of relapse are followed with assertive outreach (ACT) care by the same team, working with a shared caseload for this subgroup. Nowadays approximately 200FACTS teams are set up in the Netherlands.

Methods

Experts in FACT developed a fidelity checklist FACTS covering 60 quality indicators. Over 100 teams have been audited by a certifying body.

Results

Teams score high on the basic functions of FACT (such as nurses in the team, multidisciplinary care and support) and lower on specialties and recovery oriented care (such as vocational specialist, peer specialist, substance abuse specialist), although the score on rehabilitation items is rising in the past few years. The psychometric characteristics of the checklist will be presented.

Discussion/Conclusion

The fidelity checklist has proven to be an important instrument to promote the quality and recovery orientation of FACT. The Dutch Health Care Inspectorate now advises FACT teams to be audited. The FACT model is spread to other European countries, such as England and Norway.

Psychoeducation for patients with bipolar disorder: a study of effectiveness in Italy

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Background

Evidence-based guidelines for the clinical management of Bipolar Disorders (BD) recommend that “all patients with BD should be offered group or individual psychoeducation” to prevent relapse, improve treatment adherence, quality of life and functioning. The studies conducted so far on psychoeducation have reported controversial findings: some trials have shown that psychoeducation reduces the rates relapses compared to treatment as usual, others have shown that psychoeducation is ineffective to prevent mood episodes or improve functioning. The present study is aimed at evaluating the effectiveness of psychoeducation in the reduction of hospitalizations at 1-year follow-up.

Methods

One hundred and two outpatients were recruited from two DMHs in northern Italy. Inclusion criteria were a lifetime diagnosis of BD type I or II as assessed by SCID-I, and being euthymic for at least 3 months. Exclusion criteria were a DSM-IV Axis I comorbidity, mental retardation (IQ <70), organic brain damage. All subjects received standard psychiatric care, with standard pharmacological treatment; the experimental group received additional 21 weekly sessions of psychoeducation, delivered according to Colom and Vieta’s model. The clinical psychologists who conducted the groups were trained directly by Colom and strictly followed their methodology.

Results

The psychoeducation group consisted of 57 participants (27 men and 30 women). Control group were 45 (23 men and 22 women). The psychoeducation group’s mean age was 41.5 (SD=9.1; range 23-60), and the control group’s was 44.8 (SD=8.8; range 23-59). There were no statistically significant differences between the two groups with regard to sociodemographic characteristics, and approximately half of patients in both groups were currently employed. The number of patients hospitalized during the 1-year follow-up, the mean number of hospitalizations per patient and the mean number of days in hospital were significantly lower for psychoeducated patients.

Conclusion

This study supports the view that group psychoeducation is an effective intervention to prevent patients’ hospitalization and decrease hospital days in pharmacologically treated patients with BD, also in routine clinical settings. The results seem to confirm that the psychoeducation promotes an improvement in the course of illness, avoiding acute recurrences, and producing a greater stabilization of the disorder and consequently an improvement in quality of life in people with BD.

User embracement at the Psychosocial Care Center (CAPS) in Brazil: one strategy to user compliance

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Background/Objectives

the Psychosocial Care Center (CAPS) is, currently, the leading community mental health service in Brazil, strategically replacing the previous psychiatric hospital centered model. It's based on a multidisciplinary team, free access and the development of singular therapeutic projects to the needs of individuals in their social context. The care involves protection against vulnerability and risks, prevention of disorders, and treatment, rehabilitation and recovery. The main institutional strategy of the CAPS is the user embracement, which is a technique of qualified talking and listening in order to establish an efficient relationship between professional and patient, adapting the care to the needs of the patient, in an ethical, human, and sympathetic way. The National Health System and the mental health service's reform have the deinstitutionalization, the territorialization and user embracement as their main guidelines. Aim: to evaluate the user embracement in a sample of CAPS in São Paulo City, Brazil.

Methods

The authors used the database record of 8 CAPS from São Paulo City (4 for adults, 3 for drug and alcohol dependence and 1 for children and adolescents) in the first half of 2012.

Results 3,723 users were embraced: 1,147 adults (A), 2,183 alcohol and drugs users (Ad) and 393 children and adolescents (IA). Of the 3,723 users embraced, 1,276 (34%) became patients, respectively 436 A (38 %), 729 Ad (33%) and 111 IA (28%).

Discussion/Conclusion

About two thirds of the users did not become patients. Although the user embracement is considered a strategic tool, it is not formally assessed. The teams informally indicated as the responsible for the losses the free membership as a facilitator for not meeting the inclusion criteria. The barriers were: severity of illness; loss of autonomy or ability; socioeconomic and financial difficulties; refuse to treatment or different expectation regarding the type of treatment; presence of other patients or lack of family support. The authors conclude that it is important to employ process management tools, promote controlled trials and assess the user perception about the quality of the care, before stating that the user embracement is not fulfilling its function of promoting better outcomes.

Social functioning and participation in society in an Amsterdam cohort of patients with severe mental illness

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Background/Objectives

In the late nineties it was hoped that by living more independent, SMI-patients would improve their quality of life and their social functioning and would better integrate in society. The Amsterdam SMI-study follows a cohort of patients with severe mental illness and points out their functioning, living-situation and use of care.

Methods

Symptoms, quality-of-life, need for care, social and daily functioning and victimization and discrimination were assessed in a sample of 225 SMI-patients in 2005 and 2011. Differences on the outcome variables are computed and linked to changes in living conditions and care provision.

Results

Although patients participated more in society in terms of daily activities like membership of an organization and work, their quality of life did not improve and their needs for care remained high. However they remain to be rather satisfied with their life and the care they receive.

