

**A B S T R A C T S B O O K**

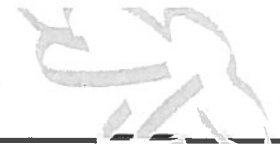
**MULTIPLE**  
**PERSPECTIVES**  
**ON OUTCOME**



**SANTANDER (SPAIN)**

**MAY 15-17, 1998**

Berte Noreco



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## ENMESH

The European Network for Mental Health Service Evaluation was established in 1991 under the auspices of the World Health Organization, Regional Office for Europe, with the following main objectives:

- To develop and maintain a network of active researchers in mental health service research in Europe (Eastern, Central and Western Europe).
- To promote the development and dissemination of study designs, research instruments, mental health outcome indicators, and relevant forms of statistical analysis.
- To function as a clearing house for mental health service evaluation information in Europe.

Since 1991 more than 200 researchers -psychiatrists, sociologists, psychologists, health economists and epidemiologists, from more than 20 European countries have registered in ENMESH.

The ENMESH Executive Committee, organises, in June of every second year, an international conference. Each of the previous conferences (1st. International Conference, Amsterdam, 1994; 2nd International Conference, Verona, 1996) have addressed relevant topics which have been thoroughly discussed. The conferences are also arranged in such a way as to provide an opportunity for researchers in the field to meet and develop international collaboration.



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**O P E N I N G      S E S S I O N**





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## OUTCOMES: BACK TO KRAEPELIN'S HERITAGE

**Prof. Juan J. López-Ibor, Jr.**

Professor and Chairman of the Psychiatric  
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Complutense University of Madrid. Spain.

DSM- III authors considered that the new version of the classification went back to the Kraepelinian roots of psychiatry as they took as main criteria for the description and differentiation of the illnesses the symptoms present. Actually this perspective is more related to an earlier stage of the history of psychiatry namely the Pinelian classification, at the beginning of the 18th century. Kraepelin was more concerned about outcome and forms of evolution considering that the difference between one disorder and another laid in the result after a long evolution. This true Kraepelinian perspective should be useful for the evaluation of modern treatments and interventions, which should have an impact on the natural history of the disease itself and not only on the symptoms present at a certain moment.



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## DEVELOPING OUTCOME MEASURES: FROM RESEARCH TO CLINICAL PRACTICE

**J. K. Wing.**

Research Unit, Royal College Of Psychiatrists, London, U.K.

Does good research influence clinical and administrative practice? Two projects during the 1960s measured the progress of patients with schizophrenia in 3 large psychiatric hospitals, each of which had distinctively different policies, in order to compare and contrast outcomes. One study compared, over 8 years, the clinical and social conditions of a cohort of long-stay patients. The other compared the outcomes, after 5 years, of all patients admitted in 1956. Many of the problems that came later, during the development of 'community psychiatry' in the 1970s and 80s were already before the end of the 60s beginning to be evident from these and other studies. But the impact on public policy was minimal. Some recently published projects concerned with instruments for the routine audit of clinical and social outcomes will also be described in brief. A range of such techniques, within the context of a 'minimum data set', would meet 'clinicians' needs, make good quality information available to pilot innovations in selected districts, and provide a sampling frame for comparative health service studies. This is the way forward to evidence-based community services.



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## CONCEPTS AND INSTRUMENTS FOR MENTAL HEALTH SERVICE EVALUATION: A CROSS-CULTURAL PERSPECTIVE

**N. Sartorius, M.D., Ph.D., FRC. Psych.**

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Evaluation as a formal and structured procedure is a culture bound notion. It depends on the acceptance of a set of concepts and epistemological propositions currently prevalent in certain Western European and other industrialised countries (e.g. United States of America and Australia). This set includes at least the "Western" concepts of time and space, Aristotelian uni-dimensional logic, principles of determinative causality and adherence to the predominance of ethical imperatives over local needs.

Evaluation as currently conceived and carried out can (and perhaps should) be used in settings characterised by other cultural norms and conditions. When this is done, it is important to use knowledge about other cultures in the process of evaluation, in the interpretation of results and in decision on future course of action based on results.

t h e m e



**THE EVALUATION OF QUALITY  
OF CARE IN MENTAL HEALTH**

**I N T R O D U C T I O N**

W O R K S H O P S

P R O S P E C T S F O R T H E F U T U R E

P O S T E R S



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## THE PRINCIPLES AND PRACTICE OF MEASURING QUALITY OF CARE IN MENTAL HEALTH

**A. Arteman & V. Kovess**

ENQUAM. European Network for Quality in Mental Health .

The principles of measuring quality of mental health services are in many ways the same as in other areas of medicine although they necessitate some degree of adaptation.

Quality assessment in mental health should follow the major principles of quality care evaluation:

- 1.-The patient should be at the centre of the assessment along with his family.
- 2.-The process should involve the entire process of care including the more trivial aspects, so all the people involved should participate in it.
- 3.-The process should be continuous: it should be designed in order to stimulate continuous involvement of as many people as possible and avoid the one-shot inspection pattern.
- 4.-Measuring quality should involve structure, process and outcome.
- 5.-Some degree of institutional involvement is required.

However some specific aspects should be involved:

- quality measures should apply to community care as well as hospital based care since most of the care is given outside hospital settings.
- a special attention should be given to the respect of patients rights and to the mechanisms to protect them in case of involuntary admission.

Concrete examples will be given and discussed according to the Canadian system, the Australian and recent French and Spanish experiments concerning mental health field.



t h e m e



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P O S T E R S



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## GUIDELINES FOR THE MANAGEMENT OF DELIBERATE SELF HARM IN GENERAL PRACTICE

**DJ Sharp, A. Liebenau, N Stocks, MO Evans, W Bruce-Jones,  
TJ Peters, D Gunnell.**

Division of Primary Care, University of Bristol, Bristol, UK

In England and Wales, 120,000 people present at hospital annually following deliberate self harm (DSH), of whom 15-30% make a repeat attempt, most often within 3 months. About 70% of patients see their GP within 4 weeks of an episode of DSH. Guidelines for the management of DSH in general practice might reduce repetition rates. As the first phase of an RCT to test the effectiveness in reducing repeat rates of a letter from the GP inviting the patient to a consultation after an episode of DSH, a clinical practice guideline was developed to assist the GP at the index consultation. The guideline was initially constructed using the ICD10-PHC template by the core research group and subsequently refined using a modified Delphi technique involving GPs, psychiatrists, patients and the voluntary sector. The guideline is currently being evaluated in an RCT involving 90 practices in SW England. The paper will describe the guideline development process and the subsequent trial methodology.



## THE STATUS OF ENGAGEMENT IN AN ASSERTIVE COMMUNITY TREATMENT SERVICE.

**R Bale and T Burns**

St George's Hospital Medical School, London, England

Successful engagement is considered to be strongly associated with lowered hospital usage. The interaction between both (a) the case manager/client relationship and (b) case managers' engagement activity with community stabilisation has not been clarified.

Aims To measure client's engagement with case managers in an Assertive Community Treatment (ACT) team and to assess the correlation between the different measures used.

Method 98 clients and 10 case managers of an ACT service were interviewed using:

- 1.-The Working Alliance Inventory (client and case manager versions) (WAI).
- 2.-The Helping Alliance Questionnaire (HAQ).

All contacts between clients and case managers prospectively recorded (including engagement activity).

Results Preliminary results demonstrate that clients and case managers are highly correlated in their WAI ratings. A high level of engagement activity was recorded.

Conclusion Engagement is a critical component of ACT.




## OUTCOMES OF FOUR YEARS OF INTENSIVE CASE MANAGEMENT

**H. Kroon**

Trimbos-Institute (Netherlands Institute of Mental Health and Addiction),  
Utrecht, The Netherlands

In most cases research into case management for people with severe mental disorders has a follow up period of 24 months or less. It is generally believed that the outcome will be more positive when the follow up period is longer, since the severe mental and social problems of the population require intensive support for an extended period. At the same time results suggest that case managers start with high ambitions and enthusiasm and end up with more realism but often also with a lower morale. In this presentation we present outcomes of four years of case management of five projects in the Netherlands. Variables are program characteristics, clinical and social functioning of the patients, working alliance between patient and case manager, and job satisfaction and burnout of case managers. The results are put in the perspective of a nationwide study of program characteristics and job satisfaction of professional caregivers within home-based services in the Netherlands.



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DOES WORK EXPAND TO FILL THE TIME AVAILABLE?  
A PROSPECTIVE STUDY OF THE IMPACT OF ENHANCING  
COMMUNITY MENTAL HEALTH TEAMS WITH  
INTENSIVE CASE MANAGERS

A Kent and M Fiander.


St. George's Hospital Medical School, London, United Kingdom.

Aim To investigate the impact on staff activity of team enhancement with intensive case managers targeting the needs of the severely mental ill within an inner-city catchment area.

Method A detailed event record was used to measure the clinical activity of all staff in two CMHTs during six week-long intervals spanning pre and post enhancement periods over 30 months. Allowance was made for changes in staff establishment and referral rates.

Results A total of 1939 clinical activities were recorded over the six weeks: 312 activities a week before enhancement and 325 a week after enhancement. The overall frequency of face to face patient contact for existing staff did not change significantly following enhancement in spite of the additional resource targeting the severely mentally ill. Patterns for other activities were less consistent.

Conclusions Assessment of work practices is difficult and complicated by changes in staff establishment and the permeability of the secondary care filter. When teams are enhanced it is important to consider the impact on existing staff and their work practices if the full benefit is to be realised.



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“THE PARACHUTE PROJECT” - A SWEDISH MULTICENTER  
STUDY OF FIRST EPISODE PSYCHOTIC PATIENTS  
TREATED WITH SPECIAL SERVICES.

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Center for Psychosocial Research<sup>2</sup>, Stockholm, Sweden.

18 psychiatric clinics with a total catchment area of 1.2 mill. inhabitants take part in a project designed to develop the care for all first episode psychotic patients. The collection of cases started on January 1, 1996 and ended on December 31, 1997.

The work is guided by the following principles: 1. Early intervention. 2. Crisis and psychotherapeutic approach. 3. Intense family participation and support. 4. Continuity and easy accessibility during at least 3 (possibly 5) years. 5. Low-dose neuroleptic strategies if possible including neuroleptic-free early phase. 6. Over-night care in non-clinical, personal milieu. The research part of the project comprises:

a) a naturalistic long term follow-up study designed to better differentiate subgroups with different background factors, treatment needs and prognosis. A large set of base-line diagnostic tools is used including symptom check lists, neuropsychological testing, projective tests, family climate scales, MR or CT scan, EEG, records from the patients' delivery clinic are ordered etc. Follow-up investigations including LQ scale, satisfaction with care etc. are done at 1, 3 and 5 years.

b) a comparison with “ordinary care” is performed with a retrospective control group consisting of a total group patients from some of the same areas, collected with the same criterias but with their first psychosis 3 years earlier. Another prospective comparison group with the same criterias was started in Uppsala in 1997. These cases will be compared regarding diagnosis, consumption of care, prescription of neuroleptics, and outcome data.

Early results. During the first 22 months 302 patients have been recorded, and 176 patients have accepted to take part in the research. 47 patients have not yet given their permission. The drop-out is 79 cases (26%). Some early findings and research implication will be discussed.



## COMPREHENSIVE MENTAL HEALTH CARE IN THE NETHERLANDS

**F.G. Brook**

Department of Social Psychiatry  
University of Groningen, The Netherlands

In 1995 a multi-functional mental health care service started for a catchment area of approximately 160.000 inhabitants. In this multifunctional service two psychiatric hospitals, a psychiatric department of a general hospital and a community ambulatory mental health care institute work together. Their aim is to offer a wide range of integrated mental health care with the emphasis on community care and substitution of inpatient care. Longstay inpatient care is still offered by the psychiatric hospitals. Specific inpatient care, like for example childpsychiatry and psychogeriatric care, is not delivered by the multifunctional service.

We used the Groningen psychiatric case register to evaluate this service by comparing the service-consumption in the period before the start of this new service (1986-1995) with the service-consumption in the period that this new service came into operation (1996).

The following research-questions were investigated:

- Is this multifunctional service able to offer all the care that the inhabitants of this catchment area need?
- Is this multifunctional service able to prevent and substitute the inpatient care?



## MEASURING QUALITY OF CARE AT THE INSTITUTIONAL LEVEL: THE MGEN EXPERIENCE

**V. Kovess**

MGEN, Research Laboratory Paris V University, Paris France

MGEN is the biggest French "Mutuelle" which administrates the health social security system of 2.6 millions of people and owns 39 hospitals or related institutions.

In the context of the French recent reform of quality insurance, this organisation conducted an original project based on eight grids concerning three major patient risk topics: medication, hygiene and emergency situations. These one page grids were designed by people working in these institutions and were first used for self evaluation at the unit level.

Each unit's measures were grouped to form an institution hote; then 31 one day cross visits were organised using a multidisciplinary approach allowing many people from diverse institutions to be either visitors or visited.

This very simple and concrete approach appears to be very successfull to initiate a quality evaluation in a country where that sort of evaluation was nearly unknown.



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## MEASURING QUALITY OF CARE ON CLOSED PSYCHIATRIC ADMISSION-WARDS: AN INSTRUMENT

**Y. Nijssen, A.H. Schene, R. de Haan**

Department of Psychiatry, Academic Medical Center, University of Amsterdam,  
Amsterdam, the Netherlands

**OBJECTIVES:** The objective of this study is to develop an instrument to assess the quality of care on closed psychiatric admission-wards. Application of this instrument should offer these wards reliable and relevant information to increase the quality of care.

**METHOD:** First patients, relatives, nurses, psychiatrists, insurers and health inspectors participated in the conceptualization process of 'quality of care' in closed admission-wards. Results were summarized in a concept map which was the basis for the construction of the instrument. This instrument contains a structured interview for patients and questionnaires for professionals. Both are categorized in different modules. Patients are asked to judge the domains of care that focus on staff-patient relationship, patient influence, information, privacy, day-activities, safety and the use of emergency control measures. Professionals fill in questionnaires with items that focus on continuity of care and staff competence. The feasibility, reliability and validity was evaluated on five closed admission-wards (132 patients in total).

**RESULTS:** We will describe the content of the instrument. Next we discuss the feasibility. The mean administration time of the interview was 35 minutes and of the questionnaire 10 minutes. Of the 132 patients 23 were evaluated as 'somewhat unreliable' by the interviewers. Factor analysis on data of 109 patients showed that patient-items could be clustered in five scales. Doctor and nurse-items showed two scales each. Scales have Cronbach's  $\alpha$  between .64 and .86. Finally we discuss validity and show the correlations found between the scalescores and other quality of care scores.

**CONCLUSION:** Feasibility, reliability and validity of the instrument is promising to assess the quality of care on closed psychiatric admission-wards.



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## USER-DEFINED OUTCOMES OF QUALITY OF CARE

**J. Carpenter, S. Sbaraini**

Centre for Applied Social Studies, University of Durham, UK.

Focus groups of mental health service users, carers, professionals and managers were used to define criteria for good practice in the involvement of users and carers in a care management system (the Care Programme Approach, CPA). Criteria agreed included: being treated with respect; being asked for views on care and treatment; involvement of carers; information about medication, rights and services; participation in decision making; and how to make complaints.

The operation of the CPA service was evaluated against these criteria using anonymous questionnaires and interviews conducted by trained service users. Service users (N=109) had been involved with services for 10-15 years and all had serious mental illness. Comparison of users with, and without CPA revealed positive benefits for the care management system.

Reference: Carpenter J and Sbaraini, S (1997) Choice, information and dignity: involving users and carers in care management in mental health. Bristol, Policy Press.



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## QUALITY ASSURANCE USING A DATABASE IN COMMUNITY MENTAL HEALTH

**P.B. Vendsborg, O. Garsdal, H. C. Knudsen**

District psychiatry Vesterbro - Kongens Enghave, Copenhagen. University Hospital,  
Psychiatric department, Hvidovre, Denmark.

Community mental health centres in Denmark and especially in Copenhagen have serious mentally ill patients mainly with schizophrenia as their target group. The quality assurance program was made to suit this population.

The indicators for quality with criteria's and standards were chosen by a working group in a community mental health centre. For process quality were used 11 indicators and for outcome quality 8.

The process indicators were: Waiting time, diagnostic intake, information to general practitioner, need assessment, treatment plan, social action plan, continuity, frequency of contact, control of medication, psychotherapy and family involvement. The outcome indicators were: Diagnostic population, completeness of target group, frequency of aggravation, frequency and duration of hospitalisation, retention, need fulfilment, level of functioning (GAF) and satisfaction.

Routine data in existing databases were used together with collection of quality specific data which were stored in other databases.

All the data were combined in one database and the necessary programs made to calculate the value of the defined indicators.



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## WHAT HAPPENS IN DAY ACTIVITY SETTINGS?

**J. Beecham, J. Schneider and M. Knapp**

PSSRU, University of Kent and London School of Economics

Day activity settings form a central component in support packages for people with mental health problems. Descriptions of settings have tended to rely on broad categorisations of orientation; social, treatment or work-related. In a 1997 survey of all day settings in the South Thames area of England by PSSRU, specific questions were asked regarding service content. Respondents were asked to say whether or not they provided any of the eleven 'modalities' identified in the WHO *International Classification of Mental Health Care* which include: assessment of problems or functioning; supervision of mental health medication; psychological interventions; (re) education for users in daily living, interpersonal or social skills.

Data are available on 155 day activity settings and include information on their scale, staff and user characteristics, and costs. The paper will present information showing how service content differs by sector of provision (National Health Service, local authority social services department and voluntary sector) and that, within the broad categorisations of orientation, there are overlaps in terms of service content.



## A COMPUTER-ASSISTED QUALITY TECHNOLOGY FOR THE EVALUATION OF MENTAL HEALTH SERVICES

Nils Gustaf Lindgren MD,

Assoc Professor Ulf Malm MD, and the OTP/PCO research group. Institute of Clinical Neuroscience, Department of Psychiatry, Sahlgrenska University Hospital, GÖTEBORG, SWEDEN

An empirically based platform for decision makers is critical for the development, and provision of good and cost-effective mental health services for one of the world's most costly diseases: schizophrenia: The main objective of the present project in progress is the building of a computer-assisted tool kit for the evaluation of mental health services, by bringing together multiple categories of outcome data, with commercially available good quality and well standardised computer technology.

The tool kit is intended to be used by a broad range of mental health care workers, consumers and decision makers, and will contain technologies for the description of program fidelity, quality assurance, social network characteristics, cost-effectiveness, and delivery systems.

The concept is based on the idea that the input of reliable empirical data by independent raters and consumers, will be transferred from patient to the computer database and then represented not only to users for continuous quality improvement, but also providing adequate information to policy and decision makers by easy-to-read, frequently delivered, dynamic reports.

Empirical data from repeated assessments during one year based on 10 categories of effects from two ongoing RCT - studies will be presented.



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## THE EVALUATION OF QUALITY OF CARE IN MENTAL HEALTH

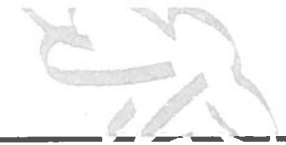
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P O S T E R S





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## FUTURE PERSPECTIVES ON QUALITY OF CARE EVALUATION

**C-G Westrin.**

Department of Social Medicine, University of Uppsala and the Swedish Institute  
for Health Services Development (SPRI)

The two workshops May 16-17 on the evaluation of quality of care in mental health will be discussed in a frame of reference in two dimensions:

(1) The need for a comprehensive evaluation and monitoring, taking into account e.g. the contributions of social welfare services, voluntary organisations etc and not only - as hitherto was common - the specialised mental health services

(2) The need for coordination of different components is what has been called 'medicine's third revolution' ('confronting an era of assessment and accountability') - i.e. Quality Assessment/Quality Assurance, Assessment of Medical Technology, Medical Audit, Health services research.



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**EVALUATING OUTCOME IN A REHABILITATION  
AND CONTINUING CARE SERVICE FOR PEOPLE WITH  
SERIOUS AND ENDURING MENTAL HEALTH PROBLEMS**

**R. Perkins, N. Fisher, S. Santana.**

Springfiled University Hospital, St. George's Medical School, University of London,  
England, United Kingdom.

The difficulties in evaluating outcome in a population with serious ongoing mental health problems will be discussed together with the limited utility of traditional mental health measurement. The range of measures used in a rehabilitation and continuing care service will be considered in relation to the aims of the service. The functioning of different subgroup of the population will be compared on a range of measures addressing social functioning, symptomatology, behavioural disturbance, social networks, quality of life, medication side effects and the way in which people spend their time. The pattern and intercorrelation of these variables will be considered.



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## PATHWAYS TO CARE FOR PATIENTS WITH FIRST EPISODE PSYCHOSIS IN MEXICO

Apiquian R, Páez F, Lozaga C, Nicolini H, Fresan A, Vallejo G.

