

European Network for Mental Health Service Evaluation [ENMESH]

4th INTERNATIONAL CONFERENCE  

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PSYCHIATRIC REFORM  
AND SERVICE RESEARCH  
IN EUROPE

Abstracts

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## Keynote Speeches (Friday)

### Mental Health Services in Eastern Europe

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#### Psychiatry in Eastern Europe: From Totalitarianism to Innovation?

R. van Voren

Geneva Initiative on Psychiatry, Hilversum, The Netherlands

A decade after fall of the Berlin Wall and the collapse of the Soviet empire, mental health care in many countries in Central and Eastern Europe and the New Independent States (CCEE/NIS) is still very much lagging behind. Soviet psychiatry was cut off from the rest of the world for half a century, and during this period of total isolation it degenerated, became deformed and resulted in an almost exclusively custodial, hospital-centered and biologically oriented psychiatry. At the same time, it is totally clear that there are no valid descriptive accounts, statistical data, or epidemiological findings on the current psychiatric situation in the region at central or local level. Inputs into psychiatric care are conceived narrowly, i.e., there is no notion of intangible inputs, such as team-work skills, communication skills, etc., and that no meaningful costing of services, i.e. with respect to outcomes, is performed. The mental structure that evolved in individuals as a result of the totalitarian culture is highly conformist and lacks integrity while engaging in professional tasks, and lacks both respect for individual human beings and of genuine interest in them. In 1989 the situation changed dramatically in the CCEE/NIS. For instance, relatives' groups sprouted, psychiatric nurses formed representative bodies and within ten years at least a hundred mental health NGO's have emerged in the region, thereby completely changing the landscape. In the coming ten years, much will change. A considerable number of CCEE will have joined the EU or will be in the pre-accession phase. It is becoming more and more evident that in the sense of reform the CCEE has a chance of overtaking the West. Flexibility, meeting patients' needs, innovative projects, user and relative involvement in mental health service development, these are all aspects that increasingly characterize mental health reform in this part of Europe. This trend is bound to continue in the years to come, turning the CCEE as a breeding ground for innovation and providing examples that many Western European institutions and services can learn from.

### Psychiatry and the Public

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N. Sartorius

Hôpitaux Universitaires de Genève, Belle-Ideée, Geneva, Switzerland

In recent years of its history psychiatry is increasingly torn apart by tendencies to become a branch of clinical medicine or a neuroscience; a humanitarian pursuit or a coercive instrument of society; a terrain of synthesis between biological, psychological and social approaches to mental illness or a source of a variety of different disciplines; a leader of mental health programmes or a contributor to the programmes of treatment of mental illness.

The stance of psychiatry in relation to the general public is marked by these unresolved dilemmas.

Depending on who speaks and when psychiatry is criticized for insufficient emphasis on exploring changes of brain tissue in mental illness and for its increasing reliance on sophisticated investigations. Psychiatry is expected to deal with the treatment of mental illness in the same way as other medical disciplines deal with illness in their domains and criticized for insufficient attention to problems of living which people with mental illness have. It is expected to be a strong advocate of human rights and to ensure that society carries out its duty to those with mental illness but to go slow in helping the community in its efforts to make its members (including those with mental illness) to perform their duties to the society.

The stigma attached to mental illness, to those who look after them, to mental health institutions and other arrangements related to mental illness is the terrain which reflects the dilemmas of psychiatry and the ambivalent relationships that psychiatry has with the general public. A brief description of the way in

which the WPA programme against stigma and discrimination because of schizophrenia has attempted to overcome this difficulty will be provided.

#### From Inputs to Outputs

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Alcohol policy as a public health issue. Reconsidering an old concept and its relevance for mental health.

J. Moskalewicz

Institute of Psychiatry and Neurology, Warsaw, Poland

Invention and the spread of a disease concept of alcoholism led to a dramatic re-orientation in alcohol policy from supply control to treatment. In public perception, alcohol changed its status from a devil drink to ordinary market commodity. For three post-war decades its consumption had risen several times including industrialised world and developing countries. Treatment was supposed to absorb a high tide of problems related to this consumption growth. Alcoholism treatment rapidly expanded consuming increasingly large public resources. E.g. in the United States funds allocated to alcoholism treatment increased more than 20 times while in Poland number of alcoholics in treatment jumped from almost zero level in the mid-1950s to more than 100 thousands in the late 1970s.

As the relationship between growing consumption and enormous spread of problems became empirically evidenced, level of alcohol consumption became a public health issue. The World Health Organisation placed reduction of an overall alcohol consumption among targets of its Health for All Strategy, while many European countries strengthened alcohol control. The 1980s witnessed continuous growth of alcohol consumption in developing countries including Latin America and a notable decrease in industrialised world (North America, Australia and New Zealand and Europe). Particularly rapid decline in sales of 27 per cent was noted in Eastern European countries, which was only in part compensated by illicit supply. Less drinking resulted in a significant reduction in mortality and morbidity related to alcohol.

Transition period in Eastern Europe brought a sudden turn towards economic liberalisation including extreme de-regulation of alcohol market, its huge uncontrolled supply and very high consumption levels. In some countries acute mortality crisis took place in the beginning of the 1990s, in which large proportion of deaths could be associated with alcohol. Despite some symptoms of improved health status of inhabitants of Eastern European countries, mortality directly attributed to alcohol (alcohol psychosis, dependence, poisonings as well as liver cirrhosis) still remains at the level several times higher than the EU average. In addition, alcohol related psychiatric complications represent heavy burden for mental health services. E.g. in Poland more than 40 per cent of all psychiatric admissions among males constitute patients with alcohol related diagnoses. Therefore, a status of alcohol consumption as a significant public health issue including mental health should be revitalised again.

#### Interventions and Service Cultures

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Lives Worth Living: Preventing Symptoms of Treatment in Mental Health Services

S. E. Estroff

University of North Carolina at Chapel Hill, USA

Over the past three decades, phenomenal progress has been made in improving the lives of people with severe, persistent psychiatric disorders. More people receive better services, and in many cases, more resources are being better spent. We have succeeded most notably at proving that community care is *feasible [ital]*. We have yet to establish that these services contribute to lives that are *meaningful [ital]* and *worthwhile [ital]* in the view of consumers. One of the most enduring barriers to achieving this goal is 'symptoms of treatment,' defined as the damage and deterioration consumers experience *from* treatment. Their subsequent flight from or refusal to participate in treatment often leads to lives needlessly impoverished. In this lecture, we review how symptoms of treatment may be reduced or prevented, and how mental health services can work toward the most significant outcomes--lives of choice, contribution, and community.

## Assessing Outcome in Service Evaluation

L. Hansson

Department of Clinical Neuroscience, Division of Psychiatry, Lund University, Sweden

Outcome assessment is a crucial dimension in psychiatric service evaluation, related to issues of efficacy, effectiveness and efficiency. Most research so far in this area has not been comprehensive or guided by any specific conceptual framework. In this talk I will address some topics, which might be considered in order to promote the research area. Firstly, outcome should be assessed both on the service level and the patient level. Assessments on the service level would benefit from linking outcome to service input and service processes, and also from a consideration of psychiatric services delivered by the surrounding health care and social service system. Secondly, outcome assessments should be comprehensive and cover multiple domains of the patient's life and care situation, and include measures which link outcome to needs and to interventions. Thirdly, assessments should cover several perspectives such as the professional, the patient and the relative perspective of outcome. Fourthly, comparative studies of service outcome should pay specific attention to standardised descriptions of service levels and service components, as well as measures of service use in order to enable valid comparisons of outcome. Further topics of essential interest concern the standardisation of outcome measures and methodological problems in relation to routine service outcome assessment as opposed to research based outcome assessment.

→ reconstruction the "black-box" of services

## Workshops

### Workshop 1

Psychiatry and the Public, WPA Programme Reducing Stigma and Discrimination because of Schizophrenia

Chair: N. Sartorius

Hall 10

9.00-10.30

#### 1. The new Antipsychiatry

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J. Arboleda-Flórez

Queen's University, Kingston, Canada

Beginning with the demonization of psychiatric symptoms in the Middle Ages and the move to institutionalization in the eighteenth century to our days, mental patients have not fared too well in many social systems and cultures. More into our century, the ideas of Thomas Szasz about the manufacture of madness created a situation in which acceptance of mental illness and a disease in need of regular medical treatment was seeing with suspicion and actual derision by medical colleagues or other specialties. Equally, the tendency of sociologists to view mental illness as a form of deviance further complicated the interest of Psychiatry to move patients out of mental hospitals and into the community. As the biological brain-based determinants of mental illness are being mapped out, however, voices are becoming louder about not forgetting the mind in the altar of biology; too much scientific proof on the biological nature of mental conditions may not be, fear some, the best way to help our patients. Psychiatric medications are coming under attack as being forms of coercion and they are being blamed as being causative of violent reactions among some patients. But on the other hand, further research on the psychological and sociocultural determinants of mental conditions, and alternative treatment modalities in the community such as assertive community treatment and community treatment orders, the mind and social part of psychiatry, are also coming under attack. They are being blamed as promoting further coercion and limiting the personal expression and individuality of the patients. The new antipsychiatry is possibly more pernicious than that of yore, and not only to Psychiatry, but to patients too. By objecting to the need for medications when properly indicated and to alternative modalities of treatment to prevent relapses, rehospitalization and even reincarcerations, it threatens to undo the good work achieved so far in community reintegration of mental patients. This paper will review the forces shaping up the modern debate on what psychiatry is. It will also review reasons why psychiatry has become the target of attack as it becomes more scientific and able to treat more effectively, and what could be done to prevent a step backwards on the gains for better treatments and more freedoms for mental patients.

#### 2. Activities of Fighting Stigma: An Example of a Regional Campaign

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W. Schöny

OÖ Landes-Nervenklinik Wagner-Jauregg, Linz, Austria

The work to eliminate stigma, discrimination and prejudice seems to be one of the most important tasks in the field of psychiatry for the new millennium. If it is possible to mobilise the public, to modify the respective laws and to improve the way to treatment and rehabilitation, the phenomenon schizophrenia and its consequences for the individual can be reduced. Life of patients and their relatives could be made easier and their integration into community could be made possible.

In Austria we try to cover the whole country with the WPA program. 3 associations are responsible for it: The Austrian Association for Psychiatry, The Austrian Schizophrenia Association, and The Austrian Federation for Mental Health. These associations guarantee that professionals all over the country who are already in contact with politicians, patients and their families as well as with the public will be engaged in that work. First a study was carried out to learn about the attitudes of the public and special target groups

like social workers, nurses, general practitioners, psychiatrists, journalists and families of patients towards schizophrenia. The results are going to be published and have been presented in media and to the respective groups.

Before the launch of the program some activities have been started in different regions:

- "To err is human - psychiatry on film" Movie weeks in the federal countries of Austria, in which the problems of mentally ill people are presented in a sensible manner. In the course of this activity public discussions in co-operation with media have been started, too.
- Special programs for schools which should help the adolescents to eliminate discrimination and prejudice.
- A special activity with posters and spots in Upper-Austria to make aware of the problem.

A steering committee oversees the program. 4 centres in Austria should be founded from which regional activities can be started. A professional public relation agency co-operates in the planning of the program. We have the intention to start with a big campaign on TV, radio and with other important media all over Austria. This campaign should be surrounded by regional activities, individual projects with special target groups and general work with media. The campaign is titled with: „Schizophrenia has many faces - we can do something against it“. The attention of the public should be attracted by help of specific subjects to make the problems of people suffering from schizophrenia more interesting. The goal of the campaign is at the beginning to attract attention and later on to increase awareness and knowledge about the nature of schizophrenia..

### 3. Public Fears of the Mentally Ill

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H. Stuart,

Queen's University, Kingston, Canada

Mental illness and dangerousness are synonymous in the minds of many people. Research showing elevated rates of violence among certain sub-groups of persons with a mental illness (such as those with untreated psychotic symptoms or substance abuse disorders) does little to alleviate public fears and may even reinforce negative stereotypes and stigmatising behaviours. However, elevated rates of violence among certain sub-groups of mentally ill should not be interpreted to mean that they are major contributors to community violence. To illustrate this point empirically, this presentation will review acts of police-detected criminal violence attributable to persons with a clinically confirmed mental illness in a large urban centre in Canada. Findings support the conclusions that public risk of criminal violence from someone with a major mental disorder is small.

### 4. Changing community attitudes to schizophrenia: working with the mass media to reduce stigma

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B. Hocking

SANE Australia, Melbourne, Victoria, Australia

SANE Australia is a national charity that helps people seriously affected by mental illness, through campaigning, education and applied research.

The aim of this presentation is to describe a community education campaign conducted by SANE Australia in 1998 and 1999 which followed a large scale advertising campaign conducted by the Commonwealth government 2 years previously which encouraged people to question their attitudes towards mental illness. SANE's campaign was to promote improved understanding of the early warning signs of psychotic illness, encourage people to get effective help early, reduce stigma and help build supportive community attitudes. Television plays a major role in influencing attitudes to mental illness, as with other issues in society today. We also know that attitudes towards people with a mental illness are better when people know someone who has an illness. So as part of SANE's campaign for improved attitudes, we set out to introduce audi-

ences to a 'friend' with a mental illness. This involved working with the national (and international) teenage soapie *Home and Away* to promote understanding of schizophrenia.

The rationale for this activity, the processes involved and the general outcomes measured will be described.

## 5. Combating the Stigma of Schizophrenia

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D. Warner

Mental Health Center of Boulder County and Departments of Psychiatry and Anthropology,  
University of Colorado, Boulder, Colorado, USA

Modern communications technology gives us tools for effective campaigns to change attitudes, knowledge and behaviour around issues of social importance. Effective campaigns to combat the stigma of schizophrenia can be developed through a process of problem analysis, project design and development (including pre-test and revision of key components), implementation (including monitoring and assessment), review and re-planning. A local action committee of key stakeholders can conduct an initial survey of the nature of stigma and discrimination in the local community, select the groups to be targeted, establish objectives for each group, define the messages to be conveyed and the media to be used, formulate the action steps required to implement the project, monitor the inputs, measure the effect of the interventions and modify the campaign based on the results of these assessments. The results of and lessons learned from such local campaigns in Calgary, Alberta, Canada, and in Boulder, Colorado, USA, will be reviewed.

## 6. Considering new perspectives: Stigma from the point of view of people with schizophrenia, their relatives and mental health professionals

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B. Schulze, M. C. Angermeyer

Department of Psychiatry, University of Leipzig, Germany

Research on the stigma of schizophrenia has mainly drawn on the literature from sociology and social psychology, and instruments for its measurement have been developed on the basis of these theoretical assumptions. In the context of the German involvement of the WPA Programme "Reducing Stigma and Discrimination because of Schizophrenia", a bottom-up approach was chosen to attempt a definition of the stigma concept from the point of view of those experiencing it in their everyday lives. Focus groups with people with schizophrenia, their relatives and with mental health professionals were carried out at the four centres involved in the German campaign: Munich, Düsseldorf, Leipzig and Itzehoe. In addition to reconsidering the definition of stigma, the study aimed at identifying the most central areas for anti-stigma interventions in the respective local contexts.

In total, 83 people were interviewed: 25 patients, 30 relatives and 28 mental health professionals. Focus groups were tape-recorded and transcribed. Transcripts were subjected to content analysis, using qualitative procedure by means of which categories were formed inductively from the texts.

Results showed that, other than conceived in the literature, stigma goes beyond the exclusion from social acceptance in the direct interaction with others and limited access to social roles. Two dimensions of stigma were found in addition to what has previously been discussed: the public image of psychiatry and structural discrimination. The four dimensions will be described and illustrated with statements from the focus groups. Differences between the stigmatisation experiences of people with schizophrenia, their relatives and mental health professionals will be discussed. A striking finding was that relatives seem to experience stigma to a large extent indirectly: when asked about their own experiences, they mainly reported experiences of their ill family member (63.7%).

Consequences of the results for the development of anti-stigma interventions will be discussed.

### 1. Care provided to patients suffering from schizophrenia across European countries

V. Kovess<sup>1)</sup>, J.M. Caldas de Almeida<sup>2)</sup>, M. Carta<sup>3)</sup>, J. Dubuis<sup>4)</sup>, E. Lacalmontie<sup>5)</sup>, J. Pellet<sup>6)</sup>, J.-L. Roelandt<sup>7)</sup>, H.J. Salize<sup>8)</sup>, B. Moreno Kustner<sup>9)</sup>, D. Walsh<sup>10)</sup>, D. Wiersma<sup>11)</sup>

<sup>1)</sup> Director public health research dept MGEN, Paris, France

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<sup>3)</sup> Istituto di Clinica Psichiatrica, University of Cagliari, Italy

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<sup>6)</sup> CHRU St. Etienne, France

<sup>7)</sup> Clinique Jérôme Bosch, Armentieres, France

<sup>8)</sup> Zentralinstitut für Seelische Gesundheit, Mannheim, Germany

<sup>9)</sup> South Mental Health Area, Hospital Universitario, Granada, Spain

<sup>10)</sup> Health Research Board, Dublin, Ireland

<sup>11)</sup> Department of Social Psychiatry, University Hospital Groningen, The Netherlands

This presentation will report on a long lasting project set up to follow schizophrenic patients across seven European countries and describe the care given to them. The patients were assessed for their clinical symptoms and their social dysfunction by diverse instruments (SCAN and others) and the interventions which were proposed to them were recorded through the systematic use of the NFCAS and a record of the diverse actions taken (Mannheim Service recording sheet). A network of clinicians and researchers (ER-GOS) set up an one year prospective cohort study which should include patients with a clinical life-time diagnosis of schizophrenia according to ICD-10 (F20) diagnostic criteria for research aged between 18 and 65 years old and who had in 1993 at least one contact with the mental health services. Patients were eligible for the study independently of whether they were receiving in- or out-patient care. 504 patients were included and 484 were followed up (whose 326 had a MSRS); the mean age was 38 years, onset appears 22 years before this evaluation, 59% were outpatients, 24% in day care and 15% hospitalised.

The populations were significantly different in almost all the variables: sociodemographic, clinical and social and these diverse problems remain relatively stable over the year. Comparisons outlined the cultural differences concerning the interventions that were proposed and were taken in account when interpreting the number of needs and the need status since the need status depends on the interventions proposed as well as the availability of them. Southern countries are proposing many interventions even though they were relatively deprived and the tendency seems to be the reverse for the Northern countries.

On average one out of four patients suffered from needs that were not adequately met by the mental health service in their region. These needs (on average 5.9 per patient) varied from psychotic symptoms to managing their own affairs. Unmet needs occurred in all the centres except one and in all kinds of care systems even in strongly community oriented systems with structural linkages to primary care. The number of interventions was not correlate to the needs status and diversely to rehospitalisation.



## 2. Does rehab meet the needs? Different way to measure the outcomes of individual rehabilitation training

J. T. van Busschbach, D. Wiersma

Department of Psychiatry, University of Groningen, The Netherlands

The effectiveness of rehabilitation training was assessed by interviewing 35 clients twice, at the beginning of the training and 1 year later. The training was formatted along the lines of the Boston school. Our research questions were:

- Which goals do clients achieve with the support of the rehabilitation training?
- In what way can the effectiveness of the rehabilitation be assessed? Is there a change in need for care, quality of life and the social situation (work, housing, social relations) of the trainee as a result of the rehabilitation training?
- How can differences in the amount of 'success' with different clients be explained?
- What are the specific needs of the group entering this training, in comparison with a sample of 100 long term users of psychiatric care?

The Camberwell Assessment of Needs (Phelan et al, 1995) was used to get information on the changes in and present need for care as judged by both client and staff. The EuroQuol was used to compare quality of life-scores of the rehabilitation. Data were also gathered on psychiatric diagnosis, cognitive functioning (verbal memory, planning) of clients. Satisfaction with the services and the working relationship with the counselor were also established.

## 3. Needs for care and mental health care provision for mentally ill homeless people in a well equipped catchment's area for community

H.J. Salize

Central Institute of Mental Health, Mannheim, Germany

Homeless people are an increasing problem for mental health care, but are still a neglected clientele. This study detected the prevalence of mental disorders and the needs for mental health care in a representative sample of homeless people (n=102) in the City of Mannheim, which serves as a model region for community based mental health care in Germany. Prevalences were assessed by SKID, Needs and met needs-status (as an indicator of outcome of care) by the „Needs for Care Assessment“ (NCA), which has been developed for chronically mentally ill patients living in the community. The application in homeless people with mental disorders proved to be difficult, but was successfully managed in this study.