Discussion/Conclusion

The creation of activity-centers, sheltered working places and projects for integration improve participation in society of SMI-patients. However that doesn't mean that social functioning and quality of life improve. Therefore improvements for this group of patients on a political and societal level are necessary.

Mental Healthcare Delivery System Reform: Stakeholders and Policy Priorities Compared

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Background/Objectives

Since 2010, Belgium is in the process of reforming its mental healthcare delivery system with the aim of simultaneously strengthening community care and improving care integration. The new policy model is based on networks of services. The literature on networks of services is heterogeneous and little is evidenced about their ability in effectively provide care integration in a community-based care supply. Moreover, deinstitutionalisation contributed to decrease continuity of care. In this context, we explored how stakeholders involved with the reform prioritise the reform policy goals and how they might interlock community care and care integration.

Methods

First, we carried out an evaluation of the programme theory of the policy reform. Seventeen key goals were identified and classified in three levels of action: user, service, and system. Then, we undertook a web survey with 122 stakeholders involved with the reform implementation. Respondents were asked to rank those goals according to their priority order. Average rankings and 'coreness' of the goals, defined as their level of interrelation with other goals, were computed and processed within a factor analysis. Cross referencing coreness and policy priority, four categories of goals were defined: strategic (high priority and coreness), specific (high priority and low coreness), controversial (low priority and high coreness), and secondary (low priority and coreness). Priorities of stakeholders were compared with policy priorities and coreness.

Results

The factor analysis revealed conflicts between at the three levels of action mainly concerning patient's choice vs. provider's choice, and diversification of care delivery vs. coordination. Policy priorities at the user and service levels were acknowledged as strategic: deinstitutionalisation and social inclusion. However, system-level policy priorities, i.e. de-categorisation and the decrease of hospital treatment, were rated as controversial or secondary. By contrast, patient's quality of life and accessibility were rated as priorities by stakeholders.

Discussion/Conclusion

There is a potential clash between policy priorities and stakeholders' priorities, particularly for what concerns diversification vs. coordination of care, and the reduction of the influence of hospitals in treatment vs. deinstitutionalisation at the system-level. This clash might constitute a threat to the effectiveness of the reform that might be unevenly implemented.

Multidimensional outcome after involuntary treatment from 2010 to 2013 of a consecutive cohort in a mental health centre of Trieste

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Background/Objectives

Involuntary treatment and/or admissions in the 24 hours Mental Health Centres remains a controversial practice as to assertive community treatment (ACT) although every year the rate of involuntary treatment is very low.

Methods

A cohort of 25 consecutive admissions from 2010 to 2013 was recruited. Data collected for the whole sample were achieved through some items of WHO/DAS II and Lancashire Quality of Life Profile and SF36. The period taken into consideration for each patient was of one year.

Results

One third of patients were characterized by use of substances (legal and/or illicit) with poorer global functioning and worse social outcome respect to patients without substances.

Discussion/Conclusion

A favourable outcome after involuntary treatment is possible but the relationship with the substances is a fundamental tool to stimulate psychosocial interventions to promote better outcome.

A cluster randomised controlled trial of an oral health intervention for people with serious mental illness

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Background/Objectives

People with serious mental illness tend to have poor oral health compared to the general population due to medication side effects, issues with self-care and barriers to treatment. Guidelines suggest oral health should be monitored for people with serious mental illness but this is often not reflected in current practice. The aim of this trial is to investigate whether a simple one page dental checklist, used by Care Co-ordinators in Early Intervention in Psychosis (EIP) teams, affects oral health behaviour of people with serious mental illness.

Methods

This trial was designed by the collaborative effort of local clinicians, researchers and service users in the East Midlands, UK. Service users from the local EIP teams aged >18 years old were eligible. Ten EIP teams caring for 1074 people with serious mental illness were cluster randomised to receive a dental intervention or continue with standard care for 12 months. The dental intervention group Care Co-ordinators received a dental awareness training session before initial use of the dental checklist with their service users. Twelve months later the checklist was repeated. Control group Care Co-ordinators continued to deliver standard care for 12 months before receiving the dental awareness training and using the checklist with their service users. The primary outcome was oral health behaviour.

Results

Baseline data showed 64% of service users had visited a dentist within the previous 12 months but only 44% brushed their teeth twice a day. Reasons for not having visited a dentist included no perceived need, not being able to find a dentist, treatment cost and dental anxiety. Twelve month follow-ups have just begun.

Discussion/Conclusions

This simple intervention and method shows how a bottom-up design may work. These trials are potentially powerful and can produce interventions that, if effective, could be widely implemented with little time and cost implications.

Ten years of individual placement and support in Italy

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Background/Objectives

Individual Placement and Support (IPS) is an evidence-based approach to supported employment for people who have a severe mental illness.

Concerns are frequently expressed on work, claiming that it might worsen the mental health of people with severe mental illnesses. Several trials on IPS, however, have found associations between working and better non-vocational outcomes.

Methods

From 2003 to 2006 a multisite randomized trial of IPS (Eqolise RCT study) tested the hypothesis that IPS would prove more effective than comparison treatments in Europe. Since 2003 IPS has been successfully practiced in Rimini (the first Italian centre).

In 2008 Region Emilia-Romagna, appraising evidence from the pilot site in Rimini, put IPS in its policy and financed a program for the dissemination of IPS in all its NHS trusts.

This program, called TIPS (Training in IPS), is carried out through the following phases: preparation of training material, training of IPS specialists, integration of IPS specialists into existing Mental Health Centres (MHCs), recruitment of clients, delivery of treatment, supervision and monitoring of experience, collection of baseline and outcome data, evaluation of experience with a view to further implementation in all Regional MHCs.