Clinical Research, Institute of Mexican Psych, Calzada México-Xochimilco, México.

The psychotic disorders presents a period of untreated psychosis (mean=2 years). Delay in the onset of the treatment was associated with a poor prognostic.

**Objective:** The aim was to determine the pathways of care and the duration of untreated psychosis (DUP), in patients with first episode of psychosis.

**Method:** We recruited 50 patients. Psychiatric diagnoses were assessed with the SCAN system and to determine the pathways and DUP, patients and their carers were interviewed using a semi-structured questionnaire designed by the OMS.

**Results:** Forty-eight percent (N=24) of the patients were male. The mean age was 28 years (SD=10.1). Patients were classified as having Schizophrenia (N=18). Affective psychotic disorders (N=17) or non-affective psychotic disorders (n=17). The mean age onset was 27 years. The first contact with attention services was after 35 weeks of onset. The DUP was long (mean= 56 weeks, SD=67.2). The principal causes to seek for help were the psychotic symptoms. Schizophrenic patients delayed in seeking for help with comparison in affective psychosis patients (F = 3.55, 2, 47 <gl>, p < 0.05).

**Conclusions:** The results show a great interest in evaluating our care services to assure that DUP patients are cared on time for a better prognosis.



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## THE EFFECTIVENESS OF PSYCHOTHERAPY IN ROUTINE CLINICAL PRATICE.

E. Wennström.

University of Uppsala, Dept of Psychiatry, Ulleraker, Uppsala, Sweden.

**Background:** The efficacy of several approaches of psychotherapy is established, however, there is still a lack of research on the effectiveness of psychotherapy in routine clinical practice.

**Method:** All treatments started during 1996 (n=80) and given by selected psychotherapists in independent practice after referral from community clinics in Uppsala were evaluated. Psychiatric assessments of the patients were provided by the referring clinicians before as well as after treatment. Clinical outcomes were measured by changes in scores on the global assessment of function scale (GAF) (DSM-IV) and general severity index (GSI) on the Hopkins Symptom Checklist. Patient satisfaction with treatment was also assessed.

**Results:** From a subsample of 12 patients for whom complete clinical follow-up data were available in September 1997, a preliminary analysis indicated a significant gain in global functioning, by a mean increase of 10.1 in GAF scores. There was a nonsignificant decrease in GSI mean score. The mean lengths of the treatments were 20 sessions, with a range from 8 to 38 sessions.

**Conclusions:** The preliminary analysis indicated that psychotherapy was effective in routine clinical practice.



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**IS QUALITY OF DEATH POSSIBLE? MORTALITY LONG-TERM ADDICTS TAKING PART IN A METHADONE PROGRAMME. A FIVE-YEAR FOLLOW-UP.**

**Ruiz de Apodaka J.\*; Gutierrez M. \*\* ; Landabaso M.A. \*\*\***

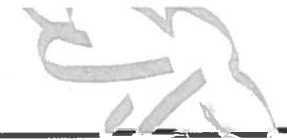
\* Methadone Program C.T.T. Vitoria-Gasteiz ; \*\* Psychiatric Clinic. Basque Country University ; \*\*\* Centre Drug Abuse. Bilbao. Osakidetza. A.P.C.A.D. SPAIN.

**OBJECTIVE:** Our aim was to study the mortality of patients with many previous treatment failures included in the Methadone Maintenance Treatment Program (MMTP) Vitoria-Gasteiz and the causes and circumstances of their deaths.

**METHODS :** We followed all clients entering the MMTP between 1992 and 1993 till February 1997. Standardized information on sociodemographic features, history of drug use, etc. was gathered in the MMTP, the Courts Forensic Medicine Department, local hospitals and prisons. Programme included urinalysis.

**RESULTS:** There were 28 deaths during the follow-up period (27 men, 1 woman). Their baseline characteristics on entry were: aged 22 to 35 (mean 28.46); HIV antibodies: (+) 27, (-) 1 , known for five years ; an average 11.32 years of heroin use ; maximum heroin-free period : 13 months ; 92.85% had been in court, 64.28 % in prison. The average daily dose of methadone chlorhydrate was 61 mg. Of the 28 , 89.28% (25) were receiving continuous care when they died (9 in hospital, 5 "hospital at home" service, 1 in AIDS home). Mean last hospital stay was 11.73 days (1-29). Mean last CD4 count was 171.38 (127.95 in the 23 HIV-related deaths, 504.33 in the 4 deaths from adverse drug reaction). The seronegative patient died in hospital from pulmonary embolus.

**CONCLUSIONS:** Continuous MMTP care until death enables family reconciliation and a better quality of dying.



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**PREVALENCE AND NEEDS ASSESSMENT OF THOSE WITH SEVERE MENTAL ILLNESS OUT OF CONTACT WITH SECONDARY MENTAL HEALTH SERVICES.**

**J Evans, G Evison, R Espisito, C Smith, \* T Croudace, D Sharp, G Harrison**

Division of Psychiatry, Bristol University, \*University of Nottingham

Prevalence estimates for cases of severe mental illness (SMI) who have had no recent contact with secondary mental health services are between 8-25%, but there are no reliable needs assessment data for these patients. We therefore carried out a case-finding study as part of the Bristol based Evaluation of Guideline Outcomes (EGO) study. Using the population covered by 30 General Practices (120 000) we identified, by a stepwise screening process all potential cases of SMI. Those who were known to have had contact with secondary services in the previous year were excluded.

Preliminary data indicate that 20% of the expected prevalent cases of SMI were not receiving specialist care. We will describe the process of case ascertainment, and report prevalence and needs assessment data for these patients.



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**PSYCHIATRIC MORBIDITY AMONG CONSECUTIVE  
ATTENDERS IN PRIMARY CARE: PREDICTORS  
OF ILLNESS AND GP DETECTION FROM 30 UK  
GENERAL PRACTICES IN THE EVALUATING  
GUIDELINE OUTCOMES (EGO) STUDY**

**\*T. Croudace, G. McCann, T. Deave, G. Evison, D. Sharp,  
G. Harrison, J. Evans**

Division of Psychiatry, University of Bristol, UK \*University of Nottingham

The Evaluating Guideline Outcomes (EGO) study in Bristol is a cluster randomised controlled trial involving 30 practices whose aim is to evaluate the development and local adaptation of the ICD-10 Diagnostic and Management Guidelines for mental disorders in primary care. One component of this evaluation involves assessing the effects of the introduction of guidelines on the detection and outcome of minor psychiatric morbidity among consecutive attenders (aged 16-65). We will profile the characteristics of consecutive attenders (over 1000 patients) surveyed during the baseline data collection period for the trial and describe the proportion of patients scoring above 3 on the GHQ-12. We will then report GP detection rates against this criteria for caseness and explore the characteristics of patients and GPs that either increase or decrease the likelihood of detection.

Preliminary data on 3 month outcomes may also be discussed.




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**DESIGN CONSIDERATIONS IN CLUSTER RANDOMISED  
TRIALS IN MENTAL HEALTH: ESTIMATES OF INTRA-  
CLUSTER CORRELATION FOR INTERVENTIONS AT  
THE PRIMARY/SECONDARY CARE INTERFACE**

**\*T. Croudace and P Jones**

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Interventions in Mental Health Services Research are often necessarily, or more appropriately, randomised at the level of clusters e.g. general practitioners or therapists, general practices or hospitals. This has implications for both design and analysis of intervention studies and in particular for power calculations. Since observations within clusters e.g. patients who see the same general practitioner, are likely to be more similar than patients selected at random, conventional sample size formulae for power will usually underestimate the number of patients required and will not give clear guidance as to the required number of clusters (practices, GPs or hospitals). Power formulae for cluster randomised trials require quantitative estimates of the similarity of patients within a cluster relative to the differences between clusters. This is typically quantified by an intra-cluster correlation coefficient (ICC). Although estimates of ICCs are required for cluster randomised trials in mental health services estimates of their magnitude are as yet unreported. We therefore present ICCs for a number of relevant scenarios of patients nested under clusters that can inform the development of future studies and/or improve their efficiency. Practical issues in the implementation of cluster randomisation are also addressed.



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## USE OF DOCTORS TIME. DIRECT AND INDIRECT TREATMENT OF PATIENTS AT A PSYCHIATRIC HOSPITAL.

**U. Søgaard and A. Lindhardt.**


Roskilde County Psychiatric Hospital "Fjorden", Roskilde, Denmark.

During a period of two weeks in May 1994 all twenty-seven doctors employed at the psychiatric hospital "Fjorden", made a diary-registration of how they used their time. 32% of total worktime was used for direct patienttreatment (doctor and patient were together face to face). Further 32% for indirect treatment (conferences, ward-rounds, report to social services, etc.). The remaining time was used for other purposes, as training, administration, supervision and research.

According to a quality assurance terminology standardized criteria for the lenght and number of treatment sessions were defined. The survey revealed that according to the criteria far too little time was spent on each patient per session and that number of treatment sessions with inpatients were low. Furthermore that most of the doctors time was spent in the acute phases of illness or in the outpatient care. The senior doctors used more time for administration and planning than junior doctors.

It is often discussed, whether doctors time should be used, mainly in the directly contact with patients or rather with indirectly and consultancy functions. The demands made on community psychiatry, involvement of relatives, etc., would rather tend to give rise to more obligations in the area of indirectly patientcontact and administrative procedures. However the effectiveness of in-patient treatment probably would be improved if more doctors time was allocated here.

The psychiatric hospital "Fjorden" has undergone great organizational changes throughout the last two years. There has been a buildup of new community psychiatric centers, and more doctors are employed. Thus a follow-up study with the same methodology was carried out in November 1996. Results from this will be presented in comparison with the results from the study from 1994.



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## NON-LINEAR RELATIONSHIP BETWEEN SOCIO-ECONOMIC DEPRIVATION AND NEW CASES OF SERIOUS MENTAL ILLNESS: A VALIDATION STUDY OF THE MENTAL ILLNESS NEEDS INDEX

**T. Croudace, P Jones and \*G. Harrison**

Department of Psychiatry, University of Nottingham \*University of Bristol.

Measures of population socio-economic disadvantage expressed as weighted deprivation indices have shown strong relationships with psychiatric morbidity in populations activity and provide the basis for indicators of need for services. In England the Mental Illness Needs Index (Glover, et al., in press) was developed to predict need for mental health services using data on the prevalence of admission rates from London populations.

We explore its generalisability to a non-metropolitan area (Nottingham) and an alternative indicator of need for services, all new cases of psychosis. Poisson regression was used to investigate the relationship at electoral ward level between the MINI and the incidence of psychosis, adjusted for the age and sex characteristics of the population.

The Mental Illness Needs Index was linearly related to the (natural) logarithm of the incidence rate over the range of MINI scores for Nottingham health district, implying that MINI is non-linearly related to the number of new cases of psychoses. This relationship may be useful in the planning of service innovations oriented to secondary prevention. It suggests that services for new psychosis (but possibly more generally) may be quite sparse in areas of low and medium deprivation but should target the most deprived areas.



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## CARE COSTS OF SCHIZOPHRENIA IN TWO DIFFERENT SMALL AREAS IN NORTHEASTERN SPAIN

Romero C, Madoz V, Cabasés J, Vázquez-Barquero JL, Haro JM, Salvador L.


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**Background:** Among mental disorders, schizophrenia implies a major burden on the health care system. The cost-incidence of schizophrenia in Spain is analysed in two scenarios with different health service systems.

**Methods:** Costs of patients with schizophrenia in the three years after the first service contact in an area with mental health community programs ("A": Burlada, n: 41) and one without ("B": Cantabria, n: 40). The assessment included clinical, social and disability aspects (GAF, SOFAS, DAS-s), as well as a standard description of services (ESMS).

**Results:** Sociodemographic and clinical characteristics were comparable in both subsamples, except time from onset to first health service contact. No differences were found in the outcome parameters in the three years after the first health contact. Global mean direct costs for the three-year period were, respectively, 722.810 pts., 354.602 pta. and 266.736 pta. Direct costs due to health and social care in scenario "A" were 35% lower than in scenario "B" in the first year, 16.4% lower in the second year and 12.2% higher in the third year. Cost distribution showed marked differences between both scenarios, mainly due to hospitalisation in scenario "B".

**Conclusions:** Direct costs related to health and social service utilization during the first three years after onset were higher in a scenario lacking intermediate mental health services. This finding suggests that not providing intermediate mental health care may lead to inefficiencies in the health care system. However, these findings should be regarded with caution, since informal care costs were not taken into account.



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## COST-EFFECTIVENESS ANALYSIS OF A HOME-BASED SOCIAL WORK INTERVENTION FOR CHILDREN AND ADOLESCENTS WHO HAVE DELIBERATELY POISONED THEMSELVES

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Centre for Health Economics, University of York, York, UK.

Attempted suicide is a serious health problem amongst children and adolescents and trends show it to be on the increase. Little evidence exists regarding the quality of available services for this group and less is known about the cost-effectiveness of these interventions. Without such research, it is impossible to determine whether limited child psychiatry budgets are being distributed efficiently, that is, directed towards those services that provide the greatest benefit, for the level of resources available. This paper describes the results of a cost-effectiveness analysis of a family-centred social work intervention for the treatment of young people who deliberately poison themselves and discusses the implications for mental health service providers.





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**PATIENT SATISFACTION AS AN INDICATOR OF QUALITY  
OF CARE: LIMITATIONS EXPERIENCED IN FOUR  
EVALUATIONS OF COMMUNITY PSYCHIATRIC  
SERVICES IN MONTREAL**

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Evaluation of patient satisfaction has been implemented since 1988 at the Douglas Hospital in Montréal. During these last 10 years, evaluation of patient satisfaction of acute care inpatient units (n=320), of outpatient clinical services (n=464), of crisis intervention services (n=80) and of primary care services in a Community Centre (n=59) have been assessed. Even when different protocols and tools were being utilized, results continued to present similar problems: 1) limitations of standardized scales which seem to underestimate dissatisfaction, 2) need to obtain valid norms and criteria to interpret satisfaction scores, 3) poor construct validity of many available scales which are not necessarily "multidimensional", 4) difficulties in evaluating mediating variables that influence satisfaction results, such as social desirability, perception of confidentiality, receptivity of protocols, and response style of patients, 5) complexity of protocols where expectations are measured in order to interpret satisfaction.

In each study, several procedures were implemented to address these problems, including: use of a qualitative approach in relation with the satisfaction scales, evaluation of expectations/service requests at the beginning of the treatment, development of specific multidimensional questionnaires and development of a validity scale to evaluate the tendency to report high satisfaction answers. Results of these procedures will be briefly reported in order to conclude with practical recommendations that aim at improving the utilization of patient satisfaction evaluation.



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**NEED FOR CARE IN A GROUP OF HEAVY USERS OF THE  
PSYCHIATRIC HOSPITAL SERVICES IN A DANISH  
COUNTY HOSPITAL.**

**L.F. Nielsen, G. Werdelin, L. Petersen.**  
Roskilde County Hospital Fjorden, Roskilde, Denmark.

The purpose of the study was to examine the need for care in a group of "heavy users" of the psychiatric hospital services with Camberwell Assessment of Need - CAN. Methods: All patients (63) in 5 districts, who at a specific date had been in contact with the Roskilde County Hospital Fjorden for at least 180 days in the preceding 1 1/2 year and had contact with the hospital for at least twice a week at the time for the interviews were selected for the study. Diagnostic and demographic data were obtained and the patients and the staff-members completed the Camberwell Assessment of Need - CAN. Results: 48 patients (76%) participated in the study. 62,5% were males. Mean age (SD) was 37 (13) years. 60% were diagnosed as schizophrenics. The second most common diagnosis was personality-disorders (21%). 52% had drug and/or alcohol abuse. None of the patients had own income. 17% had no accommodation. 67% of the patients with accommodation lived alone. According to the 26 topics in the Danish version of CAN the mean number of needs identified by the patients was 10.2 +/- 3.9 with a range from 1 to 18. The mean number identified by the staff-members was 12.0 +/- 3.8 with a range from 3 to 22. The patients seldom received help from friends and relatives except from the areas psychotic symptoms, psychological distress and company. Unmet needs assessed by rating of the adequacy of help were found to be low. In only three of the 26 areas more than 20% of the patients were found to have unmet needs. In 3 areas both the patients and the staff found that over 75% of the patients received the right type of help. Conclusions: In this study the heavy users of the psychiatric hospital services were found to be a heterogeneous group regarding diagnosis, age, living conditions and need for care. The hospital seemed to meet these patients need for care regarding the amount of help. This is not so obvious in regard to the type of help.



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## NEED FOR CARE IN A GROUP OF "DIFFICULT-TO -PLACE" PSYCHIATRIC PATIENTS IN A DANISH COUNTY.

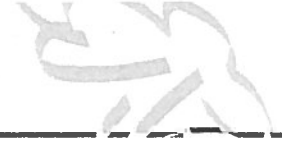
**L.F. Nielsen, L. Petersen, G. Werdelin.**

Roskilde County Hospital Fjorden, Roskilde, Denmark.

The purpose of this study was to make systematic need-assessments of the so-called "difficult-to-place" psychiatric patients in Roskilde County, Denmark in order to describe their need for care after discharge to a newly build institution in the county designed for this particular group of patients.

Methods: Based on the following criteria's 20 patients were selected: They all had a very long and continuous contact to Roskilde County Hospital, and none of them were found suitable to live in their own home or in sheltered accommodations in the community at the time of the study. Diagnostic and demographic data were obtained and the patients and the staff-members completed the Camberwell Assessment of Need - CAN.

Results: 70% of these patients participated in the study. Only 1 patient was woman. Mean age (SD) was 41 (12) years. All of the patients lived alone and they all received pension. The most common diagnosis was schizophrenia, complicated by drug and alcohol abuse. They lacked insight in their illness and in their violent behaviour. According to the 26 topics in the Danish version of CAN the mean number of needs identified by the patients was 11.0 +/- 4.4 with a range from 5 to 18. The mean number identified by the staff was 15.4 +/- 3.6 with a range from 10 to 22. The patients seldom received help from friends and relatives. They were all very heavy users of the psychiatric services. Conclusion: The patients were all seriously disabled. The services needed to this group of patients should be intense, massive, flexible and targeted.



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## NEEDS ASSESSMENT OF PEOPLE WITH MENTAL HEALTH PROBLEMS, IN THREE PSYCHOSOCIAL REHABILITATION CENTERS, IN PORTUGAL

**J. Gago**

Hospital Miguel Bombarda, Lisbon, Portugal

I'm going to present a study of needs assessment of psychiatric patients (n=51) on rehabilitation in three centres. The aim of this research was to determinate separately the needs identified by staff and patients and after to compare them, analysing the differences between this two points of view. The method was based in the application of the Camberwell Assessment of Need (Michael Phelan et al, Prism - Institute of Psychiatry, London), using the Portuguese version (CAN - Joaquim Gago, J.C. Almeida, M. Xavier, Psychiatric Department, Hosp. S. Francisco Xavier, Lisbon). With this instrument is possible to record separately staff and patients perceptions of needs, accepting that both are equally valid. This study concluded that there were significant differences, weak and negative correlation between needs identified by staff and patients, mainly in social areas, information about condition and treatment, intimate relationships, sexual expression and benefits.



## THE ASSESSMENT OF SUBSTANCE MISUSE IN SEVERELY MENTALLY ILL PATIENTS

**RA Laugharne, TP Burns and K Checinski.**

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The dual diagnosis of substance misuse and severe mental illness (SMI) affects engagement with services, treatment efficacy and prognosis. Detection of substance misuse in patients with SMI is needed to alert clinicians to this especially vulnerable group.

**Aim:** To compare keyworker assessments of substance misuse with patient self reports in a population of severely mentally ill receiving assertive community treatment.

**Method:** Subjects: Patients with a psychotic illness receiving care from an assertive community treatment (ACT) team in South London, UK (n=73).

**Data:** Patients interviewed using a standardised questionnaire of drug and alcohol use. The keyworkers completed the Clinician Drug/Alcohol Rating Scale (developed in the US for dual diagnosis) for each of their patients.

**Results:** According to the clinician scales 21.5% of patients had a substance misuse problem. The scale assessment correlated with patient reported daily consumption (Spearman coefficient:  $p=0.002$ ).

**Conclusions:** Keyworkers using ACT can detect dual diagnosis with satisfactory validity.



## CREATION AND INTRODUCTION OF A MANUAL ON CLINICAL PROCEDURES IN THE DEPARTMENT OF PSYCHIATRY IN GENEVA

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University Hospitals of Geneva, Geneva, Switzerland

### 1. Circumstances

The evaluation of the quality of care is fundamental concern and has been integral to the conduct of the Department of Psychiatry since 1994. A pilot experiment carried out at Psychiatric Clinic I allowed a manual on administrative and clinical procedures to be drawn up. It contains guidelines for the organization of care and for care procedures. Included in each subject are the underlying philosophy, the general objectives and the procedures practiced in the Service as well as the attribution of responsibilities. It constitutes a reference book for the Units and teams.

