

icantly. There was a significant decrease in hospital utilisation for the sample as a whole (mean days in first 9 months 16.7; mean days in second 9 months 18.3). There were no significant differences in clinical outcome or hospital days by project status (case management or control). However, there was a significant difference in favour of the case management condition in satisfaction with care (MANOVA, $F = 3.34$, $p = 0.049$) and a difference approaching significance in favour of case management in global quality of life (MANOVA, $F = 3.07$, $p = 0.059$). Clients from ethnic minorities had a better clinical outcome than white clients, regardless of treatment condition. They were also not less satisfied with their treatment.

QUALITY MANAGEMENT IN COMMUNITY MENTAL HEALTH CARE OF CHRONICALLY MENTALLY ILL PEOPLE

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There has been a fundamental change in mental health care in Germany within the last 25 years. In 1970 mental health care was provided nearly exclusively by resident psychiatrists and central major hospitals. In the meantime many of these psychiatric hospitals have been reduced in size and supplemented by psychiatric departments in general hospitals, outpatient services and complementary institutions. For patients as well as for professionals it is often difficult to recognize the structure combining all these mental health services and the institutions responsible for their funding. Major problems involved in the institutionalization of quality management in such a heterogeneous mental health care system are discussed. Approaches to quality development for single case treatment as well as for general mental health care of a specific region are illustrated by referring to the example of Tübingen county in the south of Germany with 200,000 residents. The focus is on the development of standards of cooperation and coordination.

QUALITY OF LIFE IN CHRONIC MENTAL ILLNESS: THEORETICAL MODELS, EMPIRICAL FINDINGS AND IMPLICATIONS FOR FUTURE RESEARCH

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This contribution resumes the most important research on the topic of quality of life in chronic mental illness. The historical development covers three phases, recently research is in the phase of "empirical quality of life studies". Methodological problems of quality of life assessments, sample selection and designs of studies are discussed. A review of theoretical models shows only few empirically tested. Major empirical results are presented in eight theses [1]: 1. Quality of life in psychiatric patients is lower than in other ill persons or in the normal population, 2. Patients of community based programs display a better quality of life compared to patients in longterm hospitalization, 3. Staying in treatment and rehabilitation improves quality of life, 4. Mentally ill women report a better quality of life than mentally ill men, 5. Psychopathology and relapses show negative correlations with quality of life, 6. Medications side-effects impair quality of life, 7. Additional psychotherapy improves quality of life, 8. Self-esteem is one of most important predictors of quality of life not only for healthy but also for mentally ill persons. Finally the contribution gives hints for improvement of future investigations and on poorly studied topics in psychiatric quality of life research.

[1] Lauer, G. (in press). Die Lebensqualität psychiatrischer Patienten. Report Psychologie.

FALLING THROUGH THE NET: DISCREPANCIES BETWEEN COMMUNITY MENTAL HEALTH SERVICES AND PRIMARY CARE SERVICES IN CARE PLANS FOR PATIENTS RECENTLY DISCHARGED FROM A COMMUNITY MENTAL HEALTH TEAM

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Deficiencies in communication are often identified by enquiries into the care of patients where there have been tragic outcomes. This study aims to identify which parts of community care plans are the most difficult to communicate between community mental health teams and GPs (general practitioners) and which patients are associated with communication failures. Community health team worker's care plans were compared with GPs care plans after discharge from the team for 61 consecutively discharged patients. The agreements were counted. 30 patients had a diagnosis of severe mental illness (ICD10 schizophrenia, bipolar affective disorder or severe depressive disorder).

The key worker identity produced only 31% agreement, while physical treatment parameters produced better agreement. The need for a community psychiatric nurse was agreed for only 45% of patients. No particular group of patients was identified which was associated with low agreement levels. Adequate communication between primary care and community mental health teams is a crucial task for both parties and strategies to improve it should be carefully considered.

UTILIZATION OF HOMECARE SUPPORT SYSTEMS AS A FUNCTION OF THE BURDEN ON CAREGIVING RELATIVES: ALZHEIMER'S DISEASE VERSUS VASCULAR DEMENTIA

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Objective: To study how the caregiving burden on relatives of patients with Alzheimer's disease or vascular dementia affects the utilization of available homecare support systems.

Methods: Caregiving relatives of 41 patients with clinically diagnosed (including imaging procedures) vascular dementia and of 33 patients with Alzheimer's disease were questioned regarding the homecare burden using the Screen for Caregiver Burden. The rate of utilization of available homecare support systems, including medical and legal services, was measured applying a new instrument.

Results: In both patient groups the caregiver's burden grew in proportion to the severity of the dementia. On the whole, the burden on relatives of patients with vascular dementia was markedly less than that on relatives of Alzheimer's patients. This result can be explained by the fluctuating disease course in patients with vascular dementias. With the sole exception of visits to personal physicians, overall utilization of support systems was low in both groups and increased proportionally to the caregiver burden. The general low rate of utilization by both groups was due to inadequate knowledge regarding availability of resources and concerns about costs. The earlier and more frequent use of supports by patients with vascular dementia resulted from their earlier need of physical care.

Conclusions: Providing early, comprehensive information to caregiving relatives regarding expected disease course and available resources can promote wise and timely use of support systems. This would alleviate the caregiver burden, delay or prevent the need for institutionalization, and reduce costs.