Results

IPS is found to double the access to competitive work for people with psychotic illnesses, without any evidence of increased relapse. 50% of users found a competitive job and about 40% of clients at each time is working.

In 2010, 13 over 41 MHCs of the Region started offering IPS to their users.

In 2012 also the MHCs of Pordenone and Lecco started with IPS.

MHCs in Sicily and Rome are about to implement the program.

Discussion/Conclusion

Concerns among clinicians about possible detrimental effects of working and supported employment have been misplaced.

Large populations of mentally ill patients wish to work and consider working as the hallmark of recovery.

Key factors in supporting recovery processes

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Background/Objectives

In order to make mental health care services more effective in supporting personal recovery processes of persons with a severe mental illness, we need to know much more about the nature of recovery processes and the factors which can positively influence recovery.

The aim of this study was to explore and identify these factors.

Methods

Two methods were used: Systematic literature review and grounded theory analysis. The literature review included 28 studies from 10 countries, comprising more than 950 subjects. A factor and cluster analysis was conducted. Second, a narrative study involving 13 service users in the Netherlands provided more data on the role of mental health services and professionals.

Results

The findings show that the process of recovery generally goes through three stages: stabilization, reorientation and reintegration. It is not a linear but rather a dynamic process in which constant interaction takes place between the self and the environment. For professionals it is important to connect to the needs in the specific phase of the process. Four clusters of recovery factors could be identified: empowering factors, identity (re)formation, transition factors, and self-management competences.

Discussion/Conclusion

Recovery can be defined as a developmental process that can be described on a continuum from disintegration to integration, or from being disconnected to being connected. Integration and connection are related to two entities: the person or the self and the environment or community. The recovery process is motivated by a drive to 'move forward'. In the stabilization phase of the process this direction may still be vague, and none other than fuelled by the desire to get rid of the oppressive character of the situation, which causes much suffering. In the reorientation phase, the desired future perspective becomes more articulated, and may obtain shape in the form of concrete goals. In the reintegration phase, specific steps are taken to attain these goals. All studies mark the encouraging and on-going support of professionals and other people as indispensable. This support has to focus on the factors which are important to the person in the context of his recovery process and specific situation. This requires new ways of assessment and professional treatment and counseling. Mental health services should adapt their orientation to a recovery focus.

“Medical Pedagogy” - a national social psychiatry development project in Denmark

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Background/Objectives

“Medical Pedagogy” is a new field, supporting cooperation, shared decision making and coherence between service users and staff within clinical psychiatry and social psychiatry. “Medical Pedagogy” focus on:

- The use of medicine as a part of the recovery perspective, where medication is not an aim in itself but a means to recovery
- Aiding the individual to use the medicine to give the best possible conditions to achieve their goals
- Adjusting medicine use to the individuals needs, wishes and expectations
- Enabling the individual to have a say and to have control over their own treatment adapted to the individual’s needs and background.

Methods

The project was designed as a co-productive innovation project where users and staff participated in the development of the different methods on a common basis. The participants were psychiatric patients who live in sheltered housing or who receive community support, somatic and pedagogic staff in Social Psychiatry and GP’s, psychiatrist and district nurses.

Eight Danish municipalities (teams) participated in the development and testing of the “Medical Pedagogy” methods: Bornholm, Høje-Taastrup, Slagelse, Holbæk, Odense, Vejle, Horsens and Aarhus. All 8 project teams had 3-4 service users actively involved in the development of the methods. During a period of two years 2010-12 they have meet at three learning seminars sharing their experiences and qualifying the methods. A total of 30 service users have been actively involved in the project, participating in the learning seminars on equal terms with staff. The qualities of having staff and users work together in the development of the ‘medical pedagogy’ concept and testing the related methods, has been a great asset in the project.

Results

The project resulted in the development and use of three methods to strengthen the “Medical Pedagogy” work:

Group psycho-education in Social Psychiatry: A concept for group psycho-education in Social Psychiatry has been developed. The participants become more conscious of their own medicine use and strategies for mastering their own medicine through teaching, dialogue and reflection. The course is based on life story narratives, motivation work and the good life.

The Good Consultation: Central to the user achieving more influence over their own medicine is the cooperation between the individual, the GP and the psychiatrist or district nurse. A dialogue tool, to help the patient to prepare for and carry out consultations has been developed in the project. The dialogue tool is an aid to enhance shared decision making and ensure that the individual’s wishes are at the top of the agenda.

Complementary strategies to the medicine

Many patients use other strategies than medicine, such as acupuncture and massage. These strategies are most often not a part of the overall treatment plan. A tool to identify the individual use of these complementary strategies has be developed in the project so that users of medicine has a treatment strategy package that underpins their needs.

Method descriptions has been developed for municipalities, professionals and service users that want to work specifically with “Medical Pedagogy” and is now being spread to other institutions and

municipalities. Easily available and easy to use e-learning material for “Medical Pedagogy” initiatives has been developed during the project, for instance method manuals and descriptions of how the “Medical Pedagogy” work can be organized.

There has been an ongoing process evaluation during the project period showing that both staff and service users have been very satisfied with the methods and the co-productive format the project initiated. There will be a formal evaluation of the national project during 2013.

Discussion/Conclusion

Medicine is not always a sufficient support to help mentally ill people to have a satisfactory everyday life. In order for the medicine to be an aid to taking care of oneself and as an aid to recovery, it is important that the medicine be adapted to the individual's needs and background. Medical pedagogy and the new methods can help users/patients in a recovery process and at the same time provide a common professional platform for both mental health workers and pedagogic staff in rehabilitation work.