### 2. Drawing up the Manual

Service staff met for two hours every two weeks over a 6-month period to put together and write this manual (using playscript techniques). Each heading was prepared from pre-existing documents, legislation, official regulations and adaptations of foreign manuals. The group discussed and corrected the document as it was assembled. A consensus was arrived at on the various standards to be applied by both psychiatrists and other professionals. The Head of the Department gave his approval to the manual. Each year, the same procedure allows it to be updated.


### 3. The Content

The manual contains descriptions of procedures to be applied in the following areas:

- a. general service procedures, b. description of clinical job positions, c. admission and clinical evaluation of the patient
- d. ongoing evaluation during therapy; e. search for and collection of information for the patient; f. events occurring during treatment; g. nurse manual

### 4. Introduction

After a trial-period within the psychiatric clinic 1, the Manual was reviewed and discussed and will be applied throughout the Department of Psychiatry.



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## EVALUATION OF THE PSYCHIATRIC REFORM IN SWEDEN

**C.-G. Stefansson, P. Brusén, L. Steinholtz-Ekecrantz**  
The National Board of Health and Welfare, Stockholm, Sweden

1995 the psychiatric reform was implemented in Sweden meaning that all social needs of the long-term mentally ill patients should be taken care of by the social services and not by the psychiatric care organization. Approximately 4000 patients living at nursing homes and hundreds of day care and rehabilitation units were transferred to the social services. The money followed patients and units and the psychiatric care organization lost some 15% of the budget. New laws and a state subsidy directed to the counties of about £12/inh would reinforce the process.

An evaluation programme was established at the National Board of Health and Welfare. This programme included qualitative as well as quantitative methods. Case register studies including for example the whole psychiatrically treated population in Sweden were combined with case studies directed single patients or activities. The poster describes the state of the art concerning psycho-social treatment of the long term mentally ill in Sweden, the content of the reform as well as results of the evaluation of the reform.



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## LIAISON PSYCHIATRY IN PRIMARY CARE A GP'S PROFILE TOWARDS MENTAL HEALTH

**F. Peres Rodrigues, J.M. Caldas de Almeida**  
Hospital S. Francisco Xavier, Department of Psychiatry and Mental Health. Lisbon, Portugal.

A descriptive study of the Primary Care GP's profile towards Mental Health, working in the catchement area of the SFX Hospital, was performed.

All 145 GP of the catchement area were considered. Of those, 141 were included in the study. 122 of the 135 inquired GP answered a questionnaire specially elaborated for the study of their attitudes and beliefs towards Mental Health.

The 135 inquired GP were personally contacted in their Primary Care setting during a two months period. Each one of them had one month to answer the questionnaire.

The questionnaire questions: GP training in Mental Health, their interest in the subject, estimated prevalence of psychiatric disorders in Primary Care, use of psychotherapeutic drugs, duration of the symptoms, mode and timing of the referrals, interest and disposability to different liaison models and beliefs towards Mental Health.

The answers show different GP's profiles, a lack of training in Mental Health with all its consequences and provide clues to the development of a better liaison between GP and the Psychiatric Service of SFX Hospital.



## DISSEMINATION AND IMPLEMENTATION OF RESEARCH FINDINGS. A EUROPEAN PERSPECTIVE

Liz Brooks and Graham Thornicroft

PRISM. Institute of Psychiatry, London, U.K.

Aims: Although there is an increasing emphasis on evidence-based health care in health policy internationally, there is a scarcity of evidence on how to get research findings into clinical and managerial practice. We describe some initiatives, based on available research evidence on dissemination, which we have conducted to increase the impact of our research on practice. We aim to use these to effectively disseminate the results of our current European projects.

Method: The following methods have been used to disseminate research.

- Professionally published newsletter circulated to 23,000 health professionals giving resumes of recent research findings.
- A booklet and video targeted to carers of people with schizophrenia, produced in-house but commercially packaged for distribution.
- Publication and distribution of a computer programme (MINI) for planners and purchasers of residential places for mental health.
- Setting up of a joint health service/academic department dissemination working party.
- Focus group based study to determine information needs of managers and clinicians in the south of England

### Outcome:

- The newsletter was circulated to 23,000 health service managers at a cost of £7,000. The MINI software packages were effectively publicised through the newsletter, but the overall cost-effectiveness of the exercise is in doubt.
- The booklet and video package was highly effectively distributed by using a pre-existing commercial distribution network. It was also taken up by the National Schizophrenia Fellowship for use throughout the UK.
- The working party developed a strategy for disseminating existing research findings to local services by creating new channels of communication.
- Focus groups established clear priority areas for managers and clinicians, and new channels for information emerged, resulting in production of information resource.

### Conclusion

We have developed a knowledge base in dissemination through a number of projects. These methods of dissemination have wide applicability to Health Services Research in the European Community. Our experience will be discussed with particular reference to the EU Biomed Study into Costs and Needs for Care in Schizophrenia.



## REHABILITATION IN SHELTERED HOUSING: EFFECTS OF PROCESS-STANDARDISATION ON CLIENT PARTICIPATION, QUALITY OF CARE AND CLIENT SATISFACTION

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There is hardly discussion about the desirability of client participation in rehabilitation. The extent to which clients actually participate is rather disappointing, however. This discrepancy between supposed and actual participation can partly be explained by the lack of a clear view on the meaning of participation. This implies that a more methodical approach to client participation is required.

In Rotterdam a methodology has been developed to facilitate client participation. It focuses on the process of rehabilitation rather than the type of care provided. A structured rehabilitation plan was developed which should guarantee that the appropriate issues are addressed in care balancing.

From 1992 on this protocol has been applied in a organisation for sheltered housing in Rotterdam (n=325). The issues that were raised by the clients differed from those that were put forward by the staff. Mutually agreed goals by both the client and the member of the staff were most likely to be effectively solved. Participation and satisfaction have been shown to increase as a result of the protocol. The application of the methodology will be further studied in a Finnish, German and a Belgian organisation for sheltered housing. The protocol, its effects and the design of the European pilot-studies will be presented at the conference.



## PERCEIVED COERCION DURING HOSPITAL ADMISSION

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Aims: Patients may feel subjectively coerced by hospital admission whether or not objectively coercive measures such as legal compulsion or physical force are used. Services should minimise the experience of coercion on ethical grounds, and because community treatment after discharge from hospital, which depends on collaboration with the patient, may be impeded by the legacy of coercive admissions. The MacArthur Foundation in the US have developed measures of perceived coercion, and 'voice' (procedural justice). We aimed to:

- Adapt scales developed in the US for use in a UK sample
- Measure perceived coercion and 'voice' in a sample of patients admitted to an acute psychiatric unit in London
- Investigate the relationship between coercive experiences at admission and subsequent engagement with community treatment.

Methods: Consecutive admissions to a catchment area acute psychiatric unit were approached for interview within 72 hours. The Admission Experience Survey developed by the MacArthur Coercion Study was completed together with a semistructured interview. Demographic and service use information, and data on objective coercion (e.g. arrest, forcible medication, detention) were obtained from case note. Clinical ratings were obtained from nursing staff.

Results: We report the results of baseline interviews.

- 100 patients were interviewed, a response rate of 85%
- The mean age was 39, 40 had a diagnosis of schizophrenia and 33 of other functional psychoses, 80 had been admitted to hospital previously, 48 compulsorily, and the mean number of previous admissions was 6.5
- 32 were compulsorily detained prior to interview and the remainder were voluntary patients.
- Of those who were voluntary, nearly half believed that they would have been compulsorily detained if they had not agreed to admission.
- Half of the patients had a high perceived coercion score, 80% of those who were compulsorily detained had a high score, as did 34 percent of those who were not.
- High perceived coercion scores were negatively correlated with 'voice' scores.

Conclusion: Patients admitted to this inner city acute unit often feel coerced, in some cases despite their voluntary status. This may relate to their perception that they have no 'voice' in the decision making processes relating to their care. Ways in which this can be addressed for both voluntary and compulsorily detained patients, and the implications for community treatment, will be discussed.



## A SATISFACTION SURVEY IN TWO DIFFERENT TYPES OF ACUTE WARD: RESULTS AND METHODOLOGICAL CONSIDERATIONS

N Greenwood, T Burns, A Key, M Bristow

St Georges Hospital Medical School London England

433 inpatients in either a large specialist psychiatric hospital (80%) or a smaller unit attached to a district general hospital (20%) were interviewed using both the Client Satisfaction Questionnaire (CSQ) and a longer questionnaire designed and piloted with the help of a hospital focus group. This questionnaire contained one question on 'overall' satisfaction. The majority of patients in both sites reported themselves satisfied and the score on the 'overall' satisfaction correlated strongly with the CSQ score. In those who scored dissatisfied or neutral on the 'overall' question problems in various areas were identified using the longer questionnaire. Conclusions: A single 'overall' question is as useful as the CSQ and can be used to screen for dissatisfied or neutral patients whose areas of dissatisfaction can then be probed with a more detailed and specific instrument.

t h e m e



**THE MEASUREMENT OF QUALITY  
OF LIFE IN MENTAL HEALTH**

**I N T R O D U C T I O N**

W O R K S H O P S

P R O S P E C T S F O R T H E F U T U R E

P E R S O N S T E R S



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## NEW PERSPECTIVES IN QUALITY OF LIFE MEASUREMENT

**H. Katschnig**

Department of Psychiatry, Vienna, Austria

While the treatment of symptoms and diseases is the traditional aim of medicine, the improvement of „Quality of Life “ is increasingly regarded as a major purpose of health care. The issue has first come up in chemotherapy for cancer, where many patients decide to live a shorter but better life. Basically, quality of life is a subjective issue, stressing the patient's point of view and his subjective well-being, as opposed to professional evaluations of the patient's health status. While the quality of life concept has an intuitive appeal and integrative power for all those concerned with health care - patients and their families, professionals, administrators, politicians and the general public - it is scientifically still „soft“. Much progress has been made though in recent years in measuring quality of life for the purpose of outcome evaluation in general medicine and for the assessment of needs of sick individuals and of populations. Psychiatry has somehow lagged behind this development, mainly because of the intrinsic problem, that subjective evaluations are potentially misleading in a number of psychiatric states. Katschnig (1997) has identified four methodological fallacies in the subjective assessment of quality of life in psychiatric patients (the affective, the reality distortion, the cognitive and the standard drift fallacy) and has concluded that in psychiatry a broader approach has to be used: besides subjective well-being, also functioning in daily activities and in social roles, as well as the material and social environment should be assessed. When evaluating outcome in intervention studies the different possible speeds of changes in these domains should be considered (subjective well-being can change and fluctuate rather quickly, role functioning and environmental conditions are slower in this respect). In addition, the views of relatives and of close friends, and also of professionals who know the patient well should be included in a comprehensive assessment of quality of life of psychiatric patients, especially of those living in the community. Available research instruments will be discussed in view of these methodological issues, Katschnig, H., H. Freeman, N. Sartorius (eds.): Quality of Life in Mental Disorders. John Wiley & Sons, Chichester New York (1997) 3-16.



t h e m e



**THE MEASUREMENT OF QUALITY  
OF LIFE IN MENTAL HEALTH**

I N T R O D U C T I O N

**W O R K S H O P**



P R O S P E C T S F O R T H E F U T U R E

P O S T E R S




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## PERSISTENT FEATURES OF QUALITY OF LIFE IN WORKING AND NON-WORKING PSYCHIATRIC SERVICE USERS

**J. Schneider,**

PSSRU, University of Kent at Canterbury, Kent, UK.

Identification of the essential elements of quality of life for users of psychiatric services could guide intervention and evaluation. This paper uses a meta-analytical approach to the results (but not the data) of four studies of people with long term mental health problems to draw out some consistent findings. All used OLS multiple regression analysis to identify the variables associated with outcomes defined as quality of life. In a seminal study, Anthony Lehman (1983) used as the dependent variable Global Well-Being from his Quality of Life instrument. A similar approach was taken by Levitt et al. (1990) and Sullivan et al. (1992). Most of the subjects in these three studies were not in employment. Here, comparisons are made with a study of 93 people attending specialist work schemes conducted by the author and colleagues (Schneider and Hallan, 1997). By imposing upon the findings of all four studies a theoretical framework derived from Maslow (1971), clearly consistent results emerge. While these may be partly attributable to the instruments used, they nevertheless suggest a core set of considerations which are crucial to quality of life. Implications for service provision and evaluation will be discussed.




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**QUALITY OF LIFE AS AN INTEGRATED OUTCOME  
MEASURE : THE EXTENDED DUTCH VERSION OF  
THE LANCASHIRE QUALITY OF LIFE PROFILE.**

**Ch. van Nieuwenhuizen, A.H. Schene, M.W.J. Koeter**

Frederik van Eedenstichting, Research & Development Department.  
Amsterdam, The Netherlands.

The objective of our presentation is to make a contribution to the discussion about the applicability of 'quality of life' as an integrated outcome measure for the effectiveness of care. First of all, we will discuss the developmental process of the extended Dutch version of the Lancashire Quality of Life Profile (LQoLP). Then, we will discuss the psychometric properties of the extended LQoLP for which the data of 606 respondents from 10 different settings were available - ranging from respondents in ambulatory care to hospitalised patients. Finally, we will discuss possible applications of the extended LQoLP. To this end, two possible ways to present quality of life data are explored: using mean scores and percentages of people with a low quality of life score. The advantages and disadvantages of both approaches are mentioned and it is explained that - at the group level - the use of percentages is to be preferred. Thereupon, we will present several quality of life profiles based on general and objective features of our research population (mental health care facility, gender, and so forth).



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**QUALITY OF LIFE OF THE MENTALLY ILL. RELIABILITY  
OF THE SWEDISH VERSION OF THE LANCASHIRE  
QUALITY OF LIFE PROFILE.**

**L. Hansson, B. Svensson, T. Björkman.**

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

There has been a growing interest in the quality of life of the mentally ill, and a number of instruments to measure quality of life have been developed. One of the measures of quality of life which has received considerable attention is the Lancashire Quality of Life Profile (LQOLP).

The present study investigated test-retest reliability and internal consistency in the Swedish version of the LQOLP, using a cross-sectional sample of 29 patients admitted to inpatient psychiatric services. The time interval between the interviews were 2 weeks. The same interviewer performed both interviews with the patient. The results showed that test-retest reliability of subjective life satisfaction in the nine life domains covered by the LQOLP was satisfactory in seven of the domains, and acceptable in two, social relations and religion. Test-retest reliability for total subjective satisfaction score, global well-being, and the interviewer rated quality of life measure were all on a satisfactory level ( $r > .80$ ). The internal consistency and homogeneity of the total subjective quality of life scale and the nine life domain subscales was satisfactory, except for the social relations scale where it was somewhat low.



## COMPARISON OF QUALITY OF LIFE IN UK AND GERMAN SAMPLES

**Sherril Stone.**

University of Manchester, UK

This presentation will compare the quality of life (QOL) of people with severe mental illness, from 3 data sets - 2 UK samples and a German sample. The first of the UK samples (n=706), provide psychotic cases drawn from a study of intensive versus standard case management, whereas the second UK sample (n=1279) consists of long-term psychiatric cases drawn from the open caseloads of health and social services workers in the community. The German cases consist of 5 groups of schizophrenics (n=386) from Berlin and includes in-patient (n=243) and out-patient (n=143) groups. Assessments were made using the Lancashire Quality of Life Profile and its German equivalent Berliner Lebensqualitätsprofil.

The purpose of this study is to establish whether there are:

- consistent similarities of differences between socio-demographic and quality of life data.
- consistent effects of mood/depression upon subjective well-being.
- effects upon subjective well-being caused by intellect, side effect insight.
- predictive attributes of objective data (material circumstances) in relation to global well-being.
- consistencies or variabilities in the internal factor structure of the Lancashire Quality of Life Profile.

The results support the view that depression is an important but not dominant influence upon subjective well-being. The effect of depression is to reduce well-being ratings across all life domains but still permits the individual to distinguish between domains, to the same extent as non-depressed groups.

The groups differ in some demographic respects but are very similar in terms of their internal structure. 40% of the variance in the factor analysis is explained by subjective well-being ratings which suggests that other determinants, such as objective and material circumstances and perhaps personality are important.

The data reported is cross-sectional. However, the 2 UK samples offer the potential for exploring changes in QOL over time. Data may be available in time to report some complementary findings from this follow-up element along with the main findings of this paper.



## QUALITY OF LIFE AND DEPRESSION: GENDER DIFFERENCES

**J. Bobes<sup>1</sup>, E. Baca<sup>2</sup>, L. Casais<sup>3</sup>, M. Roca<sup>4</sup>, MP. González<sup>1</sup>**

Universidad de Oviedo, <sup>2</sup>Universidad Autónoma de Madrid, <sup>3</sup>Universidad de Cádiz, <sup>4</sup>Universidad de Palma de Mallorca, Spain.

**Objectives:** To determine quality of life gender differences in a group of depressed outpatients.

**Method:** A six months, observational, multicentre follow-up study was carried up. Out of the 985 patients who entered the study, 729 remained at the end of above period. Complete quality of life data is available for 692. Evaluation was made using the Hamilton Depression Rating Scale (HDRS), the Clinical Global Impression (CGI) and the SF-36. Statistical analysis was made using the Wilcoxon test.

**Results:** Sociodemographic Data: Mean age 47.3 (SD 13.4), 71% females, 69.5% married, 55.6% had completed Spanish "primary" education (up to 14 years of age), 56.1% employed. Basal Clinical Data: Diagnosis: depressive episode 42.7%; recurrent depressive disorder 37.6%; dysthymia 19.7%; CGI: mild 5.4%; moderate 49.8%; severe 33.7%, very severe 11.1%; HDRS: males 24.2, females 23.1 (p.01). Quality of life: At baseline women presented significantly worse scores on two of the 8 scales of the SF-36: physical functioning (55.1 vs 61.4, p.001) and pain (56.5 vs 63, p. 004). After 24 weeks statistical significance was maintained on the scale of physical functioning (84.2 vs 86.1, p01). No significant differences were found in the improvement of quality of life according to gender.

**Conclusions:** In spite of the lower severity of the depressive disorder, depressed females presented a worse quality of life in physical functioning terms than males.



THE NEEDS AND QUALITY OF LIFE OF AN  
EPIDEMIOLOGICALLY REPRESENTATIVE COHORT  
OF PEOPLE WITH PSYCHOSIS

**Mike Slade, Morven Leese, Ruth Taylor, Graham Thornicroft**  
PRISM, Institute of Psychiatry, London, England.

Care in the UK is provided for the severely mentally ill on the basis of need, with quality of life (QoL) used as an outcome indicator. This assumes that level of need predicts quality of life, an assertion that is investigated in this study. 133 psychotic patients completed the Camberwell Assessment of Need (comprising staff and patient ratings of met and unmet need) and the Lancashire Quality of Life Profile (comprising staff and interviewer ratings of QoL).

The data were analysed using multiple regression and covariance structure modelling (Bentler-Bonett normed fit index 0.930), and produced four main findings. Firstly, patients rated about 0.7 more total (met plus unmet) needs than staff, mainly due to differences in rating unmet need. Secondly, of the sociodemographic and illness variables, only increasing age and a non-schizophrenia diagnosis were associated with QoL (both positive effects). Thirdly, patient ratings were more reliable than staff ratings of unmet need and QoL. Fourthly, both underlying unmet need and met need were negatively associated with underlying QoL but unmet need was the stronger relationship. These findings underline the importance of ensuring that the patient's perspective about their difficulties is central to the process of planning and providing mental health care.

A LONG TERM COMMUNITY FOLLOW-UP STUDY OF  
PEOPLE WITH SEVERE MENTAL DISORDER IN THE UK

**Susan Knight.**  
University of Manchester, UK

The purpose of the study is to investigate the changes in the quality of life (QOL) of people with a severe mental illness when they are discharged into the community and their health and social care status in the community after 4 years.

Two groups of patients, old long-stay patients who had been in a mental hospital for more than 1 year continuously (n=98) and new long-stay patients who had been in contact with community psychiatric services for more than 3 years (n=168), were assessed at the beginning of the study in 1992 (total n=266). The assessments were made using the Lancashire Quality of Life Profile (LQOLP). Four years later 218 patients were reassessed using the LQOLP. In addition, the services used by the patients, and whether they received organized after-care and their use of physical health care resources were all assessed. This paper presents the results concerning the use of services and physical health status of the patients. In general, very few were receiving comprehensive care and many were unaware that they had been the subject of care planning. In line with other studies approximately half of the subjects had physical health problems. A small group of patients consumed a disproportionate amount of health care resources with high costs to general hospital services. For example, in one extreme instance a patient made more than two dozen visits by emergency ambulance (costing several hundred pounds sterling each time) to the hospital A & E department.

In conclusion, the results are discussed in respect of both the new and old long-stay patients, the costs to general health care services, the implications for the integration of health and social care services, and attempts to maintain or improve QOL for these patients in future.



