

WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION  
REGIONALBÜRO FÜR EUROPA



ORGANISATION MONDIALE DE LA SANTÉ  
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ  
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

INDEXED

*Mental Health services - conf*

*Europe*

*Meeting on*

MENTAL HEALTH SERVICES IN PILOT STUDY AREAS

Report on the Seventh WHO Meeting

Tampere  
27-31 May 1980



↓  
ICP/MNH 007(7)  
4911B  
ENGLISH ONLY

1980

CONTENTS

	Page
1. Introduction . . . . .	1
2. Scope and purpose . . . . .	1
3. Publication of results of phase I and phase II . . . . .	1
4. Repetition of phases I and II: report on population, services and patient censuses . . . . .	1
5. Phase III: cohort study . . . . .	2
6. Study on costs . . . . .	3
7. Comparability of data across pilot study areas: general considerations . . . . .	4
8. Phase IV: effectiveness and efficiency . . . . .	5
9. Future work . . . . .	5
Annex I Existing pilot study areas . . . . .	6
Annex II Economic aspects of mental health costing - Dr D. Walsh . . . . .	7
Annex III Mental health services in pilot study areas: phase IV - Professor M. Shepherd . . . . .	9
Annex IV Provisional timetable for future work . . . . .	11
Annex V List of participants . . . . .	12

## 1. Introduction

The Seventh Meeting on Mental Health Services in Pilot Study Areas, convened by WHO in collaboration with the Government of Finland, was attended by 29 psychiatrists, health service administrators and research workers from 14 countries, appointed as temporary advisers not paid by WHO, and by 4 members of the staff of the WHO Regional Office for Europe. The participants represented 14 of 20 existing pilot study areas (see Annex I). In addition, two observers from the local mental health services were also present. The list of participants forms Annex V to this report.

The Director-General of Health of Finland, Professor E. Kivalo, welcomed the participants on behalf of the Finnish Government.

The participants were also welcomed by Professor R. Erma, Rector of the University of Tampere.

Dr M. Postiglione, Director, Disease Prevention and Control, WHO Regional Office for Europe, on behalf of the Regional Director, expressed gratitude to the Finnish Government for its hospitality and support and stressed the importance of the pilot study area project for the development of community mental health services and data collection systems for mental health planning in the European Region.

Dr J. Eskola was elected Chairman and Dr H. Katschnig Rapporteur. Dr A.E. Baert acted as Secretary and Mr J.U. Hannibal as Co-Secretary.

## 2. Scope and purpose

The broad scope and purpose of this series of meetings has been described in previous reports. The specific tasks faced by the seventh meeting were (1) to discuss the reports of the participating pilot study areas on the population, service and patient censuses carried out since the sixth meeting in Madrid, October 1978; (2) to discuss the progress and the difficulties encountered in the cohort study; (3) to discuss the problems of a study on direct and indirect costs, and (4) to start preparations for another form of cooperation between pilot areas after the completion of the project in its present form, as foreseen by the Regional Office.

## 3. Publication of results of phase I and phase II

A certain amount of disappointment was expressed by several participants that an official publication about the work carried out during the past years had not yet been published. It was stated that some kind of official document should be prepared quite soon. However, it became clear during the discussions that an official publication by WHO, for example, in the EURO Reports and Studies series, in the four working languages of the Regional Office, would not be feasible at the moment, but that a mimeographed report in English on phases I and II prepared by Dr R. Giel and Mr J.U. Hannibal, could be circulated to those interested.

In addition to this rather technical report the hope was expressed that WHO would produce a short general document about phases I and II in the four working languages, which could then be sent to governments and health administrators. Finally, agreement was reached that the Regional Office would prepare a list of publications which have grown out of the activities of the individual pilot areas. All participating centres were therefore invited to send two copies of relevant publications to the Regional Office.

## 4. Repetition of phases I and II: report on population, services and patient censuses

Of the 14 centres represented in Tampere, 10 had actually sent in or brought to the meeting a written progress report; the remaining 4, all in French-speaking areas, claimed translation difficulties for not presenting a written report but gave oral accounts of their work since the sixth meeting.