DRAFT

Facts and figures on societal participation in people with severe mental illnesses in the Netherlands; First findings of a national panel

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Background/Objectives

Mental health care increasingly aims at contributing to recovery and societal participation of people with severe mental illnesses (SMI). Yet little knowledge is available on a national level about these outcomes. Recently a national panel was developed consisting of members representing people with SMI to fill this gap. Aim is to gain more knowledge and insight in how persons in this group live, work and participate in society. Participation and recovery (and related topics as relevant support) are core themes.

Methods

Panel members are recruited both in mental health services' divisions for people with SMI and in public, e.g. through calls on internet and in newsletters. The panel uses several methods, e.g. surveys amongst members - either online or in paper form, according to their own choices. In part, standardised scales are used to be able to detect trends. At this point three surveys were conducted.

Results

The panel has started in 2010 and consists of more than 800 members. Response within members to the first questionnaires was 81%. 81% is client of mental health services. Considering duration of mental health problems and disabilities experienced in daily life and participation domains the target population is adequately reached. Between 15 and 20% of panel members work competitively, far less than national figures in the total labour population (70%). A majority of members wishes for changes in societal participation, especially regarding relationships and work. Loneliness is more often reported in the member population as it is nationally measured in other civilians (77% against 30% feeling moderately or strongly lonely).

Discussion/Conclusion

The panel figures and data were proven to be useful for (applied) science and administration & policy makers. Panel figures have been used in presentations, policy documents and are published in fact sheets. The panel data support further efforts to gain insight in effective rehabilitation support and implementation of evidence based rehabilitation interventions. In the near future the panel team will seek collaboration with research groups to increase the use of data, broaden the scope of the research, and improve insight in the degree of representativeness of the panel.

Mindfulness - a guide for clinicians in distress reduction practices to support recovery

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Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is a teaching hospital specializing in comprehensive mental health and addiction services for those with complex serious and persistent mental illness. The facility, in Whitby Ontario, Canada has 17 specialized inpatient units and extensive outpatient and community services. The Centre is staffed by approximately 1200 employees and provides mental health treatment for 339 inpatients, with approximately 50,000 annual outpatient visits.

Our recovery-oriented model of care places direct emphasis on the effective collaboration with patients and families to implement a proactive approach towards care. Recognizing that the combination of therapy and medication is crucial to recovery, the addition of self-awareness tools and skills is increasingly seen as beneficial. These methods of self-discovery and help patients become more in touch with their mind, body and soul while giving them an increased sense of control over their recovery process.

The presentation will detail the author's experience as Physician-in-Chief in implementing and championing mindfulness-based stress reduction techniques in the outpatient urgent care assessment clinic at Ontario Shores.

Everyone's recovery and experience with mental illness is unique and different. Whether they are just beginning their recovery or are further along on their journey, the holistic practices discussed in this presentation are an excellent compliment to therapy and medication in reducing patient's distress and increasing their overall well-being.

DRAFT

Can Obstetric complications predict a more severe functional and clinical outcome? Data from the 2-year follow-up of a large first episode psychosis study (PICOS)

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Background/Objectives

Understanding and improving outcome of psychosis remains a major challenge for clinical research. The search for consistent and reliable prognostic factors that could identify at the illness onset which patients will recover completely from those who do not has become an important goal. Since several meta-analyses have confirmed the role played by obstetric complications (OCs) as risk factor for schizophrenia (OR 2.0), in the past decades, OCs have been investigated as potential predictor of outcome in relation to illness severity and poorer treatment outcome. However, despite several indirect evidence of a link between OCs history and poor prognosis, there are few direct tests of this hypothesis in first episode psychosis (FEP) patients. We test whether OCs, collected in a large cohort of FEP patients can predict outcome, specifically illness severity and course type after 2 years from the onset.

Methods

The study was conducted within the framework of the Psychosis Incident Cohort Outcome Study, a multi-site collaborative research on incident cases of psychosis attending Psychiatric Services in Veneto Region, Italy. Standardized instruments have been used to collect socio-demographic, clinical information and the history of OCs was recorded by the Lewis-Murray scale to patients' mothers.

Results

Out of 397 patients enrolled in the study, OCs were assessed in 264 patients. Out of these, 78 patients (29.5%) reported at least one OCs.

Discussion/Conclusion

We predicted that patients with the poorest course (continuously psychotic or episodic) could be distinguished from those with the best course (recovered), by the presence of OCs. In a secondary, exploratory analysis we investigated whether the presence of another putative marker of neurodevelopmental deficit, Neurological Soft Signs, can best distinguished patients with a continuous or episode course from those recovered.

Association between the COMT gene and neurological abnormalities and poorer executive function in Caucasian patients with psychosis

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Background/Objectives

Minor neurological deficits in motor and sensory functions, and executive function deficits are present in excess in psychoses, and could reflect the same pathophysiological process underlying these disorders. In fact, both neurological impairment and worse executive function have been associated with reduced prefrontal cortex volume. It is possible that the Val158Met polymorphism of the COMT gene that codes for the enzyme responsible for dopamine cortical availability influences both neurological and executive impairments by affecting the function of prefrontal regions. We evaluated a large cohort of Caucasian patients with psychosis to investigate whether subjects homozygous for the Val158 allele had greater neurological impairments and worse executive performance than carriers of the Met158 allele.

Methods

We evaluated 211 individuals from four different cohorts of subjects with psychosis recruited in Italy and the United Kingdom. All patients underwent neurological and neuropsychological evaluations, and were genotyped for the COMT Val158Met (rs4680) polymorphism.

