erably less prominently, particularly in male patients. These data indicate that increasing duration of initially untreated psychosis is associated with more prominent negative symptoms and greater general cognitive impairment, but not with greater executive/frontal dysfunction; such executive/frontal deficits appear to be 'locked in' considerably earlier in the evolution of the illness, especially among males.

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NR11. Clinical services and community care — II

Chairmen: D Olajde, T Brugha

OUTCOME OF REHABILITATION PROGRAMME: IS THERE A DIFFERENTIAL RESPONSE?

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Outcome measures of various Rehabilitation Programmes of Psychiatric patients have often lacked specifity. Various criteria have been taken into consideration and the outcome measured, some of these being number of subsequent hospital admissions, employment status or change in the social and mental status of the individual. However very few studies have looked into the differential response of patients with different psychiatric diagnosis to the given Rehabilitation programme. This was tried to be evaluated in our study. The study is based on a retrospective design, where notes of patients admitted to the rehabilitation unit of the hospital during the years 1992–94, were evaluated semiquanti-tatively. The Demographic data, symptom profile at admission and discharge, the Psychiatric diagnosis and the overall outcome of these 27 patients were noted. Each of these patients underwent the standard Rehabilitation Programme. The outcome in these patients was compared with the symptom profile, psychiatric diagnosis and the duration of illness prior to their admission to the programme using the Chi square test and t-test. It was noted that the outcome was not influenced by any particular symptom or the duration of illness before admission to the Rehabilitation programme in a statistically significant manner. However the only statistically significant finding was that, the patients with personality disorder showed poor outcome to the programme when compared with other patients who had similar disabilities but differed only in the diagnosis. This differential response seen, points to us that probably patients with personality disorder have different set of needs, and a successful programme might be devised for them taking into account these needs.

SERVICE PROVISION — A DIFFERENT APPROACH TO MOTHER AND BABY SERVICES IN NEW SOUTH WALES, AUSTRALIA. THE WENTWORTH TRESILLIAN

I. Bialas, G. Boyle.

Some of the Mother and Baby Services are provided in New South Wales (10 million population) by 4 Tresillian Family Care Centres. This is a Government funded organisation which offers a broad range of support services to parents with children aged 0–5 years. The 4 Tresillian Centres have 42 residential units. I will concentrate on a description of one of them, the Wentworth Tresillian.

The Residential Programme: The Wentworth Tresillian has 14 residential units for mother and baby diads. The units can accommodate other family members. Each unit includes en-suite nursery, bathroom and bedroom. There are common areas such as dining, group rooms and play areas. A programme of 6 days is offered. Clients are seen by the nursing staff, psychologist, social worker and other staff as required. A paediatric specialist medically examines all babies on admission. Groups are conducted during the programme including relaxation and discussion, education, parenting and relationships.

Reasons for admission include feeding and sleep problems, low weight gain, behavioural problems, post-natal depression, parent craft and parenting education, Department of Community Services referrals etc.

Referrals are made by telephoning the intake officer and received from General Practitioners, Paediatricians and Community Nurses.

The Day Stay Programme: Families attend 9.00am–2.00pm Monday to Friday. There are 5 nurses running this programme. Time is given to discuss problems, devise a management plan, assist, educate and support.

Referral is made by clients or health professionals.

Total Cost: Salaries are the bulk of the $1.9m (£0.9m) annual expenditure of the unit. 67% of these are for nursing staff and 1% for Paediatric and Psychiatry cover.

Staff Profile: 3 Counsellors (1 social worker and 1 psychologist), 21.8 Registered Nurses, 4.7 Enrolled Nurses, 2 Nursing Managers, 3.8 Cleaning/Hotel Staff, 3 Clerical Staff, 1 Educator and 1 Unit Manager.

Clients Assisted: In 1994, 843 babies and 797 mothers were assisted at the Wentworth Tresillian. 675 new registrations were made at the Day Stay Unit.

Access is currently improving with opening of the 24 hr free 'phone Parents Help Line which offers advice, support and referral. It is staffed by 4 workers on 5 hr shifts and takes 60,000 calls per year. This is in addition to the usual referral channels.

SERVICE PROVISION — A DIFFERENT APPROACH TO COMMUNITY MENTAL HEALTH TEAM SERVICE ORGANISIATION IN NEW SOUTH WALES, AUSTRALIA. THE WENTWORTH AREA MENTAL HEALTH SERVICE

I. Bialas, M. Wheeler.

The Wentworth area has a population of 326,000 and is located at the far western edge of Sidney encompassing the Blue Mountains, Penrith and Hawksbury Local Geographical areas. Service to the area is provided by a 30 bed inpatient unit with 2.5 consultants and 4 registrars in psychiatry. The area also has 2 main community bases and 3 smaller satellite community centres operating 9.00 am to 5.00 pm Monday to Friday.

After business hours the 2 Extended Hours Teams (EHT) operate from the 2 main community bases. The EHTs have 3 shifts per day. They take written and telephone referrals from families, clients, GPs, social workers and police. This way, round-the-clock care and crisis intervention in provided 7 days per week. After an assessment by a team worker who often goes out for the visit, the client is either managed by the team or referred to the on-call psychiatric registrar. The EHT carry a stock of medication and can take verbal orders for dispensing. The Team Base files records on existing clients which are readily available after hours. Team members on call carry mobile phones and pagers and use cars provided by the Health Authority ("community cars"). They generally visit in pairs after hours and sometimes may request police escort. Occasionally the on-call registrar is required to go out with the team and schedule a client under the Mental Health Act. This can also be done by a GP or Accident and Emergency doctor.