No major problems were reported for data collection in the reports. However, only seven centres had given a social-demographic description of their area(s) according to the guidelines suggested in the study protocol. As far as the inventory of services and patient census was concerned, only four centres had provided a report in accordance with the instructions. As this uneven reporting was regarded as a major obstacle not only to comparing results from different areas but also to communicating between different areas, the need to comply strictly with the instructions was stressed (in some instances misunderstanding of the instructions may have been the reason for non-compliance, e.g. some centres did not correctly interpret the term "full-time

equivalent" - and it was strongly recommended that in such cases the Regional Office should be contacted for clarification). It was appreciated, however, that for local reasons it might have been difficult or even impossible to strictly adhere to the instructions, especially in those cases where the institutions serving the pilot area also serve other areas - a situation which makes the calculation of staff, beds, etc., serving the pilot area extremely complicated, particularly when costs are to be calculated.

Following this discussion a useful distinction between three different types of pilot study area was proposed: type A would be a pilot area having the same boundaries as that of the catchment area of the services; type B would be a pilot area where the relevant institutions also serve a population outside the area; type C would be a pilot area where no clear care situation exists, i.e. where patients living in the pilot area can go to any institutions inside or outside it, and patients from outside the area could attend institutions within or outside it.

It was agreed that those pilot study areas which had either not sent a report at all or had not followed correctly the instructions on the population, service and patient censuses, should prepare their report strictly in accordance with the guidelines and send it to the Regional Office by 31 October 1980, with all figures double checked. Whenever possible the diagnostic category of mental retardation should not be included under "other diagnosis" but should be noted separately (see data sheet 4 and instructions 4 point 4.13, where mental retardation should have its own code).

#### 5. Phase III: cohort study

It turned out that only two centres had actually started a prospective cohort study before 31 January 1980, in accordance with the instructions. As it had been announced at the beginning of the meeting that the project in its present form would come to an end in 1983, it was stated that apart from the two prospective cohort studies already in progress no new prospective cohort study could be started if the deadline of the project as a whole were taken into consideration. Much discussion was therefore devoted to this new situation and it was finally suggested that all those centres which had not yet started a proper prospective cohort study should do a retrospective cohort study. Given the new situation some centres wanted to consider the possibility of a combined retrospective/prospective cohort study.

In progress reports delivered by each centre it became clear that many centres were in fact doing cohort studies but that in most cases the cohorts were not selected according to the instructions. It was made clear by WHO that only those studies (retrospective or prospective) which had selected their cohort in strict accordance with the rules laid down in the study protocol would be included in the final publication and that such cohort studies only would qualify for a central data analysis, when this becomes available.

It was restated that each cohort should include only patients living within the pilot area (at least 200) and only those patients who had not had a contact with the psychiatric institutions participating in the cohort study within the previous six months. It was appreciated that the range of institutions participating in the cohort study would vary to a large extent but that this rule should nevertheless be strictly followed. Thus patients who had had a contact with psychiatric institutions outside the area, and patients who had had a contact with psychiatric institutions other than those participating in the study inside the pilot area, should be included in the cohort even if their last contact with these institutions had taken place within the previous six months. Furthermore, centres should give a qualitative and quantitative estimate of those patients who are cared for in the pilot area by institutions other than those participating in the study.

With regard to the addition of the diagnosis "mental retardation" in the patient census, it was noted that this diagnosis should also be kept separate in the cohort study.

Agreement was reached that, contrary to the existing instructions, the variables "marital status", "employment status" and "diagnosis" would no longer be obligatory for continuous registration, but only optional. Thus no time series analysis would be carried out on changes in these variables. The only change now to be registered by all participating centres would be change in treatment status. Making the continuous registration of "marital status" and "diagnosis" optional means that provision must be made to register these variables on the front page. It was agreed that variable No. 11 ("admitted from") on the front page would be too complicated for a retrospective study and that the two boxes of this variable should be used for "marital status" and "employment status" at the time of entry into the cohort.

It was also suggested that the many different coding possibilities for variable No. 12 on the back page of the cohort study data sheet ("type of action") should be replaced by a simpler code which also incorporates "discontinuation by death" for patients in part-time or full-time care. The new code for variable No. 12 on the back page of the cohort study data sheet will read as follows:

- 1 = admission
- 2 = discontinuation by return to the community
- 3 = discontinuation by death
- 4 = discontinuation by transfer to other services.