Results

Patients with higher motor sequencing scores exhibited a worse block design performance (ANCOVA, $p=0.002$). Contrary to our hypothesis, individuals with high motor sequencing signs and poorer executive function were significantly more likely to be homozygotes for the Met158 allele. In contrast, there were significantly more Val158 homozygotes among patients with low motor sequencing signs and good executive function (Chi Square, $p=0.016$).

Discussion/Conclusion

Our finding of an association between the Met158 allele and both neurological and executive deficits was not predicted and needs to be replicated.

Positive symptoms in first-episode psychosis patients experiencing low maternal care and stressful life events: the mediating role of the comt gene

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Background/Objectives

Interaction between stress and COMT may contribute to the emerging of psychotic symptoms. Exposure to stress is also associated with mesolimbic dopamine release in individuals experiencing low maternal care.

We test the hypothesis that recent stressful events are associated with more severe positive symptoms in first-episode psychosis (FEP) patients who experienced low maternal care during childhood and that COMT Val158Met moderate this association.

Methods

The study was conducted within the framework of the Psychosis Incident Cohort Outcome Study, a multi-site collaborative research on incident cases of psychosis attending Psychiatric Services in Veneto Region, Italy

Psychopathology was assessed by the Positive and Negative Syndrome Scale (PANSS), maternal care by the Parental Bonding Instrument (PBI), and stressful events were collected by the List of Events Scale.

Results

A total of 149 FEP patients participated in the present research. We found that low maternal care and recent stressful events were associated with higher level of positive symptoms at the onset (ANOVA, $p=0.020$), and that those with homozygous COMT Val158 allele had the highest level of positive symptoms (ANOVA, $p=0.030$).

Discussion/Conclusion

Low maternal care and severe stressful events may contribute to positive symptoms at the onset possibly due to an increased mesolimbic dopamine release. Homozygosity for the Val158 allele may confer a biological predisposition to the stress-related hyperactivity of the mesolimbic dopaminergic system.

Bridging the gap between research and practice through the development of GRADE recommendations for psychotropic drug interventions

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Background/Objectives

Evidence-based treatment recommendations are considered a valuable link between primary research and daily clinical practice, as they allow clinicians to take research findings into account when making decisions under ordinary circumstances. The present project aims to develop a set of evidence-based guidelines on controversial issues in clinical psychopharmacology and to build up a shared strong methodology for choosing and managing pharmacological treatments under everyday clinical practice.

Methods

Psychiatrists with a specific interest in the rational use of psychotropic drugs were identified and appointed as members of a Guideline Development Group (GDG). The GDG identified controversial areas in the use of psychotropic drugs, defining scoping questions and outcomes of interest. The GDG was supported by a scientific secretariat (Unit of Clinical Psychopharmacology of the University of Verona), which searched the evidence and provided scientific support with the GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology for summarizing the evidence base and grading its quality. On each topic identified a recommendation was drafted and discussed among GDG members, and then in two plenary sessions involving all medical staff of the DMH in order to reach a consensus and a formal agreement.

Results

After their development, recommendations were collected in a format suitable for dissemination to all clinicians of the local Department of Mental Health, with the request of taking this material into consideration in their everyday clinical practice. Different guideline implementation strategies will be employed to maximize the uptake of guidelines into the decision-making process.

Discussion/Conclusion

The present project of guideline development raised several challenging aspects, including the appraisal and synthesis of evidence, the relative weight of values, preferences and feasibility issues, as well as the group composition and the identification of clinical questions. An innovative aspect is that a “bottom-up” approach was followed, where recommendations were developed by those who were supposed to follow them. Furthermore values, preferences and feasibility issues were indeed considered, paying due attention to local variables. Hopefully, the monitoring phase, which is currently ongoing, will clarify whether such a bottom-up approach in guideline development is likely to be an effective implementation strategy.

Guideline implementation strategies for specialist mental health care: a systematic review

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Background

During the last decades a wide range of therapeutic interventions have been developed for individuals with severe mental disorders. These evidence-based interventions are not easily translated into practice, resulting in a gap between the production of evidence and its upload in routine care. One approach to improve the translation of evidence into practice is the dissemination and implementation of clinical guidelines.

Objective

To examine the efficacy of guideline implementation strategies in improving process outcomes (performance of healthcare providers) and patient outcomes, and to explore the performance of different strategies for guideline implementation.

Methods

A systematic review of randomised as well as non-randomised evidence assessing the effects of guideline implementation strategies on provider performance and patient outcomes, for the treatment of adult patients with severe mental disorders recruited in mental healthcare settings. Medline, EMBASE, PsycLit, PSYINDEX, the Cochrane Database of Systematic Reviews (CDSR) and the Cochrane Central Register of Controlled Trials (CENTRAL) were searched for relevant literature using a comprehensive search strategy. Two reviewers independently selected studies and discrepancies were solved by discussion.

Results

1386 references were inspected and 48 potentially eligible articles were identified after abstract screening. Of these, 15 finally met the inclusion criteria. Although the included studies are heterogeneous in terms of design, implementation strategies and outcome measures, a trend toward an improvement in process and patient outcomes was observed.

Discussion/Conclusion

Current knowledge about how guidelines should be implemented is still sparse and inconclusive in mental healthcare. It is therefore very difficult to draw firm conclusions about which implementation strategy is effective in different healthcare contexts.

An evaluation of REFOCUS Personal Recovery and Coaching Training

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Background

The REFOCUS Trial (ISRCTN02507940) is currently underway in two mental health trusts in the UK. The trial intervention was designed to support the development of a recovery-orientation in community mental health teams and to promote personal recovery among service users. Part of the intervention involved training mental health professionals on personal recovery and to develop coaching skills.