Presented results show that there is a higher than average prevalence of mental disorders in homeless people, but that their symptoms and behaviour problems as well as their needs in skills and abilities are widely unmet. Additionally, there are many untreated somatic diseases and symptoms, many of them alcohol-related.

Analysed patterns of the homeless people's self-perception of health care needs and their satisfaction with applied health care indicate that mentally ill homeless people show a rather different help seeking behaviour than non-homeless patients. Community mental health care in Germany, which is in principle easily accessible and free for homeless people too, is not adapted to that. As a consequence adapted thresholds of care or specialised services for this clientele must be considered.

#### 4. Recognition and measurements of patients' needs in clinical mental health rehabilitation.

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A longitudinal study over two years

E. Wennström, F.-A. Wiesel

Department of Neuroscience, Psychiatry, Ulleråker. Uppsala University Hospital, Uppsala, Sweden.

In order to be able to shed light on patients' needs of care and support and how these needs are affected by interventions, these need to be semi-quantified and followed up over time. Camberwell Assessment of Needs (CAN) is an instrument which enable such needs to be rated and which can therefore be used for evaluation of needs and interventions. Annual cross-sectional studies with CAN since 1996 of patients, mainly with schizophrenia, have shown that the majority of the patients need care and support for psychotic symptoms and other psychological distress, and in social contacts and daytime activities. A large proportion of the identified needs were not met to a sufficient extent. The patients' key workers often have considerable difficulties in assessing circumstances concerning patients' personal relations and sexual expression and whether patients are receiving all the benefits that they are entitled to.

With the aim of carrying out a longitudinal study of changes in the need for care and support, CAN-assessments of the patients included in all three cross-sectional studies in 1996, 1997 and 1998 ( $n = 171$ , of a total of 545 patients) were analysed with the following questions: Are needs reduced over time? Are the needs for care and support for psychotic symptoms, psychological distress, social contacts and daytime activities satisfied to a greater extent over time? Is there an improvement in the key workers' knowledge of the patients' personal circumstances and of their access to the benefits they are entitled to? In the statistical analysis Cochran's Q-test and post hoc tests with McNemar Chi-square were used, with a Bonferroni correction to accommodate for the increased risk of Type 1 error ( $\alpha = 0.017$ ).

Results: In 1996 87 % of the patients were in need of interventions for psychotic symptoms, 77 % for other psychological distress, 78 % in social contacts and 64 % in daytime activities. Only the need of interventions for problems with social contacts was reduced significantly over a two-year period, from 78 % to 69 % 1998 ( $p = 0.014$ , one-sided test). Otherwise, no significant changes occurred in any direction. Approximately a third of the needs identified in 1996 were not met (psychotic symptoms 33 %, psychological distress 27 %, social contacts 32 %, daytime activities 23 %). These needs were not met to any significantly greater extent during the two-year period, except as regards interventions for psychological distress (from 73 % to 84 % 1998,  $p = 0.007$ , one-sided test). The key workers' knowledge about the patients' intimate relationships increased significantly from 1996, when these circumstances were known for 53 % of the patients, to 65 % in 1998 ( $p = 0.008$ , one-sided test), as well as their knowledge of patients' sexual expression (from 23 % in 1996 to 44 % in 1998,  $p = 0.011$ ). However, the proportion of patients among whom one or both of these circumstances was still unknown in 1998 was large, despite at least two-years' regular contact. The key workers' knowledge of whether the patients were receiving all the benefits they were entitled to remained unchanged over the two-year period.

Conclusions: The results from the study indicate that the needs of care and support in this patient group are relatively stable and that only small changes are achieved over a two-year period. Care and support must consequently be planned over a long period and made continually available during this time. The results also point to the need for improved competence among staff in systematic assessment of needs, as a basis for individual care planning and following up results.

#### 5. Agreement on the Assessment of Need between Patients, Key- Relatives and Psychiatrists

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R. Gößler, B. Kaup, L. Machacek, J. Wancata

Department of Psychiatry, University of Vienna, Austria

In our investigation we examined the needs of 70 chronically schizophrenic patients concerning their state of health and their current period of life. Key-relatives, whose influence on the course of illness of the chronically ill is well known, and psychiatrists used the same questionnaire to assess their meaning about

the needs of the patients. The aim of our examination is to ascertain and compare the judgements of the three groups.

We used a self rating questionnaire structured in 9 areas (treatment, housing, housework, company, relationship, work, leisure, money, law) with 65 items. The questionnaire is based on the items of the common need- instruments (MRC- NCFAS, CAN, Cardinal Needs Schedule, Needs and Resources Assessment, Berliner Bedürfnis Inventar and Management Oriented Needs Assessment).

The comparison of the results of the three groups showed some differences especially in the areas treatment, leisure, relationship and money:

Need for neuroleptic treatment: patients 60%, relatives 86%, psychiatrists 97%

Need for occupational therapy: patients 33%, relatives 69%, psychiatrists 60%

Need for structuring leisure time: patients 20%, relatives 53%, psychiatrists 50%

Need for partnership: patients 70%, relatives 33%, psychiatrists 20 %

Need for structuring financial matters: patients 28%, relatives 46%,

psychiatrists 47%;

More detailed analyses of the attitudes of 70 patients/key-relatives/psychiatrists will be presented.

## 6. Does need predict quality of life?

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A. Kent on behalf of UK700 Group

Community Psychiatry, St. George's Hospital Medical School, London, UK

Methods: Patients with psychotic illness and a history of repeated hospital admissions taking part in the UK700 trial of intensive case management were assessed at baseline on quality of life (Lancashire Quality of Life Profile), needs (Camberwell Assessment of Need), psychopathology and social functioning. Variables that were amenable to change through case management were investigated as predictors of quality of life.

Results: 708 patients were recruited and assessed. Social variables accounted for 7% of the variance for subjective quality of life, compared with 19% for clinical variables, and 20% for unmet needs. The strongest predictors of subjective quality of life were unmet basic, social and functioning needs, depression and positive psychotic symptoms. All variables combined accounted for 27% of the variance in quality of life, leaving 73% unexplained by a combined clinical, social and needs model.

These findings will be presented and discussed in the context of the wider literature on predictors of quality of life amongst the severely mentally ill with reference to the implications for clinical case management.

1. The 'human element' in psychiatry: Methods of assessment and empirical findings

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R. McCabe, R. McGuire, S. Priebe

Unit for Social and Community Psychiatry, St. Bartholomew's and the Royal London School of Medicine and Dentistry, Queen Mary and Westfield College, UK

The therapeutic relationship between patient and practitioner is central to the practice of psychiatry but has been widely neglected in psychiatric research. Research conducted to date has tended to employ conceptual frameworks and methods developed in psychotherapy. However, dyadic relationships in psychiatry are different from, and more complex than, those in psychotherapy. Conceptually, patient-clinician relationships in psychiatry are uniquely characterised by heterogeneous treatment goals, a variable setting and statutory responsibilities for care. Methodologically, there is limited evidence supporting the reliability and validity of therapeutic relationship measures typically constructed in an *ad hoc* manner for psychiatric interactions.

In the main, the therapeutic relationship has been studied in relation to outcome. It has been consistently reported that a more positive relationship predicts increased treatment adherence and better outcome. This finding holds across different diagnoses and treatment settings. Some studies have found an inverse association between the quality of the relationship and psychopathology. The present paper will show that therapeutic relationships are influenced by a number of factors including quality of life indicators and that this association varies depending on the sample and treatment setting.

2. Different theoretical frameworks for understanding the therapeutic relationship and their implications for psychiatric practice

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R. McGuire, R. McCabe, S. Priebe

Unit for Social and Community Psychiatry, St. Bartholomew's & the Royal London School of Medicine, University of London, UK

Each definition of the professional-patient relationship in psychiatric research is necessarily framed by a theoretical model which, in turn, informs the methods used to assess it. The underlying theory is often not explicitly stated in this research, and many methods that are explicitly presented as representing a particular approach, when examined more closely, may more appropriately reflect a different theoretical model than the one suggested. Furthermore, the field of psychiatry has often adopted conceptual frameworks and measures developed for other fields without examining their applicability to a psychiatric setting.

An explicit analysis of research on the therapeutic relationship is therefore required with a view to 'unpacking' the theoretical presuppositions that have framed the definitions and methods on this concept. Five central theories are identified as framing the therapeutic relationship: role theory, systems theory, social constructionism, psychoanalysis, and the cognitive behaviour model. An explicit description of each theoretical model is made, an account of methods informed by each approach is provided, and specified dimensions in relation to outcome are examined with regard to their implications for training, service development, supervision and clinical practice.

### 3. Researching quality in community mental health care

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S. Priebe

Unit for Social and Community Psychiatry, St. Bartholomew's and the Royal London School of Medicine, University of London, UK

Ensuring and improving quality of mental health care is the aim of many initiatives on a political, administrative and clinical level. Yet the definition of good quality is a complex and value-laden issue. The underlying values have changed over time and vary across nations, as will be illustrated by the aims of "patient empowerment" and "risk containment".

For research and practice a reductionistic approach has to be taken. Various quality management programmes have been developed and applied to community mental health care. Their pros and cons will be summarised.

Finally, it will be suggested that prevailing models of evaluative research that use individual patient outcome as a criterion for quality may fail to capture relevant variation in quality of services.

A conceptual framework and strategies for researching that quality more specifically will be proposed.

### 4. Evidence based medicine and user involvement: Some post modern tensions

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R. Laugharne

St. George's Hospital Medical School, London, UK

Mental health in the UK has been influenced by two important movements - evidence based medicine and user involvement. Psychiatrists are expected to incorporate

both policies but possible conflicts between them are not being acknowledged. Evidence based medicine is firmly rooted in a modernist scientific philosophy, the main outlook being rationalist, materialist and reductionist. User involvement has its roots in the consumerist model of market economics together with the advocacy of civil rights for the mentally ill. As a result what the patient wants, even if not evidence based, should take precedence over needs assessed by a paternalistic professional. As such user involvement has a post modern philosophy where multifaceted descriptions of truth and reality are accepted. These tensions are likely to increase in coming years and will have consequences for psychiatry.

### 5. Does a smaller caseload affect the balance of care of individuals with severe, long-term psychotic illness?

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T. Burns, M. Fiander

Community Psychiatry, St. George's Hospital Medical School, London, UK

Methods: Structured records, based on 10 categories of therapeutic activity derived by a modified Delphi process were collected for all face-to-face contacts over two years. The patients were randomly allocated to intensive case management (1:12) or standard case management (1:30). Event recordings were subject to validation by checking through the case notes. The frequency of contacts and the distribution of the differing categories of contact were examined.

Results: A total of over 30,000 records were collected for 196 patients. The case note validation demonstrated that 85% of contacts had been reported. As a result of the validation audit this rose to 97% (33,500 records). The ICM group demonstrated predictably higher rates of contact throughout the whole of the two years. Analysis of the rates and proportion of these interventions demonstrated a significant shift in the balance of 'medical' and 'non-medical' interventions.

These differences will be presented and discussed with particular reference to threshold and ceiling effects. They will be located in the current controversies surrounding the 'transportability' of Assertive Community Treatment.

### 1. Outcomes assessment in routine mental health services

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There is emerging consensus on the key domains of outcome to assess when evaluating services, and a range of assessment tools and mathematical techniques are available. These innovations in mental health service research are not being accompanied by shifts in clinical practice. Services are still commissioned on the basis of how many patients are seen, resources are allocated on the basis of structural needs rather than intended outcome, and 'normal' (i.e. non-researching) clinicians remain generally uninterested in routine use of outcome assessments.

This talk will identify why outcome assessment is used so minimally on a routine basis, and will propose a framework for understanding the processes involved in changing practice towards routine outcome assessment. One challenge for researchers will be to develop clinically useable ('feasible') assessments. It will be suggested that to meet criteria for feasibility should be brief, simple, relevant, acceptable, available and valuable. The implications for the process of developing assessment tools will be illustrated with reference to the Threshold Assessment Grid (TAG), an assessment tool to identify the severely mentally ill. The TAG was developed using non-traditional consensus-based approaches to ensure external validity, following which the reliability and internal validity is now being investigated.

### 2. Satisfaction with mental health services among schizophrenic patients in South-Verona. Preliminary results from the EPSILON Study on Schizophrenia

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*Background.* Patients' satisfaction is an important outcome variable and its measurement represents an essential aspect of mental health service evaluation. Aims of the present study are 1) to measure satisfaction with mental health services in a sample of schizophrenic patients, 2) to examine the factors predicting patients' satisfaction using as explanatory variables a series of sociodemographic, service utilisation and outcome variables (psychopathology, global functioning, needs for care, quality of life and family burden).

*Methods.* The study was conducted on a sample of 107 subjects with a ICD-10 diagnosis of schizophrenia attending the South-Verona community-based mental health service in the frame of the *EPSILON Study of Schizophrenia*. Satisfaction was assessed by using the European version of the Verona Service Satisfaction Scale (VSSS-EU). Other measures included: the Brief Psychiatric Rating Scale (BPRS), the Global Assessment of Functioning (GAF) and the European versions of Camberwell Assessment of Need (CAN-EU), Involvement Evaluation Questionnaire (IEQ-EU) and Lancashire Quality of Life Profile (LQoLP-EU).

*Results.* 1) Overall, mean satisfaction was between 'mixed' and 'mostly satisfied', with higher satisfaction scores in 'Overall satisfaction' and 'Professionals' skill and behaviour' dimensions and lower scores in 'Information' and 'Access' dimensions. Satisfaction was positively correlated with age and subjective quality of life and negatively correlated with psychopathology (correlation coefficients were in all cases below 0.4). No significant correlation was found between satisfaction and the other sociodemographic, service utilisation and outcome variables. 2) A low explanatory capacity was found for a broad range of the sociodemographic, service utilisation and outcome variables. The only factors predicting service satisfaction were *living with the family* and higher subjective *quality of life* (but the model explained only 21% of the variance).

*Conclusions.* The study suggests that schizophrenic patients can reliably reports their views on the care they receive by using a well established standardised instrument. With few exceptions service satisfaction is not associated with the majority of sociodemographic, service utilisation and outcome variables. Similarly service satisfaction is predicted only by a very limited number of sociodemographic, service utilisation and outcome variables. It is therefore, conceivable, that satisfaction may depend on service-specific variables as the kind of service organisation or the overall service atmosphere.

### 3. Outcomes assessment in routine inpatient psychiatric care: Implementation and practice

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Swiss providers of inpatient services since 1997 face a legal mandate to install scientifically based systems of quality management. The behavioral health community in Switzerland has responded to this challenge by rapidly investigating ways to assess and improve structure, process and outcome quality of mental health care delivery. The transfer of knowledge and skills from other countries, notably the U.S., has been an important enhancing factor in this activity. In this paper we describe one practical approach to integrating the assessment of inpatient care outcomes in a large tertiary rural psychiatric hospital in German-speaking Switzerland into the routine delivery of care in a program of general acute and rehabilitative psychiatry. The organizational parameters of implementation are described. Data on clinical outcome, satisfaction, occupancy, readmission rates and expenditure, collected during the first 12 months of operation of this adaptation of a questionnaire-based, patient self-report system used in a large American academic medical center are presented. A case for the feasibility of economical and valid outcome assessment in routine clinical practice is made and the construction of a comprehensive performance measurement system for deployment in all types of psychiatric delivery settings and at all levels of care is proposed from the data presented. Data analysis on 410 or more admissions/discharges is reported. Multivariate data analysis yields findings that include inter-unit variance in clinical outcome, satisfaction and cost as well as initial trend data, and specific quality gap data that is suitable for deduction of practical remedial action by management.

### 4. Data bank of evaluative studies on community-based psychiatry

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*Objective:* The aim of the bank are to transfer information for decision-makers and managers at all levels, to provide researchers with information on methods and technics used in the studies, an to promote studies in countries which have limited possibilities of publishing papers in international journals. *Method:* The computerised bank covers structured syntheses of papers published since 1993 in 8 international journals. Collected are syntheses of relevant reports on evaluative studies, reviews of such studies and relevant methodological papers. The summaries are prepared in English according to the special IFEI questionnaire which comprises information on study design, intervention under study, characteristics of patients, evaluative measures and tools used, and results achieved. The IFEI consists of bibliographical date, 12 descriptive items and 58 categorised variables, covering over 600 categories and subcategories that can be used as key words for searching data. The inter-rater agreement of the IFEI amounts to 89%. *Use of the bank:* Two types of output are available for users: a list of papers fulfilling criteria required by the user, and structured summaries of papers fulfilling the user's criteria. Unlimited number of choice criteria can be used for searching. For example, one can choose the following papers: reports on outcome studies, published in Br. J. Psychiatry or AM. J. Psychiatry, in 1993-1996, describing prospective pre-post studies on comparison of day hospital and domiciliary care, covering adults schizophrenic patients, using patients'

social skills, vocational activity, and family burden as evaluative measures, using instruments X, Y, Z as evaluative tools. At present, one can communicate with the bank by mail or fax.

#### 5. On the application of the CES-D with the elderly:

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Dimensional structure and artefacts resulting from oppositely worded items

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In order to avoid acquiescence it is a common strategy to use oppositely worded items. Employing the Center for Epidemiological Studies Depression Scale (CES-D) we are confronted with specific artifacts resulting from the confounding of one aspect of the construct ("well being") with the direction of the item wording. The goal of this study is to investigate different artifacts resulting from the specific operationalisation of the instrument and from several characteristics of the sample. We investigated the structure and applicability of the CES-D by means of a sample of 986 individuals over 75 years of age within the "Leipzig Longitudinal Study in the Aged". Since the assumptions of a partial-credit-Rasch-model in one latent class turned out to be too restrictive, a 2-component model is adopted to map both depression and the response artifact simultaneously. Results are compared with a 4-class latent-class-model for ordered categories where three classes of the latter were ordered on a latent continuum "depression", one class comprises those respondents who exhibit response patterns indicating the artifact which results from the wording of the items. It can be shown that depression is overrated at least for these respondents. Associations with age and the Mini-Mental-State-Examination-Score are presented. Results show that care should be taken when the CES-D is employed particularly within a population of the elderly and the sum-score should not be used as a statistic for depression. The results may serve as an indication that oppositely worded items not necessarily solve the problem of acquiescence but rather may distort both the dimensional structure and the reliability of the scale.



1. Psychiatric reforms in Eastern Europe: adding ethics to care

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An overview of the reformist mental health movement in Eastern Europe reveals the involvement of an ever bigger variety of activist groups, persuasions and perspectives. Most arrive to commitment to reforms driven by interests, the pursuit of which has brought about awareness of human rights issues. In the face of as yet unrelenting psychiatric institutions ethical principles translate readily into political activism. The issue of changing institutional culture acquires critical importance for the pragmatics of mental health reforms.

The paper discusses attempts to develop dimensions to the practice of psychiatry that may challenge the institutional culture of dependence and corruption. Approaches such as developing team work, client orientation and psychiatric nursing are discussed among others. The issue of measuring the impact of such efforts is raised.

2. Mental health services as organizational cultures - Toward a systematic description

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The paper presents the development in six Eastern European countries of an instrument for the study of service culture in psychiatry. Paternalistic attitudes in post-totalitarian EE psychiatry foster patient's dependence and the violation of their human rights. These attitudes have a very strong impact on service provision, which could not be captured with the instruments collecting demographic, epidemiological and service utilization data. The paternalistic attitudes could be measured in connection to specific interactions in institutions (e.g. patient's participation in treatment, hospitalization etc).

Qualitative interviews were carried out and a pool of questions describing important aspects of service culture in Eastern European psychiatry was generated. Focus groups with patients, professionals and relatives were held by the six national teams in order to generate new items, to improve the formulation of the old ones and to study their face and content validity. The questionnaire was changed in accordance with the results from the focus groups. The draft of 31 questions was field tested. As a result of the factor analysis and the item reliability analysis some of the items were dropped out.

Four factors were identified. The Chronbach's alpha for three of the factors were above 0.7. Additional items were required for the forth factor. The questionnaire established statistically significant differences between the groups of patients and professionals.

The instrument needs further improvement and a test of psychometric properties of the shortened version.

### 3. Needs assessment and natural course in mental illness as a social construct: Development at two questionnaires collecting data in Eastern Europe

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This paper presents the development of two questionnaires, exploring the social constructs of “needs” and of “natural course” in mental illness in six countries from CCEE/NIS (Hungary, Lithuania, Bulgaria, Ukraine, the Kyrgyz Republic and Azerbaijan). The questionnaires and the research work they belong to are an attempt to make valid judgements for the success of the reformist movements in Eastern European mental health and the most likely trends in their development.