Following discharge of clients from hospital the team are often

requested to follow them up. This may include telephone contact, twice a day, daily or weekly visits, supervision of medication and facilitating transport to hospital appointments.

The 2 Extended Hours Teams have 34 staff (nurses, social workers, psychologists), there are in addition 12 community mental health staff members who are not part of the after hours rota.

Statistics for 1994 show 21,290 occasions of service provided by the Extended Hours Teams in the area with just over 1,000 new clients assessed in the same period by the teams.

It may be helpful in the current process of service reorganisation to examine other forms of service provision available and already tried elsewhere.

CAN LACK OF QUALITY IN ACUTE PSYCHIATRIC CARE BE IDENTIFIED BY ANALYZING ROUTINE DATA FROM A PSYCHIATRIC INFORMATION SYSTEM?

H. Loevdahl, S. Friis.

Oslo pioneered Psychiatric Information Systems by establishing it's own system in 1980. In 1993, the Norwegian National Minimal Basis Data Set for Psychiatry was introduced, and it has been implemented in Oslo since 1994. Global patient status (GAF) was one of the new variables that was introduced then.

In 1994, the two acute wards at Ullevål University Hospital were under severe pressure due to their overloaded capacity. In 1995, a third acute ward was opened, and the situation improved substantially.

One major objective with information systems based on routine data, is to be able to detect quality problems in Psychiatric treatment as they arrise. If this objective is met, then the experienced problems in 1994 should be reflected in the data of our Psychiatric Information System.

In our study, we compare data from 1994 with data from 1995, in order to see if the known problems are in any way detectable in our data set. We further discuss the implications of our findings with regards to how one may continuously monitor quality in Mental Health Care Systems.

PROFESSIONALS VIEWS ON PATIENTS' SOCIAL FUNCTIONING IN THE LONG-TERM TREATMENT

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An implementation of Quality of Life Studies into psychiatric practice to great extent depends on the attitude of the rehabilitation process participants towards different elements of the process. An analysis of discrepancies of the specialists modern views on patient social functioning is carried out in this research. The opinion about the goals of the long-term treatment and its efficacy were estimated by the use of the questionnaire for psychiatrists and patients' relatives. The questioning had been carried out so that the opinions concern the experience of treatment of 110 schizophrenic patients. An analysis indicates that out-patients care physicians as well as patient relatives have an opinion that management of the schizophrenics must be mainly directed at relapse prevention. The in-patient care psychiatrists think that the treatment in the aftermath must not impede patient social functioning in the first place. Among the factors determining management effectiveness the out-patient physicians more often single out the treatment duration, while in-patient care practitioners — quality of interpersonal contacts of patients, patients' relatives more often mention the low rate of side-effects. Obtained data give evidence that the treatment process participants have certain notions that the effectiveness of psychiatric care is not determined exclusively by clinical and biological showings, but at the same time they do not have common viewpoint on relationship of social and biological factors in the patient management.

FAMILIES AND MENTAL ILLNESS INITIATIVE

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Background to the FAMILI research project: It is well documented that having a mentally ill parent presents the child with a greater risk of emotional and behavioural problems in addition to poorer social adaptation and academic attainment. For ill parents there is insufficient awareness about the mutual influences and interactions between the parental role, child care burden and the nature and course of mental illness.

The structure of current service provision within health and social services does not meet the needs of these children and their mentally ill parents.

Objectives of the study:

- Quantify the prevalence of mentally ill parents with dependent children in West Lambeth area (London). *Ascertain the degree of awareness that exists amongst professionals in respect of the particular needs of mentally ill parents and their children. *Assess the needs of children of mentally ill parents and their children.
- Obtain a comprehensive picture of which mainstream services these families are coming into contact with.

Method: A 3 month prospective study (Dec. 95–March 96) of families in contact with a sample of adult and child health and social services over 6 sites in West Lambeth. Professionals were asked to complete a questionnaire on all current and new clients during this period. This entails the 'assessment' of 1000+ families.

Preliminary results: Initial returns (280) point to a prevalence of 15% of mentally ill parents having dependent children.

CONTINUING CARE OF THE LONG TERM MENTALLY ILL. A STUDY OF THE ROLE OF GENERAL PRACTITIONERS AND THE MULTI-DISCIPLINARY TEAM

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Recent studies have shown that patients with chronic mental illness make considerable demands on General Practitioners (GPs). However, it is not clear whether the role of the GP is primarily that of caring for physical illness, or also involves psychiatric management. This study investigated the frequency of, and recorded reason for, attendance of such patients with GPs, and whether this was influenced by involvement with the multi-disciplinary team (MDT).

Method: Patients were entered into the study from a single catchment area, served by a stable MDT within a typical District General Hospital in England. Criteria were; continuous contact with the MDT for a year or more during a 1 year test period, and a diagnosis, or strong differential diagnosis of, schizophrenia, schizo-affective disorder or paranoid disorder. Data was recorded for the 1 year period from the notes. In particular, whether the reason for seeing the GP was primarily for physical or psychiatric problems.

Results: 42 patients satisfied the entry criteria, 29 suffered from schizophrenia, 10 from schizo-affective disorder and 3 from paranoid disorder. The mean number of contacts with the GP was 5.9. 29 (69%) of the patients regularly saw a CPN for the full year, and 99% of these contacts were home visits, whereas 32% involved administering depot medication. There was no relationship between the number of contacts with the CPN and the number of contacts with the GP. However, when the sample was divided into 3 equal groups according to the total length of continuous contact with a