Personal recovery training was designed to allow staff time and space to reflect on the meaning of recovery. It also aimed to give staff the chance to learn new recovery knowledge and skills via face to face learning, group discussions and learning by doing. Coaching training was designed to give staff practical coaching skills tailored towards delivering the working practices of the REFOCUS intervention (understanding values and treatment preferences, assessing strengths and how to support goal striving).

Method

Participants were Personal Recovery and Coaching for Recovery trainers and staff from the intervention teams of the REFOCUS trial. Data Sources: (A) Trainer reports; Trainer reports were written by trainers after both the personal recovery training and coaching training. (B) Participant training evaluation forms; Staff were asked to complete feedback forms at the end of the personal recovery training and coaching sessions. Analysis: Trainers reports for personal recovery and coaching training were collated and were thematically analysed using Nvivo 9.

Results

Preliminary analysis indicates that three higher order themes are emerging around i) recovery and practice (staff members perceptions on the meaning of recovery and how this is implemented in practice), ii) organisational context (difficulties faced by teams in their working environment) and iii) team dynamics (similarities and differences in the team in attitudes towards recovery and training).

Conclusions

This poster will outline key lessons learnt around providing personal recovery/coaching skills training to community based mental health teams.

Recovery-oriented practice in psychiatric wards: organizational challenges

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Background/Objectives

Despite intentions of creating a recovery-oriented psychiatric practice, making recovery-oriented approaches a natural and an integrated part of the daily practice of mental health services is not an easy task. Well-known challenges include staff attitudes towards and knowledge about recovery and mental illness. But even when staff has an extensive knowledge about recovery and agrees with the ideas, a recovery-oriented approach is still far from daily practice. Paradigmatic differences may contribute to the problem as the traditional medically based psychiatric care, which is still dominating the organizational structures and daily work procedures in many psychiatric wards, might oppose the multimodal and humanistic approach, which recovery-oriented practice is based upon. The aim of this study is to identify these organizational structures and procedures in psychiatric wards that might have an impeding effect on the implementation of a recovery-oriented practice.

Methods

The project falls in three parts: 1. An initial literature review of the international scientific literature on implementation of recovery-oriented practice. 2. An observational study conducted in two Danish general psychiatric wards, one closed and one open ward for adults aged 18-67, focused on existing organizational structures, which can have an impeding influence on the implementation process. 3. Focus group interviews with psychiatrists, nursing staff and patients aimed to extract the different experiences with implementation of recovery-oriented practice.

Results

There are no results from the study at this time.

Discussion/Conclusion

It is expected that findings can contribute to strengthening the implementation of a recovery-oriented practice. By identifying impeding structures and procedures in the organization, it will be possible to eliminate or change these structures, and thereby reduce hurdles in the implementation process.

Decision-making and Information Needs in Mental Health Care: A Mixed-methods Study

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Background

The internet is considered as a way of providing health information to patients also as a prerequisite for shared decision-making. Due to a lack of web-based systems for mental health care in Germany, we are developing a mental health website integrating patient decision aids for treatment decisions in mental disorders. Aim of this study is to investigate decision-making and information needs among mentally ill people.

Methods

We conducted a needs assessment as a descriptive mixed-methods study. First, we implemented focus groups including 8 service users with mental disorders and 7 mental health providers. Using a semi-structured interview schedule, types of decisions, factors influencing decisional conflict, and resources to support decision-making were explored. The discussions were analysed using qualitative content analysis. Moreover, an online self-report questionnaire was developed that is administered to an estimated sample of 360 people with mental disorders and relatives from January until April 2013. The questionnaire consists of five key issues: internet use, online health information needs, treatment decisions, decisional conflict, and role in decision-making. Participants reporting experience with mental disorders either as patient or as relative and being at least 18 years old are included.

Results

Overall, the most prominent decision topics discussed in the focus groups were psychotherapy, medication, and inpatient treatment. Disorder specific topics were suicidal thoughts, somatic diagnostics, and withdrawal. The most often reported source of difficulty were experiences of lacking participation and compulsory treatment, lack of information, and lack of ability or skill to make a decision. Fundamental sources of ease were peer support and both acceptance and support of the patients autonomy by the provider. To verify the results in a larger sample, an online survey is currently conducted. So far, 300 participants provided analysable data. Results will be presented at the conference.

Conclusions

Decision support interventions for patients with mental disorders should be targeted to the need of people with mental disorders. However, limitations referring to the health care system and common practice in psychiatric care should be considered. The results of the study will be used for developing web-based decision aids for this patient group.

Systematic review and meta-analysis of psychiatric disorder and the perpetration of partner violence

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Background/objectives

Mental illness is known to be associated with an increased risk of violence to others, but the extent to which psychiatric disorders are associated with an increased risk of violence to partners is unclear. Violence against partners is likely to have a different time course and profile of risk factors and consequences than violence against strangers and acquaintances, and hence is likely to require distinct interventions. Identifying the extent to which different mental disorders are associated with violence against a partner is important since it would inform violence prevention efforts.

This review aimed to establish risk of violence against partners among men and women with diagnosed psychiatric disorders.

Methods

Systematic review and meta-analysis. Searches of eleven electronic databases were supplemented by hand searching, reference screening and citation tracking of included articles, and expert recommendations.