(With regard to code 4 = discontinuation by transfer to other services, there has to be specification by the Regional Office as to which services are to be included here. It has to be taken into consideration that in retrospective studies it might not always be easy to find out which institution the patient was supposed to be transferred to when discontinuing care in one institution.)

It was agreed that WHO would send a simplified and corrected data sheet for retrospective cohort studies to all participating centres, together with the report on the seventh meeting.

The centres carrying out retrospective cohort studies would only need to go once (at the end of the two-year period) to the institutions participating in the study and look through the files in order to find out whether the patients in their cohort had been treated by the service in question. For this purpose a master copy of the cohort data sheet can be used and it would not be necessary that contacts with outpatient services, as well as admissions or discharges from partial or full-time care, be written down in chronological order. Additional data sheets may of course be used for patients with frequent contacts, admissions and discharges.

No agreement could be reached during the meeting as to the basic tabulations for presenting the cohort study data. Several centres suggested specific strategies for data analysis. Although no final decision was reached, the majority of the participants found it more useful to analyse the data according to specific patterns of care and did not favour the use of repeated censuses at fixed intervals for the longitudinal analysis (as they had been used in the report on the cohort study in phases I and II). The Regional Office committed itself to work out new simplified guidelines for basic tabulations of the cohort study data and to send these guidelines to the centres not later than 31 December 1980.

No conclusion could be reached as to whether the complete data analysis of the cohort study should be carried out by the centres themselves or whether at least the more sophisticated analyses should be carried out by a central facility. It was felt that if a collaborating centre could be established in Groningen (on which decision was pending by the Netherlands Government), the more sophisticated analyses could be carried out by this centre, otherwise by the Regional Office. It was agreed that the most basic tabulations showing the composition of the cohort should in any case be carried out by the centres themselves. In the case of a centralized data analysis, the individual centres should send the data of the cohort study in a clean and checked form on either magnetic tape or punched cards to the institution carrying out the analysis. Only exceptionally would it be possible to allow a centre to send just the data sheets. Discussion of the analysis of the cohort study data will be a major topic at the eighth meeting in May 1981.

#### 6. Study on costs

Only four centres had filled in table 3.5 of the "inventory of services" data sheet, which contains global direct cost data for the institutions of the pilot area participating in the study. The main reasons for this under-reporting of cost data were the practical problems of not getting cost data from the institutions concerned and the fact that the cost data were not extractable from the accounting systems used in institutions of several areas. However, analyses of direct and indirect costs carried out during the past few years in the Tampere pilot study area show that, although the work was cumbersome, a lot of useful cost information can be gathered. Most centres, however, stated that it would be very difficult for them to carry out an analysis of direct costs which would lead to results comparable across different pilot areas.

The index of direct cost per capita of the population of a pilot area was briefly discussed as a possible means of comparing direct cost in different pilot areas but was abandoned again after too many drawbacks had been demonstrated.

Given this complicated state of affairs it was decided to abandon the problem of indirect cost in the framework of the present project and to concentrate on that of direct cost. All centres stated their interest to at least make efforts to fill in table 3.5 in the "inventory of services" data sheet. Further consideration should be given to the question of direct cost at the eighth meeting to be held in 1981. In the meantime centres are encouraged to carry out direct cost studies using guidelines laid down at the eighth meeting and taking the Finnish studies as an example.

It was stressed that the question of cost should not be left aside too quickly as it is strongly interrelated with the question of evaluation, and both issues are becoming of greater and greater concern to governments in the European Region. It was stated that a stronger case should be made for health services research in general. It was announced that in September 1980 the WHO European Advisory Committee for Medical Research would have a meeting to discuss priorities and that there was no doubt that health services research would be ranked among the first priorities. The French centres expressed their special interest in the question of direct cost and evaluation and announced plans for specific studies on this problem. For more details on the discussion of direct and indirect costs see Annex II.

#### 7. Comparability of data across pilot study areas: general considerations

The main aims of the project were restated as (1) to encourage the establishment of data collection systems for mental health services and to stimulate the setting up of community mental health services in the pilot areas, and (2) to compare data from different pilot areas in order to analyse differences in the mental health services and their operation in different countries.