Eastern Europe generally lacks data about the needs for mental health services as experienced by the different stakeholders on the mental health scene (psychiatrists, nurses, social workers, public administrators, relatives, patients, etc.). Similarly no follow-up data about the natural course of mental illness is available. Managerial decision making in the field of mental health service delivery and planning is based on attitudes and expectations rather than on solid scientific data.

The questionnaires developed have taken into consideration this fact of Eastern European reality. The aim of the preliminary work has been to analyze what the implicit meanings of the two constructs are in CCEE/NIS. Qualitative interviews, focus groups, and factor analysis have been the methods used for this purpose. Five factors have been identified for the construct of needs and three for the construct of natural course of mental illness. The findings suggest that the two instruments are applicable and may produce plausible results.

The significance of the two constructs and how the questionnaires may be utilized for the designing of a policy and planning framework for mental health reforms is discussed in the article.

### 4. Psychiatrists' professional attitudes to mental illness in Eastern Europe: Victimization in the culture of dependency

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This study intended to verify the assumption that the professional identity of psychiatrists in Eastern Europe (EE) is dominated by the beliefs fostered by the culture of dependency, namely the attitude of concealed victimization and the idea of psychiatry as an agency for control. For the purposes of the study, the attitude of victimization was defined as a tendency to regard the patient as incapable of taking on social responsibility.

The study employed a case-vignette method. Each vignette described a hypothetical individual involved in a situation that takes a problematic course. Four vignettes were associated with a kind of mental breakdown; the fifth, control situation was not related to mental ill-health. The respondents were asked to assess the contribution of the characters to the problem in the case vignettes using a pair-comparison procedure. An unfolding technique was used for the analysis of the data.

The data of total of 1017 respondents from six countries of EE were analyzed. The study revealed three predominant views about the role of psychiatry in EE, all of them sharing a belief that patients should be held under control: psychiatry as an institution of control, psychiatry as a helpless institution and psychiatry as a protective institution. A tendency to attribute responsibility to the doctor rather than to the patient was found which supports the victimization hypothesis.

The implications of the study in terms of transition from the culture of dependency to a culture of participation are discussed.

## 5. Polish mental health programme - Mental health promotion and standards of care

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Social and economic changes deeply affect mental health in Poland. The process of integration with the world economy, freedom of travelling and information exchange, pluralistic socio-political system – all these factors create new perspectives and opportunities of development to the Polish society. On the other hand the ongoing transformation is connected with an increase in the mental health risks.

According to these changes the new Mental Health Programme had been developed based on the Mental Health Act adopted by the Polish Parliament for the first time 1994. Main goal of the programme is to provide the mentally disordered with the comprehensive, accessible health care and other forms of assistance necessary to the living in the community. It means a need for de-institutionalisation.

The examples of the programme implementation will be presented.

## 6. Tetralogue in Slovakia

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From 1997 till 1999 we realised a pilot project "Reintegration of persons who are psychosocially disabled". During this project we organised three international conferences, where we informed about the pilot project and the development of the tetralogue (dialogue between users, relatives, professionals and representatives of the society) at the local level in Michalovce and the national level. During this pilot project started in Slovakia users and relatives to organise themselves in NGOs. So we could in the tetralogue cooperate as equal partners. The results of tetralogue are important in two view of point: 1. involvement of users and relatives in the reform of psychiatry; 2. winning the society in the fight against stigmatisation. Concrete activities will be presented.

1. Ten years on: outcomes and costs of people with mental health problems and people with learning disabilities who were resettled in community residences

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<sup>4)</sup> Mathematics and Statistical Consultancy Unit, University of Durham

Background: The Care in the Community demonstration programme in England in the mid-1980s oversaw the resettlement of over 550 people with long-term needs. Researchers at the University of Kent (Knapp et al. 1992) evaluated this process and its outcomes. Two hundred service users with learning disabilities were followed up 5 years later (Cambridge et al. 1994).

The study: During 1998/9 over 400 users from the original cohort, 278 with learning disabilities and 128 with mental health problems, were followed up and interviewed. They were living in a variety of accommodation types, including residential and nursing homes, staffed group homes, unstaffed group homes and domestic environments. New measures of social networks, user-defined outcomes, and mental health status supplemented the original instruments. Costs information was collected using the CSSRI.

Findings: We will present findings on user characteristics at ten years on and a preliminary analysis of trends over time.

2. Costs, needs and outcomes for schizophrenia in five European countries: the EPSILON study

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Background: There is growing interest in multinational studies of disease burden and alternative models of mental health service delivery, but there remains a shortage of empirical research into comparative measurement of service utilisation, costs and their inter-relationship with needs and outcomes.

Aims. a) To describe and compare the resource implications of care and b) to explore and predict cost variations for people with schizophrenia living in different countries and settings.

Method. Service utilisation data were collected via an interviewer-administered questionnaire as part of a cross-sectional study of schizophrenia in five European countries. Service costs were estimated by attaching site-specific unit costs to each individual's use of resources, subsequently transformed into a single currency (UK £) using purchasing power parities (PPPs). Multivariate regression analyses were performed in order to explore cost variations and associations with key sociodemographic and outcome variables.

Results. The total annual cost per patient for the combined sample of 404 subjects is an estimated £5,038 (95% CI £3,888-6,237). Cost comparisons of adjusted means between sites reveals economically and statistically significant differences, ranging between £1,444-7,460 ( $p=0.005$ ). There were widespread and considerable differences between the participating sites both in the proportions of patients in contact with services and in the absolute level of service utilisation. A series of site-specific and pooled regression models were also derived which revealed those factors that are most closely associated with costs.

Discussion. Comparative analyses of the use and cost of mental health services can usefully demonstrate the economic burden of schizophrenia and other mental disorders, and highlight existing variations in health service provision and uptake.

### 3. The adulthood costs of behavioural and emotional problems in childhood

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There is now a great deal of clinical and social evidence which clearly links behavioural and emotional problems in childhood and adolescence to a variety of problems in adulthood. The UK government, in common with some other governments around the world, is looking to break these connections through more appropriate primary and secondary preventive measures in the early years. This presentation will first summarise evidence from UK studies that explore the long-term relationships between behavioural and emotional problems in childhood and the costs associated with a variety of personal and societal problems in adulthood. Second, the presentation will discuss policy and practice issues for child and adult services.

The presentation will draw in part on joint work conducted with Juliet Henderson, Paul McCrone, Barbara Maughan and Stephen Scott.

### 4. Does co-morbid substance abuse affect the pattern of care and cost of treatment for patients with severe long-term psychotic disorder?

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**Methods:** A detailed drug and alcohol history was collected as part of a randomised-controlled trial of case load size in the care of patients with severe psychotic illness. Patients were followed up for two years and data collected prospectively on their case manager contact and retrospectively on in-patient and other treatment resource uses. These data were subjected to a rigorous economic analysis.

**Results:** The treatment patterns and total treatment costs demonstrated a highly skewed distribution with a small number of patients responsible for a significant proportion of the total costs. Apart from alcohol and cannabis, current drug usage was overall quite low in this patient group and highlights problems about how drug and alcohol use are determined in studies of co-morbidity. After factor analysis it was found that alcohol consumption was associated with lower cost of care over two years. A number of possible explanations will be explored:

1. Patients consuming more alcohol exclude themselves from services.
2. This group are excluded by services.
3. Patients drinking more alcohol have better premorbid functioning and need fewer services.

### 5. A systematic review of home treatment compared with admission for mental health problems evaluated in terms of clinical, social, and cost outcomes, user and carer acceptability, and sustainability of programmes

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Inpatient services remain the major mental health cost within integrated services, thereby limiting developments within community provision. Studies of home-based care generally demonstrate that it is highly acceptable, with some clinical and social function gains. European studies, however, do not find the substantial reduction in hospitalisation demonstrated in North America and Australia. Translation into routine practice is further limited by studies' short-term follow-up, varied outcome measures, absence of detailed programme description, doubts about programme sustainability, and lack of definition of service models.

Literature (published and unpublished) reporting trials of home-based care as an alternative to admission was systematically and comprehensively reviewed. Studies were ranked according to their scientific rigour,

and sensitivity analyses used to determine the contribution of RCTs compromised by methodological flaws and of non-RCT studies. Studies were evaluated in terms of their inclusion of economic data and outcome measures (hospitalisation, social and clinical outcome, and acceptability to users and carers). Service use and cost data, where insufficiently detailed, were sought by direct approach to researchers. Follow-up was also used to answer questions about sustainability of programmes. Results will be discussed with particular reference to: the methodology of both individual studies and meta-analyses, the comparability and classification of service models, and implications for mental health service policy.

1. Integration in front line mental health services in the South-West of Montréal:

A study on the link between traditional specialized psychiatric services and a community treatment model

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For the past 25 years, the collaboration between the Montréal Community Clinic of Pointe-St-Charles, a primary care centre, and the Douglas Hospital, a centre specialized in psychiatry, has transpired into a partnership model specifically aimed at mental health services for adults. With the support of a team of consultants in psychiatry, affiliated to a neighbouring hospital, the front line professionals of the multidisciplinary team are responsible for establishing the treatment plan and for assuring a long-term follow-up, if necessary. The intervention focuses both on the district clinic rooted in the community and on a tradition of collaboration with numerous other community organizations that welcome people followed at this clinic. This model of organising services is currently subjected to pressures due to the changes in the health and social services network. This study was conducted at a time when the health services of Québec were being reorganized. The research generated a greater understanding on the conditions required to carry out the treatment model of the Community Clinic of Pointe-St-Charles and helped identify the path towards improvement, by considering the point of view of users and those of the professionals involved.

2. Patterns of care for schizophrenia in different regions of Spain

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Introduction: Service availability has been found to be of the main determinants of mental health service use. Many other factors also influence practice variability and equity of care. The study we present analyses the differences and the determinants of patterns of care for schizophrenia in several areas of Spain.

Methods: Representative samples of prevalent cases of schizophrenia were selected from four catchment areas in Spain (La Loja, Granada; Salamanca district, Madrid; Burlada, Navarra; and Gavà, Barcelona). The areas differ in sociodemographic characteristics and health service development and organization. Patients were evaluated with the CECE (Cost Evaluation Questionnaire in Schizophrenia). Service characteristics and availability has been determined through the European Service Mapping Schedule.

Results: A total of 258 cases were selected. Mean number of outpatient visits per year per patient ranged from 5.9 to 15.7 in the different areas. Mean number of acute inpatient care days ranged from 4.2 to 12.2. Mean number of stays in rehabilitation centers varied from 25.7 to 12.6. Service availability only partially determined differences in use. For example, the center with the highest number of outpatient visits per patient with schizophrenia had the lowest rate of visits per total population. DISCUSSION: Health service organization and service priorities can be as important as service availability in health service use by severe mental disorders.

### 3. Residential care in Andalusia and London: A comparison

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In recent years there has been a growing recognition of the need to standardize the assessment of mental health services across Europe, with the ultimate goal of establishing general norms of quality of care.

This collaborative study aims to evaluate the newly developed residential care facilities in Southern Spain, and compare them with the established community network in England.

The Spanish group comprises 77 former long-stay patients, currently living in 18 residential settings in Granada and Seville. The English sample consists of 59 residents, closely matching the characteristics of their counterparts, who live in 14 residential care settings in north London. Data were obtained by schedules commonly used by the Team for the Assessment of Psychiatric Services (TAPS), which were translated into Spanish and tested for reliability.

Various domains are explored, including the profile of residents, the objective measures of the care environments, the cost of services provided and the clients' satisfaction.

The results will be discussed in the context of the cultural and socio-economic differences between the two communities.

### 4. Needs, Satisfaction and Quality of life in chronic psychiatry

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**Objectives:** What are the needs of care of chronic psychiatric patients in various settings, how satisfied are they with the service provided and to what extent is their quality of life related to needs and service satisfaction?

**Method:** An epidemiological representative sample of 101 chronic psychiatric patients were personally interviewed with the help of the Camberwell Assessment of Need (CAN), the Verona Service Satisfaction Schedule (VSSS) and the EUROQoL. This sample consisted of 54 % woman and was on average 49 years old. Their first contact with mental health care dated back than 10 years in 48% of the cases. About one third was admitted to a mental hospital or lived in a sheltered accommodation.

**Results:** Prevalence of needs is on average 7.8 per patient of which 1.9 was unmet. Care was adequate in 57% of the patients, particularly in intramural settings. Satisfaction with care was relatively low. The experienced quality of life is strongly related to the number of unmet needs but not to the settings of care.

**Conclusions:** Despite the availability of varied services there is a lack of tailor made care which takes into account specific needs with regard to information, social contacts, daily activities etc. The possibilities of further extramuralisation are limited given the cognitive and (increasing) physical impairments of this patient population.

### 5. Inter-organizational differences in community interventions

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The coordination of community interventions sometimes run into counterproductive conflicts between the psychiatric staff and the local social services.

**Method:** A study of incidents of successes and failures in the daily coordination in four community psychiatry programs in Denmark. The incidents are content-analysed for themes across programs.

**Results:** The dominant themes of success and failures are very similar across programs.



The data reflects three dominant themes of conflicts 1) differences in professional cultures 2) differences in organisational cultures 3) missing adequate models and rules for cooperation in inter-organizational networks.

Conclusion: Cultural competence and detailed contracts on behavioural rules in the coordination of community programs prevent inter-organizational conflicts.

## 6. Brief psychological treatment in community mental health services

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Introduction: Long waiting times and clients who seek specific and focal problem resolution rather than general personality “overhauls” led many community mental health services to develop brief psychological treatment programmes (BPTP). Because little was known about the content and application of these BPTP we conducted a study to outline the state of affairs.

Method: In a national survey informants of all 57 Regional Institutes for Ambulatory Mental Health Care (RIAMHC) in the Netherlands were interviewed (by telephone) with a semi-structured questionnaire. In this study we only report BPTP which are intended to remain restricted to six sessions or less.

Results: Over two thirds of all RIAMHC have BPTP. There appear to exist few directives in the field concerning (contra)indications for BPT, the content of BPT and the timeframe over which the contacts take place. Almost all informants declare that for a BPT to succeed, the clients and the therapist must quickly reach an agreement about the nature of the problem and the aims for therapy. Therapists do not aim at “total cure” but help the client up to the point that he can deal with his problems without professional help. Most informants also state that only experienced therapists are able to do BPT.

Discussion: Although many RIAMHC have BPTP and claim that this kind of treatment is useful, efficient and applicable to a variety of potential clients, the outcome of BPT has still not received empirical examination. To describe the BPT process and the potential benefits in six RIAMHC, we used an eight-month follow-up design with four occasions of testing. Information was obtained from the client pertaining to concepts like specific target systems or problem areas, general levels of psychiatric symptoms, self-esteem, mastery, stages of change and the quality of client-therapist interaction. The first results of this second study will also be presented and discussed.

1. The emics and etics of quality of life assessment

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Background: Among quality of life (QOL) researchers there is a debate over the value of subjective measures because subjective ratings of different areas of people's lives often bear little relation to their objective life circumstances. Anthropological theory can illuminate this debate since cultural anthropologists grapple with a similar issue — the difference between emics and etics. Emic data, in anthropology, deal with distinctions which are real and significant to natives of the culture while etic statements depend on distinctions judged appropriate by scientific observers.

Conclusions: The study of emics and etics suggests the following conclusions for QOL researchers. Subjective and objective appraisals are different kinds of data, both of which can be collected from subjects. Both are valuable, but it may be necessary to override subjective data to develop a predictive model. Objective circumstances do not reliably predict subjective evaluations of those circumstances or vice versa, particularly in evaluating change over time. The combination of subjective and objective measures, however, can lead more directly to service improvements that are sensitive to consumers' needs.

2. What do schizophrenic persons mean by quality of life?

A qualitative content analysis of 268 open-ended interviews

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There is growing number of different theoretical approaches to quality of life (QoL) and a corresponding number of different QoL-scales in psychiatry. However, constituents and range of the subjective frame of reference of QoL in schizophrenic patients are still indeterminate. The present study, therefore, aimed to reconstruct the perspective of schizophrenic patients on their own QoL.

270 open-ended interviews explored individual understanding of satisfaction, happiness and QoL in newly admitted acute, chronic long-stay and community-treated patients.

Results of qualitative content analysis showed that schizophrenic patients view on their QoL could be systematised in a limited, circumscribed frame. Domains of their QoL were neither 'insane' nor incoherent but - even in 'acute' patients - meaningful, comprehensible and reasonable. They reflected specific aspects of the features of a 'schizophrenic' life, providing a meaningful framework for assessment and interpretations of QoL in schizophrenic patients.

3. Subjective and objective dimension of quality of life in psychiatric patients:

A factor-analytic approach

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Objective: The study was designed to investigate the relationship between quality of life (QOL) and a number of mental health indicators both cross-sectionally and longitudinally, focusing on the differential role of subjective and objective QOL dimensions.

Method: The study investigates the relationship between QOL, as measured by the Lancashire Quality of Life Profile (LQL), and demographic variables, diagnosis, psychopathology, affect balance, self esteem, disability, functioning, service use and service satisfaction at two points in time, using factor analysis and multiple regression techniques, in a cohort of patients with a full range of psychiatric conditions attending the mental health service of South-Verona, Italy.

Results: Three latent constructions of QOL, one subjective and two objective (work/income and living-situation/safety), with strong face-validity, were identified by factor analysis of the LQL. Cross-sectionally, the predictors of the subjective factor were primarily other subjective measures; longitudinally few predictors of the subjective factor were identified. The cross-sectional and longitudinal predictors of the objective factors were primarily demographic variables and observe-rated measures such as diagnosis, treatment, psychopathology, disability and functioning.

Conclusions: Subjective and objective data are distinct types of information. Objective measures may prove to be more suitable in detecting the effect of treatment interventions. Subjective information is necessary to complete the QOL picture and to enhance the interpretation of objective data.

#### 4. Determinants of subjective quality of life in patients attending community-based mental health services

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Background: The growing popularity of quality of life as an outcome measure in medical research has not been matched with research to establish its relationship with established indicators of health status and service use. As part of the South-Verona Outcome Project, this study has investigated the relationship between subjective quality of life and socio-demographic variables, diagnosis, psychopathology, social disability, global functioning, service utilization and service satisfaction.

Methods: Information was collected on 268 patients in contact with the South-Verona community mental health service during a three-month period. Measures included: Lancashire Quality of Life Profile, socio-demographics, ICD-10 diagnosis, Brief Psychiatric Rating Scale (BPRS), Disability Assessment Schedule (DAS), Global Assessment of Functioning, service utilization and Verona Service Satisfaction Scale (VSSS). Analyses were conducted using a block-stratified multiple regression model.

Results: Demographics, diagnosis, psychopathology, disability, functioning and service use together accounted for only 5.9% of the variance in total quality of life. The inclusion of the VSSS in the model explained 20.9% of the variance. Some mental health and service indicators had significant associations with specific domains of quality of life.

Conclusions: A low explanatory capacity for subjective quality of life was found for a broad range of established indicators of health and service use. The VSSS alone explained more of the variance than the other measures, supporting that self-perceived effective care has a real impact on the quality of life of patients with mental disorders. This opens perspectives for planning mental health services towards the improvement of patients' quality of life.

#### 5. Health-related quality of life in schizophrenic outpatients as measured by MOS SF-36

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Introduction: The MOS Short Form 36-Item Health Survey (SF-36) is a widely used self report measure for assessing health-related quality of life. The SF-36 includes 8 subscales: 1. limitations in physical activities because of health problems; 2. limitations in social activities because of physical or emotional problems; 3. limitations in usual role activities because of physical health problems; 4. bodily pain; 5. general mental health (psychological distress and well-being); 6. limitations in usual role activities because of emo-

tional problems; 7. vitality (energy and fatigue); 8. general health perceptions. Its psychometric properties appear to be good in normal groups, in groups of patients with chronic physical as well as mental illness. Recent research with this instrument among people suffering from schizophrenia showed that the instrument has good psychometric properties and feasibility in this particular group.

The aim of this study is to replicate the results of the SF-36 in a group of schizophrenic outpatients. Also, scores of the SF-36 in our sample will be compared with results of the following concepts that are related to subjective mental health care evaluation: needs for care, quality of life and symptomatology.

Method: In the study 140 outpatients diagnosed with schizophrenia participated. All subjects were living in two regions in the Netherlands, a rural and an urban region. Patients of the urban area also participated in the "EPSILON"-study. Subjects were aged between 18 and 65 years and received some form of outpatient care at the moment of this study. Instruments: the SF-36 (health-related quality of life), the Camberwell Assessment of Needs (needs for care) and the Brief Psychiatric Rating Scale-E (symptomatology).