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## THE COMPEER MODEL IN THE NETHERLANDS. A NEW PHENOMENON IN MENTAL HEALTH CARE.

**N. van Erp, K. Geelen.**

Trimbos Institute (Netherlands Institute of Mental Health and Addiction),  
Utrecht, The Netherlands.

This article describes the results of a study on the Compeer model in mental health care. In the Netherlands a network of over 25 Compeer programs exists and their number is still increasing. The focus of our study was on the Compeer philosophy, the organizational types, the guidance process and the obstacles to implementation. The philosophy of the programs is similar: volunteers are matched with people with a mental illness and they undertake all kinds of activities. The aim is to decrease their isolation and improve their quality of life. The model is based on rehabilitation principles: the client learns the skills that are necessary to reintegrate in the community. A significant difference in the organization of the Compeer programs is their positioning. Some programs are imbedded in mental health organizations, others choose to operate outside the professional circuit: they stay independent or affiliate themselves to general welfare services. The main obstacle to implementation of the Compeer model is insecurity: while most programs are financed for a limited period of time the staff is unable to make plans in the long term.



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## THE EVALUATION OF QUALITY OF LIFE IN SECURE PSYCHIATRIC SERVICES.

**J. Oliver, M. Swinton, J. Carlisle.**

National Health Service Executive, Department of Health, Warrington, United Kingdom

The workshop reports on work in progress developing a simple, robust QOL measure for use in secure psychiatric settings and then employing the instrument in a study of UK patients. Future service studies will be able to use this measure as a key outcome indicator. The study plan involves interviewing a random selection of 50 patients from a maximum security hospital as well as 50 patients from a network of high dependency hospital facilities, both in the north-west of England using an unmodified version of an established instrument, the LQOLP. Poorly performing questions and domains are being identified and rewritten or replaced to produce a set which best captures the variations in well-being. Statistical results are being confirmed against information obtained through both professional and patient focus groups. Also, the LQOLP is being compared with a standard mental state rating (PANSS). Following refinement, the instrument is being repiloted on a second set of 50 high security and 50 high dependency patients. To make the information more easily recordable and accessible, the new QOL measure will be computerised utilising a platform now being developed and piloted in the UK called the Lancashire Quality of Life Analytical Support Software for Windows (Oliver and Harris, 1997, DoH).



**THE OUTCOME OF INDIVIDUAL REHABILITATION TRAINING ON NEED FOR CARE AND QUALITY OF LIFE.**

**JT VanBusschbach, D Wiersma.**

Department of Social Psychiatry, University Hospital Groningen, Groningen, The Netherlands.

In this service-evaluation 50 patients in rehabilitation training were interviewed at the beginning of the training and 6 months later. The training was formatted along the lines of the Boston school (Anthony, Farcas). Our research questions were:

- What are the specific needs of group coming for training, in comparison with a sample of 100 long term users of psychiatric care?
- How is need for care, quality of life and the social situation (work, housing, social relations) of the trainee effected as a result of the rehabilitation training?

The Camberwell Assessment of Needs 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. To shed more light on differences in the 'success' of individual rehabilitation training, 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.

t h e m e



**THE MEASUREMENT OF QUALITY OF LIFE IN MENTAL HEALTH**

I N T R O D U C T I O N

W O R K S H O P S

**PROSPECTS FOR THE FUTURE**

O U T L O O K



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## FUTURE PERSPECTIVES ON QUALITY OF LIFE MEASUREMENT

**Peter Huxley and Susan Knight**

University of Manchester, UK

This presentation will be in two parts. The first part will be a brief summary of measurement issues as they apply to the assessment of the quality of life of people suffering from severe mental illness. Among the issues that may be are the following:

The measurement of QOL in people with cognitive impairment.

What QOL measures are best for demonstrating change?

Is subject response influenced by knowing the interviewer?

In what way can QOL measurement be made suitable for operational purposes.

How should we take account of the influence of depression?

How can objective summary measures be developed and employed?

Is there a need to include measures of self-esteem as part of QOL assessment?

Which aspects of QOL measures predict resource utilization?

The second part of the presentation will consider those issues that have arisen during the course of the workshops and which are considered relevant to the following themes:

Research into QOL

Management of services using QOL as an outcome indicator

Political aspects of QOL assessment

User and carer perspectives.



t h e m e



**THE MEASUREMENT OF QUALITY  
OF LIFE IN MENTAL HEALTH**

I N T R O D U C T I O N

W O R K S H O P S

P R O S P E C T S F O R T H E F U T U R E

**P O S T E R**





## THE LIFE SITUATION FOR THE LONG TERM PSYCHIATRIC ILL IN THE COUNTY OF STOCKHOLM SWEDEN.

**O. Lönnberg,**

Community Mental Health Center, DANDERYD (Stockholm),  
County of Stockholm, Sweden.

**M. Sundgren.**

Department of Social Medicine - Socialmedicin Kronan, SUNDBYBERG (Stockholm),  
County of Stockholm, Sweden.

One psychiatrist (OL) and one social worker (MS) were commissioned by the Swedish Ministry of Health, the County of Stockholm and the Stockholm County Association of Local Authorities, to interview a sample of long term psychiatric ill people in the county of Stockholm Sweden. We performed our interviews in different parts and settings in the county from the remote parts to inner the city of Stockholm - from out-patient clinics to sheltered livings.

Very many dropped out of the interviews. 16 patients/clients accepted in the end to be interviewed for one - two hours about their life situation.

Some themes were expressed regardless of diagnosis, sex, age, community or setting:

- The suffering was connected with traumatic life-events
- The feeling of being abandoned and lonely
- Being "hospitalized" in an out-patient setting
- The television set as substitute for relations
- Work as possibility or anxiety
- Change - a slow and frightening process
- Lack of "sense of coherence and meaning"

We would like to discuss the short-comings from both the mental health professionals and the social workers to support the long term psychiatric ill and give some ideas how to avoid some common problems.



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**“PEDAL POWER FITNESS PROGRAMME”  
AN EVALUATION OF A CYCLING PROJECT  
FOR ADULTS WITH MENTAL RETARDATION.**

**S. Williams, A. K. Thomas.**  
Ely Hospital, Cardiff, Wales, UK.

Several British government health strategies have identified the importance of exercise in achieving healthgain. Cycling was chosen as a form of exercise to improve fitness, mobility and quality of life for a group of adult patients with mental retardation in Cardiff, Wales and a specialist cycling project was developed. Specific fitness parameters were measured and skill handling techniques assessed. Psycho-social measurements were introduced after a three month period.

Results showed an overall improvement in fitness and psychosocial skills. The project resulted in an enhanced quality of life for individuals.

This project could be extended to a wider group of people with a mental retardation, particularly those who need to improve their level of fitness or who lack a purposeful activity.

It is recommended that further study is undertaken to determine whether cycling improves the behaviour of people with a mental retardation who display challenging behaviour. It is suggested that a similar cycling project could successfully be extended to other client groups such as those with a chronic mental illness such as schizophrenia or physical disability.



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**THE EXPERIENCE OF FAMILIES OF PATIENTS WITH  
SEVERE MENTAL ILLNESS**

**K Harvey, T Burns**  
St George's Hospital Medical School, London, UK

Many relatives of patients with severe mental illness perceive their caregiving role as a burden, and some experience high levels of distress. This study examines the assumption that the bulk of caregiving responsibility falls mainly upon one family member. In families where there are multiple carers the responsibilities associated with caregiving may be shared and levels of distress reduced.

**Method:** All relatives in frequent contact with patients (N=49) were interviewed using the Involvement Evaluation Questionnaire and the GHQ-12. Relatives were divided into three groups: single carers, primary carers in a multiple carer family and secondary carers in a multiple carer family.

**Results:** Preliminary findings indicate that the three carer groups do not differ significantly on the four domains of caregiving: tension, worrying, supervision and urging, nor does the amount of distress they experience differ.

**Conclusions:** Whilst the responsibilities associated with caregiving do not fall upon one individual alone, having a greater number of relatives involved in caring for a patient does not reduce the amount of distress experienced by each.



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## SOCIAL SKILLS TRAINING FOR CHRONIC SCHIZOPHRENIC PATIENTS

(COMPREHENSIVE STUDY)

Maryla Sawicka

Institute of Psychiatry and Neurology, Warsaw, Poland.

The aim of this paper is to describe the cognitive-behavioral methods for social rehabilitation and psychotherapy of chronic schizophrenic patients. Our study shows the influence of a comprehensive social skills training program on positive and negative emotions intensity of chronic schizophrenic patients. Comprehensive rehabilitation program using social skills training methods corresponding to the social readaptative "modules" from Liberman and Wallace's Social and Independent Living Skills Program - "medication management module, "conversational skills module", "interpersonal problem solving skills module". We noticed the evolution of social skills and functioning of schizophrenic patients having benefited from this program, and we compared results regarding dynamics of positive and negative emotions intensity with two other schizophrenic patients control groups. Results indicate a clear dissociation between direct benefits of social skills training-knowledge, social skills, social functioning and symptomatology. These all show a significant improvement in the experimental group. Subjective benefits are constant, as well when considering intra-group as well as between group comparison.



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## PSYCHOLOGICAL FACTORS AND PERSONALITY TRAITS IN PATIENTS ADMITTED AT AN INTENSIVE CARE UNIT.

Ruiz Ruiz M.\*, Bedia Gómez M.A., Rodríguez-Rosado A.,  
Leûn Macía M., Carpintero Avellaneda J.L., De la Torre Prados M.V.

\* Chairman of Psychiatry. University of Málaga, Spain.

With the introduction of the term Consultation-Liaison Psychiatry (partially replacing that of Psychosomatic Medicine) the conviction is that psychological factors are important in the development of cardiovascular diseases. We used a longitudinal design and assessed personality traits, basic attitudes, quality of life, life events and emotional state in patients suffering from the first myocardial infarction. The findings, with an absence of association between emotional state (measured by Hamilton Depression Rating Scale and Hamilton Anxiety Rating Scale) and life events occurred in the last year (Social Readjustment Rating Scale) lead to consider the role of specific traits of personality and defence mechanisms in the emotional response, hypothesis that would be sustained by the results in the MMPI (Minnesota Multiphasic Personality Inventory), the EMDB II (Basic Mechanisms of Defence Scale) and the Quality of life Measurements (Bech, 1993).

Key words: myocardial infarction, quality of life, life events, personality, defence mechanisms, emotional reaction.



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## QUALITY OF LIFE IN MAJOR DEPRESSION: A STUDY USING THE WHOQOL-100

H. Matschinger, R. Kilian, K. Stengler-Wenzke, M.C. Angermeyer

Department for Psychiatry, University of Leipzig, Germany

The purpose of this study is first to compare patients suffering from major depression (n=105) with those suffering from schizophrenia (n=22) or somatic diseases (n=150) as well as with a random sample of the general population of the city of Leipzig (n=325) with respect to the 6 dimensions of the WHOQOL-100 questionnaire. There is not much difference in the QoL between depressive and schizophrenic patients but considerable difference compared to the other two study groups. Secondly, we explored the development of QoL after discharge depending on the severity of depression. A 7 month follow up study with 3 points in time (1, 3 and 6 month after discharge) was conducted for 118 inpatients with depression (ICD<sup>10</sup> F31-F34). Depression was measured by the SCAN-PSE 10 which yields a 4-point graded scale for the extent of major depression. Patients were then allocated to three groups according to whether their diagnostic status had improved, deteriorated or remained unchanged over time. It can be shown that for depressive patients, a deterioration of symptoms results in an overall decrease of QoL, whereas a reduction of symptoms has a positive effect only on the psychological domain of the WHOQOL-100.



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## THE RELATIONSHIPS BETWEEN COMPONENTS OF SOCIAL SUPPORT AND QUALITY OF LIFE IN SEVERELY MENTALLY ILL: A COMPARATIVE STUDY

Jean Caron, Raymond Tempier, C line Mercier.

Département des sciences du comportement, Université du Québec,  
Québec, Canada.

Baker et al. (1992) have shown an increase in satisfaction with life domains over time for psychiatric patients who have increased their availability of social support and for those who have maintained adequacy of social support. However, in order to plan specific interventions in mental health program with more efficiency, another step has to be taken; it appears quite important to identify precisely which components of social support seem to be the most related to quality of life and to which specific aspects of it. This study will examine the pattern of relationships between components of social support and dimensions of quality of life of chronic mentally ill patients, low income individuals and for the general population. Satisfaction with social support and quality of life were assessed for 60 psychiatric patients, 79 welfare recipients and 266 people of the general population with the Social Provisions Scale (SPS) and the Satisfaction with Life Domains Scale (SLDS). Psychiatric patients showed less satisfaction than population on all components of social support. They have a comparable level of satisfaction with the low income population on most of the components except with the provisions which permit emotional integration and opportunity of nurturance. However their level of satisfaction with quality of life is quite similar to the general population and even higher in some dimensions than the welfare recipients. Their lower satisfaction with the personal-intimate dimension in QOL, confirm their deficiencies in social support. All components of social support were consistently related to dimensions of quality of life in general population. Attachment and reassurance of worth were systematically related for psychiatric patients, but only attachment was related to dimensions of QOL for the low income group. Finally a discriminant analysis has shown that the pairing of SPS and SLDS scales, permits the discrimination of 75% of the psychiatric patients among other groups.



## QUALITY OF LIFE IN THE CLIMATERIC PERIOD

A. del Fresno, MP. González, PA. Sáiz, M. Bousoño, J. Bobes

Area de Psiquiatría, Dpto. de Medicina, Universidad de Oviedo, España.

**Objectives:** To determine the quality of life level in the climateric period, and also differences in quality of life according to the demand for specialised treatment or not.

**Method:** A transversal observational study was made. Three groups were established: group 1: females requesting assistance in the Menopause Unit of Hospital Central of Oviedo (n=73); group 2: post-menopausal females who attended screening for breast cancer in Hospital Monte Naranco (n=171) and group 3: peri-menopausal females who attended screening for breast cancer in Hospital Monte Naranco (n=31). Evaluation was made using the Kupperman Index and the SF-36. Statistical analysis was made employing anova oneway analysis and the Duncan test.

**Results:** Sociodemographic Data: females in group 2 were significantly older than those in groups 1 and 3 (58.3 vs 50.4 vs 50.7, p. 0000). Clinical Data: females in group 1 presented a significantly greater severity of the menopausal syndrome than those of group 2 and 3 (24.1 vs 14.8 vs 13.8, p. 0000). Quality of life: Group 1 presented significantly lower scores than group 2 on the scales of pain, vitality, social function, role emotional and mental health. Compared with group 3 these presented significantly lower scores on all scales of the SF-36, except on the mental health scale (significant lower score in group 2).

**Conclusions:** Females who request help in the Menopause Unit suffer from a more severe climateric syndrome and present lower levels of quality of life than those who do not request such assistance.

t h e m e

# THE APPLICATION OF OUTCOME MEASURES IN ROUTINE CLINICAL PRACTICE

I N T R O D U C T I O N

W O R K S H O P S

P R O S P E C T S F O R T H E F U T U R E

T O S T E R S



## OUTCOME MEASURES IN ROUTINE CLINICAL PRACTICE

**J. Cullberg.**

Parachute project,  
Stockholm Söder Psychiatry, Stockholm, Sweden.

The necessity of routinely doing outcome research is discussed. The situation is more complicated in countries with a dominating private care. Three levels: 1. Special outcome studies for defined interests (drug company research etc.). 2. Routine collection of aggregated data from every patient including possibilities for an epidemiologic approach. 3. Combination of aggregated analyses of patient cohorts, catchment area data and individual follow-ups.

The greatest obstacles usually lie in keeping motivation of staff members high. To do that you must

(a) Know why you want to do the outcome research. It must be congruent with the outspoken goals of the clinic.

(b) The staff members must feel the absolute determination and support from the chief administrators of the clinic.

(c) The methods must be reasonable and not too time consuming. All kind of evaluative and qualitative data in routine register research will prove to be difficult to validate.

(d) Reasonable economic, data, and staff resources must be granted.

In the lecture examples will be given of the implementation of these principles.

Individual qualitative follow up is very time consuming and thus only possible in brief projects when your research resources are limited. However, it is a general experience that such qualitative narrative investigations give much knowledge for the organisation about how it works and whether it fulfills humanistic goals. For example: Interviewing the families of the 10 last schizophrenic cases, interviewing families after the 10 last suicides, investigating compliance of medication and possible reasons for non-compliance etc.

t h e m e



**THE APPLICATION OF OUTCOME  
MEASURES IN ROUTINE  
CLINICAL PRACTICE**

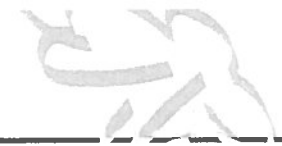
I N T R O D U C T I O N

**W O R K S H O P** 

P R O S P E C T S F O R T H E F U T U R E

P O S T E R S





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## THE OUTCOMES ARCHITECTURE PROJECT

Peter Huxley, Susan Knight

School of Psychiatry & Behavioural Sciences, The University of Manchester, UK

In conjunction with 10 local social and health service agencies the Outcomes Architecture Project at The University of Manchester is a method for selecting mental health outcome indicators at the system, programme and individual levels. The first component of the project has been the development of a matrix for the description of the range of possible indicators by level (on the Y-axis) and by aims, access, provisions and outcomes (on the X-axis). In order to facilitate benchmarking of services all existing items of information on mental health services (both health and social care) in the UK supplied to the Department of Health have been located in the matrix cells. This shows where current indicators are most and least adequate. The second component of the project involves working with the agency partners to locate the locally operated indicators within the matrix cells. This process will assist in the identification of useful outcome indicators at the programme level. The third component is to operationalise a number of brief outcome measures that contribute to the assessment of individual and programme outcomes. Among these are a brief scale for the assessment of the community or primary care treatment of substance abuse (MANDOS) and a reduced version of the Lancashire Quality of Life Profile (MANQOL).



## MENTAL HEALTH SERVICES OUTCOMES. A POPULATION AND MULTIDIMENSIONAL PERSPECTIVE.

**T. Sørensen, K.W. Sørgaard**

Department Group of Psychiatry, I. Sandanger, Institute of General Practice and Community Medicine, Dept. of Social Insurance, University of Oslo, Norway

In Norway mental health services is both taken care of at the municipal and county level. The health insurance scheme is on the national level, but administered locally. The various mental health service contributors may have different focuses as to outcome measures and time perspective. Here the point of departure is the total population at two sites. A representative sample (n = 2015) from four municipalities in North Norway, and a borough in Oslo, were personally interviewed. The survey makes it possible to look at outcome variables in the following categories: 1) Mental health (symptoms by HSCL-25, general well-being, domain satisfaction), 2) Alcohol and substance abuse. 3) Function (work, social network, participation), 4) Help-seeking (different profession, personal network), 5) Consumer satisfaction (mental health services at different levels). The respondents are categorised by currentness and type of mental health service use. The paper will discuss the present level on the various outcome dimensions for different groups (as to demography and help-seeking), as well as the interrelation between outcome variables. The paper will argue that the ultimate outcome evaluation of mental health services must be related to total population of responsibility, and not only look at they who has got a particular service.



## USE OF THE GRAPHICAL CHAIN MODELS IN THE MULTIDIMENSIONAL ASSESSMENT OF OUTCOME.

**M. Ruggeri, A. Biggeri, P. Rucci & M. Tansella**

Institute of Psychiatry, University of Verona, Italy.

**Aim.** Aim of this study is to assess the outcome of community mental health care using a multidimensional perspective and by means of a graphical chain model. Graphical chain models are a new multivariate method which enables to analyse the relationship between variables conditionally, i.e. taking into account the effect of antecedent or intervening variables. Specifically, we study: 1) the conditional relationships among a series of variables which are presently considered as the most useful indicators of the outcome of psychiatric care: global functioning, psychopathology, social disability, quality of life and satisfaction with services; 2) the associations between some of these variables (global functioning, psychopathology, social disability) at baseline and after six months; and 3) the effects of these variables on direct costs of care as well as the effects of costs on outcome.

**Method.** Data were collected in the South-Verona community based psychiatric service. The Global Assessment of Functioning Scale, the Brief Psychiatric Rating Scale, the Disability Assessment Schedule, the Lancashire Quality of Life Profile, and the Verona Service Satisfaction Scale. Scale were administered to 194 patients as part of the South-Verona Outcome Project. Direct costs in the six month interval were also assessed. A graphical chain model was used to analyse the multivariate dependencies among all variables. **Results.** Overall, a complex picture emerged. Outcome indicators appeared to polarise in two groups: global functioning, psychopathology and disability were highly correlated with each other, as were the dyad satisfaction with services and quality of life. The baseline value of global functioning, psychopathology and disability predicted the corresponding score at the six month follow-up. Satisfaction with services was highly related with quality of life and was predicted by low disability and good global functioning. No predictors for quality of life were found. Higher psychopathology and poorer functioning at baseline predicted higher costs in the following six months, and, in turn higher costs predicted poor functioning at follow-up. **Conclusion.** This study on the one hand throws some light on the complex relationships between clinical, social and economic variables affecting the outcome of mental health care, on the other hand confirms the usefulness of graphical chain models as a methodology for further analyses in this developing area of research.