It was agreed that the first aim had been largely achieved by centres participating in the project since 1973. On the other hand the achievements concerning the second aim were not regarded as satisfactory. It was even stated that it might be of little value to compare data from different areas, given the vast diversity in cultural backgrounds and in the organization of health services in different countries. It became clear that it was only natural that participants with such different backgrounds develop their own systems of data collection and analysis and that it is difficult for many to adhere strictly to the common instructions laid down to make data from different pilot areas comparable. Given these limitations the opinion was expressed that it might be better to study and compare only specific categories of patients and it was suggested that perhaps several centres should join to form subgroups for more specific studies (e.g. of those aged 65 and over; of depressive patients; of those who have made only one contact with the mental health services, etc.), in order to reduce the heterogeneity in the populations studied. However, the crucial point for a common project like the one carried out here would be the amount of diversity which can be tolerated without losing the common goal and splitting up into many small unrelated projects.

Another point of concern was the simplification of the research procedure, especially in terms of a reduction of the number of variables used. It was pointed out that even such a seemingly simple variable as marital status may not be very meaningful in those countries where the official marital status does not say anything about the de facto living situation of a person. Furthermore, many of the variables now in the study protocol are not equally available in all centres and, if available, not always with a satisfactory degree of reliability. A further argument for a reduction of the number of variables and the number of codes used per variable is the fact that with the relatively small number of patients in each pilot study area the figures in the individual boxes of cross-tabulations would become very small and meaningless.

It was concluded that, if the number of variables is kept small and the coding simple, then simple comparisons between centres would be quite useful. For instance, in one study area the diagnostic composition of patients in private and public institutions was not different whereas in another pilot area this difference was quite considerable; it turned out that it was probably the different financing structure of the private mental health services in the two areas which was responsible for this disparity. Similarly, in one pilot area the proportion of homeless people among the patients was quite high as opposed to other areas and it was clear that this was so because in that specific area private institutions and private psychiatrists were not participating in the study. In addition to simple comparisons between different pilot areas, the usefulness was stressed of comparisons within each area over different points in time in order to monitor change.

Another general point was the question whether the study should rather be service centred or patient centred. The latter tendency was expressed in the wish to study specific diagnostic groups. However, it was pointed out that the pilot study area project could serve both purposes, for example in answering the questions whether certain types of patient elicit certain types of care.

Finally, the question of coordinating the research work carried out in the different areas came up several times during the meeting. Two possibilities were mentioned: if the establishment of a collaborating centre in Groningen were agreed upon by the Netherlands Government, the task of coordination could be taken over by this centre. Otherwise it would be advisable to have a coordinator travelling around to the individual centres.

#### 8. Phase IV: effectiveness and efficiency

While it was stated on the one hand that descriptive data like those collected in the project were of a certain value in themselves, dissatisfaction was expressed, on the other hand, about the purely descriptive nature of the studies carried out so far. Broad descriptive data about the use of services, for example, cannot disclose the reasons why certain patients have not come back to the services, i.e. because they were healthy and did not need them any more, or because they did not want or were not able to use them in the same way; thus no information can be obtained in the present study about the outcome of the care and therapy delivered to the patient and no assessment is made of specific intervention techniques. It was therefore emphasized by many participants that what is really needed is an evaluative study.

Furthermore, in the light of the plans of the Regional Office to end the present project in 1983, the opinion was expressed that provisions should be made now if the cooperation (albeit in another form) between at least some of the pilot areas is to be continued after 1983.

In appreciation of these two facts, Professor Shepherd had been approached by the Regional Office to make a proposal for an evaluative study to be carried out by a number of centres as a continuation of the present project. His suggestion was to carry out an evaluative study on psychiatric patients aged 65 and over who have been treated in a psychiatric hospital and subsequently discharged (see Annex III). As the amount of work to be carried out would be considerably greater in an evaluative study than in a purely descriptive study, it was underlined that the study could be carried out only if adequate funds are made available and that it would include only those centres which are able to guarantee that the work will be carried out as defined in the research protocol.