Results

Seventeen studies were included, reporting on 72,585 participants, but only three reported on past year violence. Pooled risk estimates could not be calculated for past year violence against a partner and the three studies did not consistently report increased risk for any diagnosis. Pooled estimates showed an increased risk of having ever been physically violent towards a partner among men with depression (OR 3.0, 95% CI 2.1-4.4), generalised anxiety disorder (GAD) (OR 3.1, 95% CI 1.4-6.6) and panic disorder (OR 2.5, 95% CI 1.4-4.6). Increased risk was also found among women with depression (OR 2.4, 95% CI 1.8-3.2), GAD (OR 2.3, 95% CI 1.6-3.4) and panic disorder (OR 2.2, 95% CI 1.2- 3.8).

Discussion/Conclusion

Psychiatric disorders are associated with high prevalence and increased odds of having ever been physically violent against a partner. As history of violence is a predictor of current violence, mental health professionals should ask about previous partner violence when assessing risk.

Examining the recovery impact of emancipatory action research for service user and carer researchers in the UK

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Background/Objectives

In the UK the quality and delivery of care coordination has been questioned and it is unclear to many what good practice in this area means. Mental health recovery is also a contested term which has only been in part owned by service users and professionals. This paper is based on a National Institute for Health Research funded 3 year study exploring whether there is a pathway to mental health recovery through care coordination. A key project objective is its emancipatory design in utilising a high level of service user and carer collaboration in designing the project, collecting and analysing the data along with the dissemination of findings.

Methods

Included in the original methodology was the design and running of a UK university accredited mental health research training course for both service users and carers. As the project has developed further training opportunities have been requested and delivered. The levels and quality of the collaboration of service users and carers within the evolving project form part of an ongoing evaluation. Data is being collected around individual dimensions of recovery and the impact of involvement for both mental health service user and carer participants and researchers.

Results

The ongoing evaluation and experiences of service user and carer researchers within the project will be presented in this paper along with the impact of researchers identifying themselves as service users and carers to research participants.

Discussion/Conclusion

This will include personal accounts of recovery and theorising around changes in identity and role in relation to both research and researcher inputs and impacts.

Trust in patient- therapist relationship

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Confidence is the act of trust, a state of the will, a conscious choice. Trust, therefore, is the act of choice, it does not happen by chance.

Trust in the other person is related to respect to that person which involves also respecting their individuality and autonomy. Hence, trust is a bilateral relationship; it has no subject and object, but there are two subjects.

A special dimension of trust is trusting oneself. In mental illness trust is betrayed at the most elementary level. The experience of psychosis teaches man that he cannot trust his own senses. In psychosis man is one hundred percent sure of the situation and the events that really do not exist. The moment when he is “waking up” from a bad dream - called psychosis - is difficult and deeply painful. Trust is in crisis. When people realize which mechanisms govern them, they begin to despise themselves. In mental illness a person loses credibility in their own eyes and in their milieu. Those who take the effort of undergoing therapy learn from the beginning how to trust oneself and the others.

The therapist should truly give patients to understand that he believes in their humanity, their ability to return to health, their ability to rebuild the social relations and their power of deciding about themselves.

Trust developed in the relation between the therapist and the patient leads to restoring the confidence in oneself, in other people and the surrounding world.

DRAFT

Communication Improvement through Narrative Therapy: Case Study on Schizophrenia in Adolescents

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Background/Objectives

This study explores narrative therapy that could work positively on teenagers who were diagnosed as schizophrenic to improve their communication competence.

Methods

Twelve teenage schizophreniacs (ten males, two females) from the Daegu area participated in this study. From 2011 to 2012, the data including records, conversations, processes of the therapy, and mutual feedbacks was collected during a volunteer session of a literary therapy program. The participants in the study are high school dropouts. The methods used by literary therapy process are (a) uses of media, such as literature, picture, music, play, role play, situational representation, and body language (b) taking pictures, (c) text techniques, (d) self-narrative, and (e) mutual feedback.

Results

Over 1 year of therapy process, two results are found. First, their linguistic competences are re-activated through various situational representations and role interchanges. Second, the process of delivering situational circumstances is beginning to take shape in the treatment session with medical staff.

Discussion/Conclusion

- Finding out why teenage schizophreniacs suffer from poor communication skills based on the analysis on their circumstances and surroundings
- Preparing plans for the improvement of communication competences through narrative therapy
- Analysis on characteristics of the narratives that the patients produce, and patients' mind: focus on the treatment of the patients' inner mind through sharing stories
- A proposal of increasing daily communication competences and rehabilitation using a narrative therapy

Development of employees' skills in recovery-oriented activities

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Background/Objectives

The Capital Region Psychiatry, has a set of goals for the future of psychiatry, in particular, based on recovery-orientated treatment and rehabilitation. To support this, we have launched a number of initiatives.

The purpose of this effort is to develop and implement a management supported training program for employees in the Capital Region Psychiatry where employees develop their understanding of how methods, values and ways of thinking promote a recovery-oriented treatment and rehabilitation.

It also aims to disseminate three recovery-oriented values - hope, opportunity, and empowerment, which should be reflected in employees' rehabilitative efforts.

Time period: 2013-2015.

Methods

The effort will be carried out through three interconnected parts.

1) Workshop days (recovery seminars) these includes all employees in the clinical units corresponding to approx. 4000. The teaching team consists of An employee with user background and a health professional.

2) Conference for leaders in 2013 with the aim of presenting the latest knowledge about recovery and inspire to anchor a recovery-orientated culture. At the regional level, the success of the project Is dependent on the leaders' support of the development process. Therefore a close cooperation and dialogue with leaders – ranging from the executive group to department managers - will be set up to make sure that the leaders are supporting the development processes.