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## THE USE OF THE HoNOS SCORE IN A PILOT STUDY FOR A NATIONAL MENTAL HEALTH STATISTICAL REPORTING SYSTEM.

**Dr. Gyles Glover**

Institute of Psychiatry, London, U.K.

Statistics of the activity of mental health services in the UK have been collected since the middle of the 19th century. The focus has been mainly upon in-patient activity. As styles of clinical care have changed with greater emphasis on multidisciplinary care in community settings, the statistical measures have become increasingly inadequate to describe care as it is practiced. The English health ministry is piloting a new system of statistical data collection which, it is hoped, will have the HoNOS score at its heart.

This paper will present preliminary findings about the extent to which clinicians in the pilot sites find the HoNOS system useable in routine clinical practice and the types of data about caseloads and the progress of individual patients which emerge from it.



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## 'THE HEALTH OF A COHORT' - VALIDATING THE HoNOS INSTRUMENT IN FIRST ONSET PSYCHOSIS.

**S. Amin, S. Singh, T. Croudace, G. Harrison, I. Medley and P. Jones**

Department of Psychiatry, University of Nottingham, U.K.

The U.K. Government's 'The Health of the Nation' policy, identifies mental illness as a key area. The policy includes a target to "improve significantly the health and social functioning of mentally ill people". This required the production of an instrument to measure outcomes in routine clinical practice, i.e. the Health of the Nation Outcomes Scales (HoNOS). We wished to demonstrate the validity of HoNOS in a clinical setting. A cohort of subjects, (n = 168) with first onset psychosis was assembled in Nottingham over 2 years. These were assessed 3 years later, (n = 166) using a variety of instruments including SCAN, HoNOS, GAF, SANS, DAS and Bleuler rating of symptom severity. Some subjects had named community keyworkers (n = 47), who also made independent HoNOS ratings. Total HoNOS scores were broken down into two of the four suggested subscale scores; HoNOS-symptoms (items 6-8) and HoNOS-social (items 9-12). Results showed that research HoNOS scores correlated highly with GAF, Bleuler, SANS and DAS (Spearman's r ranged from 0.62 - 0.82; p < 0.001). Use of subscale scores did not improve the correlation. For keyworker HoNOS scores the correlations, though lower, remained significant (0.26 < r < 0.48; p < 0.05). The lowest correlation involved keyworker HoNOS social scores and research GAF-d and DAS. These results suggest that the HoNOS is a valid outcome measure, and that its widespread use is justified.



## WHO GETS REFERRED?

### PROFILING REFERRALS TO SECONDARY PSYCHIATRIC SERVICES USING THE HONOS AND KEY WORKER SUBJECTIVE JUDGEMENTS OF APPROPRIATENESS

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The Health of the Nation Outcome Scales (Wing et al., 1996) have been developed to measure the health and social functioning of patients in contact with specialist psychiatric services. The scales are currently being used in the Evaluating Guideline Outcomes (EGO) study in Bristol - a cluster randomised controlled trial involving 30 practices (15 to receive the intervention). The aim of EGO is to evaluate the development and local adaptation of the ICD-10 Diagnostic and Management Guidelines for mental disorders in primary care.

One component of this evaluation involves assessing the effects of the introduction of guidelines on the casemix and appropriateness of referrals to secondary care. Over a five month baseline period all referrals made by GPs in participating practices have been rated on the HoNOS scale by the member of the secondary care team making the initial assessment.

We will report baseline HoNOS scores and explore their relationship with ICD-10 Primary Care diagnostic groups and key worker judgements of appropriateness. Discussion will focus on how this data may be used to improve the process and quality of care for patients who are referred to specialist psychiatric services.



## OUTCOMES AND COSTS OF ALTERNATIVE CARE FOR THE MOST SEVERELY DISABLED LONG-STAY PATIENTS

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### Aims:

1. To evaluate the clinical and social outcomes of the most 'difficult to place' (DTP) patients discharged from hospital to specialised care facilities.
2. To assess the cost effectiveness of alternative facilities for these patients.

**Method:** The study is part of a joint TAPS/CEMH longitudinal study of the reprovizion programme for a large psychiatric hospital in London. The sample comprises 72 residual long-stay patients regarded as 'DTP' in the community. The patients underwent comprehensive assessments before leaving the hospital, and were reassessed twice thereafter, at one year and five years.

### Results:

I. Clinical and social outcomes: one year after transferring the DTP patients into four specialised units, 4 patients moved into ordinary community homes. There has been no overall change in the patients' mental state, social networks remained restricted, but basic living skills have improved slightly. 5 years later, over 50% of the study group have moved to live in the community. Eight patients died during this period. Results of the five year follow-up assessment, currently being analysed, will be presented alongside the one year follow-up results.

II. Cost of care: in the first year following the reprovizion, the average cost of specialised care for DTP patients was £ 1,065 per week per person. The average cost of community care for the whole hospital long-stay population (excluding DTP patients) was £612 per week pp - nearly half the cost for DTP patients.

**Conclusions:** from a long-term perspective, most patients previously regarded as unsuitable for community placement, could eventually move to ordinary group homes. The reprovizion of costly care facilities for DTP patients exerted a major impact on the overall cost of the reprovizion programme.



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## FAMILY INTERVENTION IN SCHIZOPHRENIA: HOME-BASED FAMILY THERAPY VS. RELATIVES GROUP

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It is currently unduobtable that family interventions in schizophrenia are efficacious in reducing relapse and hospital admissions, and provide at the same time a multidimensional approach to care. In general the therapeutic packages share some common aspects but they show notable variation in approach. The aim of this study is to analyze the outcome of two different types of psychosocial interventions (a home-based family therapy -HBFT- and a relatives group R.G.), offered as a standard therapeutic measured to the schizophrenia population seen in one catchment area. No difference in relapse rates between both types of psychosocial interventions had been found (OR=0,89) but they do differe in the effect that each of them produce on the different aspects with have been studied: HBFT produced a significant change in social functioning (DAS II) than RG; on the other hand R.G. has a strong influence on the relative's health than the former type. The R.G. with the same effectiveness to reduce relapse, as the aparently more costly HBFT strategie, would be the better choice in a National Health System, but the fact that the proportions of non-compliers is so high makes it unsuitable as the "only-choice". As the different approaches were not equally effective in all the outcomes other aspects may be taken into account.




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## SCHIZOPHRENIC PATIENTS IN COMMUNITY CARE: DETERMINANTS OF SERVICE UTILIZATION

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The aim of this study is to identify the psychopathological and psychosocial variables, that are determinants for the utilisation of community psychiatric services by schizophrenic patients. Starting from one day prevalence (31/12/94), 203 patients with a ICD-10 F2 diagnosis (schizophrenia and related disorders), and residents in an Northern Italy Local Health Unit, have been evaluated on three areas: disability (by DAS), psychiatric symptoms (by 24 items BPRS) and family burden (by Family Problems questionnaire). From evaluation the outpatient, hospital and residential care contacts of the patients have been collected for six months by the service information system. For each area (DAS, BPRS and FP) a factor analysis has been performed and eleven factors, derived from three scales, have been retained as explanatory variables. Finally, a multivariate regression analysis by means of genetic algorithms has been performed to assess the influence of explanatory variables on the set of response variables (number of community contacts, days of hospitalisation, days of residential care, Lavik's Service Consumption Score).



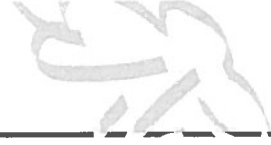
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**QUALIG: A PROGRAMME FOR QUALITY GUARANTEE  
IN THE INTERFACE BETWEEN PSYCHIATRY  
AND PRIMARY CARE**

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The need to improve quality of care for psychotic patients can only be attained if GP assume responsibility in the management of minor psychiatric pathology. A one year duration pilot programme including three practices of 14 GP and about 20.000 inhabitants was devised to establish a consultation liaison model predominantly based in written information and telephone contacts: GP receive typed answers with a content adequate to the management of new cases referred as well as to their individual needs of mental health attitudes and management knowledge.

Programme development departed from presented retrospective data for the previous year: GP characteristics and attitudes towards mental health and liaison, GP individual pattern and quality of referrals and clinical data on new patients (100). Outcome measures in relation to GP and patients are described as well as defined standards and indicators of quality of the process of liaison. Evaluation of the impact of this consultation liaison intervention in GP pattern and quality of referral and on patient outcome includes comparison with the previous year and with GP liaised in the usual unstructured way. The whole methodology and procedures, as well as preliminary results, are presented and discussed.



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**EFFECTIVENESS OF COMPREHENSIVE COMMUNITY  
BASED MENTAL HEALTH CARE FOR SCHIZOPHRENIC  
PATIENTS - A COMPARISON BETWEEN  
MANNHEIM/GERMANY AND GRANADA/SPAIN**

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This study is comparing effectiveness of comprehensive community based mental health care for schizophrenic patients of the catchment areas of Mannheim, Germany and Granada, Spain. Aims were a.) to develop a simple but reliable indicator which allows to compare effectiveness of care in catchment areas with different structure. and b.) to find out, in which region care input relates „better“ or „more effective“ to outcome of care.

In both areas service utilization and outcome of care of patients (Mannhem n=66, Granada n=81) was assessed prospectively in a one year follow-up by using a common and standardized methodology.

A detailed and complete pattern of service utilization was provided by the ‚Mannheim Service Recording Sheet (MSRS)‘, outcome of care was assessed by the ‚Needs for Care Assessment (NCA)‘ which describes the number of mental health care problems or needs as well as the number of met or unmet needs of patients also in a standardized way.

Results showed a similar effectiveness in managing symptoms and behaviour problems of schizophrenic patients despite of the remarkable differences in service offers in both regions, while there was a significant better performance of the Mannheim region in meeting the needs of patients in the area of skills and abilities.

The study indicates that it is feasible to use the Needs for Care Assessment as an indicator of outcome of care in a long term approach across different centres and can contribute valuable information to the methodological challenge of comparing mental health care of different countries cultural regions (Central and Southern Europe e.g.)



t h e m e

## THE APPLICATION OF OUTCOME MEASURES IN ROUTINE CLINICAL PRACTICE

### SOCIO-DEMOGRAPHIC AND CLINICAL CHARACTERISTICS AS PREDICTORS OF COSTS AMONG PSYCHIATRIC PATIENTS TREATED IN A COMMUNITY-BASED SYSTEM OF CARE.

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**BACKGROUND.** Economic assessment is becoming increasingly popular in the mental health field, because of the growing emphasis on cost containment within health care. Little information is still available on predictors of costs of care for people with mental health problems, and there are very few research data on how or why the costs vary among patients.

**METHOD.** All patients resident in the South-Verona catchment area who had at least one contact with psychiatric services within a three months period were eligible. Five hundred and thirty-seven patients met the criteria for the study, 366 were assessed at starting time with Global Assessment of Functioning Scale and Brief Psychiatric Rating Scale, and after three months each patient was interviewed with ICAP (an instrument developed to collect retrospective information on service utilisation and income). Of those assessed at starting time, 339 patients completed all scales. For each patient costs were calculated using a unit cost list. We calculated two cost component: direct psychiatric service costs and direct non-psychiatric health service costs (including GPs, medical and surgical contacts, other specialists, etc.).

**RESULTS.** The socio-demographic characteristics of study sample and drop-out were compared. Analyses of variance were conducted, testing for cost differences by diagnosis and by socio-demographic and clinical variables. There were significant differences between diagnostic groups in relation to psychiatric services costs ( $p < 0.004$ ) and no differences in relation to non-psychiatric costs. Patients with a diagnosis of schizophrenia and related disorders are most costly (10,878 USD '93), followed by those with other diagnoses (8,519 USD '93) and affective disorders (4,685 USD '93).

Multivariate analyses were also conducted to test for associations between yearly costs and patient characteristics when taken together with GAF and BPRS scores and to identify predictors of costs. The predictors of resources requirements resulted, for psychiatric services costs: employment status, marital status and GAF score; for non-psychiatric costs: anxiety/depression subscale score and duration of psychiatric history.

**CONCLUSIONS.** It is possible to explain statistically some of the costs variation between psychiatric patients by reference to differences in patient characteristics, using information routinely collected together with easily assessable instruments.

**PROSPECTS FOR THE FUTURE**



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## OUTCOME ASSESSMENT IN ROUTINE CLINICAL PRACTICE. FUTURE PROSPECTS.

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"Outcomes research" is focused on developing models for evaluating successful interventions and optimal treatment choices, while "outcomes management" has been defined as the daily application of these models in the clinical setting. As a matter of fact, routine clinical practice is becoming a major focus of research in related areas such as pharmacoepidemiology, health economics, effectiveness analysis and quality of care analysis. However, outcome measurement in routine clinical practice rises a number of unsolved questions particularly in the mental health sector. These problems include:

1) Appropriate indicators. The overall importance of satisfaction and non-expert opinion on mental health planning is open to debate. Other relevant dimensions such as health status, quality of life and disability are not fully independent from each other. Furthermore, there is a lack of international consensus on operational definitions of nominal measures such as relapse, remission or recovery.

2) Appropriate assessment instruments. Scales to be used in routine practice should be brief and simple. Although a number of instruments are available (e.g. GAF, SF-36, Euroqol), their reliability, validity or their usefulness in mental health outcomes management has not been fully established.

3) Appropriate analysis and index calculation. Attempts to develop a universal index, such as QALYs or DALYs are moving from preference assessment to the conversion of health status measures obtained from routine clinical practice. However, a number of methodological problems regarding the use of ordinal measures as a base for global indicators have not been solved yet. New designs (e.g. cross-design synthesis) and new statistical techniques (e.g. data envelope analysis) have been suggested in order to incorporate data from different sources and any number of cardinal, ordinal, or ratio inputs into the efficiency analysis.

4) Appropriate information use. Health management and health decision making rely increasingly in clinical practice data, favouring intangible outcome parameters (e.g. satisfaction, health status) over other surrogate and proxy measures related to the process of care and organizational structure. Findings from recent studies rise some questions over the indiscriminate use of such outcome data.

Langsdale T. Outcome research - Overcoming conflict and challenges. PharmacoEconomics and outcomes news

McGhan WF et al. Implementing pharmaco-economic outcomes management. PharmacoEconomics 6: 412-416, 1994.





t h e m e

**THE APPLICATION OF OUTCOME  
MEASURES IN ROUTINE  
CLINICAL PRACTICE**

**P O S T E R**





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## COMPARISON OF PSYCHOTIC PATIENTS' SATISFACTION WITH HOSPITAL VERSUS COMMUNITY-BASED PSYCHIATRIC SERVICES:

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Background: Ensuring high levels of patient satisfaction enhances the efficacy of psychiatric services. Satisfaction is a multidimensional concept and its valid measurement presents some difficulties. Previous work suggests patients are more satisfied with community based services, but it is unclear whether this can be generalised to routine services. Aim: To compare levels of satisfaction on the part of patients with psychosis between a hospital-based service in London and a community-based routine service in Italy. Method: The Verona Service Satisfaction Scale (VSSS) was used to measure levels of satisfaction amongst patients with a psychotic disorder in Nunhead (South London) and South Verona. The VSSS is multidimensional and unique amongst satisfaction instruments in having established and adequate psychometric properties. An English translation was prepared for this study. Results: Satisfaction across all dimensions was higher in South Verona than Nunhead. Differences between the two samples in terms of demographic and service use variables were insufficient to explain this finding. Conclusions: Service satisfaction can be measured among patients with psychosis. The findings from previous experimental settings, that such patients prefer community based to hospital mental health services, can be generalised to routine services.



**CALLIBRATING THE CAMBERWELL ASSESSMENT OF  
NEED AGAINST ESTABLISHED OUTCOMES SCALES:  
EMPIRICAL APPROACH BASED ON REGRESSION  
ANALYSIS**

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The Camberwell Assessment of Need (Phelan et al., 1995) has been developed for the assessment of clinical and social needs of patients with severe mental illness. We used it to summarise the unmet needs of a cohort of 168 patients with first onset psychosis assembled in Nottingham, three years after their first contact with psychiatric services.

We describe the prevalence and severity of needs and the help received from friends relatives and local services (where the patient expressed a need). Since current recommendations for summarising the results of the needs assessment weight all needs equally e.g. need for accommodation and need for a telephone we explored the utility of an empirical approach, using regression analyses, to develop weights for CAN items.

More specifically we regressed all, and (factor analysis derived) subsets of the CAN items onto established measures of global outcome, the Global Assessment Scales (Symptoms and Functioning) at the 3 year follow-up.

Our results suggest ways in which the unmet needs identified by the CAN may be aggregated to a total score. The weights reflect the impact that each area of identified unmet need has on global ratings from established outcome scales. Ways of developing these methods to extend and increase our understanding of the complex relationship between service provision, disability and other outcomes, and unmet needs are also discussed.



**THE PSYCHIATRIC QUALITY ASSURANCE PROCESS:  
FURTHER STEPS IN BASEL, SWITZERLAND**


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Data collection in Basel began in 1993 in response to psychiatry reform efforts in 1990. Initial analyses of this data set have focused upon ascertaining parameters of this population in order to provide participating institutions feedback about patient characteristics and service utilization, enable comparative analyses of outcomes, and to establish indicators for long term monitoring of service processes and outcomes.

From this register, cases with a first hospital admission diagnosis of Schizophrenia were examined, in order to compare differences in processes and outcomes between men and women, and to enable comparisons with international experiences. This sample consisted of a total of 122 patients (55 females, 62 males), ranging in age from 16 - 79 years. Differences between men and women with regards to age of first admission were observable in Basel, (women  $X = 40.7$ ; men  $X = 29.9$ ;  $p = 0.0002$ ) and reflect what has been widely reported in the literature. This group was also characterized by high rates of entry into the system as an emergency, although 65% were also described as having entered voluntarily. 73.1% of this group was of Swiss nationality and 26.9% was of foreign nationality, reflecting the population composition of Basel (75% Swiss and 25% foreign). Differences among men and women with regards to follow up services were observable. For instance, women were more likely to have been referred to a private psychiatrist for follow up treatment in comparison to men ( $p = 0.02$ )

As the Basel Stadt Case Register (i.e. Basisdokumentationsprojekt in Psychiatrie) grows, data begin to emerge, that enable us to pursue the goals stated upon its inception: i.e. to ascertain the characteristics of the severely mentally ill population and to provide us with a means to evaluate their quality of care.



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## THE FURTHER VALIDATION OF THE INVOLVEMENT EVALUATION QUESTIONNAIRE (IEQ): SENSITIVITY TO CHANGE AND CULTURAL DIFFERENCES

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**AIM:** We developed the 81 - item Involvement Evaluation Questionnaire (IEQ) for the assessment of the consequences of a psychiatric disease for relatives or friends of the patient. The items are scored on Likert scales and can be summarized in four scales: tension, worrying, supervision and urging. The IEQ is one of the instruments in the BIOMED-project: 'Standardising outcome measures of Schizophrenia in Five European Countries'. Although its widespread use, some psychometric qualities of the IEQ are not yet assessed. First, all items have an equal weight in the IEQ-scales, which results in rather low average score. This reduces the IEQ's sensitivity for changes. Second, the impact of cultural factors on IEQ-scores is not well known.

**METHOD:** Relatives of psychiatric patients (N=100) indicate which consequences have most impact on their lives by assigning weights to the IEQ-items. Based on these weights new scoring algorithms are tested with regard to the sensitivity for changes. Cultural influences are studied by comparing IEQ-scores from the five countries collaborating in the BIOMED-project (N=25 per country), and comparing 25 nativeborn Dutch relatives with 25 relatives originating from other countries.

**RESULTS:** Data collection is still in progress. The results of the IEQ weighing procedure and the new scoring algorithms are presented, and their effect on the sensitivity to changes is discussed. Also, the impact of cultural factors on IEQ-scores and its consequences for the use of the IEQ in different countries are discussed.



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## MEASURING MULTIDIMENSIONAL OUTCOMES IN MADRID PSYCHOSOCIAL REHABILITATION CENTERS: A PROPOSAL

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In 1997, the Comunidad Autónoma de Madrid ( i.e., the Madrid regional government), proposed to our team to select a set of outcome measures to be used in all the psychosocial rehabilitation centers for chronic patients depending of the CAM. After a through review of the literature on different outcome measures in several dimensions of functioning (general functioning, leisure activities, general well-being, feelings of self-efficacy, consumers' satisfaction with services) we decided, after consulting with service providers and experts, to use the following set of measures which, from now on , will be used in the CAM centers (Muñoz et al., 1997): 1) Cuestionario de Satisfacción Global con los servicios (CSG-VP) -Questionnaire of Global Service Satisfaction (López, 1994); 2) Empowerment Scale (Rogers et al., 1997) 3) Index of Well-Being (Campbell et al., 1976); 4) Rehabilitation Evaluation (REHAB) (Hall y Baker, 1983); 5) Schizophrenia Outcome Module (Cuffel et al., 1997).