Results: Correlations between the SF-36 and the other instruments will be shown. It will be discussed if the SF-36 has good validity and whether it is usable as a short and feasible screening instrument for detecting (health-related) quality of life and needs for care among patients with serious chronic mental illness.

#### 6. The Spanish version of the World Health Organisation disability assessment schedule: Development and reliability testing

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To complement the revision process of the International Classification of Impairments, Disabilities and Handicaps –ICIDH–, the World Health Organisation is developing, in parallel with the classification, the World Health Organisation Disability Assessment Schedule –WHO-DAS II–. This is an instrument to assess mental and physical health related disablement in a way that is consistent with the new ICIDH-2 classification system. The WHO-DAS II has six major domains covering activities that are considered important in most cultures: understanding and interacting with the world, moving and getting around, self care, getting on with people, life activities, participation in society.

The objective of this paper is to present the process of developing the Spanish version of the WHO-DAS II. This included, in the initial phase, a process of translation and cross-cultural verification of the concepts and items to be incorporated in the instrument. This was subsequently followed by the application of qualitative and quantitative methodological strategies in the simplification of the instrument, and finally a process of reliability and validity assessment.

The sample investigated in the final stage was composed by 161 persons (74 female and 87 male), classified in five categories and distributed as follows: general population (15,52%), mentally ill patients (29,2%) physical patients (36,2%) patients presenting alcohol and drug related problems (19,2%). The reliability and validity analysis of the instrument, based on classical test theory, demonstrated a high reliability indices for the instrument. The figures for the different domains will be presented in the paper.

### 1. Social-stress disorders in refugees and forced migrants in modern Russia. Activity of civic assistance committee

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Since 1990, pioneer Russian public charity organizations which help refugees and forced migrants have started to work in Moscow. After the disintegration of the Soviet Union the migration on the post-soviet territory turned into suffering of millions of people. Mass manifestation of psychoemotional tension and psychological disadaptation in the ethnic Russian in former republic of the Soviet Union became the natural "experimental model" of Social-Stress Disorders (SSD). Likewise the posttraumatic stress disorders (SSD) appear in the majority of people as a result of the revolutionary changes in entrenched consciousness and way of life. Since 1994 the therapists and psychotherapists began to act in "Civic Assistance" with the aim to improve the refugees' somatic and mental health and also promote their psycho-social rehabilitation. We present here the psychopathological analysis of 1245 migrants from Chechnya, Tadzhikistan, Abchazia, Azerbaijan. It was shown that: 12% of migrants suffered from pre-disease reactions with emotional tension, obsessive reminiscences of tragic events during civil war or pogroms; 18% - affective-shock reactions (with amnesia) with confusion of consciousness, psychomotor excitation; 31% - psychoadaptive states with neurasthenical, hysterical, anxiotical reactions; 39% - pathological personality development or psychosomatic disorders. Nosologically all above mentioned groups of patients were determined as SSD. In the treatment of these patients the combination of different kind of psychotherapy (rational, suggestive, behavioral) and varied psychopharmacotherapy (valium, phenazepam, clonazepam, alprazolam, coaxil, zoloft, neuleptil, melleril, nootropil) was the most effective.

### 2. Organization of psychotherapeutic services in Russian' somatic hospitals and out-patients (poly)clinics as a result of reforms in psychiatry

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In 1995 the Ministry of Health of Russia promulgated the Order "About psychiatric and psychotherapeutic care". In 1997 according to this Order the Department of Psychotherapy started to work in the large (more than 1300 beds) multiprofile hospital 36 (2 psychiatrists, 1 psychotherapist, 1 medical psychologist and 2 medical nurses). The main tasks of Department's psychiatrists and psychotherapist consist of the psychopharmacotherapy and psychotherapy the somatic patients with accompanying (comorbid) psychiatric diseases. For the last 2,5 years psychiatrists, psychotherapist and medical psychologist carried out 4825 consultations and 380 of seances of group psychotherapy and unnumerable sea-nces of individual psychotherapy. There were the following groups of somatic patients with comorbid psychiatric diseases: 1st group (75,2%) - different neurotic and neurotic-like disorders, 2nd group (21,1%) - psychotic disorders, 3rd group (3,7%) - mental retardation. The 1st group of patients consisted of neurosis (33,2%), neurosis- and psychopathy-like disorders as result of cerebral atherosclerosis (12,5%), psychosomatic disorders as a result of hypertonia, bronchial asthma, ulcer of stomach, colitis (9,6%), neurosis- and psychopathy-like disorders in alcoholic persons (8,5%), neurosis- and psychopathy-like disorders in patients with

organic diseases of brain (5%), psychopaties (2,1%), reactive states of neurotic level (1,9%), epilepsy with neurosis- and psychopathy-like disorders (1,6%), specific symptoms and syndromes (stutter, tick, psychalgia, etc.(0,8%). The 2nd group consisted of psychosis and dementia in senile age (9,35%), alcohol delirium of abstinent type (5, 41%), schizophrenia (4,16%), reactive psychosis (2,2%).The 3rd group consisted of those with learning impairment (as above mentioned 3,7%).The somatic patients with comorbid psychiatric disorders were treated with varied psychopharmacotherapy and individual or/and group psychotherapy (rational, suggestive, behavioral). The combination of psychoparmacotherapy and psychotherapy was the most effective.

### 3. Correlation between the type of mental care organisation model and the number of mentally ill persons

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Two different time periods are observed during the last 40 years in Georgia. The first one till 1988 and the second period - after 1988. Stable quantitative increase of mentally ill patients was observed during the first time period (1959-1988) and significant decrease is stated in 1989-1999. If we consider the correlation of this process with issues, such as the number of psychiatric facilities, number of appropriate staff and their qualification, level of technical equipment used in psychiatric facilities, financing of psychiatric services, then strong relationship does exist. Between those ones and the number of registered mental patients. The fact, that the decrease of number of mentally ill patients is caused by a decrease of registered non-psychiatric diseases leads to the conclusion that the reason of decrease of mentally ill persons is not biological, but social determined. This conclusion is supported by stating the fact that the number of psychiatric patients stays on the previous level as the government manages to finance non-psychiatric services some how.

### 4. The organization of treatment of mentally ill patients and their crimes

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The attitudes of the mentally healthy part of the human society to mentally ill person were considered as an important problem of human society development. Unfortunately, this attitude in the most cases turned be strict, even cruel. Legislative acts for protection of human rights on of mentally ill persons, are to be the most important tool for solving above mentioned problem.

Changes taking place in the post soviet area (including Georgia) seem to be very interesting in this aspect for radical turn from paternalisation principles towards the personal freedom principle.

Our studies of 10 - year experience showed significant increase of crimes committed by mentally ill persons. This is main reason for discussing substantial correctives in present legislation in this field.

### 5. The influence of 1990s transitions on legal psychoactive drugs supply and demand

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Drug abuse in Poland and many other countries is usually perceived with the narrow perspective of opiate dependence. For this reason the hidden problem of psychoactive pharmaceuticals abuse has not received public attention. Since the beginning of the country's sudden political and economic transformations the prevalence of using psychoactive substances has grown. The growing process has much to do with the difficult and stressful process of adopting to the new reality. This is one from the main reasons of growing up of the demand for psychoactive pharmaceuticals. The demand has been also affected by the increased

availability of medicines on the market and ever-present aggressive advertisements. Polish consumers are not used to viewing items, specially pharmaceuticals, as free market products and are more likely to interpret literally the advertisements slogans. In the current situation the real chemical content of advertised drugs is less important than the ideological aspects of mass drug advertisements. A common belief has been created that every pain, trouble and daily life problem can be overcome if one spends enough money to buy a miracle drug. The paper will present the issue of current psychoactive pharmaceuticals use in the context of drug abuse as well as society's attitudes to the pharmaceuticals

#### 6. Psychiatric service reforms in Armenia: theoretical problems

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Social, political and economic changes of recent years in Armenia, as well as changes of theoretical and methodological conceptions of health care require the reorganization of Armenian psychiatric service. Characteristic features of the present period are: liberalization of economy and social and political system; divergence between the declared and real opportunities, rights and duties; lack of legislation in the field of mental health; establishment of social organizations; problems of professional education, etc.

The aim of the present project is the establishment of a Mental Health Service which would have social orientation, high effectiveness and accessibility for every layer of society. Principles of the project are demopolization and decentralization of service, differentiation and specialization, and liaison between services. The main goals of reforms are: establishment of adequate legislation, re-structuring of psychiatric services, improvement of mental health specialists' ( psychiatrists, psycho-theraputists, clinical psychologists, social workers, nurses) education and training, and increasing the role of social organizations.

### 1. The definition and prevalence of severe and persistent mental illness

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**Background.** Services should especially target those suffering from severe mental illness (SMI). The definition of SMI provided by the National Institute for Mental Health (NIMH) in 1987 is the one with the widest measure of consensus and the most representative. As this definition is not clearly operationalized, there is very little consistency in how SMI is defined in practice.

**Method.** Rates of SMI in two epidemiologically-based catchment areas in Europe (London and Verona) have been calculated by using two operationalized definitions derived from the NIMH definition formulated in 1987. The 3-D definition of SMI consists of (1) diagnosis of any non-organic psychotic disorder, (2) duration since first service contact of over two years, and (3) disability score of less than 50 on the GAF scale. The 2-D definition is based on the fulfilment of criteria (2) and (3) alone.

**Results.** Annual period prevalence rates of SMI, using the 3-D definition, are 2.55/1000 adult inhabitants in London (UK) and 1.34/1000 in Verona (Italy). In the latter site, the wider 2-D definition includes a further 0.98/1000 for non-psychotic disorders, giving a total prevalence rate of SMI of 2.33/1000 for all disorders. The proportion of all prevalent non-organic psychotic cases which fulfilled the 3-D SMI criteria was 32% in London and 40% in Verona. Among all non-psychotic cases in Verona, 9% fulfilled the criteria for SMI.

**Conclusions.** The 3-D and 2-D definitions presented in this paper represent an advance in that simple and operationalized criteria are used. This potentially allows more accurate population-based calculations of prevalence rates to be made, with important implications for service planning. In addition, the proposed 2-D approach for the first time allows estimates of SMI prevalence rates which include not only functional psychoses, but all forms of severely disabling mental disorder.

### 2. Accessibility as one basis for planning mental health services

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The objectives of mental health care planning are to ensure adequate accessibility of psychiatric and psychosocial care. In our study an attempt was made to evaluate accessibility by using 'spatial' and 'non-spatial' indicators.

Based on the inpatient case register of the Dept. of Psychiatry we investigated the relationship between treatment prevalence and the distance from the patients' residence to institutions providing psychiatric inpatient-care in the Austrian province of Tyrol. Distance was measured in terms of travel time by public transportation. After controlling for possible influences of selective migration, the distance-dependent utilisation of inpatient facilities was adjusted for 'non-spatial' indicators such as urban/rural differences and sociodemographic and - economic variables.

We found an inverse relationship between treatment prevalence and geographic distance to inpatient facilities. In our mixed-urban/rural catchment area this effect was only slightly weakened by 'non-spatial' factors, which alone could not explain this inverse relationship.



Our investigation demonstrates that the temporal dimension of distance is also important when defining accessibility to psychiatric services in a mixed urban/rural catchment area. The use of travel time also made it possible to determine the critical distance acceptable to patients. When public transportation is used we found this to be limited to 30 minutes of travel time. It is advisable that mental health services are located relatively close to those they wish to serve.

### 3. Determinants of help-seeking behaviours of people with mental health problem

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A multi-method strategy was implemented in the Montreal region in order to assess community mental health needs. Three general procedures were used : a telephone survey of a random sample of the general population (sample size : 4626), a face-to-face survey of users or persons with mental health problems (sample size : 357), and a mail survey of informal caregivers (sample size : 423). The dimensions under study were : prevalence of specific mental disorders; related disabilities; service utilization; informal caregiving; knowledge and beliefs; and demographics. Data were collected between March and June 1999.

Our contribution summarizes the principal findings from the three surveys regarding help-seeking behaviors of people with mental health problems. The specific objective is to contrast characteristics of mental health services users versus non-users in terms of demographics, nature of symptoms, perceived needs, past experience of the health care system, knowledge and beliefs regarding mental health problems and services, problem recognition, social support, and features of the treatment system.

We also outline the way in which our results contribute to decision making in regard to : services reorganization in the Montreal region; a communication plan to modify help-seeking behaviours when necessary; improvements in the screening and reference procedures by professionals.

Finally, we identify the input data presented here that appear most promising as outcome measures to monitor the impact of the services reorganization and of the communication campaign.

### 4. Multi-problem persons in Stockholm: Multi-care consumers - a file study of psychiatrically disturbed offenders

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Method: Care and support given to the 563 Stockholm county residents who underwent forensic psychiatric examination 1989 - 1993 were compared to a matched reference group of the same size. This file study was possible because of the Swedish civic registration number system.

Results: Large efforts for our probands, associated with large costs, were shown to be made by different categories of caregivers. A very uneven distribution of the probands with more than 10-fold differences between districts of the county points to geographical differences in needs. The probands were treated in hospital for somatic reasons more than three times as often as the controls, and even more often for intoxication, injuries, and "ill-defined conditions". Especially, persons with personality disorders had many admissions. In all, over a 10-year period, 410 probands and 159 controls were admitted to hospital on 1018 and 332 occasions, respectively. 136 of the probands and 129 of the controls were on vocational rehabilitation programs. 115 of the probands and 42 of the controls received other rehabilitation services. Only a few persons in each group received pension due to age or handicap. However, 267 of the probands received sickness pension, as compared to 34 of the controls. Other types of social security allowance were uncommon.

Conclusion: Patients examined in forensic psychiatry have many different types of needs, and make use of caregivers from many different public sectors with substantial cost implications. Cooperation between

professionals seems important. Geographical differences should be met with adjusted services in different areas.

##### 5. The impact of social and clinical variables on length of stay in a General Hospital Psychiatric Unit.

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In recent decades, inpatient psychiatric care in Western Countries has undergone a profound transformation. The production of alternatives such as psychiatric units in general hospitals, day hospital, residential facilities and outpatients treatment allowed the process of deinstitutionalization. In 1978, the Italian psychiatric reform imposed the closure of the State Mental Hospitals and introduced the acute psychiatric wards within the General Hospitals. Although the changes have been applied in the South-Verona area since the reform was approved, the inpatient care is still the most expensive component of the mental health care system. Changes in length of stay have considerable impact on costs and are thus considered a fundamental issue for cost-effectiveness. The South-Verona Community Mental Health Service (CMHS) runs a 15-bed psychiatric unit in a General Hospital that provides admission for acute psychiatric patients. The sample comprised all consecutive admissions (174) to the South-Verona in-patient unit occurring from January to December 1998. A simple instrument was designed to assess the presence of the following conditions during each admission: risk of danger to themselves or others, substance abuse, medical consultations, involuntary admission, need for physical restraint, family history of psychiatric illness, accommodation problems, GAF score at admission. Data from the South-Verona Psychiatric Case Register were used to obtain information on age, gender, living situation, occupational status, educational status, marital status, diagnosis, duration of psychiatric history, intensity of psychiatric contacts lifetime, numbers of admission in the previous year, continuity of care index.

The association of all these variables with the length of stay was assessed using a multiple regression analysis with cluster procedures, that allows to take into account the repeated measures for patients with more than one admission.

The mean length of stay for the whole cohort was 25.6 days (95% C.I. 19.8 - 31.4), while patients with a diagnosis of schizophrenia had a mean value of 38.2 (95% C.I. 24.3 - 52.0). The presence of accommodation problems doubled the duration of stay (19.2 vs. 42.2). The regression analysis showed that a longer duration of stay was associated ( $R^2=0.25$ ) with accommodation problems, medical consultations during the admission, duration of psychiatric history, living alone, having a diagnosis of schizophrenia and higher intensity of contacts lifetime.

The results of this study indicate that non-clinical as well as clinical variables are important contributors to length of stay, but that much of the variance remains unaccounted for.

1. How do people with chronic schizophrenia evaluate their psychiatric outpatient treatment. A qualitative study

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In order to obtain information about the subjective assessment of psychiatric outpatient treatment by patients with chronic schizophrenia, a qualitative study approach was adopted using a problem focused interview. Methods: The sample consists of 100 persons with the diagnosis of schizophrenia according to ICD-9 (F.295) living in the community. All interviews were transcribed and analysed by means of computer based content analysis. A categorical system was developed to classify patients along the dimensions of whether they understand the purpose of their medical or non-medical treatment, whether they assess their treatment as useful, whether they express their own demands with regard to the treatment or the psychiatrist, whether they feel able to communicate their demands or criticisms to the psychiatrist; whether they feel in the position to modify treatment in co-operation with the psychiatrist, and whether they feel able to change the psychiatrist if they are dissatisfied with current treatment. Results: As a result of a classification of the patients according to these criteria we found that only 25 % of the patients understand the aims and the objectives of their treatment and feel able to influence or modify the treatment in co-operation with the psychiatrist. More than 50 % of the patients are satisfied with their treatment but experience it in a passive way, they neither really understand aims and objects of the treatment nor do they see any possibility to influence the treatment process. Nearly 25 % of the patients feel completely helpless. They are dissatisfied with the treatment and do not understand its aims and objectives but they don't see possibilities to cause any changes in the treatment process. Conclusions: A majority of patients with chronic schizophrenia experience psychiatric outpatient treatment as an incomprehensible process out of their control and therefore efforts should be undertaken to enable these patients to understand modern psychiatric treatment alternatives and to take a more active role in the treatment process.

2. Primary care doctors talk about mental health. A qualitative study using focus groups.

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Background: After 30 years of research in the interface between Mental Health and Primary Care, there is a feeling of disappointment. There is huge epidemiological evidence confirming the relevance of mental health disorders in primary care settings and the definite role of primary care providers in their "de facto" management. Many programs have been developed in order to improve this situation but results are inconclusive for the most cases.

Therefore, there is a chance for opening the scope of research using qualitative methodologies that can offer new and more creative inputs.

On the other hand, some regions of Spain have implemented mental health care systems based in Primary Care that have reached a considerable degree of development in recent years.

Aim: To obtain meaningful information on the interface between Psychiatry and Primary Care by listening and analyzing the discourse of family doctors.

Method: A focus group approach with two groups of doctors: one of experienced generalists with a proven interest in Mental Health topics and a second group of last year family medicine residents. A similar technique was used in previous studies.

Both groups run initially open, non-directive session that were analyzed according the methodology proposed by Miles and Hubermann (1996). Main topics arising from this first step were brought again to a new group session for rediscussion in a more directive way.

Results: Data are not yet fully analyzed. There is a trend that mental health problems are viewed as a collaborative area where a more bidirectional and closer interaction is necessary.

### 3. Team working in community psychiatry

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**Introduction:** The climate within which mental health staff work may be an important factor in the effectiveness of community care. Community psychiatry in England is increasingly delivered by multi-disciplinary teams. These teams bear the brunt of resource limitations and changes in mental health policy. Their attitudes towards the system which they are meant to operate, the functioning of the team and the job satisfaction and psychological wellbeing of the individual staff are of interest in themselves in relation to service culture. They may also affect service user outcomes.

**The study:** This paper will explore data collected from two studies of community mental health care. They comprise about 200 staff in five mental health services in England in 1998-99. The study replicates parts of previous research (West et al., 1994) and its findings may also be compared to other recent surveys of mental health workers (e.g. McLean et al., 1999; Carpenter et al., 1997)

**Findings:** We will look at measures of: team identification, professional identification, team functioning, participation, support for new ideas, clarity of team objectives, task style, reviewing processes, working in the team, innovation in the team, role clarity, role conflict, job satisfaction and psychological well-being (General Health Questionnaire). Differences between districts and between professional groups will be explored. We will explore associations between the measures used and the dependent variables job satisfaction and psychological well-being.

**Implications:** These data help us to identify those aspects of team working which perform less well than other aspects. They also show that the subjective experience in teams of some professional groups is less satisfactory than others. Such findings can inform service organisation and planning, training agendas and resource allocation.

### 4. Quality of care on closed psychiatric admission-wards: strengths and weaknesses

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**Introduction:** In the Netherlands closed admission-wards fulfil an important role in psychiatry. A third of the annual psychiatric admissions take place on these wards. For most patients a closed admission is a traumatic experience.

**Objective of the study** is to gain insight in a) the quality of care on closed psychiatric admission-wards from the perspective of the patient and caregivers and b) the correlation between ward-characteristics, patient-characteristics and quality of care.