3) Evaluation of the effort. A: Use a combination of quantitative and qualitative methods (triangulation) to evaluate employees' perception of how the workshop day has contributed to a greater understanding of recovery-oriented practices and methods that can promote recovery-oriented culture. B: A quantitative cross-sectional study of 100 patients in each psychiatric center with the aim of measuring the extent to which users experience how the help supports their recovery process. C: The study is followed up by a semi-structured focus group interview with 5-7 patients in addition to the quantitative data.

Results

The Workshop days are tested as a pilotproject. Evaluation of these shows employees' different experiences which might range from having been inspired and presented to new knowledge and methods - to having known it all in advance.

The final results from employee evaluations of patient experiences are expected to be ready in 2015.

Discussion/Conclusion

It is expected that the teaching interventions have an effect on the employees' knowledge of recovery orientation, but the question that is also examined in this project is how to ensure that this knowledge will be put into practice, and whether the patients will experience a better support in their recovery process as a result of the project.

The logics of everyday psychiatric work

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Background/Objectives

With psychiatric organizations being the units organizing formal approaches to mental illness, a main question in understanding the possibilities for recovery is: how is psychiatric work understood and practiced in psychiatric organizations? I address this question from a micro-organizational perspective investigating the logics which shape the employees' handling of everyday situations occurring at a psychiatric hospital and a long-term residential facility.

Methods

I apply a new-institutional theoretical framework for the analysis of eight months of ethnographic fieldwork, which comprises participant observation and interviews with 25 employees/managers. Employing the concept of institutional logics, data analysis focused on how everyday work is practiced and on the beliefs, assumptions, norms and rules which shape the approaches to the work.

Results

Six logics shape approaches in both organizations.

Four therapeutic logics shape the employees' approaches. These logics build on the use of 1) consequences, 2) medication, on 3) building up the service users' own resources and 4) providing care. The logics of consequence, medication and the service users' resources build on the assumption that the service user is able to evolve personally, while it is assumed in the logic of care that the service user's situation is stable or devolving.

Two organizational logics create boundaries for the approaches to the service users: 1) the logic of the customer's purchase requires that approaches are in accordance with a new public management ideology, and 2) the logic of collegial relations, which balances the employees' obligations towards the service users with the need for a good collegial relationship.

The logics are based on somewhat different assumptions of how to conduct psychiatric work, but still they co-exist in the organizations.

Discussion/Conclusion

The support of a service user's recovery process is shaped not just by one logic or paradigm, e.g. the recovery orientation, but by a mixture of logics that co-exist in the organizational culture and therefore are reproduced in the everyday work of the professionals. In order to improve support of service users' recovery processes, we need to address all of these logics and how they shape the employees' approaches.

Empowering service users and health professionals and improving health services through coaching interventions

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Background/Objectives

Coaching interventions are not new. Several industries, such as sports and business organisations, have made use of empowering, solution-focused and capacity building coaching interventions for decades. More recently, coaching interventions have started to find their way into healthcare as well. These interventions can have a powerful impact on:

- (a) service users (prevention of ill health, early intervention, self management) as well as carers
- (b) health professionals (better communications with / providing empowering tools to service users, and addressing own work-life balance)
- (c) improving health services (better communication with service users, their families and other healthcare professionals, addressing own work-life balance, improved leadership leads to more efficient healthcare and improved patient safety)

Methods

As a professional accredited coach and one of the official in-house coaches at the University of Cambridge and King's College London, I will discuss case studies from my own work in the UK and further afield as well as this of colleagues in Belgium and the Netherlands in order to demonstrate and explore the benefits of coaching interventions for the health sector (for service users, health professionals and health services).

Results

The discussed case studies and data from three different countries will demonstrate the effectiveness of coaching interventions for service users, health professionals and improved health services and show how this can be a powerful tool in terms of prevention of ill health, early intervention, self management of long term conditions as well as improved patient care and safety due to better communication and capacity building tools for service users, health professionals and health organizations alike. These coaching interventions also hold the potential to economically unburden health systems.

Discussion/Conclusion

In the light of the positive data from the UK, Belgium and the Netherlands, the audience will be invited to actively discuss the benefits and potential shortcomings of these interventions, to compare this with experiences from their own countries, and to discuss the feasibility of rolling this out across the health system in their particular country.

Assessing leadership profiles in Portuguese public mental health services

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Background/Objectives

There is emerging evidence that organisational culture and leadership profiles influence the way health services implement their systems of care. The identification of factors that may facilitate or hinder the implementation of evidence-based practices and subsequent innovation in mental health settings is an area of recent development.

Studies regarding organisational culture of services are widespread in economical and managerial areas but very few evaluate mental health care contexts. Most of these studies aim to help in the management of human resources.

The objective of this study is to assess the organisational culture and leadership profiles in the Portuguese mental health services.

Methods

Cross-sectional study, conducted at public mental health services. Evaluation was made by means of the 'Competing Values Framework Tool (Quinn, 1990) (Portuguese version - MJ Felício, 2007), which includes dimensions such as organizational culture and leadership profiles in the framework of more open or closed systems and with more control or flexibility strategies.

Results

There is no organisational or leadership profile clearly outstanding in the Portuguese mental health services. However, Director and Coordinator leadership profiles scored higher in the results. These higher scores profiles were linked with activities such as assignment of duties, delegation of tasks and planning activities. Innovation profiles had the lowest scores, linked with the ability to cope with change and to manage change.

Discussion/Conclusion

Further studies are critical to develop a clearer view regarding the influence of organisational culture and leadership profiles in the organisation of mental health services. Low scores on innovation components may influence the way evidence based practices are welcomed and implemented in services. Organisational culture may have an important role in the implementation of best practices, namely for the design of programmes that aim to translate evidence into everyday care.

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