In this presentation we explain the process of selecting outcome measures that we have followed as well as the process of data-gathering that we have just started. Finally, we discuss some data collected, so far, with this set of instruments.




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## THE SPANISH ADAPTATION OF THE SCHIZOPHRENIA OUTCOMES MODULES (SCHIZOM): SOME PRELIMINARY DATA

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In this paper we show some data regarding the utility of the recently developed SCHIZOM module (Cuffel et al., 1997), in its Spanish version: The SCHIZOM is a new, *theory-driven* tool designed to assess different dimensions of outcomes in schizophrenic patients. This tool has shown good psychometric characteristics in a recent US field trial with 100 schizophrenic patients. The SCHIZOM, which includes items derived from well-known instruments (e.g., CIDI, CAGE, BPRS, etc.), focuses on four different outcome dimensions: 1) Clinical Status; 2) Functional, rehabilitative status; 3) Humanitarian (life satisfaction); 4) Public welfare (suicide and violent behaviors) Besides these four dimensions, the Shizom also assess physical and emotional functioning by using the *Health Status Questionnaire-34*.

The SCHIZOM has a number of characteristics that make it a feasible choice to assess multiple outcomes in schizophrenic patients: 1) Easy administration (about 30 minutes each interview); 2) Multiple dimensions of measurement: Outcomes, Pronostic, and Treatment, 3) Multiple views of outcome measures (i.e., information gathered from subjects and significant informants); 4) Good reliability and validity correlates (Cuffel et al., 1997); 5) Sensitive to change in 6-month periods. We show some preliminary data with Spanish schizophrenic patients. In our assessment strategy, besides the SCHIZOM we also include some other outcome measures (e.g., feeling of self-efficacy) which are not provided within this instrument.



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## AGREEMENT BETWEEN STAFF AND PATIENTS IN THE ASSESSMENT OF NEEDS FOR CARE IN COMMUNITY PSYCHIATRIC SERVICES.

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**Background.** The concept of *needs for care* and the development of methods for their measurement is a new paradigm in the planning of mental health service interventions. However, need is an ambiguous concept with no clear cut definition and several approaches have been proposed for its definition and measurement. In a negotiated perspective, needs are considered a dynamic, changing, context-dependent and relative concept. Thus their measurement should take account of the view of both patients and staff. **Aim.** To evaluate the agreement between patients and staff perceptions of needs, according to this definition. **Methods.** The Italian version of the Camberwell Assessment of Need (CAN) has been used. The CAN is a brief and reliable instrument for assessing the needs for care of mentally disabled people. It covers a comprehensive range of health and social needs (22 areas) assessing: the presence of need (Section 1), the informal (Section 2) and the formal received and the formal help needed (Section 3). Versions for use with patients and staff have been developed. 253 key professional-patient pairs were separately interviewed in South-Verona CMHC. Kappa (for Section 1) and weighted Kappa (for Section 2 and 3) coefficients were used as measures of agreement. **Results.** The mean total number of needs identified by patients (3.32, SD 2.85) and by staff (3.28, SD 3.13) is similar. *Psychological distress* and *physical health* represent the predominant areas of expressed needs for both patients and staff. The agreement on the presence of a need is low for both Section 1 ( $-0.05 < K < 0.2$ , with the exception of *Accommodation*,  $K = 0.75$ ), and for Section 2 and 3 ( $-0.09 < \text{weighted } K < 0.4$ ). In case of disagreement, the patients tend to express more needs in areas such as *Basic education*, *Use of the telephone* and *Benefits*, while staff tend to identify more needs in the areas of *Psychological Distress* and *Psychotic symptoms*. **Conclusion.** The poor agreement on the level of need, the help received and the help needed, suggests that patients and staff have very different perceptions about the needs for care and underline the importance of an active involvement of the patients in the needs assessment process.



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## ASSESSMENT OF THE PATIENT-THERAPIST-RELATIONSHIP IN COMMUNITY CARE

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The patient therapist relationship has been relatively neglected in recent community mental research despite its obvious clinical importance, and despite its central role in psychotherapy research.

**Aim** To develop a theoretical framework for understanding relevant qualities of therapeutic relationships in community care and to generate adequate methods for assessment in research and practice.

**Method** 1. An extensive review of the concepts for understanding therapeutic relationships in psychology and psychotherapy literature and investigate their applicability in community care. 2. A review of the literature on the therapeutic alliance in community care.

**Results** Four major traditions are discerned (psychodynamic, behavioural-cognitive, systemic, and client-centred). Approaches to assessment vary markedly between these four traditions, and the scales presented have limited applicability in community care settings. Some findings suggest a predictive validity of simple measures of the therapeutic relationships in community care.

**Conclusions** Extensive work is required to derive and test specific theoretical models.



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## HEALTH CARE COSTS OF SCHIZOPHRENIC PATIENTS TREATED WITH CLOZAPINE: A STUDY IN A COMMUNITY PSYCHIATRIC CENTRE IN ITALY

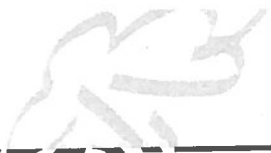
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The study is based on data collected on the 15 schizophrenic patients who started clozapine therapy between 1993 and 1996 at the Psychiatric Department of Magenta. Patients included in the study were resistant to at least two conventional antipsychotic treatments in the twelve-months period prior to clozapine therapy. This was a mirror-image designed study with data covering the year prior to commencing clozapine ('pre-clozapine') and the year following the establishment of the clozapine therapy ('post-clozapine'). Clinical outcome (CGI and GAF scales) was assessed prior clozapine treatment and after one year of treatment. Cost analysis followed a two steps procedure: i) to record all health care services provided to patients; ii) to assign to each service a monetary value.

Three of the 15 patients who received clozapine dropped out before the twelfth month of treatment. Considering the 12 patients on clozapine treatment for at least one year, average score in item 1 of CGI changed from  $6.3 \pm 0.8$  (SD) at the commence of the clozapine therapy to  $4.8 \pm 0.9$  after one year of treatment. Over the same period GAF improved from  $20.9 \pm 7.4$  to  $43 \pm 13.4$  ( $p < 0.05$ ). The 12 patients had 32 admissions for 1,294 hospital days in the "pre clozapine" period and 16 admissions totalling 706 hospital days in the "post clozapine" period. In the "post-clozapine" period patients had a higher utilisation rate of days spent in residential rehabilitation centres (+33,9%) and of community services, especially in the rehabilitation area. The total annual cost per patient of antipsychotic therapy "pre-clozapine" was 534.085 It L. and after commencement of clozapine was 3.441.439 It L. Cost of community services was higher after commencement of clozapine (4.680.083 It L. per patient, compared with 1.770.458 It L. in the post clozapine period). However, higher cost for drug therapy and community services in the post-clozapine period were more than offset by lower cost of acute hospital care (43.672.500 It L. vs. 23.827.500 It L.). Consequently, the total cost per patient of clozapine regimen (55.521.464 It L.) was 13% lower than traditional treatment (63.406.584 It L.).



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## DETERMINANTS OF LENGTH OF STAY IN PSYCHIATRIC HOSPITALIZATION: ORGANIZATIONAL FACTORS AND CLINICAL ACTIVITY.

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Review of literature on psychiatric epidemiology shows that the combination of inpatients characteristics (demographics, diagnostic data, "new chronic" patients...) with structural factors can help to identify predictors of length of stay in psychiatric units in general hospitals.

The purpose of this paper is to identify the influence of organizational factors as well as the clinical activity in the length of stay in the Psychiatric Unit of the University Hospital in Málaga (Spain).

The length of stay was: Year 1991 = 19.78 days, year 1992 = 25.54 days, year 1993 = 23.07 days. The clinical team changes in March 1994 (no other characteristics changed). Actually the length of stay is : Year 1994 = 10.21 days; year 1995 = 9.51 days and year 1996 = 8.7 days.

We discuss our results, its influence towards the number of admissions and readmissions of patients, and the role of clinicians as determinants of length of stay in psychiatric hospitalizations.



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## LIAISON PSYCHIATRY IN PRIMARY CARE IMPACT ON THE REFERRAL PROCESS

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A descriptive and comparative study of all referrals from two General Practitioners Surgeries to a Hospital Outpatient Clinic was performed.

A model of liaison psychiatry in general practice (liaison attachment) was established with one of the centers several years ago, and its impact is comparatively assessed according to some socio-demographic and clinical variables.

A sample of 81 referrals by general practitioners over one year period was studied.

Some differences between the two populations (with statistical significance) are presented:

- Number of total psychiatric outpatient referrals; Duration of symptoms; Presented problems; Suggestion of referral; Time between GP consultation and referral; Previous treatment.

The results, their implications and consequences are considered for the development of an effective liaison between primary and secondary care.



## READMISSIONS IN A GENERAL HOSPITAL PSYCHIATRY UNIT.

**Ruiz Ruiz M.\***, **Pena Andreu JM.**, **Rodríguez-Rosado A.**,  
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Department of Psychiatry. Clinic University Hospital. Málaga.

\* Chairman of Psychiatry. University of Málaga, Spain

The aim of this study is to determine the relationship between demographic, social, clinical and treatment factors and the readmission of the patient in a short period of time in a General Hospital Psychiatric Unit. We have examined the readmitted patients at the Psychiatric Unit of the Clinic University Hospital in Málaga for a period of three months paying attention to the following variables: age, gender, residence, occupation, diagnosis, abandonment of treatment, previous admissions in the Hospital, and precipitating or predisposing factors. The results have been contrasted with those of the patients admitted only once in the same period. The results show that factors such as being male, diagnosis of schizophrenia, abandonment of treatment, and previous admissions in the Hospital, are positively associated to readmission. They could be used as outcome measures in routine clinical practise.

Keywords: admission. Psychiatric patients. Social factors. Demographic factors. Clinical factors.



## CHARACTERISTICS OF FOREIGN PATIENTS IN A GENERAL HOSPITAL PSYCHIATRIC UNIT

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We have revised the pre-existent literature about foreign patients in Psychiatric Units, to determine the characteristics of this population. We have found few papers about this subject. The aim of our study is to evaluate the sociodemographic and clinical characteristics of foreing people admitted at the Psychiatric Unit of the Clinic University Hospital in Málaga. For this purpose we examined all the foreign inpatients for a period of one year (January 1997-December 1997). We designed a Protocol including three main areas: a) Sociodemographic characteristics: gender, age, language, marital status, laboral status, educational level, original country, situation in Spain, and type of insurance; b) Previous psychiatric history if exists: diagnostic according to DSM-IV criteria, onset of the illness, number of previous admissions, and substance abuse; c) Data of the present illness: form of admission, readmissions if exist, reason for the admission, precipitants or predisponent factors, length of the admission, and ways at discharging. Absence of social and family support and substance abuse are constant characteristics of the population in study.

Keywords: Foreign psychiatric patients. Demographic characteristics. Social characteristics. Clinical characteristics.





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**MEASURING HEALTH STATUS IN PSYCHIATRIC  
COMMUNITY SURVEYS: RELIABILITY AND VALIDITY  
OF THE SPANISH VERSION OF THE SF-36**

**Ayuso-Mateos J.L., Lasa L., Vázquez-Barquero J.L.,  
Oviedo-Aguila A., Díez-Manrique J.F.**

Clinical and Social Psychiatry Research Unit. "Marqués de Valdecilla"  
University Hospital, University of Cantabria, Santander, Spain.

The present study was aimed at determining the acceptability of the Spanish version of the SF-36 questionnaire for its use in mental health research on the general population, as well as evaluating its internal consistency and validity, and providing population norms from a representative community sample of 1250 working-age adults. Internal consistency of the different dimensions of the questionnaire was high. Concurrent validity was tested by examining its correlation with the GHQ-12. Construct validity was determined by studying the extent to which scores on different variables reflected the expected distribution of health status for and between certain groups. Our findings provide strong evidence for the acceptability and validity of the SF-36 when used as part of a community mental health survey.

Key words: SF-36-reliability-validity-mental health-community survey.



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**PRIVADO COSTS, CLINICAL OUTCOMES AND  
DISABILITY OF THREE SAMPLES OF PATIENTS WITH  
SCHIZOPHRENIA IN DIFFERENT AREAS OF SPAIN**

**Haro JM, Agustench C, Romero C, Martínez A, Gaité L, Roure P  
and the PSICOST Group**

Barcelona, Spain

Cost studies on schizophrenia have tried to relate differences in costs with differences in outcome. However, this relationship has usually turned to be weak. We present a study about costs of schizophrenia and its relation to outcome in three areas of Spain.

**METHOD:** Three incident samples of patients were recruited in three areas (Cantabria, Burlada in Navarra and the Example in Barcelona). A total of 109 patients were evaluated in the third year after onset using the Questionnaire for Evaluation of Costs in Schizophrenia (Cuestionario para la Evaluación de los Costes en la Esquizofrenia-CECE), the GAF, the WHO-Disability Assessment Scale-short version, and the BPRS. Univariate and multivariate analysis were carried out to relate total costs with the outcome measures. due to the skewed distribution of costs, a logarithmic transformation was used in the analysis.

**RESULTS:** A pattern of increasing costs with the worsening of clinical status and social disability was detected. However, at a given point, worsening of clinical status no longer increases, but decreases costs.

**DISCUSSION:** An interpretation of these results is that patient with the worst clinical status and social disability may have less access to care, which decreases health care costs. The implications of these findings on the methods to be used to relate costs and outcomes will be presented.



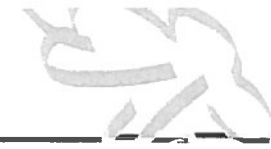
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## ALZHEIMER'S DISEASE IN SPAIN: ENBEA, PRIMARY NEEDS, CARE DEMANDS AND QUALITY OF LIFE.

E. Ochoa, A. Hernández, D. Losada, R. Martínez, M. Nevado

Section of Epidemiology and General Practice/Old Age. Institute of Psychiatry.  
The Maudsley. London, UK.

Results and future implications of the first study developed in Spain about primary needs and life demands of Alzheimer's disease (AD) caregivers as well as the direct cost, will be presented. The primary needs of 140 Spanish carers and their family sufferers were assessed. An specific instrument (ENBEA) was drafted by the authors to determine the main deficiencies of the AD caregiver's quality of life. A pilot study was carried out using 15 cases to examine the reliability and validity of the ENBEA questionnaire by means of a qualitative analysis of the variables. Into THE ENBEA final version contains 70 open-ended questions divided five areas: 1. Socio-economic data on the AD subject and principal carer, 2. Clinical history of the AD subject; 3. Current condition of the AD subject; 4. Family/employment/emotional/social conditions, basic needs and requirements of the AD carer. A block of items was used to assess the level of dependency/independency of the AD subject. Katz index and AD stage were analysed as well. -ENBEA's results with 140 AD carers will be stressed.



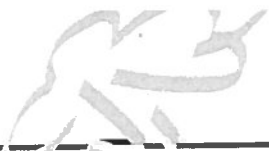
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## EFFECTS OF ESTABLISHMENT OF COMMUNITY BASES PSYCHIATRY IN THE MUNICIPALITY OF AALBORG, DENMARK

J. Aagaard, P.S. Schrøder

Aalborg Psychiatric Hospital, Aalborg, Denmark.

The aim of the study was to illustrate effects of community based psychiatry. The catchment area (150,000 inhabitants) was divided into 3 homogeneous districts, East, North and West. Teams were established on 01.09.1990, 01.10.1991 and 01.05.1992, respectively. Social, diagnostic and treatment related data was gathered from 2 cross section investigations (I: February 1992 and II: February 1993) and from in-patients' and out-patients' files. In cross section I (397 patients) a majority of long-term ward patients and hospital based employment offers was found in the district, where the community district team had not yet been established. In the district, where the first community district team was established, most primary target patients were treated as pitåatoemts. In cross section II (505 patients) the hospital-based psychiatric service was more homogeneously distributed between the districts. The establishment of community bases psychiatry teams resulted in new referrals and increasing number of patients attached to the psychiatric teams, but crowding and compulsory means at hospital also increased.



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## VARIATIONS IN HOSPITAL BASED PSYCHIATRIC SERVICE BETWEEN AALBORG AND ÅRHUS, DENMARK. A REGISTER-BASED 10 YEARS' INVESTIGATION

**J. Aagaard, T. Nielsen**

Aalborg Psychiatric Hospital, Aalborg, Denmark.

The study was based on data from the Danish Psychiatric Central Register. It consisted of 11,753 persons with permanent residence in the municipalities of Aalborg or Århus, who had 32,557 admissions to a psychiatric hospital in Denmark during the period of 1982-91. The admission rates declined 30%. The involuntary admission rate increased during the later years of the period, and it was higher at the Psychiatric Hospital in Århus (PHÅ). The admission rate for schizophrenia increase, but was unchanged for manic-depressive psychosis. For organic psychosis as well as reactive disorders the rates declined. The percentage of readmission was 8% higher at PHÅ. The bed-day use per admission was 5.5 weeks in average at Aalborg Psychiatric Hospital (AAPH), and 9 weeks in average at PHÅ. Through the period the bed rate (beds in use) was gradually reduced by 40%, most significantly at PHÅ. It can be concluded that the treatment at AAPH was less time-consuming. This is mainly caused by the fewer beds available. Indices for quality of outcome did not give reason for conclusions in regard to difference in quality of treatment.



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## FROM NATIONAL DEVELOPED TO INTERNATIONAL APPLICABLE MEASUREMENTS; THE FOCUS GROUP PROCESS

**Knudsen HC, Welcher B, Vázquez-Barquero JL, Gaite L et al.**

During recent decades of international research of comparison of mental health services the need for internationally standardised and reliable measurement has emerged. Often instruments are translated without further notice of the procedure and estimation of culturally and conceptually acceptability. The Focus Group is a formal group interview which in its structure and methodology takes advantage of the methodology of group psychotherapy. It is a qualitative research method which among other purposes is used in health service research to obtain information about a given problem, service or other phenomenon. or to evaluate cross-cultural adaptation of concepts, constructs and instrumentation. The aims of this paper are: 1) To present a method of translation procedures used for improving instruments; 2) To present the focus group process as a method to develop instruments for international comparison, 3) To present results on five instruments applying this method in five European countries. Method: A protocol was developed describing the focus group process of each instrument, the designation of professionals and non-professionals (including patients and relatives) participating in the focus groups, the issues to be raised and the sequence, and the information to report on from the focus group process. The focus group reports were summarised for each instrument for cross-cultural comparison and to recommend changes of instruments. Results. Changes of measurements were within three areas: 1) We made profound changes of the instrument (2 measurements), 2) We adjusted concepts/structure (1 measurement); 3) We developed extended manuals (3 measurements). Discussion: The focus group work process gave information regarding the applicability of the instruments in different cultures and different health care systems showing the importance of culturally and conceptually adjustments of instruments for international use. The extend to which instruments were adjusted in accordance with focus group results varied.

t h e m e



**THE APPLICATION OF QUALITATIVE  
METHODOLOGIES IN CLINICAL RESEARCH  
AND PRACTICE**

**I N T R O D U C T I O N**

W O R K S H O P S

P R O S P E C T S F O R T H E F U T U R E

P O S T E R S



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## THE APPLICATION OF QUALITATIVE METHODOLOGIES IN CLINICAL RESEARCH AND PRACTICE.

**R.T. Trotter.**

II Northern Arizona University, Flagstaff, Arizona, USA

Qualitative research methods are proving to be very valuable in clinical research. In the past 10 years, a large number of new methodologies have been developed and tested for cross-cultural psychiatric research objectives. This paper will summarize all of the qualitative research methods in use in clinical research and practice. It will link the methods to midrange theories that explain and predict behaviors associated with clinical research and practice. And it will provide a model for future directions for research in this area. Qualitative methodologies utilize ethnographic sampling strategies, rather than relying on probability based samples. This allows researchers to apply qualitative and statistical analysis to clinical and community data, using samples carefully selected for key research characteristics, including rare conditions, cultural variability, and clinical needs. The new qualitative methods include such diverse techniques as linguistic instrument assessment (Cross-cultural language assessment, concept mapping), classification systems research (pilesorting, triads tests, etc.), research on values and beliefs (key informant interviews, focus groups), techniques for understanding key decision making (Ethnographic Decision modeling), and comparative research linked to policy development (Cross-cultural Applicability Research). Examples of successful applications of each method will be provided.

t h e m e



**THE APPLICATION OF QUALITATIVE  
METHODOLOGIES IN CLINICAL RESEARCH  
AND PRACTICE**

**W O R K S H O P**



PROSPECTS FOR THE FUTURE

PROSPECTS FOR THE FUTURE




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## QUALITATIVE EVALUATION OF COMMUNITY MENTAL HEALTH SERVICES FOR PEOPLE WITH CHRONIC SCHIZOPHRENIA

**R. Kilian, M.C. Angermeyer, M. Uhle, I. Lindenbach, U. Löbig, K. Rolle**  
Dept. of Psychiatry, University of Leipzig, Leipzig, Germany

For the planning and evaluation of community mental health services extensive information on the subjective needs and the objective life circumstances of the patients are needed. A critical review of recent studies on mental health service evaluation show that it is difficult to draw detailed conclusions about service needs and the usefulness of existing services from commonly used standardised measures alone. As a solution for this methodological problem a qualitative approach based on a problem focused interview and a computer assisted content analysis for the assessment of quality of life and the service needs of people with chronic schizophrenia has been developed by the authors. In a study of 100 outpatients with chronic schizophrenia this interview has been applied together with the standardised Lancashire Quality of Life Profile and standardised measures of positive and negative symptoms (BPRS, SANS). The results of the study show that in comparison with the standardised quality of life measures the qualitative interview allows a more comprehensive description of how useful existing services are for the patients and what kind of additional services would be needed for the improvement of their quality of life.