**Methods:** Based on already existing quality of care instruments and a concept mapping procedure we developed an instrument, the KWAZOP, to assess quality of care on closed psychiatric admission-wards.

**Results:** The KWAZOP consists of three parts: one for patients, one for the psychiatrist, one for the nurse. Patients assess the quality of care via an interview, the psychiatrist and nurse complete a questionnaire. Based on a factor analysis the patient items are grouped in four core scales and two facultative scales: medical treatment, nursing care, reliability/safety, privacy/personal freedom, use of compulsory

measures and family involvement. Similarly the items concerning psychiatrists and nurses are grouped in four scales: continuity of care, treatment plan, nursing plan and efficacy.

The reliability of the KWAZOP scales in terms of homogeneity and for the core scales of the patients part in terms of test-retest reliability was encouraging (Cronbachs 0.67-0.86; ICC 0.79-0.90).

The results of a quality assessment with the KWAZOP in 1999 on 20 admission-wards of 16 Dutch psychiatric hospitals will be presented. Strengths and weaknesses of those closed admission-wards will be indicated. Dissimilarities in quality between wards will be discussed.

Conclusions: The KWAZOP has proven to be an useful instrument for closed admission-wards to obtain reliable and valid feedback on quality of care. The feedback gives rise to initiatives to improve the quality of care.

## 5. Treatment philosophy and practice in inpatients/units

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Objectives: The aim of the study was to explore the relationship between the treatment philosophy, treatment practice, staff profile and patients profile. This was done as a part of a large study of the specialised mental health services in seven catchment areas with one tenth of the population in Norway.

Methods: Data was collected from 53 psychiatric inpatients units, - including acute wards, intermediate open wards and long-term rehabilitation wards. Treatment philosophy was measured using an extended-version of CPPS completed by the staff. Treatment practice was measured by daily recording of what treatment activities the patients attended in a two week period. Data collected on patients included age, sex, diagnoses, GAF and length of stay.

Results: There were predictable variations between types of wards in many of the system variables that were measured. But there were also variations within the same type of wards that seems to be related to the staff profile and not only the patients profile. This is likely to influence the quality and type of services delivered.

Conclusions: Measuring treatment philosophy may give valuable contributions in assessment of mental health services. Combining several types of variables and different measures may also be important when assessing the mental health services as a system.

## 6. Involvement and participation of older clients in mental health care.

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Since the enactment of the Law on Medical Treatment Agreements mental health institutions in the Netherlands are obliged to involve clients in their care and treatment plans. The involvement of older clients, however, appears to be difficult to achieve. The present study focuses on the factors that facilitate and interfere with the involvement of older clients in two substudies.

The study takes place in different settings (ambulatory, day care, short-stay and long-stay) in two regions in the Netherlands. In the first substudy 100 clients and their immediate staff member, are interviewed on their involvement and the perceived facilitating and interfering factors. The second substudy entails a comparative contrast case study, focusing on 20 client-staff member combinations. The combinations are selected from the first substudy on the basis of maximal versus minimal agreement between client and staff member on the subject of client involvement. The clients and staff members are interviewed in more detail on the topic of client involvement. This substudy also includes observation of five standard care situations (1 day per client) in order to detect latent factors that may be of influence.

The results will be used in the development of a methodology that will facilitate the involvement of older clients in mental health care. Interviewing is currently (November 1999) in progress and results will be presented at the conference.

### 1. Downsizing psychiatric hospitals in Montreal: needs for care and services of long-stay inpatients discharging in the past decade, and costs

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Purpose. As the movement of psychiatric deinstitutionalisation is entering its fourth decade in Québec and Canada, questions arise regarding its relevance for long-stay inpatients with great handicaps and the risks of abandonment in the community. Methods. A random sample of long-stay inpatients in 1989 from L-H Lafontaine Psychiatric Hospital in Montreal, allowed to examine 92 pairs of patients either discharged between 1989-1996/8 or remaining hospitalised. Patients and staff were interviewed using standardised questionnaires. A panel consisting of a psychiatrist, social worker, clinical psychologist and research scientist assess the needs for care and services. Utilization of services during this period were recorded and costs established. Findings. Discharged patients moved to highly supervised settings: professionally supervised group homes, supervised hostels or foster families; including 20% to nursing homes because of loss of autonomy due to physical disorders. Only 4 discharged patients were lost to follow-up and available information suggest that 2 of these may be vagrants in Canada. Both discharged and remaining inpatients present important clinical problems and daily living skills deficits. The needs for care of discharged patients were generally met and placement in the community were considered appropriate. Among patients remaining hospitalised, over half could move to supervised settings immediately or following 1-2 years in a discharge unit; 20% shall be directed towards nursing homes; over 25% would require more intensive individualised treatment and rehabilitation efforts in the hospital or in 'hostel wards'. Costs decreased over time for discharged patients- and nearly 90% were related to residential facilities & ward staff; costs remained high for discharged patients, \$US36425 per year per patient at the end of the follow-up Conclusions. It is reassuring that the deinstitutionalisation movement conducted from the largest Canadian psychiatric hospital does not lead to abandonment in the community. The outcome of these patients is in line with the few recent studies of psychiatric hospital downsizing in a favourable financial and organisational context: discharge to highly supervised settings; little or no change in symptoms, daily living skills; improvement in social relations and quality of life.

### 2. The politics of de-institutionalisation in Norway

P. B. Pedersen

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As in most western countries, the number of inpatients in Norwegian psychiatric institutions has been drastically reduced over the last decades. There is hardly any evidence suggesting a similar reduction in the number of people suffering from mental problems. The de-institutionalisation of psychiatric services, then, implies a major shift in the relationship between mental problems and services provided. Public agencies play a major part in the financing, regulation and provision of mental health services. The services provided are, in a real sense, a result of public policy. Despite this, theories on de-institutionalisation have usually attributed only a marginal role for politics in the process. Political factors

included are either focused on "spill-over" from other sectors (development of the welfare state, insurance systems, the fiscal crisis of the state etc), and/or view political decisions and reforms as an adaptation to processes already initiated by the services themselves.

The purpose of this paper will be to examine the explicit *content* of the mental health policy at the national level. A similar paper, covering policy at the local level, will be presented in another paper at the conference (Hatling T and Pedersen PB: De-institutionalisation in a de-centralised system). Central questions are

- In what way are "needs" perceived/studied, and then related to services, and how do these relations change over time?
- To what extent does fiscal considerations play a part in the redefinition of services?
- To what extent do policy reforms play a part in the development of services, or alternatively, to what extent are "policy reforms" merely an adaptation of official policy to processes already initiated by the services themselves?

Method: Central government documents covering mental health services over the period 1950-1998 will be reviewed, focusing on the "need for services" and fiscal considerations. The documents studied will be related to actual changes in provision of services, as recorded in official statistics. These statistics, covering *all* specialised mental health services in Norway, including beds, patients at the end of the year, average number of in-patients, discharges etc by type of institution. Data have been reviewed and revised for completeness and consistency.

### 3. De-institutionalisation in a de-centralised system

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T. Hatling and P. B. Pedersen

SINTEF Unimed NIS Health Services Research, Trondheim, Norway

As in most western countries, the number of inpatients in Norwegian psychiatric institutions has been drastically reduced over the last decades. There is hardly any evidence suggesting a similar reduction in the number of people suffering from mental problems. The de-institutionalisation of psychiatric services, then, implies a major shift in the relationship between mental problems and services provided.

Public agencies play a major part in the financing, regulation and provision of mental health services. The services provided are, in a real sense, a result of public policy. Despite this, theories on de-institutionalisation have usually attributed only a marginal role for politics in the process. Political factors included are either focused on "spill-over" from other sectors (development of the welfare state, insurance systems, the fiscal crisis of the state etc), and/or view political decisions and reforms as an adaptation to processes already initiated by the services themselves.

Most mental health services in Norway are owned and run by the 19 counties. Although regulated through the same national laws, system of financing etc, there are striking differences between the counties in the development of services over time. Focusing on 4 counties, the purpose of this paper is to examine the explicit *content* of mental health policy at the county level. Developments in national policies will be covered in another paper presented at the conference (Pedersen PB and Hatling T: The politics of de-institutionalisation in Norway).

Method: In-depth studies of policies based on

- interviews with key policymakers and administrative personnel (representing the entire period),
- and documents (policy papers, health plans, annual budgets, etc)

from 4 counties with different trends of de-institutionalisation over the period 1980-96. The documents studied will be related to actual changes in provision of services in these counties, as recorded in official statistics. These statistics, covering *all* specialised mental health services in Norway, including beds, patients at the end of the year, average number of in-patients, discharges etc by type of institution. These data are available for each institution and include location of institutions, making it possible to analyse developments on a county level. Data have been reviewed and revised for completeness and consistency.



#### 4. Effects of reprovision on 'difficult-to-place' patients: The Hessian Deinstitutionalization Study

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In most countries, a major issue of deinstitutionalisation (DI) is posed by a group of 'remnant', severely ill long-stay patients difficult to move into the community. There is concern that these patients may lose more than they win throughout DI as it happened in former DIs. Unfortunately, only few studies focus on the effect of DI on this particular group.

Therefore, a study was undertaken with 'remnant' schizophrenic long-stay patients in the 7 largest mental hospitals in the German state of Hesse. Patients were assessed with a comprehensive set of medical, social, psychological and functional measures. Discharged patients and respectively matched non-discharged hospital patients were followed up after one year (matched-control design).

Results demonstrate a surprisingly strong, positive effect of the DI at 1-year-follow-up, e.g. increased outward activities, significantly reduced negative symptoms accompanied by a significant decrease of antipsychotic dose. However, social contacts and occupational situation worsened.

Implications for further DI-concepts are discussed.

#### 5. Deinstitutionalisation, living situation and subjective satisfaction of schizophrenic patients

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After German reunification the deinstitutionalisation of long-term hospitalised psychiatric patients and the restructuring of the complementary psychiatric care has become necessary in the "new" German states. Hereby it became possible to offer alternative residential settings and new community-oriented care programmes for the mentally disabled. Ten years after the beginning of this process we analysed effects on the housing conditions and the subjective satisfaction (German version of Lancashire Quality of Life Profile) of 245 chronic schizophrenic (ICD-10) patients living in different residential care-settings (psychiatric nursing-home [n=50], residential home[n=51], supervised community residence [n=39]) or with family (n=50) resp. on their own (n=55) in the Dresden region. Additionally we asked for the satisfaction with the organisation of the deinstitutionalisation process. The subgroups - defined by the residential setting - differ in sociodemographic variables (e. g. nursing home vs. living with family: average length of illness 35,5 [ $\pm$  9,9] y vs. 16,2 [ $\pm$ 10,9] y; divorced 22 % vs. 8 %; old age pension 26 % vs. 4%) and in the levels of psychopathology (PANSS: e.g. 94,8 [ $\pm$  17,8] vs. 59,9 [ $\pm$  16,4]) and social disabilities (DAS-M: e.g. 4,0 [ $\pm$ 0,5] vs. 2,1 [ $\pm$ 1,1]). It is shown how deficiencies and restrictions of the living situation and the deinstitutionalisation process are reflected in the respective judgments of the patients especially referring to autonomy and self-determination. Demands on for the further development of the complementary psychiatric care system are outlined.

### 1. The relationship of depression to self-rated morbidity and mortality in a changing society

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In the last years several studies have shown depression and its preclinical forms to be a major independent risk factor in cardiovascular and all cause morbidity and mortality. The aim of our studies was to analyse the effect of depression, as psychiatric risk indicator in connection with ill health in a suddenly changing society.

In 1988 20,902 and in 1995 12,640 people were interviewed. They represented the Hungarian population over the age of 16 by age, sex and county. Self-rated morbidity characteristics, shortened Beck Depression Inventory, hopelessness, hostility, vital exhaustion, ways of coping, social support and socioeconomic characteristics were examined. Age-standardised mortality rates and GDP in 1995 were obtained for each county.

Age dependent changes could be observed between 1988 and 1995, with increasing depressive scores in the population above 40 years, while in the younger population improvements in depressive symptomatology could be seen. According to hierarchical loglinear analysis, depressive symptom severity mediates between relative socioeconomic deprivation and higher self-rated morbidity, especially among men. Severity of depression is closely connected with hostility, low perceived social support and emotional ways of coping. In 1995 among men the variations in GDP, depression score and income inequality explained 78,6% of the variance of total mortality, while in a regression model among women these variables cannot explain mortality.

It is important in future preventive and rehabilitative interventions to consider depression as psychosocial risk factor, especially in societies in transition.

### 2. Mental health reform in Czech republic

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After political changes in Czech republic in 1989 quick changes started in lot of fields of public life including health and social sector. Parallel with these processes important changes take place also in mental health care. A process of decentralisation, deinstitutionalisation, humanisation and development of community services occurred. In the last ten years number of beds in big psychiatric hospitals reduced more than 20%. Nowadays there are 111 beds for 100 000 inhabitants. 20% of this capacity is in small psychiatric department of general hospitals. Length of stay in hospital facilities declined significantly – from an average 80 days in psychiatric hospitals to 24 days in psychiatric departments. Proportion of patients for one doctor in hospitals improve. There is approximately 1 doctor for 19 patients. In outpatient care a lot of new activities and programmes start to operate: day clinics, club house centres, support housing facilities, working rehab projects, system of home care etc. This service already existed before 1989 in fact.

This process of change is described on the basis of “field experiments”, which were co-ordinated by Centre of Mental Health Care Development in years 1995-1997. In three regions a new system of co-ordination of activities of different mental health providers was facilitated and development of new community services was supported. The process of change, function and effectiveness of a new system was evaluated. The system of care in community centres led to a significant reduction in number of readmission and length of stay in psychiatric hospitals. The system of outreach assertive teams showed capacities to deliver help to the clients not known to the mental health workers before.

### 3. Studies on effects of community mobile team intervention in Poland

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Two studies on community mobile team intervention have recently been conducted in Poland. All the teams were newly created services established in the years 1995-1998 with the help of colleagues from HC. Rumke Groep, Utrecht, Holland. The first study focused on a team acting in Drownica hospital catchment area. This uncontrolled 1995/1996 study measured social functioning, treatment satisfaction, family burden and hospital utilization of 88 patients with chronic psychoses before and after 1 year community mobile team programme. A clinically significant improvement of social functioning, as measured by Britwood's SFS, was noted in 56% of patients, 81% of patients showed a significant increase in satisfaction level and family burden decreased markedly. Time hospitalised decreased fourfold and number of admissions decreased twofold. In the second study, carried out in four sites in 1998-1999, pre-post controlled design was used. The study showed a tendency for greater effectiveness of team intervention than traditional care in four areas of social functioning, behavioural problems and treatment satisfaction of patients, and in hospital utilization measures. The following factors could possibly limit the scope of effects of team intervention: small numbers of patients in particular centres (N=114), relatively short observation period (10 months), rather low level of patients' pathology at baseline and, probably, conservative approach of mental hospitals related partly to the change in their financing.

### 4. The European Schizophrenia Cohort: description and first results

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The European Schizophrenia Cohort is an epidemiological and socio-economic study of patients with schizophrenia in nine centres in France, Germany and the UK. It was started in 1998, and involves the identification and follow-up of over 1200 patients over a period of two years. Patients are evaluated every six months on measures of psychiatric state, general functioning, treatment needs, treatment received, treatment-compliance, side-effects of treatment, quality of life, and service use. The design allows for powerful statistical analyses that permit the building of plausible models using sociodemographic, clinical and treatment variables to account for outcome. An economic evaluation forms an essential part of the investigation. The design also allows comparisons between the different health systems in these European countries. This paper will provide details of the study and some early results, which will be available by the time of the conference.

## 5. The social context of insight in schizophrenia: Report from the European Schizophrenia Cohort

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Psychiatrists place great weight on impaired insight in schizophrenia, generally attributing it to pathological mental processes. However, denial of illness may be based on attitudes common in patients' social and cultural groups. Moreover, even where denial of illness has a pathological element, it may be affected by the social context. We used data from the London arm of the European Schizophrenia Cohort to test the prediction that denial of illness would be associated with social distance between clinician and patient, and reduced by access to 'normalizing' social interaction. One hundred and fifty patients with schizophrenia were assessed using the 'Awareness of Illness' (AI) subscale of David's Assessment of Insight. Clinical and social attributes could then be related to AI. There was scant evidence for our social distance hypotheses: there was little variation in AI by social class, ethnicity, membership of a drug taking culture or the presence of strongly held religious beliefs. However, there were strong relations between AI and the size of primary group, consistent with our normalizing hypothesis. The normalizing function of social support is in line with modern psychological models of delusion formation. Longitudinal data will eventually be available from the current study that will assist in establishing the causal direction of this association.

## 6. The ESEMeD/ MHEDEA 2000 project

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The ESEMED-MHEDEA 2000 project will estimate and compare the disability burden of psychiatric disorders and evaluate the use of formal and informal treatment and care services in 6 European countries (Belgium, France, Germany, Italy, the Netherlands and Spain). Specifically the project will: (a) estimate the prevalence of selected psychiatric disorders and associated risk factors in the general population; (b) assess the quality of life (general health perceptions, disability and handicap) of persons with different psychiatric disorders; and (c) evaluate the extent and appropriateness of mental health services use in order to assess unmet need. This study is integrated in the WHO Mental Health 2000 project that will coordinate the implementation of similar investigations in more than 20 countries around the world. A total of 29.000 face-to-face interviews will be conducted in nationally representative samples of adults of the six countries. The main instrument to be used in the survey will be the CIDI-2000, that has been developed from CIDI 2.1 and includes diagnostic algorithms, course specifiers, severity ratings for main disorders, disability assessment and health service use. A subsample of respondents will be interviewed by a clinician using a semi-structured psychiatric instrument.

1. Service utilization of schizophrenia patients in Granada. A case-register study

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Due to the changes that have taken place in mental health care in recent years, patients are cared for by networks of services within which a community based care system is developed and they receive care from a variety of services and institutions which on occasions have joint review meetings regarding particular cases. Therefore it is not easy to summarise the history of mental health care that a patient receives and it is also difficult to follow and evaluate the patterns of use of services.

The monitoring of information with regard to an activity of the mental health services relies on the continuous collection of data. In this way the cumulative registers of psychiatric cases prove to be a useful tool in documenting the activity of a mental health services network, and it is considered one of the most adequate and systematic methods in collecting information on the use of mental health services.

In this study we are using the survival model to analyse the time which passes between outpatient contacts and to determinate the factors associated with intervals between contacts.

Data we are analysing comes from The Andalusian Case Register for schizophrenia started in January 1995 which is covering a population of about 400.000 inhabitants. Nowadays, some years of patient contact data are available in this register

Applying standardised models of analysis and use of mental health services involves a methodological challenge in view of the stage of service development and the need to make available this type of information for its application to the evaluation of services, planning and research.

2. Present care, service utilisation and unmet needs of severely mentally ill needing long term co-ordinated care

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Objectives: The aim of the study was to assess the needs of care of severely mentally ill needing long term co-ordinated care. What is their present level of care and their utilisation of health care and social services, and what are their unmet needs? Methods: Data on 3 400 patients with psychiatric disorders and a need for long term co-ordinated care were collected from 40 municipalities that had used the same methods and instruments for assessing these persons and their need for care. Results: Only half of the patients received specialised mental health care. Half of these were outpatients, one third were inpatients and the rest were day-patients. There are several different patterns of utilisation of health and social services, and these patterns seems to be related to several different factors, including severity of illness. The largest amount of unmet needs were in the domains of work or other daily activities, but the pattern of unmet needs was different for different sub-groups. Conclusions: There are different patterns of service utilisation and unmet needs for different sub-groups of persons with psychiatric disorders, and the need for care is to a large extent also determined by other factors than the severity or type of mental disorders. Knowledge of these needs is important for planning and monitoring of health and social services and for service delivery.

### 3. Health care utilization in a gate keeper system (Holland) as compared to a client oriented system (Germany). Data from the WHO study on psychological problems in general health care

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**Background:** Empirically supported comparisons between different health care systems are of growing interest whenever the efficacy and effectiveness of health care services are to be assessed, and predominantly when health care policy reforms are to be planned.

**Method:** In the WHO study on Psychological Problems in General Health Care two different health care systems were compared, in the Netherlands and in Germany, two European countries that are rather similar in socio-economic and socio-demographic respects, but one having a gate keeper system and the other not. The investigation studied a random sample of general practice patients using well-established diagnostic instruments (CIDI) in order to guarantee the comparability of the two national data sets.

