

NR3. Clinical services and community care — I

Chairmen: T Fahy, T Burns

SOCIAL NETWORKS, SERVICE UTILISATION AND SERVICE COSTS IN SOUTH LONDON

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Objectives: To compare service utilisation and cost for a representative group of people with psychotic disorders in subgroups with extended v small social networks.

Methods: In two defined geographical areas in South London, a random half sample of annual period prevalent cases of psychosis identified from hospital and community data were interviewed. Social networks were documented using the Social Network Schedule (SNS). Services received during the six-month period preceding interview were recorded using the Client Service Receipt Interview (CSRI) and costs were calculated. Numbers of admissions, length of stay and ever having been compulsorily admitted under the Mental Health Act were recorded.

Results: SNS data was available in 196 patients (105 m, 91 f; 43 ± 16 y). Average network size, in the total group, was 12.4 (SD 8.3) people. Functional non-psychotic disorders formed the largest diagnostic group (78%), there was a minority of affective psychoses (10%). When the total group was dichotomised (using median) into those with extended v small networks patients with small networks utilised fewer in- and out-patient services (6.2 v 7.2 , $p = 0.005$), but when admitted had a longer mean duration of in-patient treatment (44 v 21 d, $p = 0.018$). Their care resulted in higher in-patient (£ 2870 v £ 1081, $p = 0.01$) and total cost (£ 4505 v £ 2710, $p = 0.016$).

Conclusions: Social networks may have had an impact on service utilisation and cost. Small social networks appeared to be associated with fewer services used but higher costs incurred.

WHY PSYCHIATRISTS FREQUENTLY FAIL ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

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An innovative non-statutory community service for adult survivors of childhood sexual abuse, Breakfree, will be described. The service is supported, but not run by, health, social and voluntary services and functions independently of these organisations. Initial evaluation of 59 clients from the project most of whom had previously failed to respond to therapy showed that caseness on the General Health Questionnaire fell from 90% on entry to the study to 49% at completion. There was a correspondingly large improvement on symptoms as measured by the Delusions, Symptoms and States Inventory with only 8% showing no symptoms on entry to the study rising to 41% on completion. Clients views of previous sources of help were investigated. 65% had been referred to a psychiatrist before being referred to Breakfree with only 5% of that group perceiving mental health services to be helpful. 20% considered themselves to have been further damaged by their contact with mental health services. Clients were asked to give specific reasons for leaving previous sources of help and there were many indicating a lack of understanding from psychiatrists, e.g. "The psychiatrist asked me to stop because I made him feel sick — he left me in a very distressed state." This study comprises

of the largest series of adults who have experienced sexual abuse as children reported in the United Kingdom and is the first evaluation of such adults previous use of resources and the only assessment of a community based therapy and support service designed to offer help to such adults as a specific group. Traditional health services and particularly psychiatry, seem to have failed adults who have experienced sexual abuse as children. The reasons for this will be explored.

CONTROLLING PSYCHIATRIC INPATIENTS: THE RESPONSE OF STAFF TO PATIENT MISDEMEANOUR

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Rule breaking by psychiatric inpatients is introduced as a common problem, but surprisingly, how staff respond to such behaviour has attracted little specific literature. It is a subject which raises complex and difficult questions of ethics, law and clinical practice. For example, English case law allows the 'control and discipline' of detained patients, distinct from therapeutic considerations, but there is no guidance about what such power should consist of. To explore this subject, a sample of psychiatric nursing staff (574), from low, medium and maximum security settings, took part in a decision making exercise, designed to examine their attitudes towards, and concepts of, patient rule breaking. Subjects viewed a short videotape of fictional disturbed patient behaviour and their response was elicited by a semi-structured questionnaire. Subjects were shown one of a number of possible scenarios, with controlled variables including the fictional patient's gender, racial origin, diagnosis and past history of violence and the nature of the incident. The data was statistically analyzed and showed, for example, that personality disorder was associated with higher perceived responsibility, and that was associated with responses involving moral censure. Moral judgement emerged as a central theme. It influenced how staff: 1) decided what constituted reasonable patient behaviour; 2) judged patients' responsibility; and 3) may control and discipline errant patients. A theoretical model is proposed, in which the response to patient misdemeanour involves three inseparable components: containment of the unsafe, treatment of underlying pathology and moral censure. Clinical policies and guidelines must recognise the influence of moral judgement and introduce systems which ensure the reasonableness of those judgements, through education, staff support, supervision and mechanisms of appeal.

INTENSIVE CASE MANAGEMENT: DOES IT WORK?

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We carried out a controlled trial of intensive case management versus standard community care for people with a functional psychosis in a socially deprived area of London. Clients were referred by teams as being "hard to treat". They were assessed at intake and at 9 and 18 months using the Social Behaviour Schedule (SBS), the Disability Assessment Schedule (DAS), the Comprehensive Psychopathological Rating Schedule (CPRS) and the Lancashire Quality of Life Profile (LQOLP). Satisfaction with care was measured as was utilisation of in-patient beds. The treatment condition was a "continuing care team" which provided assertive case management following the Kanter model, with caseloads of 8 clients per case manager. The control condition was a Community Psychiatric Nursing Service with caseloads of 30 clients per CPN.

The study sample (N = 70) as a whole improved significantly between randomisation and first follow-up in terms of SBS and DAS scores, but not on the CPRS. Two of three summary measures of the LQOLP and overall satisfaction with services also improved signif-