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**CROSS-CULTURAL RESEARCH ON DISABLEMENTS:  
THE APPLICATION OF A QUALITATIVE METHODOLOGY  
IN THE DESIGN OF AN OPERATIONAL SYSTEM FOR THE  
ASSESSMENT AND CLASSIFICATION OF DISABLEMENTS**

**S. Herrera Castanedo, L. Gaité Pindado, M. Perez Retuerto,  
E. Vázquez-Bourgon, A. Arriaga Arrizabalaga, M. Uriarte Ituriño,  
J.L. Vázquez-Barquero**

Clinical and Social Psychiatry Research Unit. "Marqués de Valedecilla".  
University Hospital. University of Cantabria, Santander, Spain

The evaluation of the functional status, or disablement, of medical and psychiatric patients is a necessary complement to diagnosis, not only for the understanding of the patients health care needs, but also for the estimation of the cost associated to their disease and for the evaluation of the efficiency of the interventions applied. However, the lack of common definitions of the concept of disablement and of dysfunction and the absence of an internationally accepted instrument to measure these concepts, make cross-cultural comparisons in this area very difficult. To resolve this problem a WHO-NIH Joint Project on the "Assessment and Classification of Impairments, Disabilities and Handicaps" was initiated. The main objectives of this Project were:

I) to test the cross-cultural applicability of the construct of disablement, and of the different concept incorporated in the new version of the International Classification of Impairments, Disabilities and Handicaps, ICDH-2.

II) to develop a set of instruments to measure disability that will be applicable in different cultures. In the first phase of this Project the objective will be to verify, from a cross-cultural perspective, the concepts and items used in the classification system and in the assessment instruments to be developed. For this, qualitative methodologies were applied, including: Focus Groups, Pile Sorting, Concept Mapping, and Key Informant analysis. Thus the objective of this paper will be to present data on the application of these qualitative methodological strategies.



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**FOCUS GROUPS WITH PSYCHIATRISTS:  
METHODOLOGICAL ISSUES**

**Munarriz, M; Santiago, C; Marqués, MJ; Gómez-Beneyto, M; Sanjuan, J.**  
U.S.M. Burriana., Castellón, Spain

The authors carried out a focus group study with psychiatrists in an attempt to explore, in a creative manner, their views about their roles, future and training. Some methodological issues aroused through the different phases of this project. Advantages and pitfalls of assumed alternatives are discussed.

Design was deliberately open and inductive. Some questions (roles, future) are more liable to be discussed than others.

Discussion guidelines: Few, wide-range topics vs. Detailed guidelines.

Sampling (Segmentation): Along two axes: years of experience and academic status, including particular groups (private practice, "antipsychiatrist") based upon theoretical assumptions.

Recruiting: Through personal acquaintance. Appointed by personal letter. Sponsored by pharmaceutical laboratory.

Group sessions: Minimum number of participants 4. Neutral environment in conference hall. Moderator was himself a psychiatrist in most groups.

Analysis: Audio records were transcribed. Analysis included iterative reading, coding, selection of significant phrases, intergroup comparisons, use of graphic displays (matrix, grids) and researchers group discussion.

Triangulation: Analysis of relevant texts, non-psych groups.

Outputs: Descriptive essay, an heuristic basis for more structured studies and feedback loop of new analysis of data.





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## A QUALITATIVE INVESTIGATION OF SOURCES OF STRESS, SATISFACTION AND SUPPORT AMONG MENTAL HEALTH STAFF.

Yael Reid, S. Johnson, D. Prosser, N. Morant, E. Kuipers, G. Szmukler, P. Bebbington and G. Thornicroft.


Institute of Psychiatry, London, U.K.

**Background:** Staff well-being is of central importance in service development with evidence that staff burnout may prevent some innovative services being sustained and incorporated into routine practice. An initial quantitative study indicated high levels of burnout and poor psychological well-being among mental health staff, with especially high burnout among community-based staff.

**Aims:** In the present study we aimed to elucidate the findings of this quantitative study and to explore ways of intervening to improve staff well-being by using a qualitative method to investigate sources of stress, satisfaction and support among mental health staff.

**Method:** A representative sample consisting of 30 members of staff, including junior and senior members of each profession, from both hospital and community settings were interviewed using a semi-structured interview. The questions were formulated on the basis of the initial quantitative study and through pilot interviews. Interviews were transcribed verbatim and analysed using QSR NUDIST software.

**Results:** Contact with colleagues was one of the most rewarding aspects of the job for both hospital and community based staff. For community staff, contact with patients was highly rewarding, but was also accompanied by a strong sense of constant responsibility for patients' well-being. This sense of responsibility was one of the principal stressful aspects of the job. In contrast, ward staff reported as a central difficulty a lack of autonomy and responsibility. They expressed limited satisfaction from contact with patients because of limited time for direct contact, lack of autonomy and of opportunity to develop a therapeutic role, frustration with 'revolving door' patients and the unpleasantness of having to cope with violence and restrain patients. Excessive workloads and too much paperwork were problems for all staff. Generally there was surprisingly little evidence of conflict or difficulties defining roles between disciplines, except for the social workers for whom difficulty in defining their roles in relation to other professions was a major preoccupation. Investigation of potential sources of support for staff suggested supervision and training in clinical skills as promising focuses for developments aimed at reducing stress and increasing satisfaction.



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## A DELPHI METHOD APPROACH TO DESCRIBING MULTI-DISCIPLINARY COMMUNITY MENTAL HEALTH PRACTICE.

MT Fiander, B Chisholm and TP Burns.

St. George's Hospital Medical School, London, United Kingdom.

Attempts to measure UK mental health care practice are hampered by the lack of an agreed set of relevant descriptive categories.

**Aim** To identify clinician generated categories with which professionals across six mental health disciplines can classify their common clinical interventions in community and out-patient settings.

**Method** A three round 'conventional Delphi' method was used. Multidisciplinary discussion groups then processed the Delphi results.

**Subjects** All practising clinicians in the Adult, Elderly or Rehabilitation services of a London Mental Health Trust (n=151).

**Results** Across all disciplines consensus was present in 91.5% of the categories and strong consensus in 57.4%. Within-discipline consensus was present on average in 99.8% of categories and strong consensus in 92.7%. 35 comprehensive and mutually exclusive categories were produced including 10 multi-disciplinary categories.

**Conclusions** The Delphi based methodology succeeded in producing a meaningful set of multi-disciplinary categories for use in the Trust's computerised clinical information system. Combined with qualitative data they are being used to provide meaningful service-level descriptions of mental health practice.



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## A QUALITATIVE PERSPECTIVE ON OUTCOME OF GROUP-BASED PSYCHIATRIC DAY CARE

**M. Eklund, L. Hansson**

University College of Health Sciences, Lund, Sweden.

This presentation concerns a qualitative approach used in a process-outcome study of group-based psychiatric day care. Inductive qualitative analysis was used to detect clinically significant change among the patients, to make case descriptions, and to extract curative factors of the programme.

Interviews with 20 mentally ill patients and 12 significant others were conducted at the patients' admission and discharge. The interviews focused the patients' change and factors that had led to improvements, if any. In order to determine clinically significant change the patients were classified into five categories of improvement, the two most improved considered as clinically significantly changed. Thirteen of the patients reached clinically significant change from the qualitative perspective and did so according to a quantitative approach as well. The quantitative perspective identified another 2 patients. Thus, the two perspectives corroborated each other, although the qualitative was somewhat more restrictive.

Statements regarding helping factors were literally written down and coded according to the principles of latent content analysis. An interrater reliability of 0.69-0.78 was established. Four therapeutic dimensions emerged: the group, the occupational, the treatment milieu, and the individual therapy dimension. The factors included in the group dimension were very similar to curative factors previously described within group psychotherapy by, e.g., Yalom.



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## BREAKING THROUGH THE WALLS. HOW PSYCHOSOCIAL REHABILITATION IS PERCEIVED BY PSYCHIATRIC HOSPITAL STAFF

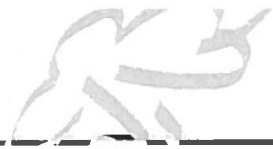
**A.D. Lesage, J-P. Bonin, N. Ricard.**

Centre de Recherche Fernand-Seguin, L-H Lafontaine Hospital and  
University of Montreal, Quebec, Canada

Objective: Psychosocial rehabilitation appears to have made little headway in the institutional sector and various authors have discerned a certain polarization between this approach and psychiatric treatment. This study explored the interface between these two apparently irreconcilable worlds by describing the beliefs, values and practices of caregivers working in the long-stay wards of Canada's largest psychiatric hospital.

Methods: Eleven focus groups (n=72) were held with members of the various categories of hospital staff: orderlies, nurses, head nurses, paramedical professionals and psychiatrists. What they said was analyzed to identify their beliefs, values and care practices and compare these against the principles developed by Bachrach; Cnaan et al. and Anthony et al.

Results: Although caregivers were not well versed in rehabilitation theory, what they said was dotted with references to such psychosocial rehabilitation principles as continuity of care, interpersonal caregiver-client relationship, hope, individualized treatment, normalization, and importance of the environment. However, client involvement in treatment and vocational training were two dimensions scarcely raised.



## THE PATIENT'S AND THE TREATER'S UNDERSTANDING OF THE PRESENTED PROBLEM.

**S. Levander and A. Werbart**

Center for Psychosocial Research, Stockholm, Sweden

Six first-time psychotic patients and six with long-standing psychotic problems were interviewed three times during a period of 18 months.

Three questions were asked: What is the problem? What is the background of the problem? What would be of best help? The treaters were asked the same questions in parallel interviews.

The narratives (45 minutes x 3) were analysed by three independent judges on two levels: 1) An identification of recurring themes and 2) unconscious or preconscious fantasies and wishes as they appear in the narratives. A consensus between the three judges was reached, and a comparison between the patients and their treaters was made. Further an attempt was made to describe the interaction between the two sets of understanding, the "subjective" of the patient and the "objective" of the treater.

The consequences of convergences and divergences, respectively, are discussed.



## EVALUATION OF A PROGRAMME FOR INFORMAL CAREGIVERS OF THE MENTALLY ILL.

**Emma Staples, George Szmukler, Elizabeth Kuipers, Tirril Harris,  
Wendy Maphosa, John Joyce and Graham Thornicroft.**

PRISM, Section of Community Psychiatry, Institute of Psychiatry, London, UK.

**Aims:** Despite their crucial role in the lives of people with mental health problems, the needs of informal caregivers are often ignored. Relatives and friends of people with mental illness can experience high levels of distress, psychological morbidity and dissatisfaction with mental health services. This programme aims to reduce psychological morbidity in the caregivers, reduce the negative and increase the positive experiences of caregiving and improve understanding and coping. Qualitative and quantitative methodologies are used in the evaluation.

**Plan of the investigation:** The design of the study is a randomised controlled trial of individual psycho-educational sessions followed by relatives groups as compared with a control condition offering limited information. The programme lasts one year and outcomes will be assessed after the programme, and then one year later. The latter assessment will examine whether improvements are maintained or whether in the absence of continued support, gains are lost. Contacts by carers with the patients treatment team will be examined during the follow-up year to see whether the intervention has enhanced their ability to use services more effectively.

Qualitative and quantitative approaches are used to describe the level of caregiving difficulty, assess the experience of caregiving and evaluate coping and social support. Psychological morbidity is detected using the computerised Revised Clinical Interview Schedule. Qualitative and quantitative data will be collected from both caregivers and patient keyworkers.

**Outcome:** This research is on-going. Baseline data will be available for the conference presentation. The discussion will explore the use of both qualitative and quantitative methodologies in this randomised controlled trial.



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## THE APPLICATIONS OF QUALITATIVE METHODOLOGIES IN CROSS-CULTURAL ADAPTATION OF ASSESSMENT INSTRUMENTS FOR PSYCHOSIS

L. Gaite Pindado, M. Perez Retuerto, A. Arriaga Arrizabalaga,  
E. Vázquez-Bourgon, E. García Usieto, A. Gómez del Barrio,  
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University Hospital. University of Cantabria, Santander, Spain

Psychosis is a severe and highly disabling disorder with a high prevalence in the European Union. As result of this several psychiatric research units in five European countries are taking part in an international BIOMED project, to evaluate quality of life, needs, cost-effectiveness and satisfaction in a sample of 500 schizophrenic patients. The main objectives of this multi-centric programme are: i) to use well standardised instruments and develop new ones; ii) to guarantee the applicability of the instruments in five different countries and iii) to obtain and compare data from each country.

The absence of psychosis assessment instruments that are applicable to different countries stress the necessity to carry out a cross-cultural adaptation strategy to guarantee the applicability of the instruments. This strategy has two phases: i) Translation, and ii) Cultural and Linguistic Adaptation.

For the initial translation of the instruments, we have developed a new methodology called "Multiphase Interactive Translation Model" that includes some characteristics of the previous methods and brings additional advantages. In order to get the cross-cultural adaptation, qualitative techniques have been used. These techniques are being demonstrated to be more and more useful in health programmes, and are specially useful for the development of psychiatric assessment instruments. Some of the most utilised qualitative techniques for are: Concept Mapping, Key informants, Life Event Interviewing, Pile Sorting, Free Listing or Focus Groups. The Focus Group methodology was applied to the multicentric project.

With these strategies we have been able to reach the proper applicability of the instruments, as well as a reliable Spanish version of each. The feasibility of applying these strategies in the cross-cultural adaptation of these sort of instruments will also be discussed in this paper.



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## QUALITY MANAGEMENT IN CONSULTATION-LIAISON PSYCHIATRY

G. Cardoso, T. Maia, A. Luis

Hospital Amadora/Sintra, Amadora, Portugal

Due to its multidisciplinary and to the complexity of the problems it deals with, Consultation-Liaison Psychiatry (C-LP) is a privileged field for the development of Quality Management (QM) programmes.

Taking part in a European Biomed 1 study, our centre developed a quality programme aimed at improving communication at different levels: 1) between referring departments in the general hospital C-LP; 2) with doctors and nurses of the referring departments; 3) between the medical staff and the patients; 4) with post-discharge medical and psychiatric caregivers.

Methodology: all C-L episodes during one year (May 96-May 97) were monitorized with a Patient Registration Form. The first four months functioned as baseline on the 1st October 96 some measures were taken in view of improving quality.

Results: the preliminary results, between May 96 and February 97 show a significant change in the way the referral was made, with more written versus verbal referrals ( $p=0.00000$ ) and more sufficient information gathered at the moment of the first consultation ( $p=0.00000$ ). There was improvement in other aspects although not significant.

Conclusion: a QM programme satisfactorily improved communication and contributed to better care provided by a C-L service in a general hospital.

t h e m e



## THE APPLICATION OF QUALITATIVE METHODOLOGIES IN CLINICAL RESEARCH AND PRACTICE

I N T R O D U C T I O N

W O R K S H O P S

**PROSPECTS FOR THE FUTURE**

C O N C L U S I O N S

A B O U T T H E A U T H O R S

A B O U T T H E P U B L I S H E R

A B O U T T H E J O U R N A L

A B O U T T H E E D I T O R

### EFFECT AND COSTS OF EMOTION-ORIENTED CARE ON DEMENTED ELDERLY AND PROFESSIONAL CARERS IN NURSING HOMES; A RANDOMISED CLINICAL EXPERIMENT WITH QUANTITATIVE AND QUALITATIVE MEASUREMENTS

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A pretest-posttest control group design with matched groups is used in this study. The sample consists of 400 demented residents and 120 nurses working at 16 wards in 14 nursing homes. Of this sample about 200 patients have the diagnosis Alzheimer's disease. Half of the sample (the experimental group) will be offered emotion-oriented care, e.g. care merely based on the Validation approach, combined with insights from other approaches such as reality orientation training and reminiscence. Nurses in the other half of the sample (the control group) are trained and given support in offering regular nursing home care based on recently developed conditions for quality of care of the Dutch Association for Nursing home Care. Quantitative as well as qualitative measurements will take place at baseline and in the 4th and the 8th month of the experimental period. Dependent variables with regard to the demented elderly are cognitive, social and emotional adaptive problems (on the basis of the adaptation-coping model). For almost all variables standard assessment scales are used. Qualitative data are gathered through participant observation on 8 wards. We observed interactions between patients and nurses in standard care situations, e.g. bathing, meals, activities in the living room. The aim of the qualitative research was to study verbal and non-verbal communication, relationships and activities where no standard assessment scales were available. In this presentation we will discuss the possibilities of qualitative measurements within a randomised clinical experiment. The project was started in April 1996, the measurements took place in 1997 and the results will be available in April 1999.



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## FUTURE PERSPECTIVES ON THE APPLICATION OF QUALITATIVE METHODOLOGIES IN CLINICAL RESEARCH AND PRACTICE

V. Mavreas

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Eginition Hospital, Athens, Greece.

The problems in comparing psychiatric studies and clinical practices along the world, are old and have limited so far the generalization of results of psychiatric studies. The difficulties of creating cross-culturally applicable instruments for research cannot be resolved only by translating psychiatric instruments from one language to another. The applicability of the translated instruments in another culture is questionable if the particularities of the culture and of the language have not been taken into account. Therefore, the use of qualitative methodologies is a useful means to create instruments taking into account these issues and being applicable in different cultures. These methodologies include the use of translation and linguistic analysis and other ethnographic methods such as concept mapping, pile-sorting, key-informant interviews and focus groups. The experience from the use of similar designs has shown to create criteria and instruments of wide applicability and acceptability. These methodologies can also give useful information on the comparison of health care and insurance systems and policies between countries in order to delineate similarities, differences and perceptions about critical issues of mental health and disease.

t h e m e



**THE APPLICATION OF QUALITATIVE  
METHODOLOGIES IN CLINICAL RESEARCH  
AND PRACTICE**

**P O S T E R**





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## EVALUATION OF A BILINGUAL PSYCHIATRIC CASE MANAGEMENT PROGRAM

**S. Ziguras, G.W. Stuart, A. Jackson, J. Pennella Victorian**  
Transcultural Psychiatry Unit, St. Vincent's Hospital, Melbourne, Australia

The Western region of Melbourne is culturally diverse, with 34% of the population born overseas in more than 50 countries. Previous studies have found that people from ethnic minority backgrounds are less likely to use community mental health services, and experience difficulties in communication and cultural understanding with mental health professionals. In order to overcome some of these problems, a program was devised to employ 11 bilingual staff in case management positions in 5 services in the region. Evaluation of this program includes an examination of the implementation of the program as well as outcomes for clients. Both qualitative and quantitative methodologies are used.

Implementation is assessed through structured interviews with staff, and analysis of service data. Outcomes are assessed using client satisfaction scales and open-ended interviews, and measures of client functioning and service use.

This paper will present the results of the implementation study using qualitative methods. It will address aspects of the design and introduction of a new program, highlighting issues such as staff acceptance of new programs, role of bilingual staff (eg direct service provision of consultation), and the impact of the geographical distribution of ethnic communities on service models.





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**PSYCHIATRISTS TALK ABOUT THEMSELVES.  
A DESCRIPTIVE ASSAY THROUGH FOCUS GROUPS.**

**Munarriz, M; Santiago, C; Marques, MJ; Gomez-Beneyto, M; Sanjuan, J.**  
U.S.M. Borriana, Castellón, Spain.

The authors carried out a focus group study with psychiatrists in an attempt to explore, in a creative manner, their views about their roles, future and training.

**Method:** Ten focus groups with psychiatrists segmented along years of experience, academic status and other theoretical assumptions, using open guidelines. Analysis includes transcribing, coding, graphic displays and intergroup comparisons. Triangulation was facilitated by the analysis of relevant texts, focus groups with non-psychiatrists, and researchers group discussion.