**Results:** Results show that almost 100% of the Dutch patients saw the general practitioner first when seeking medical help, whereas in Germany this rate is considerably lower, with a higher frequency in specialist contacts that substitute for general practitioner contacts. The follow-up data show that patients in the Netherlands consult general practitioners more often during the observed time intervals, whereas patients in Germany show higher frequencies in consulting other physicians, specialists included. This observation is particularly apparent in the proportions of patients having more than three consultations with other physicians, as recorded after three and after 12 months. That means that co-treatment by one or more other physicians is more frequent in a client oriented system. The overall prescription rates of drugs are also higher in Germany.

**Conclusion:** There are less patients with a high frequency of consulting in the Netherlands which can be explained by the fact that the family physician decides about the frequency of appointments and not the patient himself. The same is true for treatment as seen in the prescription rates.

### 4. Heavy users of acute inpatient psychiatric services: A view from different perspectives

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**Objectives:** This paper focuses on different approaches to identifying patients who are "heavy users" of acute inpatient psychiatric care. Based on data reflecting utilization of the acute wards of a Swiss university psychiatric service system, strategies to evaluate heavy use are compared with regard to their usefulness in the planning of service delivery.

**Methods:** Patterns of use for all patients admitted to acute inpatient care during a 54-month period (1995-1999) were analyzed. Different commonly used definitions of heavy service use were applied to this data set and compared for their usefulness in the assessment of inordinately high service use at different levels of evaluation (e.g. level of individual patient; level of service system).

**Results:** Patterns of service use for 1,830 patients, who accounted for 3,080 treatment episodes, were analyzed. From a systemic viewpoint a time-constant distributional pattern of service use for the study period emerged (about 70% of all treatment days/years were used by 20% of all patients treated). This pattern can well be described by its "systems dynamic" and the extent of inequity related to service use.

In contrast, the prediction of heavy use for single individuals by means of different statistical modelling techniques (e.g. log-regression, event history analysis) turned out to be less rewarding due to several methodological pitfalls that are rarely taken into account in the current research literature.

**Conclusions:** Heavy use of acute services appears to be intrinsic to a given service system rather than contingent upon individual patient characteristics. Thus, an evaluation of service utilization to identify patients with particular demands for care must consider different levels of evaluation. In addition, there is a clear need for evaluation strategies that lead to comparable results in different service systems.

5. Comprehensive mental health services in Vienna - 20 years after the reform. An analysis of the current provision and utilization of psychiatric services in one catchment area

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The goals of the reform of the psychiatric care system in Vienna 1979/80 were deinstitutionalization, reform of the inpatient care, and provision of a comprehensive and integrated outpatient psychiatric service. From the very beginning the risk of a fragmentation of services was present due to different agencies responsible for the in- and outpatient units. Service coordination was established to safeguard the continuity of care. Based on a systems theory point of view of organizations the emergence of different treatment cultures attracting different groups of patients has to be expected in accordance with this division.

In 1998 a one-year treated prevalence study based on administrative data was carried out in one catchment area with a population of 220.000 to find out if this process has occurred. As case registers for psychiatric patients do not exist in Austria the results of the study have some limits. The utilization of hospitals outside the catchment area and of the 3 psychiatrists in the area is unknown. The main database consists of 710 patients admitted to the psychiatric department of a general hospital, 884 treated in community mental health services, and 270 patients using both legs of the psychiatric service. The results of the prevalence study are discussed in view of self-regulation vs. planning of psychiatric services and the quality of treatment.

6. Comprehensive mental health services in Vienna - 20 years after the reform. Treatment continuity and treatment dropout in outpatient psychiatric settings

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This study examines patterns of service utilization of newly referred adult patients in three community mental health clinics of the Psychosozialer Dienst (PSD), Vienna. In a cohort of 323 first-time patients, 26 % of these patients dropped out of psychiatric treatment during the first four months, and 31 % continued their treatment at the PSD. At treatment start 116 patients out of this original cohort were interviewed face to face. At follow-up, 4 months after the first interview or when patients dropped out of treatment, 80 % were interviewed again. These 80 % consist of 50 patients who are still in treatment at follow-up and 42 patients who have dropped out. Multivariate analyses show that the diagnosis of schizophrenia, living alone and having a supportive network of significant others are effective predictors of treatment continuity. Dropping out is predicted by unemployment, previous psychiatric admissions, high self-assessment in global functioning, low treatment expectations, low patient satisfaction with staff competence and poor quality of life in the domains family, partnership and living situation. Patients who drop out of treatment are less able to form reliable relationships with their psychiatrists than continuing patients. The study concludes that the impairments of dropouts in forming and maintaining social relationships is the determining factor for treatment dropout. To compensate for these impairments, psychiatrists should therefore make a special effort to establish a trustful and caring relationship with their patients, increasing the likelihood of keeping them in treatment.

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### 1. Measures of engagement in an assertive case management

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Loss of contact between services and patients with severe and enduring illness is often cited as a cause of further relapses and admissions to hospital. It is also associated with completed suicide. Assertive case management is a well described model of working with the severely mentally ill in the community. A key element of this model is the need to assertively engage with and follow up patients and to develop an on-going therapeutic relationship. The research examining this relationship and instruments measuring it are limited. This study examines the relationship between patients and key workers in an ACT team in South London and compares two Instruments developed to measure the relationship.

Method : 91 patients of the ACT team and their key workers were approached to take part in the study. Demographic data was collected according the Demographic schedule of the UK700 study of ACT. Engagement was measured using the Helping Alliance Questionnaire (5 items completed by the patient) and the Working Alliance Inventory (36 items completed separately by patient and by key worker).

Results 71 % of patients and 100% of key workers completed all questionnaires. Overall both patients and key workers rated the relationship as positive. There was a significant ( $p < 0.01$ ) and high level of correlation ( $> 0.76$ ) between patients' scores on the patient version of the WAI and the HAQ. Correlations between the patient version of the WAI and the Key worker were significant ( $p < 0.01$ ) but much lower. The results suggest that the patients and key worker rate the relationship differently according to the WAI. The HAQ provides a clear indication of the relationship and is simpler and easier to use than the WAI.

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### 2. Predictors of long term outcomes in severe psychotic illness: a four year follow up of an RCT of intensive and standard case management

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The UK 700 study was a large multi-centre randomised control trial comparing Intensive case management (case loads 10 – 15) against standard case management (case loads 30 – 35). 708 randomly allocated patients were followed up at two years and their outcome assessed in terms of psychiatric hospitalisation, clinical and social functioning, quality of life, satisfaction and unmet needs for care. This study failed to find differences in these outcomes between the two service forms. By following up the St George's cohort (196 patients) at four years the authors aim to address some of the criticisms of the UK 700 study, namely that two year follow up is inadequate to test the impact of such services on long term disorders such as schizophrenia and that social outcomes may take years not months to stabilise.

Methods: A four year follow up interview was conducted on the St George's cohort of patients, using the standardised instruments as selected for the original UK700 study (apart from substitution of CPRS for BPRS). Hospitalisation data was collected via individual case notes.

Data to be presented at this conference includes:

1. Baseline predictors of hospitalisation.
2. Baseline predictors of clinical and social outcome.
3. To test the impact of caseload size on hospitalisation at four years.
4. Whether baseline characteristics modify any developing effects of caseload size on hospitalisation.



### 3. Does service organisation affect user outcomes?

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**Introduction:** The Care Programme Approach (CPA) has been the principal form of community mental health service organisation in England and Wales for nearly a decade. There is considerable variation in how it is implemented: the extent to which it is targeted at people with severe mental health problems, and the extent to which health and social services departments offer discrete or integrated mental health services. Recent policy guidance underlines the importance of targeting and integration, yet little is known about whether these goals benefit service users in any measurable way.

**The study:** A longitudinal study of four mental health trusts was commissioned from the authors by the Department of Health. The districts were selected because of their diverse forms of service organisation. Within these districts, a homogeneous sample of 60-70 service users were interviewed twice, six months apart. The outcome measures used include the Brief Psychiatric Rating Scale (Overall & Gorham, 1962), Life Skills Profile (Rosen, 1989), Lancashire Quality of Life Profile (Oliver et al., 1996) and other newer instruments designed to measure severity of illness, risk and empowerment. Service use was measured and costs calculated for all health and social care inputs, as well as for accommodation.

**Findings:** We will report the results of multivariate analysis which explores the relative impact of user characteristics, service characteristics and service use on user outcomes.

**Implications:** This study portrays standard community mental health care, rather than an experimental intervention. As such the findings are of interest to clinicians and service planners.

### 4. Respite care in the arctic

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At the psychiatric nursing home Jansnes in northern Norway, a model for individually tailored rehabilitation of chronic schizophrenics has been developed. The aim has been to create an arena where the life-forces in the patient may dominate the lifedamaging and selfdestructive forces. The model which will be described is based on the following principles:

Stable relationships over time, of a caretaking, supporting and protecting nature. The patient must be seen, acknowledged and corrected. Also after discharge, such relationships are being maintained through christmas and birthday-greeting, visits in patients own homes, and invitations to take part in trips, summer-feasts and so on.

Increase the patient's consciousness of own affects and ability to communicate these to others. This is done through music, play, dance, painting and being together with others in such activities.

Re-establishing of lost social network, especially to family and friends. Such members of earlier network is invited to a number of different activities at Jansnes together with the patient and staff.

Soft transition from being an in-patient and to live in own home. After discharge, all patients are given the opportunity to be re-admitted when they want to, without any troublesome procedures. The reasons for re-admissions may be a crisis connected to psychopathology, but also recreation, fishing in the fjord, visit to the dentist, regulation of medication, walks to the mountain-cottage etc. Contact by telephone is also extensive for many years for some patients.

In the presentation by Eriksen, Nordstrand and Skre, the results of this model upon the quality of life and satisfaction with social network after rehabilitation is described.

### 5. Respite care in the rehabilitation of chronic schizophrenia patients:

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Quality of life, needs and social relations in patients receiving respite care and patients receiving standard rehabilitation.

J. R Nordstrand, M. K. Eriksen, I. Skre

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Objective: The aim of the study was to investigate the quality of life, social relations and needs of chronic schizophrenic patients after completing an individually tailored respite care rehabilitation programme in a psychiatric nursing home.

Background: Since 1980, at Jansnes psychiatric nursing home in Finnmark, Norway, an individually tailored rehabilitation programme has been developed, balancing care and control, focusing on individual resources, needs and affect recognition, and offering regular respite after discharge. The rehabilitation programme is described elsewhere (see abstract from Utstoel, K. and Myklebust, E.).

Method: The study was performed as a case-control study comparing 12 chronic schizophrenic patients from the respite care programme to a matched sample of 12 patients who had received standard rehabilitation after discharge from a psychiatric hospital. More than half of the pairs were male (58%), the mean age was 40 in both groups, and mean duration of schizophrenia was 17 years. All subjects were personally evaluated with structured interviews and rating scales: SCID for DSM-IV, Lancashire Quality of Life Profile, Camberwell Assessment of Need, Interview Schedule for Social Interaction, Global Assessment of Functioning - Split version, Brief Psychiatric Rating Scale.

Results will be presented.

### 6. Coercive community care in England: 'Aftercare under supervision'

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Introduction: A new power, 'Supervised Discharge' (SD) was introduced into mental health legislation in England in 1996. It gave psychiatrists, social workers, and nurses new powers to 'supervise' patients receiving community care, and to control their place of residence and attendance for assessment and treatment, though not the power to enforce compliance with medication as an outpatient. Still more assertive forms of community treatment may soon supersede it as part of a proposed review of legislation. We aim to:

- Assess the impact of the power on patients' compliance with care plans
- Describe the characteristics of patients perceived to have benefited from application of SD
- Discuss the implications of the findings for future changes in legislation

Methods: Data on two cohorts of patients subject to SD were collected from supervisors and consultant psychiatrists in 57 randomly sampled mental health provider Trusts across England using postal questionnaires. The questionnaires were designed by the research team to collect both qualitative and quantitative data and included 3 standardised assessment instruments (CANSAS, GAF, HoNOS).

Results: Baseline data is reported.

- A total of 378 patients were identified as being subject to the order in all the 178 mental health Trusts (services) nationally in 1998, 0.74 per 100000 total population. 57 Trusts were randomly sampled, and of the 221 patients subject to SD at these Trusts, data was collected on 182 (81%).
- The mean age was 44, 68% were male, 11% were black, 45% lived alone, mean length of illness 15 years, mean number of hospital admissions lifetime 7.8, and 61% had a primary diagnosis of schizophrenia.
- The perceived risk characteristics necessitating supervision were categorised by clinicians as: risk of self neglect 64%, violence to others 57%, exploitation by others 39%, serious self harm 23%, physical/sexual abuse by others 13%.

- Actual incidents of severe violence were recorded in found in 30 cases (29% of those categorised at risk of violence; 16 % of total sample).
- SD was used in 58% of cases because medication/treatment compliance was perceived to be a problem, in 29% because of poor engagement in services, and in 21% to monitor health and social functioning.
- SD was used to enforce: place of residence for 63% patients; access to care team 70%; attendance at specified places 68%. The majority of clients were compliant with the requirements of the order. 73% of consultant psychiatrists found SD helpful in the management of their patient in the community.

Conclusions: Supervised Discharge provides community psychiatric services in England with increased powers to coerce patients to accept certain treatments (though not medication) outside hospital. The small number of patients that have been selected for the application of the order are a group with long standing psychotic illness, who are perceived to present high levels of risk, though objective evidence of risk is less often found. These patients are largely perceived to benefit from SD, and clinicians report better compliance with care plans, including medication although this cannot be enforced by the order. Though patients can be identified who appear to benefit from increased coercion, the impact on the service as a whole may not be beneficial. The difficulties of enforcing orders in the community may limit their applicability to those patients most likely to respond to coercion.

1. Testing the stress-coping model of caregiving in psychotic illness

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Background: An existing model of caregiving, the stress-coping model, suggests factors such as the severity of the patient's illness and social support impact on appraisal by the carer of caregiving and their coping skills leading to a greater or lesser morbidity in the carer. The aim of this study was to test this model to establish if there is indeed a relationship between these factors and what this relationship is. Method: Data from a range of baseline measures on 77 carers of patients in a community psychiatric service obtained as part of a random controlled trial of a psychoeducational package were available. These comprised of a detailed semi-structured Coping Interview based on previous work by Tirril Harris, a contextual rating of Severity of Caring Difficulty (a modified LEDS Scale), the Experience of Caring Difficulty Inventory, the Clinical Interview Schedule Revised and measures of general community support and specific confidants. Results: Initial results show that carer well-being is affected by both poor and good coping styles which itself is impacted upon by carer appraisal independent of social supports. Conclusion: The stress-coping model is confirmed by this data. The impact of intervention on this model will indicate what components are modified by it.

2. The experience of caring in community mental health

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Introduction: Community psychiatry has been accused of increasing the burden on carers. Not all people with mental health problems have carers who are actively involved, but for those who do, the impact of caring is an outcome which mental health care ought to take into account in service evaluation.

The study: The data were collected from 61 carers in four districts in northern England in 1998-99. The principal instrument used is the Experience of Caregiving Inventory (ECI: Szmuckler et al., 1996). Carers' attitudes to the Care Programme Approach (CPA), their GHQ (Goldberg & Williams, 1988) and demographic details were measured. The carers also rated service users with the Life Skills Profile (LSP: Rosen, 1989).

Findings: We compare carer and key worker ratings of service user functioning in terms of the LSP. We explore the associations between carer attitudes to the CPA and the way local mental health services are organised. We look at the components of the positive and negative scales on the ECI, and their associations with service user's severity of illness, and carer GHQ.

Implications: These findings are of methodological interest, because the ECI is a relatively new instrument. They also throw new light on outcomes of mental health services for carers.

### 3. The relatives of patients with severe psychotic disorders: Predictors of experience

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Despite a considerable amount of research, it remains unclear which characteristics influence the experience of relatives of patients with severe psychotic disorders. A possible reason for this lack of clarity is the diversity between studies in the way 'carer burden' is conceptualised and measured. In this study, relatives' experience was conceptualised using a stress-appraisal-coping paradigm. The objective was to investigate which patient and relative characteristics predict relatives' experience and, in particular, whether characteristics of the patient's illness influence relatives' appraisal or psychological distress.

Patients were included in the study if they had a diagnosis of psychosis, at least two previous admissions to psychiatric hospital (one recent) and frequent contact with a relative. Data was collected from 116 patients and their relatives. Few of the 24 characteristics tested predicted any aspect of relatives' experience. High negative appraisal was more likely if the patient was unemployed. Low positive appraisal was more likely if the relative was male, the patient's social functioning was poor and the patient had been continuously psychotic during the preceding two years. Once feelings of resignation had been taken into consideration, relatives experienced greater psychological distress if the patient was 'White' rather than another ethnic group.

Consistent with the stress-appraisal-coping model, relatives' negative appraisal was a strong predictor of their psychological distress, both before and after feelings of resignation were taken into consideration, however, their positive appraisal was not. Subsequent analyses demonstrated an unexpected positive correlation between relatives' negative and positive appraisal which was interpreted as showing that some relatives may be more 'emotionally involved' with the patient than others, and this may increase their vulnerability to psychological distress.

### 4. The children's need for support and the burden in families with mentally ill persons

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The prevalence of minor children in families with a severely mentally ill member, these children's need for support and the situation of the healthy relative was investigated as part of a longitudinal multi-center study of the quality of the mental health services in Sweden performed in 1986, 1991 and 1997.

The results over the years investigated showed the same proportion of patients admitted to hospital who also was a parent to minor children and a decreased proportion of patients who had the custody of their children. Female patients more often were a parent and also more often had the custody of the children. The majority of the children had needs for support caused by their parent's illness and these needs were met in half of the cases. The well spouses in families with minor children showed higher frequencies of family burden and to a higher extent experienced own need for care and support from the psychiatric services compared to spouses without minor children.

It is concluded that there is an urgent need for the psychiatric services to initiate support to the family members around the ill person and that parental issues should be more frequently included in programs for treatment and rehabilitation to ensure that the specific needs of the minor children are met.

5. When I got married I knew that my wife was mentally ill - Differences in the experience of caregiver burden in partners of schizophrenic patients

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As part of a study on the economic and health burden experienced by families with mentally ill relatives with the diagnosis of schizophrenia, depression or anxiety disorder, the authors assessed different partnership constellations present with relatives of people suffering from schizophrenia. It was our aim to collect information on the burden experienced by the relatives and to assess possible associations of caregiver burden with partnership constellations. We could differentiate three groups of partnerships: couples in which one partner developed mental illness in the course of the partnership, couples who got to know each other when one of the partners had already developed mental illness, and couples who met in the context of psychiatric care and were both mentally ill. Narrative interviews which had been carried out as part of the baseline assessment of the above-mentioned study were analysed, using the method of case reconstruction. Different types could be formed with regard to the burden experienced through the schizophrenic illness of the partner. Differences were found both in the perception and assessment of burden imposed by the illness and in the strategies applied to cope with this burden. The procedure applied for the qualitative analysis of the material from the interviews will be presented as well as the importance of these partial results for other diagnostic groups covered by the study will be discussed.

6. Burden of care, psychological distress and satisfaction with services in the care-givers of the hospital-at-home regime.

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In the hospital-at-home environment the care-givers plays an active role in attending the patient, providing hospital-quality care. These care-givers may take on greater responsibility than other groups of care providers, which may lead greater burden.

With the objective of detecting high risk care-givers and planning and coordinating resources to prevent negative repercussions in this group, this study examines many care-givers (n=268) of relatives in a hospital-at-home regime and the second one month later.

Sixty one percent of the care-givers report being over-burdened, and the degree of over-burdening is associated with the cognitive deterioration of the patient (OR=3.08, CI=1.28-7.45) and the psychiatric morbidity of the care-giver (OR=3.25, CI=1.56-6.78), the lack of social support (OR=5.92, CI=2.09-16.79), need for help and with his/her own satisfaction with preparation to care for the patient (OR=7.13, CI=1.91-26.61), The degree of dependence of the patient, after accounting for other confounding factors, is inversely associated with the overburden of the care-givers (OR=0.38, CI=0.15-0.98).

Admission to hospital-at-home regime makes it possible to provide facets of health-care education for the care-givers in the home environment, thus helping the care-givers to improve their skills and enhance the quality of care and their own sense of security.