The participants agreed that Professor Shepherd's proposal for studying psychiatric disorders in the senium was both important, regarding priorities in health research, and feasible, as the cohort to be studied would be a clearly defined one and thus homogeneous across different centres. It was therefore suggested that WHO should work out a preliminary study protocol and try to obtain approval for the presentation of an application to a grant-giving organization. The Regional Office plans to stay in touch with Professor Shepherd concerning these matters and proceed accordingly.

#### 9. Future work

At the end of the meeting a provisional timetable for future work was drawn up. This timetable was sent to centres immediately after the meeting, and is included here as a summary of the work to be carried out in the near future, as discussed in more detail in this report (see Annex IV). The eighth meeting was provisionally scheduled for 18-22 May 1981.

Annex I

## EXISTING PILOT STUDY AREAS

Country	Centre	No. of pilot study areas	Present at 8th meeting	Written report repetition phases I & II	Prospective cohort study started
Austria	Vienna	1 (Mistelbach)	yes	yes	no
Belgium	Leuven/Brussels	1 (Leuven, Brussels/Anderlecht, Brussels/Schaerbeek)	yes	yes	no
Denmark	Randers	1 (Randers)	yes	yes	yes
Fed. Rep. Germany	Mannheim	1 (Mannheim)	yes	yes	no
Finland	Tampere	1 (Tampere)	yes	yes	no
France	Paris 7e Paris 13e	1 (Paris 7e) 1 (Paris 13e)	yes yes	no no	no no
Greece	Athens	1 (Byron/Kessarini)	yes	yes	no
Ireland	Dublin	1 (St Lomans)	yes	yes	yes
Italy	Trieste	1 (Trieste)	yes	no	no
Netherlands	Groningen	1 (Assen)	yes	yes	no
Norway	Oslo	1 (Oslo)	yes	yes	no
Romania	Iasi	1 (Iasi)	no	no	no
Spain	Madrid La Coruña	1 (Leganes) 1 (La Coruña)	yes no	yes no	no no
Switzerland	Geneva	1 (Geneva)	yes	no	no
United Kingdom	Aberdeen Nottingham	1 (Aberdeen) 1 (Nottingham)	no no	no no	no no
Yugoslavia	Belgrade Zagreb	1 (Belgrade) 1 (Zagreb)	no no	no no	no no

Annex II

ECONOMIC ASPECTS OF MENTAL HEALTH COSTING  
Group report

by  
Dr D. Walsh

It was acknowledged that consideration of economic aspects of mental health care delivery in the pilot areas, although still perceived as a monitoring exercise, i.e. the measurement and recording of a health index (in this case the cost index) and the interpretation of differences and changes in this index overall and over time and between different components of the services, was moving in the direction of evaluation. Evaluation was understood as the determination of the extent to which an action in the health field is successful in achieving objectives in terms of adequacy, effectiveness and efficiency.

The group acknowledged the distinctiveness and simultaneously the complementarity of direct and indirect costs and agreed that it would mainly concern itself with the direct costs. The group recalled the difficulties in achieving even minimal direct cost information. At the same time it was encouraged by the Finnish achievement in presenting much detailed information.

The main difficulties appear often to be two. First the non-correspondence of the pilot areas and the mental health care areas used for budgetary purposes. Secondly very few centre systems distinguish component costs distributed between functional units and the services, i.e. a global accounting system which does not separate inpatient from outpatient costs. Salary costs are usually differentiated for medicines, equipment, etc.

In some cases, too, capital costs and running costs are intertwined and do not allow for separate breakdown.

The group asked itself the fundamental question: why do we need to take account of the economic point of view at all? It was agreed that national economic resources are limited and therefore must be utilized for deriving the maximum benefit with the minimum expenditure. The group felt justified in acknowledging hesitantly the economic and cost efficiency aspect.

The group stressed the importance of establishing priorities as a preliminary to identifying objectives for the examination of effectiveness. It noted that recent years have seen an expansion of the mental health field and the alleged area of its competence, sometimes unaccompanied by corresponding technical developments or therapeutic achievements, which have tended to blur priorities and objectives. As a consequence there has been a deviation of economic resources from former objectives to newer developments which have for the most part remained unevaluated.

