

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-

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.