## Posters

### 1. CARE: A computerized quality of outcome assessment instrument

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Quality outcome assessment is made difficult and expensive by the effort required to gather data from patients. A further difficulty that concerns quality control in general is the tendency of clinical staff to view it as a bureaucratic chore with little relevance for daily work. We report on our computerized system for the measurement of outcome quality designed to overcome these two difficulties.

With respect to traditional pencil-and-paper questionnaires, a computerized system offers the decisive advantage that data are automatically saved in a central database. Furthermore, to facilitate the approach of patients to the system, patients answer to questions on a touch screen. Each patient is identified by her insurance card through a chip card reader, thus avoiding the administrative burden of registering patients. Because of the cheapness of the data gathering process, it is possible to administer questionnaires daily if necessary, and to modify the sequence of the questions dynamically. This enabled us to ask questions of direct clinical relevance besides the traditional quality-of-life, ward atmosphere and patient satisfaction questions. Quality control is made more encompassing by including the responsiveness of patients to therapy. The data are available to clinicians in real time, thus involving them into the quality control process and promoting better documentation practices.

### 2. Structure, type of interventions, and organisation of Austrian psychiatric day hospitals

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The aim of this survey was to assess the treatment and rehabilitation activities, the organisation and structure of the Austrian psychiatric day hospitals. A questionnaire consisting of 68 questions was sent out to all 16 Austrian day hospitals. The questions covered the following areas: types of psychiatric interventions provided, number of patients, duration of treatment, patients' social status, diagnoses, staff, legal status of the services, and costs of treatment. 12 day hospitals participated in this study (response rate 75%). The most frequent types of interventions were activity training (100%), psychological interventions (100%), psychopharmacological treatment (91.7%), social skills training (91.7%), and training of daily living skills (91.7%). The mean number of patients per day hospital was 12.8 patients. The overall duration of treatment was 23.1 weeks. Schizophrenia and schizo-affective disorders were the most frequent diagnoses. The mean costs for treatment (per patient per day) were 2455.7 Austrian Schillings (= 178.4 Euro; range between 94.5 and 238.9 Euro).

### 3. Offering Partnership: The Taskforce on Health Promoting Psychiatric Services (HPPS) within the European Network on Health Promoting Hospitals (WHO)

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The taskforce HPPS is a Europe-wide organisation to develop and implement innovative projects on health promotion in psychiatric services and maintain the exchange of information on models of good practice in this field. The taskforce is integrated in the European Network on Health Promoting Hospitals, initiated by WHO-Euro and is based on the principles of health promotion as outlined in the Ottawa Charter 1986, the Budapest Declaration on Health Promoting Hospitals in 1991 and the Vienna Recommendations on Health Promotion in Hospitals 1998.

In the field of psychiatry we see health promotion as a new, integrative concept which can help to redirect the focus of intervention on health, the resources of the affected people and the organisation as a whole. The Task Force on Health Promotion in Psychiatric Services defines its task as follows:

- forming a network of interested psychiatric institutions
- giving support to those psychiatric institutions, who are willing to run at least three innovative health promoting projects
- development of models of good practice of health promotion in psychiatric services

The WHO/EURO has commissioned the Philipphospital to establish and co-ordinate the Task Force on Health Promotion in Psychiatric. For further information and application for membership in the HPPS Network please contact the authors.

#### 4. Suicidality of chronic schizophrenic patients treated in a community-oriented setting - Results from the first year after discharge from the psychiatric hospital

Th. W. Kallert

Department of Psychiatry and Psychotherapy, Technical University Dresden, Germany

The evaluation of restructured psychiatric community care for schizophrenic patients (n = 115) in the Dresden area is the central part of a public health research project. Selected results concerning the normative needs for care (Needs for Care Assessment) based on suicidal behaviour are presented. Contracting referred current significant problems as well as significant problems in recent past or threatening they are of therapeutical relevance for ca. 75 % of the patients 1 month after discharge and for ca. 50 % of the patients 1 year after discharge. The most frequent items of care provided and effective for suicidal behaviour are: assessment, continuous assessment of necessity for secure environment, medication and sheltered environment. Current problems concerning self-dangerous or - destructive behaviour were constantly rated for 4 - 9 % of the cohort. The need status resulting from suicidal behaviour could be assessed as characterized mainly by met needs. This is due to the sufficient establishment of psychiatrists in private practice and social psychiatry services in the investigated area. - The importance of subjectively perceived needs for support (Berlin Inventory of Care Needs) concerning suicidality as well as the patients' self-perception of disease-related items referring to this problem is substantiated by the identification of special risk-constellations (e. g. between defined stressors and suicide attempt) that should be considered during the long-term community-oriented treatment of chronic schizophrenic patients.

#### 5. Quality Evaluation in a acute in-patient unit

A. Gamito, J. Melo, N. Borja-Santos, G. Cardoso

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Assessment of quality is nowadays an imperative at all levels of mental health care delivery. An acute psychiatric in-patient unit in a general hospital was evaluated in some aspects of the quality of services during one year. Besides the number of patients discharged and psychiatric diagnosis, the mean LOS, unplanned discharges and early readmissions were also assessed. The study included 396 patients discharged. Mean LOS was 17,8 days, number of patients per bed was 14.66 and rate of occupation was 69%. Three patients were discharged against medical advice and seven were early readmitted.



## 6. A sector halved is a sorrow halved?!

B. Bergtholdt

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The structure of psychiatric services in Berlin-Reinickendorf changed during the last 15 years. This means a considerable reduction of indoor-facilities for mentally ill patients, while the community-based programs increased markedly. Different institutions like day-hospitals, therapeutic flat-sharing communities and specialised working-facilities for the mentally ill developed in this area. The psychiatric clinic reformed its internal structure and it is working sectorised since 1992.

First aim of this paper is to re-enact the changes in Berlin-Reinickendorf since 1985. Furthermore the results of one study should be presented, in which the effects of this restructuring-process on the situation in the clinic and day-hospital were assessed. Therefore the data of all patients, being treated in the psychiatric ward of Reinickendorf at two cut-off dates before and after the restructuring-measures were assessed and compared with each other. It could be shown, that the length of stay in the psychiatric hospital decreased while the number of hospital admissions remained constant. The number of coercive measures (detentions, restraining measures) decreased markedly. Connections between the described changes and the now community based structure of psychiatric services will be discussed.

## 7. How important are importance ratings in QoL assessment of schizophrenic patients?

T. Meyer, M. Franz, B. Gallhofer

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Assessing subjective quality of life (QoL) in terms of satisfaction in various life domains has been criticised for not taking individual preferences into account. A combination of importance and satisfaction ratings allows for the different weights different life domains have. The present study aimed to investigate the usefulness of combined satisfaction and importance assessments in schizophrenic patients. In a cross-sectional study, 149 schizophrenic patients and 106 healthy controls rated their satisfaction with and the importance of 19 different life domains.

Results of multidimensional scaling suggested that satisfaction and importance ratings tap different concepts in mentally healthy controls and schizophrenic patients. However, as compared with satisfaction ratings, importance ratings were even more shifted towards the positive pole of the scale and showed less variance. Very high correlations were found between the pure and the weighted satisfaction scores. No additional variance could be accounted for with regard to psychopathology, age or sex.

Although a combination of satisfaction and importance ratings fits better with the subjective concept of QoL on a theoretical level, the results of this study do not support this model in QoL-assessment in schizophrenic patients.

## 8. Disability and quality of life in psychiatric and medical patients

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In the context of the revision process of the International Classification of Impairments, Disabilities and Handicaps -ICIDH-, the World Health Organisation is developing the World Health Organisation Disability Assessment Schedule -WHO-DAS II-. This is an instrument to assess mental and physical health related disablement, has six major domains covering activities that are considered important in most cul-

tures: understanding and interacting with the world, moving and getting around, self care, getting on with people, life activities, participation in society.

This paper explores the relation between degree of disability measured by the WHO-DAS II, quality of life evaluated with the application of the SF-36 and physical and mental health status assessed by the GHQ-12. The sample investigated was composed by 161 persons, classified in five categories and distributed as follows: general population (15,52%); mental health patients (29,19%); physical patients (36,02%); persons with drug consumption related problems (9,31%) and persons with alcohol consumption related problems (9,93%). The distribution by sex was 74 female and 87 male patients (45,96% and 54,03% respectively). In relation with age, 27,95% of the sample was <30 years; 35,4% was between 31-45 years; 23,6% between 46-60 years and 13,04% was older than 61 years. This paper analyse the relation between degree of disability, quality of life and physical and mental health. We will also present the way in which different socio-demographic and illness related factors are associated to this. All the interviews were administrated by professionals (psychologist, psychiatrist and social workers) specifically trained in the application of the instruments.

#### 9. Comprehensive mental health services in Vienna - 20 years after the reform. A process evaluation of the community mental health care system

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F. Schmidl

Austrian Society for Psychiatric Care Research and Planning, Vienna, Austria

According to the aim of modern psychiatry to integrate the psychiatric patient in the community large efforts have been made to change the provision of mental health care within the past decades. From the perspective of mental health system approach the implementation of community mental health care differs across countries reflecting different problems and interactions within the care system and across time. Thus, pathways to and through psychiatric care, severity of illness, sociodemographic variables, number of hospital beds, frequency and duration of admissions, utilization of community based psychiatric and psychosocial rehabilitation services have to be seen in line with the comprehensiveness of the mental health service system, the level of integration and continuity as well as health care policy and funding.

In Vienna the mental health care system has been reorganised in 1980 (Rudas, 1979, 1980, 1990) with emphasis on dehospitalisation, sectorisation and community based service provision („agency model“). Inpatient and outpatient setting, crisis intervention and residential programs etc. are seen as „related systems“ where required interventions can be made best at a given time.

Service utilization data, treated prevalence, and incidence rates are presented that highlight the changing process of psychiatric care and service delivery from the beginning of the reform up to now.

#### 10. Are demented elderly persons disadvantaged by the German Pflegeversicherung (Long-term Care Insurance)? Results from The Leipzig Longitudinal Study of the Aged (LEILA75+)

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A. Busse, A. Sonntag, S. G. Riedel-Heller, H. Matschinger, M. C. Angermeyer

University of Leipzig, Department of Psychiatry, Leipzig, Germany

Whether demented elderly are disadvantaged regarding the coverage of the German Pflegeversicherung (Long-term Care Insurance) is currently subject to debate. The Leipzig Longitudinal Study of the Aged (LEILA75+) reports community based results concerning this discussion. In a sample of 1265 individuals we examined the prevalence of dementia and gathered information about benefits granted by the Long-term Care Insurance. The study aimed to examine the coverage of demented elderly by the German Pflegeversicherung. Using multivariate data analysis we assessed the influence of the variables mobility, degree of dementia, age, sex and place of living (private or nursing home) on asking for benefit of the Long-term Care Insurance. Additionally, the role of mobility of demented individuals on the allocation to an adequate stage of care was examined. Results indicate that more than one third of demented people are

disadvantaged regarding the Long-term Care Insurance coverage. They either did not ask for it or did not receive an adequate stage of care. Especially mobile individuals suffering from dementia are effected by that problem. The amount of care needed by demented elderly is not adequately taken into consideration by the Long-term Care Insurance.

#### 11. Service use and care process – describing mental health care in Saxony.

1. Development, implementation and evaluation of a Standardised Documentation System for Outpatient Non-Hospital Based Psychiatric Care (BADO-K) in Saxony (supported by Ministry of Social Affairs, State of Saxony)

T. Becker, H. Kluge, University of Leipzig, Department of Psychiatry, Leipzig, Germany

T.W. Kallert, M. Schützwahl, Department of Psychiatry, Dresden University of Technology

2. Implementation of an instrument documenting the inpatient care process and outpatient, community, residential and day care in South Leipzig (supported by Faculty of Medicine of the University of Leipzig)

T. Becker, H. Kluge, University of Leipzig, Department of Psychiatry, Leipzig, Germany

Describing service use and care processes in inpatient and outpatient services on the basis of standardised documentation systems is an important topic of mental health service research in Germany. The primary objective is to obtain good-quality data on service utilization in a defined population and on the care process and outcome to allow quality assurance in mental health care and psychosocial rehabilitation services. The standardized documentation system for out-patient / community, non-hospital based mental health care (BADO-K) was developed by the psychiatric university departments in Leipzig and Dresden. BADO-K is matched to the specific requirements for documentation in the fragmented German system of community psychiatric care which includes various types of services, day centres, community mental health centres, supported accommodation, work rehabilitation services for general adult psychiatric patients and people with substance misuse. The "BADO-K" includes an instrument assessing clinical and social needs (CAN), on health and social functioning (HoNOS) and quality of life assessment (BeLP, a German short version of the Lancashire Quality of Life Profile). The documentation instrument is currently tested in nearly 40 services in Saxony and will subsequently be implemented in all relevant institutions in this federal State. The second research project collects data describing mental health care in inpatient and outpatient services in a small area of Leipzig, called "Leipzig-Süd", including data from an inpatient service (University of Leipzig), a day centre for severely mentally ill people and a community-based social psychiatric service as well as data from two office-based psychiatrists in the same catchment area (providing non-sectorized care). On the basis of a standardised documentation system sociodemographic and illness-related information and data on activities of the services and staff are recorded and analysed.

#### 12. Old Age Depression - a neglected problem? The utilisation of antidepressants in community-dwelling and institutionalised elderly persons - Results from a representative survey in Germany

S.G. Riedel-Heller, S. Birkholz-Lindner, A. Busse, A. Sonntag, H. Matschinger, M.C. Angermeyer  
University of Leipzig, Department of Psychiatry, Leipzig, Germany

A representative survey on the utilisation of prescription- and over-the-counter antidepressant drugs and depressive symptomatology in community-dwelling (n=1193) and institutionalised elderly individuals (n=470) aged 75 and older was conducted in an urban region of Germany. Antidepressant use was found to be remarkably low (synthetic antidepressants: 2.2% of community dwelling individuals, 3.6% of institutionalised individuals; phytopharmaca: 4.2% of community dwelling individuals, 2.8% of the institutionalised individuals). Two thirds of the individuals treated with synthetic antidepressants received cyclic drugs. These were given at lower dosages than recommended for depression treatment. Selective serotonin reuptake inhibitors (SSRI) were used in community dwelling individuals only. None of the individuals cared for in residential and nursing homes received an SSRI. Only a minority of individuals with depressive

symptoms are treated with antidepressants. The data suggest under-utilisation of antidepressants in the elderly, in which institutionalised elderly persons seem especially disadvantaged.

### 13. Group therapy as a way to enhance self-help potentials - The attempt to make possible the impossible

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University of Leipzig, Department of Psychiatry, Leipzig, Germany

The authors describe a concept for out-patient group therapy which primarily aims at optimising the self-help potentials of psychiatric patients who had previously received treatment at the day hospital or the out-patient unit at the Department of Psychiatry at the University of Leipzig. A one-year pilot project for a closed group of patients with various disorders was set up and met with a team of three therapists for 4 hours once a month. The therapists came from different professional backgrounds and had received therapy training within different theoretical frameworks. Drawing on the method of the reflecting team systematic therapy and a balanced competency-deficit mix in the patient group, the attempt was made to support processes of self-organisation and self-help potentials of the patients.

Beside the use of standardised assessment instruments (e.g. SCL-90) and self rating scales as well as scales for rating by therapists on the achievement of therapeutic aims, evaluation was based on narrative interview carried out directly after the end of the project and six month later. The basis for these interviews was the task for the patients to write a story about their most important problem. The stories and interview were then analysed using the method of case reconstruction.

One aim of this model of evaluation was to allow to make statements about the development of self-help potentials in view of the personal therapeutic aims of the patients. The main interest was focused on the question as to whether, from the patient's perspective, the group therapy programme offered has supported these self-help potentials and whether differences could be noted with regard to therapeutic compliance and diagnosis. First results of both qualitative and quantitative data analysis will be presented.

### 14. Lay beliefs on the causes of dementia - Results of a representative survey in Germany

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Dementia is a common disorder in old age. It has been underdiagnosed and undertreated. This holds especially true for mild and moderate forms of dementia disorders, although the vast majority of the elderly see their GP regularly. Individuals suffering from the early stages of cognitive impairment or their caregivers often fail to report cognitive symptoms and to ask their GP for help. Although socio-cultural factors such as lay beliefs have been recognised as an important predictor in shaping help-seeking behaviour, no attempts have been made so far to specify the nature of lay beliefs within society. Therefore, lay beliefs regarding the cause of cognitive impairment were investigated in a representative sample of elderly individuals (n=915) in Leipzig, Germany. The impact of age and education on lay beliefs will be described. Consequences regarding the scientific knowledge of the public about symptoms, causes and management of dementia are discussed.

### 15. More than depression? Explaining and predicting subjective quality of life of people with schizophrenia by means of the WHOQOL-BREF: First results from the European Schizophrenia Cohort Study

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Subjective quality of life has become a well accepted outcome criterion in psychiatric service research but it is still suspected that the measurement of subjective quality of life of people with schizophrenia may be

nothing more than measuring depression . Aim of the study is to find out to what degree the assessment of the subjective quality of life of people with schizophrenia is confounded with depression.

Methods: The sample consists of 300 persons with the diagnosis of schizophrenia according to ICD-10 living in the city of Leipzig. General functioning, psychopathological symptoms, service use, type of drug treatment, subjective drug side effects, leisure activities, social contacts and living conditions were assessed with standardized instruments at two points of time in a six month period subjective quality of life was measured with the WHOQOL-BREF. Multiple regression analysis were computed to explain the variance of each dimension of subjective quality of life at the two points of measurement. Forward selection was used to find the best explanation model for each dimension of the WHOQOL-BREF.

Results: Depression measured by CDSS was found to be a strong negative predictor of all dimensions of subjective quality of life. Beyond this general effect, typical patterns of influence were found for each dimension of the WHOQOL-BREF. Subjective drug side effects have a significant negative effect on physical, psychological and overall quality of life. Number of social activities have a positive impact on the social dimension, the environment dimension and the overall dimension of subjective QOL. Available money has a positive effect on the environment dimension of QOL. These main effects were found to be stable over a period of six month.

Conclusions: The typical patterns of influence which were found for each dimension of the WHOQOL-BREF show that subjective quality of life of people with schizophrenia represents more than depression. However the strong impact of depression which was found for each dimension of QOL underlines the necessity of controlling the effect of depression in quality of life measurement.

#### 16. The application of the elements of IHMC in the prevention, the epidemiological role and importance of our applied method

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It is important to apply modern pharmacotherapy in treating the psychological disorder. However, in general, we only meet the patient in the Hungarian hospital cure system, when more serious mental disorder has been already appeared. The efficiency of the treatment is increased by a system, based on the integrated biological and psycho-social interventions, which assures a cure in the suitable time, being supported by the county hospital cure. Our researcher team has worked out a system of prevention, which is a prevention- stressed application of IMHC, and is for the age- group between 6 and 18 and for their family members.

The base of the model is a selecting system with two stages, which, apart from guaranteeing the availability of the majority of the population with the possibility of an early treatment, also connects the forces of surroundings which strengthens the effectiveness of prevention by circular facilitating. The operation of this worked out system can answer one of the most important challenges of our age by the productive connection of practice and of epidemiology. In addition, this system assures the new quality of the epidemiological data collection and of analyse, which, besides the advantageous cost-benefit rate of the treatment, guarantees the new quality of the research for the persons dealing with psychiatry.

#### 17. Mental health problem as a part of global health problem

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The closing century was marked by the great burden of social and natural catastrophes, which took away the thousands of human lives, and leaved the great majority of traumatized and distressed people.

Psycho- emotional stress causes a number of consequences on each level of person and in all spheres of society. Mental traumatization of population is bringing to increase of aggression, crime, suicide, alcoholization, narcotization, etc. During the XX Century Armenia had faced a great hardships, especially in the last 10 years. The extreme situation, characterized by the longitudinal multifactorial psycho- emotional stress was created in our newly independent republic.

Based on our experience we may consider the importance of:

- 1) Study of social distress
- 2) Establishment of Mental Health Departments in the Health Care Service
- 3) Development of stressology- science of antropogene psycho-emotional stress, post-stress disorders, treatment, prevention.
- 4) Considering the problem of physical and mental health as the united problem.

#### 18. Psychiatric service reforms in Armenia: practical problems

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Social, political and economic changes of recent years in Armenia, as well as changes of theoretical and methodological conceptions of health care require the reorganization of Armenian psychiatric service.

Characteristic features of the present period are: liberalization of the economy and the social and political system; divergence between the declared and real opportunities, rights and duties; lack of legislation in the field of mental health; establishment of social organizations; problem of professional education, etc.

The aim of the present project is the establishment of a Mental Health Service, which would have social orientation, high effectiveness and accessibility for every layer of society.