**Results:** Psychiatrists tend to construct their role on a core topic related with the complexity of the discipline and the personal encounter with patients. Their historical background, perceived social demands, conditions of training and organizational constrictions affect this basic core topic, according with their particular experience. Training appears as a consequence of such a situation and few specific issues are traced in group discourse. However, some questions and future challenges are raised.



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**IMPROVING OUTCOMES IN PRIMARY CARE,  
A GUIDELINE DEVELOPMENT STRATEGY**

**E.J. Wilkinson, C.U. Crilly, G. L. Harrison, J. Evans,  
T. Croudace, D. Sharp**

Division of Psychiatry, Bristol University, Bristol, England.

The EGO study (Evaluating Guideline Outcomes) is an evaluation of the development and local adaptation of the WHO "Diagnostic and Management Guidelines for Mental Disorders in Primary care." A randomized controlled trial will evaluate a 'bottom up' introduction of guidelines into routine clinical settings; the study will involve 30 general practices (104 general practitioners) across a representative urban and semi-rural area.

There is evidence to suggest that imposed Guidelines often fail to change clinicians' behaviour and there is a shortfall in anticipated improvements in quality of care. They are often generated by hospital specialists and therefore fail to engender a sense of shared ownership. In addition, development (and evaluation) may occur in unrepresentative, specially motivated academic health care settings.

We will describe, and present process measures for, the local adaptation and development of the WHO guidelines in the 'real world' general practices involved in the Bristol UK RCT.



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QUALITY ASSESSMENT PROGRAM IN GRANOLLERS'  
DAY'S CENTER FOR MENTAL ILL PERSONS  
(CENTRE DE DIA DE GRANOLLERS)

Jordi Matesanz\*, Leo Turek \*\*, Jordi Jaumandreu\*\*\*

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\*\* Centre de Salut Mental d'Adults del Vallès Oriental

\*\*\* Ajuntament de Granollers

#### INTRODUCTION

The Centre de Dia de Granollers (Granollers' Day's Center) is an equipment which task is rehabilitation and social reinsertion of mental ill people from the county of Vallès Oriental (Catalunya, Spain). The center is financed by the Catalan Health Service (Servei Català de la Salut ), and managed by the municipality of Granollers.

On 1997, the municipality of Granollers and the director of the center, started desing and implementation of a quality' assessment program for the Centre de Dia.

#### METHOD

As we are trying to evaluate efficacy, accessibility, efficiency and user's familiars and related institutions satisfaction, we have used different strategies such as surveys, monitoring of clinical course, etc.

#### RESULTS

In the communication some results of the first implemented action will we discussed, and also will be analysed changes on dayly life of the center produced by program implementation.



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THE NORDIC COMPARATIVE STUDY ON SECTORIZED  
PSYCHIATRY - AN OVERVIEW OF FINDINGS

L. Hansson, O. Saarento, L. Christiansen, G. Göstas, M. Kastrup,  
A. Lindhardt, O. Lönnnerberg, S. Muus, M. Sandlund, H. Vinding,  
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From a Nordic point of view knowledge of the impact of the transformation of psychiatric services towards mainly community-bases services is scarce, both when it comes to effectiveness, use of services, and acceptability of the new services. The Nordic comparative study on sectorized psychiatry is a prospective investigation of contact rates of new patients and use of psychiatric services during a one-year follow-up in 7 Nordic catchment areas. The main aims were to investigate the relationship of contact rates and use of services with social and clinical patient characteristics and characteristics of the services. The study included all new patients contacting the services during one year, in total 2834 patients. More than 2-fold differences in contact rates between the services were found. The most common way of contacting services was by self-referral, 39.4% of total referrals, with a great variation between services. The accessibility of services was only weakly associated to contact rates. Contact rates of psychoses were correlated to degree of urbanization. The only service characteristic associated to contact rates was rates of outpatient staff. Use of inpatient services during follow-up was correlated to supply of beds. However, highly staffed community services did not seem to reduce the use of inpatient services. On the other hand an availability of day care services was related to less use of inpatient services for psychosis patients. The use of services was very skewed insofar as the 10% of the patients constituting a high consumption group accounted for 90% of all inpatient days, 75% of all days in daycare, and 2/3 of the total use of services as measured by a Service Consumption Score. A higher utilization of services was related to older age, living alone, being unemployed, and to female sex. Clinical predictors of a higher utilization were a diagnosis of psychosis and a history of psychiatric service use.



## THE PSYCHOGERIATRIC UNIT FOR THE AREA OF HEALTH, A NEW MENTAL HEALTH RESOURCE IN GALICIA (SPAIN). EVALUATION OF SIX YEARS

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Baca E<sup>2</sup>, Rodríguez A<sup>1,2</sup>**

<sup>1</sup>Complejo Hospitalario Universitario de Santiago (CHUS, Hospital Psiquiátrico de Conxo);

<sup>2</sup>University of Santiago de Compostela, Department of Psychiatry.

<sup>3</sup>Hospital Puerta de Hierro & Universidad Autónoma, Madrid. Spain.

The Psychogeriatric Unit (UPG) of Santiago de Compostela, composed by a interdisciplinary team (first four authors of this paper), is a unique resource that was set up by the Galician Ministry of health authority by the second semester of 1991.

**Aim:** We analyse the achievements and difficulties of the tasks (clinical, teaching and research activities) carried out along the first 6 years of functioning, trying to answer the questions: Does the UPG follow the principles of quality implicit in the programmatic model?; ¿How this new experience help to develop operative indexes of quality of care for psychogeriatric patients in Galicia?.

**Method:** We analyze the coherence between sociodemographic and some clinical data of the patients who have attended the unit and the programmatic model, published years ago by the interdisciplinary team.

**Results:** Around 1300 patients have attended the unit. In spite of the relevant limitations of the UPG (small number of professionals and assistential facilities) authors consider it has brought a new model into the Galician Psychogeriatric field: 1)reducing the delay in the attention to the elderly psychiatric patient, 2)giving a holistic orientation to the diagnosis and improving its precision from the psychiatric point of view; 3)developing the domiciliary assistance and ameliorating the continuity of the care; 4)coordinating mental health network, primary care and social services; 5) coordinating assistential, teaching and research objectives.

**Conclusions:** We hope for two future goals: a) self-servingly, the consolidation of the UPG within itself; b) socially more important, the validation of a work model that persuade our Health Care Authorities to create one unit of this type in each Area of Health of Galicia.



## LENGHT OF FIRST INPATIENT STAY AND READMISSION RISK

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O Lönnnerberg, M Sandlund, HR Vinding, L Hansson.**

Salten Psychiatric Centre, Nordland Psychiatric Hospital, Bodo, Norway.

Readmission risk after first inpatient episode was investigated in this study which is part of The Nordic Comparative Study on Sectorized Psychiatry . The questions adressed concerne whether lenght of first inpatient stay (LOS) predict readmission. **Methods.** 837 consecutive patients admitted to inpatient stay during one year to seven psychiatric hospitals in four Nordic countries, were included. Only new patients (not in contact with the service for at least 18 months) were included. Survival methods were used for the analyses. **Results.** Readmission after one-year follow-up, ranged from 25% to 41% between the sectors. The difference was not significant. The risk of readmission increased with younger age, being psychotic, acute admission and no aftercare. In the psychosis group (in particulr 'schizophrenia'), LOS shorter than one week increased the risk of readmission significantly compared to longer LOS, when adjusting for the sociodemographic, clinical and service utilization variables collected. **Discussion.** The study emphasizes the importance of LOS on readmission risk for the psychotic patient. It extends previous work in this field in using survival techniques and including several hospitals in different mental health systems.



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## A PILOT STUDY OF 'CRISIS CARDS' IN A COMMUNITY SERVICE

Dr G Szmukler, Dr K Sutherby, Mr M Alexander,  
Prof G Thornicroft, Mr S Wright.


PRISM, Institute of Psychiatry and Southwark, Community Health Council

Background 'Crisis cards' originates as a voluntary sector initiative to facilitate access to an advocate and to state a service user's preferences for treatment in an emergency when he or she might be too unwell to express their wishes coherently. They are designed to be carried by the user and have the potential to record a range of useful information and advance statements.

Method Community study of the acceptability and feasibility of introducing crisis cards or joint crisis plans into a sectorial psychiatric service for patients at high risk of crisis. A 6-12 month follow-up was carried out by an independent assessor to establish users' satisfaction with the fairness of the process and the use of the cards.

Results 106 patients meeting the study criteria were identified within the community sector. Forty-two (40%) wished to develop a crisis card or joint crisis plan. They were more likely to have a diagnosis of an affective psychosis, a history of suicide attempts, and to have less frequent admissions than those not wanting a card. Patients chose to include a wide range of information including diagnosis, current treatment, contact information for carers and professionals, first signs of relapse, treatment at first signs of illness, treatment preferences and refusals, indications for admission, and practical requests. The process was experienced as non-coercive. At 6-12 months the card was considered to have been helpful in a crisis in 74% of episodes. Over 50% of users reported feeling more involved in their care, more positive about their situation, and more in control of their mental health problem. A 30% reduction in admissions occurred in the year following the card.

Conclusions Joint crisis plans are acceptable for a substantial proportion of patients with severe mental illness in a community service but take time to become established. The card served both a manifest, practical function (to provide important information when the patient is too ill to do so), as well as a latent, psychological one (positive effects on the patient's attitude to themselves, their illness and treatment, and their relationship with the clinical team).



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## THE APPLICATION OF QUALITATIVE METHODOLOGIES IN CLINICAL RESEARCH AND PRACTICE: THE WHO CAR PROJECT ON ALCOHOL. THE ICD-10 AND DSM-IV CRITERIA.

V. Mavreas

Athens University Medical School, Department of Psychiatry,  
Eginition Hospital, Athens, Greece.

Wide differences in the rates of alcohol-related problems have been reported world-wide. However, the comparability of studies on this issue is hampered by the different definitions used in different countries for alcohol problems and alcoholism. The WHO and ADAMHA launched a study in the early 90's in order to create cross-culturally applicable and acceptable criteria and definitions for alcohol and drugs and assessment instruments based on them. This study was carried out in nine different countries and included the linguistic analysis of terms referring to alcohol and drugs, key-informant interviews, questionnaires asking about the applicability of diagnostic criteria and questions in the culture and focus groups. The result of this series of studies was the refinement of the criteria, in order to apply in these cultures, and the creation of research instruments (relevant sections of CIDI and SCAN) for the assessment of these disorders. The presentation will focus on the methodology used and the reporting of the results of this project.



P L E N A R Y      S E S S I O N



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**BIOMED-PROJECT: STANDARDISING OUTCOME  
MEASURES FOR PEOPLE WITH SCHIZOPHRENIA  
IN FIVE EUROPEAN COUNTRIES**

**H.C. Knudsen, T. Becker, M. Knapp, A. Schene, M. Tansella,  
G. Thornicroft, J.L. Vázquez-Barquero**

Section of Community Psychiatry, Institute of Psychiatry, London, UK;  
Institute of Preventive Medicine, Copenhagen, Denmark

The study comprises five sites in five European countries, with specialist health economics input provided by a sixth research group. Services with catchment area responsibilities in Amsterdam, Copenhagen, London, Santander, and Verona each providing a comprehensive range of services are involved. In a first phase (concluded in autumn 1997) research instruments assessing needs for care (Camberwell Assessment of Need), service utilisation and cost (Client Service Receipt Inventory), informal carer involvement (Involvement Evaluation Questionnaire), quality of life (Lancashire Quality of Life Profile) and patient satisfaction (Verona Service Satisfaction Scale) were translated and back translated, the translated versions were checked for adequacy and applicability in the various cultural and service contexts using focus groups. In a second phase, representative groups of patients with a diagnosis of schizophrenia in contact with mental health services in each of the catchment areas are identified, and those patients who consent are interviewed to collect information on their psychiatric symptoms and functional impairment. Patients will also answer questions regarding their needs for care, quality of life, and satisfaction with local mental health services. Carers will be interviewed about their involvement. Unit cost calculation will lead to comprehensive and comparable cost data across sites. Instrument reliability will be assessed, and there will be analyses of relationships between clinical, socio-demographic and service variables within and across sites.



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**BIOMED - PROJECT:  
ORGANISING A MULTI-CENTRE EUROPEAN STUDY  
OF DEPRESSION: ODIN**

**Christopher Dowrick on behalf of the ODIN group**  
Department of Primary Care, University of Liverpool, Liverpool, U.K.

ODIN aims to provide data on the prevalence, risk factors and outcome of depressive disorders in rural and urban settings within the European community and to assess the impact of two psychological interventions on the outcome of depression and on service utilisation and costs. Five centres across the E.U. with expertise in mental health epidemiology and interventions are participating. The sampling frame is adults aged 18-64, identified via primary care data bases or electoral registers. Potential cases of depressive disorders are identified using the BDI. Then SCAN II and other validated measures are used to assign caseness against DSMIV and ICD10 criteria; assess co-morbidity, disability, genetic/familial susceptibility, psychosocial stressors, personality traits and cognitive factors; and assess provision and utilisation of local health care services. An RCT of individual problem solving treatment and a group educational programme is undertaken for respondents identified as cases. Subjects are followed-up at 6 and 12 months.

A crucial aspect of an international research project is the development of a successful and effective network of research teams. In ODIN this esprit de corps has been generated in two ways.

1. Multi-level meetings. The principal investigators have been meeting at regular six month intervals since August 1995 in order to plan and monitor the progress of ODIN. These meetings have been hosted in each of the participating countries in turn, and have included social as well as academic events. The training of research staff has been organised in as collaborative a way as possible, with a large initial meeting for all the diagnostic interviewers and mental health facilitators in Liverpool in June 1996. Key diagnostic interviewers have joined the later meetings of the principal investigators, while the mental health facilitators have had review meetings in the UK and the Netherlands.

2.-Electronic communication. An E-mail link has been established via a modem attached to each research centre computer, connected to the Internet by monthly subscription and the appropriate software. An ODIN database has been set up using the questionnaire facility of Epi-Info. With this system in operation, each centre collates its own data sets which are then sent by E-mail (plus a posted back-up floppy disc) to Liverpool for detailed computation and analysis using Epi-Info, Arcus Pro-Stat and SPSS. Each centre deploys secretarial and administrative support services in order co-ordinate interviews, and organise and collate basic data collection and transfer over the life of the project. This link also allows members of the research teams in the different countries to maintain close and regular contact, which is useful for the development of group cohesion and allows for rapid troubleshooting.



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**BIO-MED-PROJECT:  
THE EPCAT GROUP: DEVELOPING METHODOLOGIES  
FOR MENTAL HEALTH SERVICE COMPARISONS.**

**Sonia Johnson,**  
University College London Medical School, London, U.K.


**Jennifer Beecham.**  
Centre for the Economics of Mental Health, Institute of Psychiatry, London, U.K.

**Carmine Munizza.**  
Centro Studi Ricerche in Psichiatria, Torino, Italy

**Luis Salvador-Carulla.**  
Universidad de Cádiz and the EPCAT group (administrative co-ordination from the Centro Studi, Ricerche in Psichiatria, Torino; scientific co-ordination: Jennifer Beecham)

Few internationally valid instruments have previously been available for the assessment and comparison of psychiatric services. This has restricted the quality especially of cross-national studies, with a concomitant impact on the quality of evidence available to inform mental health policy and practice in Europe.

A central aim of the EPCAT group has been to fill this gap by developing a technology for assessing the scope, structure and content of mental health services which is designed to be valid throughout Europe. This technology includes the WHO International Classification of Mental Health Care developed by A de Jong and colleagues for the classification of interventions provided within particular services, and the European Service Mapping Schedule (ESMS). The ESMS has been specifically developed by the EPCAT group as a tool for the description of the set of mental health services available to the population of a particular catchment area and for the recording of levels of use of each type of mental health facility within a catchment area. This presentation will focus on the development of this tool by our group: we will describe the challenges faced and the differences in attitudes and clinical practice which emerged as we worked to arrive at a methodology with cross-national validity, and will discuss the process through which a cohesive and effective collaborative group eventually developed.



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**BIOMED PROJECT:  
ADVANTAGES AND DIFFICULTIES OF COLLABORATING  
IN EUROPEAN MULTICENTRIC PROJECTS ON MENTAL  
HEALTH RESEARCH**

**J.M. Caldas de Almeida, M. Xavier**  
Faculty of Medical Sciences, Lisbon, Portugal.

The Department of Psychiatry of the Faculty of Medical Sciences, Lisbon, has participated in several European Collaborative projects, during the last years.

Based on this experience, the authors discuss the advantages and difficulties of these projects.

A special attention is given to the contributions of Collaborative projects to: the development of national groups working in mental health research; the creation of european networks; the dissemination of methods and instruments; the implementation of studies demanding large populations and the gathering of scientific data supporting the development of national mental health policies and the improvement of mental health care.

The main difficulties found at the different levels of collaborative projects design elaboration, budget management, coordination of research, analysis of data and dissemination of findings of data - are also discussed. In spite of these difficulties, European Collaborative projects have proved to be an important instrument to mental health research in Europe.



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**THE BIOMED PROGRAMME:  
WHAT CAN BE LEARNED FROM PAST EXPERIENCE.**

**A. Vanvossel**  
European Commission, DG XII-E-4, Life Sciences - Directorate, Medical Research.  
Brussels, Belgium

The community action in Public Health is directed towards prevention of disease, in particular the major health problems, notably by promoting research and technological development activities of high quality.

Since 1990, a first "Biomedical and Health Research programme (1990-1994)" (BIOMED 1) was implemented by Directorate General XII of the Commission under the "Life Sciences" Directorate. An important part of BIOMED 1 dealt with "Health Services Research" while another chapter addressed "mental and neurological disorders".

At this occasion and for the first time "Outcome" research was taken into consideration in Community programmes with projects tackling health outcomes in ambulatory care, renal disease, stroke, oral health care etc. Mental health as such was not yet addressed. The second "Biomedical and Health Programme" BIOMED 2 (1994-1998) is running at present.

A positive trend is that in BIOMED 2 a number of projects specifically address "mental health".

Furthermore the evaluation process of these proposals demonstrated that a high quality culture of research in evidence based "mental health care" and "outcome" research is developing in the EU.

Future programmes of the Fifth Framework programme of RTD of the European Community (1999-2002) are at present discussed at the level of the Commission, Council and European Parliament.





C L O S I N G      S E S S I O N



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## MENTAL HEALTH EVALUATIONS IN CLINICAL PRACTICE: IMPLICATIONS FOR POLICIES

**David Goldberg**

Director of R & D , Institute of Psychiatry, King's College, London, U.K.

Progress towards establishing comprehensive community services, and in reducing the numbers of beds in hospital, has been very uneven in Europe. In Eastern Europe, very little progress has been made at all. In England, our new Secretary of State has recently declared that "Community Care has failed", and presumably intends to resurrect some form of institutional care for those whose behaviour poses a threat to others.

In this talk I will review the various evaluations of services that we have had; separating them by the main methods of evaluation adopted: adverse effects of the mental hospital; RCTs of acute admissions; alternatives to admission; following up cohorts of de-institutionalised patients, and two contrasting services.

These evaluations will be discussed in the light of Thornicroft and Tansella's "Three Aces" for judging the efficacy of community services. It will be argued that a range of indicators are needed to come to a decision about whether mental health services are adequate; no single indicator will do.

It will be concluded that while community care has certainly NOT failed; it could easily do so, if Ministers give in to the temptation of cutting the resources that are available to support services in the community. If services are to be delivered without unnecessary extravagance and needless waste of resource, one needs to reduce expenditure that is not producing optimal results. Examples of wasted expenditure would be: keeping dangerous personality disorders (without mental illness) in hospital rather than in prison; keeping patients in hospital for too long, when they could be cared for better and more cheaply in the community; and allowing dangerous patients to be cared for separately in the community. It will be argued that optimal services never be obtained for as long as health and social services are kept separate.



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## MULTIPLE PERSPECTIVES ON THE EVALUATION OF OUTCOME. IMPLICATIONS FOR CENTRAL AND EAST EUROPEAN COUNTRIES

**I. Tomov**

Medical School, Sofia, Bulgaria

The role of institutional culture in shaping notions of outcome is insidious and critical. The influence of central-control world views on professional attitudes results in narrow and definitions of outcome.

In order for broader perspectives on outcome to be adopted, a change in East European institutional culture is needed in addition to more advanced notions of outcome. An important first step involves: (1) doctor-patient relating, which is informed by awareness of roles, boundaries and identities; (2) organisation and management of care, which encourage variety in social participation; (3) training, which blends professional ethics with clinical skills.

The introduction of these and related topics into the professional discourse in Eastern Europe will take the good will and effort of the international professional community.

Some practical implications of the analysis of the role of institutional contexts and shared beliefs on the evaluation of outcome are: (1) the control for intervening factors by making the institutional culture explicit; and (2) the control of the role of beliefs on professional performance by studying attitudes to mental illness.



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