Principles of the project are de-monopolization and decentralization of service, differentiation and specialization, an liaison between services.

The main goals of reforms are: establishment of adequate legislation, re-structuring of psychiatric services, improvement of mental health specialists' ( psychiatrists, psycho-therapeutics, clinical psychologists, social workers, nurses) education and training, and increasing the role of social organizations.

#### 19. Psychiatric services in Sachsen-Anhalt - assessed with the European Services Mapping Schedule ESMS

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Objective: To assess the availability and structure of psychiatric services in one of the states of eastern Germany, where psychiatric care has changed drastically during the last 10 years. For this, information concerning services gathered by the inspection groups of the "Committee for Issues of Psychiatric Care in Sachsen-Anhalt" was analysed.

Method: The "Committee for Issues of Psychiatric Care in Sachsen-Anhalt" has 6 multiprofessional inspection groups, which visit all institution in Sachsen-Anhalt that offer psychiatric services to the community. Reports about these regular visits are semistandardized. With the ESMS (Version 3) all protocols were assessed retrospectively by one of us (FJ). Services were classified, number of places and client contracts were evaluated. The distribution of services was compared for 23 regions of the state. For ESMS ratings, interrater reliability coefficients were computed by double-coding a certain proportion of the protocols.

Result: 369 services were included, about half of which were residential, while the rest provided outpatient or community care. For some service types, the ratio of places (or contact) per capita varied grossly over different regions. This is illustrated by a "psychiatric service map" of Sachsen-Anhalt.

Conclusions: If regional psychiatric care shall be planned and developed to meet the needs of the population of a catchment area, measures of service availability are indispensable. Both the information source – protocols of inspection visits – and the instrument ESMS proved to be helpful to look at the present psychiatric service availability in one of the eastern German states. These results reflect aspects of recent history of psychiatry (such as e.g. a partial shift services), as well as demographic, economic and cultural features of some regions. If the mapping process will be repeated regularly, trends of change may emerge.

## 20. The ethical aspects of drug abuse treatment

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The ethical aspects of drug abuse treatment have been discussed for a long time in Poland. Public debate on this issue found a response in media which focused on following ethical problems: involuntary treatment, harm reduction including substitution programmes, needle exchange, provision of condoms, attitudes towards HIV+ and funding drug treatment.

There are two official documents in Poland: Mental Health Act (1994) and The Law on Counteracting Drug Addiction (1997) which are related to the treatment of drug addicts.

The Mental Health Act gives rules of psychiatric treatment and investigation without patient's consent and introduces court control over this procedure. The person with mental disorders has a right to communicate with family without limit.

The Law on Counteracting Drug Addiction states that treatment of addiction in public health establishments is free and voluntary. Exceptions from this rules are defined by the law and include minors and addicts who commit crimes related to drug abuse.

According to the law each treatment and rehabilitation unit should have its own specific instructions or bye-laws displayed for patients. Most of these regulations tend to limit legal rights of patients. The reason for this seems to be specificity of drug treatment, where the goal of drug free life dominates.

Besides therapeutic communities run by health sector and NGOs has own codes that follow documents of International Federation of Therapeutic Communities. These documents: Chart of Members of Therapeutic Communities, Norm and Aims of Therapeutic Communities, Ethical Principles of Staff of Therapeutic Community include a list of recommendations and suggestion related to professional and basic human rights standards.

To sum up, Poland initiated the first step to regulate ethical aspects of drug abuse treatment. However due to complexity of drug treatment documents that exist don't solve all problems that appear in everyday practice.

## 21. Compulsory admissions in psychiatric hospitals in Norway in 1997

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The use of compulsory admissions is by European standards high in Norway. Close to 50 percent of the admissions are currently on an involuntary basis. Reducing the use of coercion has been given high priority in government policy. In this paper we focus on two topics: Firstly: what types of patient characteristics are important in predicting type of admission? That is; what patient groups have a high probability of being compulsory admitted? This information can be used to evaluate whether present practice is adequate/legitimate, or if medical and/or organisational guidelines should be revised. Secondly: there are large variations in the use of compulsory admissions between institutions and regions. Is this a conse-

quence of differences in patients' characteristics, or may variations be attributed to other factors (local medical guidelines, organisational structures etc)? The last being the case, use of compulsion could be reduced through changes on the local level.

Method: The analysis had to steps. Firstly, we wanted to estimate the effect of age, diagnoses and gender on type of admission. Type of department where included as a control. Patients can either be committed on a voluntary basis, involuntary admitted for observation or involuntary admitted for treatment. Given three types of admissions, a multinomial logistic regression model was selected. Individual level patient records for *all* admissions to Norwegian psychiatric hospitals, clinics and units in general hospitals were used. Some institutions were excluded, due to low quality of data. The second step was to estimate the predicted use of compulsion at the institutional level, given patients' characteristics. These estimates were compared to the actual use of compulsion.

Results: There was a strong interactive effect between the patients' age and diagnoses on the probability of different types of admissions. Other variables held constant, women have a higher probability of voluntary admission. These variables account for a considerable part of the variation between hospitals, though far from all. There are still major variations between hospitals. The results on the individual level indicates a potential for reduced use of compulsion by evaluating present practice by revision of medical and/or organisational guidelines. The results on the institutional level indicate that local factors play a major role on type of admission. The method used makes it possible to identify institutions having a high or a low amount of compulsive admissions. These variations require further studies, with a different methodological focus.

## 22. Patient held clinical information for people with psychotic illness

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(Currently on The Cochrane Library, 1999, Issue 3, 1-13)

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Objective: To evaluate the effects of personalised and accessible patient-held clinical information for people with a diagnosis of psychotic illness.

Search Strategy: Electronic searches of AMED (1980-1998), Biological Abstracts (1985-1998), British Nursing Index (1994-1998), CAB (1973-1999), CINAHL (1982-1999), The Cochrane Controlled Trials Register (Issue 1, 1999), EMBASE (1980-1999), HEALTHSTAR (1990-1999), HMIC (King's Fund Database 1979-1998 & HELMIS 1984-1998), MEDLINE (1966-1999), PsycLIT (1887-1999), Royal College of Nursing Database (1985-1996), SIGLE (1990-1998), Sociological Abstracts (1963-1998) and the Internet (<http://www.controlled-trials.com/>) were undertaken. This was supplemented by personal contact with the Executive Board of the European Network for Mental Health Service Evaluation.

Selection criteria: The inclusion criteria were that studies should: (i) be randomised or quasi-randomised trials; (ii) have involved adults with a diagnosis of a psychotic illness; (iii) compare any personalised and accessible clinical information held by the patient beyond standard care to standard information routinely held such as appointment cards and generic information on diagnosis, treatment or services available.

Data collection and analysis: Study selection and data extraction was reliability undertaken. Analysis was not possible.

Main results: Not one study met the inclusion criteria for the review. One study (Stafford 1997) was found on the use of client held records for people with long term mental illness but the participants had not been randomised. Two important randomised studies (Lester 1999, Papageorgiou 1999) are ongoing.

Conclusions: There is a gap in the evidence regarding patient-held, personalised, accessible clinical information for people with psychotic illnesses. It cannot be assumed that patient-held information is beneficial or cost-effective without evidence from well planned, conducted and reported randomised trials.



23. A comparison of two different instruments assessing the individual need for care

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Objective: Planning mental health care facilities aligned to the needs of psychiatric patients requires the assessment of their individual need for care. The assessment in this context is a methodical consequence of the shift from institution-centred to patient-oriented mental health care. On the other hand, according to current legislation health care facilities are obliged to categorize patients with similar need for care. This requires the assessment of the individual need for care as well. In this context the linkage between allocation and need for care is discussed.

Method: In Germany two different techniques to assess the individual need for care are applied at the moment: a questionnaire devised from Dr. Metzler according to current legislation and the „Integrated Plan for Treatment and Rehabilitation“ generated from AKTION PSYCHISCH KRANKE. We applied these instruments to assess the individual need for care at 52 patients in various settings and compared the results. In a small sample (8 patients) we tested the interraterreliability.

Results: The correlation between both instruments was highly significant ( $r=.52$ ;  $p < 0.001$ ). However, focussing on individual cases showed distinct results. Interraterreliability was low and two of the 8 patients were referred in different need categories.

Conclusion: The assessment of the individual need for care is appropriate to the individual care planning and internal quality assurance in mental health care institutions. However, at present the qualification of both instruments regarding allocation aspects is questionable.

24. Assessment of Finlepsin-retard efficiency with aid of the integrative index of quality of life in patients with borderline mental disorders

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In this work it was performed a comparison of efficiency of treatment for patients with borderline disorders with finlepsin-Retard (53 patients) and without it (52 patients) by means of traditional criteria (clinical-psychopathological, psychological, electrophysiological, biochemical) and the integrative index of quality of life. Results of the work evidence the positive dynamics of quality of life in both groups. However in the group of patients received Finlepsin-Retard in the complex therapy the dynamics of the test parameters was trustworthy and especially expressed regarding categories of the physical well-being, individual self-realization, and work efficiency. The data obtained evidence a necessity to use Finlepsin-Retard in therapy of borderline disorders.

25. "Knowing - enjoying - living better" Quality of life oriented psychoeducation for patients with schizophrenia

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Traditional psychoeducation for schizophrenic patients covers mainly illness related topics. The present programme was designed to also comprise quality of life topics, which are of major interest for patients. Psychiatrists in the community are offered to refer patients, suffering from schizophrenia or schizoaffective disorders, to this psychoeducation programme in addition to their regular treatment. The programme is carried out in 9 group sessions at weekly intervals with 6-8 group members. Illness related topics, covered by the programme are "illness concept", "symptoms and early warning signs", "medication" and "illness related stigma". Quality of life topics include "improving well-being", "how to make friends",

“how to structure every day life” and “how to improve the environment”. At the end of the 9 week programme groups are randomly assigned to “no further treatment” and monthly “maintenance” sessions for 9 further months. Patient assessments are carried out pre-group, post-group and at 6, 12 and 24 month follow up. A total of 100 patients will be evaluated, and objective (relapse and rehospitalisation rates, resource utilisation etc.) and subjective (QoL, illness concept, subjective deficit syndrome etc.) outcomes will be assessed. The structure and content of the programme and first experiences will be presented.

#### 26. Differences in the burden of care in families of schizophrenic and depressive patients

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This study was undertaken to systematically assess the consequences of being a family member or close relative of someone with schizophrenia vs. depression. Based on the Involvement Evaluation Questionnaire by Schene et al. (1998) an instrument was designed to measure objective and subjective burden of care, perceived stigma, mental and physical health of the caregivers, their well-being and subjective quality of life in relation to patient's psychopathology and behaviour.

Health impairments in both groups (caregivers for schizophrenic persons: n=77, depressive :n=79) were unexpectedly high: 60% fulfilled criteria for requiring psychosomatic treatment. Subjective burden, esp. with regard to financial and social situation, was significantly higher in caregivers of schizophrenic patients. This group had a lower quality of social life, a objectively higher financial burden, more incidences of discrimination and feelings of shame. They also had to suffer from more severe verbal and physical aggression from the mentally ill patient.

It is discussed whether differences in severity and types of burden could serve as a basis to distinguished service provisions for family caregivers of schizophrenic and depressive patients.

#### 27. The main directions of reformation of psychiatric services in the Ukraine

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The main directions of psychiatric service reforms in Ukraine are perfection of legal and normative basis such as adoption of a law concerning a psychiatric aid in Ukraine, displacement of emphases on an ambulatory link from a stationary link, integration of psychiatry with general somatic services, humanization of psychiatry in general, storage and widening of psychiatric patients' rights, an active participation of psychologists and social workers in psychiatric management, reformation of the professional training system. In the poster report the contents of each direction mentioned above will be reflected in detail.

#### 28. Satisfaction with community mental health services: A follow up study

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T. Ruud

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Objectives: The aim of the study was to assess the satisfaction of severely mentally ill patients with the community mental health services that they had received during a six year follow up period. This was part of a follow up study including clinical and functional state, quality of life, use of services and costs of services for patient treated in one of the pioneering psychiatric centres of the ongoing reform of the mental health services in Norway.

Methods: A semi-structured interview was conducted with the patients treated in 1992/93 for severe mental disorder. Approximately 50 of the 60 patients agreed to participate in the study. The semi-structured

interview included quality of life as measured by using MANSA, and a part designed to measure the importance and the satisfaction of the specific elements of the received community mental health services as the patient had experienced it. The interview also included assessment with BPRS-E, HoNOS, S-GAF, CANSAS and PSF.

Result: The patients were more pleased with the specialised mental health services than with the general community services. Long term contact with continuity in the relationship was among the services elements seen as most valuable.

Conclusions: The outcome and the satisfaction with services reflects positive effects of stability and continuity in the highly co-ordinated community mental health services delivered by the psychiatric centre and the municipality in cooperation.

#### 29. Building and validation of an indicators system for mental health departments. Monitoring, evaluating and planning psychiatric assistance in the Lazio Region

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T. Losavio, M. L. Stefani, Regional Evaluation Service Group (Rome, Italy)

The project is realised by a unit of the Lazio Region Health Authority, the project manager is Prof. Tommaso Losavio, and the working group is composed by representatives of all the 12 Departments of Mental Health of the Region. Namely 13 psychiatrists and 12 psychologists appointed for this project by the Directors of each Department. The project is sponsored by the Italian National Health Department.

Organisation: Mental health assistance in Italy is community oriented. Since 1978 – because of the national law - we haven't admitted anyone else to psychiatric hospitals. We have local mental health departments in which several functions are combined in one local organisational entity, with own budget. We have 3 main functional areas: Community mental health centres (CSM) rehabilitation residential and semi-residential facilities (SR, SSR), small psychiatric wards in general hospitals (SPDC) with no more than 15 beds.

Aims of the study: To set up indicators for standards measures of activities. To compare alternative interventions, different services and different periods. To improve technical skills of professionals in measurement approach. To divert resources toward intervention that maximise health gain. The study of service utilisation is not an aim in itself. The ultimate goal is to learn how systems of mental health care function or dysfunction. This knowledge should be helpful for planners to organise services on a more scientific basis.

Indicators structure: The working group has fulfilled these items: Description. Functions to which the indicator refers. Finality. Survey method. Accuracy and reproduction, for each indicator.

The system validation which will probably involve professionals at large, users, their relatives and others will be the last phase of the project. After that phase, the indicators application of the Mental Health Departments data will be a routine duty.

## Keynote Speeches (Sunday)

### Mental Health Services in Eastern Europe

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The stigma concept: Implications for assessment and action

B. G. Link

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Goffman defined stigma as an "attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person to a tainted, discounted one." Since Goffman, alternative definitions have varied considerably. Two reasons for this variation are that the stigma concept has been applied to an enormous array of different circumstances -- from schizophrenia to exotic dancing -- and that it has been studied from the perspective of many disciplines. We attempt to advance the study of stigma by proposing a definition that encompasses these differences and that attends to important critiques pointing out that much theory about stigma is uninformed by the lived experience of the people being studied and that research on stigma has an individualistic focus, viewing stigmas as something in the person rather than a designation that others affix to the person.

We conceptualize stigma as a process. This process begins when dominant groups distinguish human differences -- whether "real" or not. It continues if the observed difference is believed to connote unfavorable information about the designated persons. As this occurs a coterminous social labelling of the observed difference is achieved. Labelled persons are set apart in a distinct category that accomplishes some degree of separation of "us" from "them." The culmination of the stigma process occurs when designated differences lead to various forms of disapproval, rejection, exclusion and discrimination. The stigma process is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the labelling of persons as different and the execution of disapproval, rejection, exclusion and discrimination.

### From Inputs to Outputs

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Linking costs to quality of life data in Mental Health

L. Salvador-Carulla, A. Martinez-Larrea, J. Cabases, & the PSICOST Group

University of Cádiz, Spain

There is lack of consensus regarding how to incorporate outcome measures into health economic analysis. A number of global indexes have been used both in research and in health decision-making (i.e. QALYs, DALYs, HUI, SAVE, DALYs). However, their overall validity and practicality is tempered by conceptual problems, different calculation methods, inadequate psychometric testing of preference measures and lack of comparability of results. These problems are particularly relevant in the mental health field. Furthermore, health economics guidelines recommend including general and specific HRQoL measures, apart from adjusted life-year indexes. This solution reduces the overall feasibility of assessment and increases bias (redundancy, terminology variance, completion and measurement errors). The use of HRQoL measures (i.e. SF-36, SF-12) for preference assessment is questionable, since these measures were not designed for that purpose. On the other hand, there are two combined measures that yield both health status and preference rating: A-QoL and EQ-5D (EuroQoL). EQ-5D is a brief, single measure suitable for use in the general population and chronic medical patients. We have recently studied the psychometric properties of EQ-5D in schizophrenia as well as its feasibility in cost studies, showing satisfactory results. Both standardisation and burden studies indicates that combined HRQoL/preference facilitate merging outcome and costs data in mental health.

## Interventions and Service Cultures

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Scientific knowledge, evidence, and the importance of service and programme characteristics

A. H. Schene

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Over the past few decades psychiatry has become a scientific field of medicine in which knowledge on biological, psychological and social aspects increased rapidly. At the moment biological and experimental psychological research is becoming more and more dominant, not only because there are a lot of new methods to collect data, but also because of its relatively high level of generalizability. This last aspect has important consequences for the publication in scientific journals and indirect also for the field of evidence based psychiatry. So far evidence is missing for a lot of daily practice in mental health care and mental health services. In this paper I will discuss the reasons for this from two perspectives: (1) the production of scientific knowledge and the importance of an optimal description of interventions, treatment fidelity and possible therapeutic factors, and (2) the implementation of scientific knowledge and evidence based practice in relation to general or more specialized programmes or services. Advantages and disadvantages of disorder related service planning will be clarified and its relevance for the further development of a scientific planning of mental health services will be highlighted.

## Assessing Outcome in Service Evaluation

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Psychiatric outcomes in light of the national economy

H. Brenner

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During the last decade intense interest has developed among health policy experts as to the effectiveness of modern health care in the areas of chronic disease management including psychiatric treatment. The reason for this great interest is known to economists and political scientists throughout the industrialized countries. It is based on a decline in productivity (i.e. the growth of wealth) in market economies since the early 1970's, in combination with a secular increase in population aging and in the widespread introduction of high technology drugs and surgeries. This has led to massive increases in access to high technology health care by the chronically ill with attendant greatly increased costs and expenditures for health care as a proportion of the gross national product.

These economic strains of health care expenditures on the gross national product, and therefore on governments, business firms and insurance companies has put tremendous pressure on the development of policies for health care cost control. Health care cost "control" is of course an euphemism for health care expenditure reduction. While it often seems to politicians and scientists that health care industry economists are simply concerned about cost efficiencies regardless of the health results to the populations involved, in fact a principal policy theme has been cost reduction through elimination of "wasteful", harmful, ineffective or relatively ineffective (i.e. in comparison to other treatments) medical and surgical procedures. These policy pressures, then, have led, particularly in the United States, to the development of what may actually be called a research industry in health care effectiveness analysis taking into account health care costs (i.e. cost-effectiveness analysis).

Cost-effectiveness analysis emphasizes the difference between efficacy (as inferred through, say randomized clinical trials or other experiments) and the performance of drugs and surgery in terms of their implications for "quality of life" outcome data. Quality of Life measurements have therefore been developed for the treatment of morbidities in general for each of the major chronic diseases that are life-threatening (cardiovascular diseases, malignancies, diabetes, injuries), as well as for psychiatric illnesses and chronic pain.

The question dealt with in this presentation has to do with evaluation of outcomes of psychiatric treatment in Quality of Life terms. Quality of life measures include clinical estimates of morbidity, social func-

tioning, including that related to work, family and community, and estimates of psychological functioning (e.g. mood) and measures of overall well-being or life satisfaction.

From an epidemiological point of view, however, it is important to keep in mind two facts before us. First, we have the internationally robust finding of inverse relationships between the prevalence of psychiatric morbidity and socioeconomic status. Second, it can be observed that measures of psychiatric morbidity relate to declines in economic conditions, especially unemployment.

Therefore, in order to properly evaluate psychiatric treatment through the use of Quality of Life measures, it will be necessary to either statistically control for, or otherwise take account of, the changing socioeconomic status of patients under treatment that has little or nothing to do with treatment effectiveness, but rather is a by-product of the state of the regional and national economy. This problem will be discussed in light of the large-scale unemployment problems in Europe, with special reference to Eastern Germany, that are the highest since the depression of the 1930's.

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