There was also comment on the considerable disparity between the theoretical objectives of newer technical developments and their actual function once established, i.e. the rehabilitation, short stay expectations of hostels and day centres and their actual function; the same appeared to be true of crisis intervention centres, as described in the WHO publication on the subject (Public Health in Europe, No. 11, 1979).

Coming back to the Finnish experience, the group was interested to hear that despite expectations no great indirect differences in cost per day emerged between "short stay" and "long stay" wards and that cost per item for service differed between that given by a psychiatrist on the one hand and a psychologist on the other. The psychiatrist's time was the more expensive but he spent less of it with the patient; the psychologist's time was cheaper but he spent more of it with the patient, and in the end the net costs were the same. Unfortunately the question was not asked whether the psychologist's time might have been curtailed without loss of efficacy.

It was pointed out that the organization of inpatient care delivery is of importance in cost considerations. Some hospitals do not have acute and chronic wards as separate entities but believe in having balanced wards to all of which patients are admitted and all of which contain some chronic and elderly patients. In these cases, acute/chronic cost comparisons cannot be made, but a comparison can be made between wards (although this may be threatening to individual psychiatrists in charge), between types of patient admitted and discharged and, most importantly, between their lengths of stay.

The merits of community care versus traditional care as they affect cost were debated. It was pointed out that there has been a movement in psychiatry from different and sometimes fallacious yardsticks to others, perhaps no more valid.

At first the standard of care was measured by the number of beds provided, then by the number of beds emptied and now by the cost per bed or per item of service. It was stressed that a given infrastructure, i.e. hospital equipment and staff, does not disappear when patient numbers fall, but outpatient and community costs grow; then community care is not necessarily cheaper, particularly as the newer outpatient and community services often attract a new customer, sometimes previously dealt with by other services at less cost and with equal efficiency.

Although the level of personnel appropriate to any given function needs examination, it was noted that sometimes a nurse will perform a function more efficiently than a psychiatrist even though the task is traditionally his. In other words roles should be examined in relation to function within a service.

The group gave a good deal of time to the question of presenting cost data and in particular to that of their usefulness. The difficulties of cost comparisons across countries were discussed. There was a suggestion that the computation of cost per capita of population between different services in the same country is relevant on the assumption that mental health status could also be compared between countries. Time-series of costing in real terms could be considered to give some idea in changes of costs. It was felt that there is a need for greater communication with budgeting staff and accountants.

The group stressed that different information would be useful to different pilot areas. Information to be gathered would have individual meaning in each pilot area relevant to its own functions, which might not be of general interest. It was felt that individual centres should be encouraged to gather such information where it is available.

Annex III

MENTAL HEALTH SERVICES IN PILOT STUDY AREAS: PHASE IV

by  
Professor M. Shepherd

Since its inception in 1973, phases I and II of the WHO study on mental health services in pilot study areas have been successfully completed and phase III is now under way. The work so far has demonstrated the feasibility of collaboration in this field. It is yielding valuable socio-demographic data and information on the disposition and direct cost of services and on the outcome of patients who pass through these services. The immediate goals of the programme may therefore be said to have been achieved.

It was also envisaged from the beginning of the project, however, that the rational planning of services must be based on an evaluation of their activities and that a long-term objective of the study would be to determine the effectiveness of different patterns of service in achieving their goals (working group on mental health services in pilot study areas, Copenhagen, 1973). It was further agreed that variety in the demography, ecology and size of the different pilot study areas would not make comparisons impossible where certain target groups (determined, for example, by age or diagnosis) were to be followed through the different systems of service.

While the results from the current cohort follow-up study may be expected to go some way towards meeting these objectives, it is already clear that the patient-populations are too heterogeneous to render detailed comparison productive. Further, practical considerations are likely to hamper complete data collection in some centres. To obtain information bearing on the defined objectives it is therefore necessary to introduce a stronger research as well as a monitoring element into the study. This is in accord with newly formulated WHO policy concerning the function of regional offices.

As early as the 1977 conference on mental health services in pilot study areas, Lysebu, it was anticipated that it might be necessary to study cohorts of initially selected patients, not derived from a general cohort, for example patients with schizophrenia or the elderly. There are several reasons why the elderly especially commend themselves for attention. In the first place, they constitute an important and increasing segment of the European population. Secondly, they are already being studied by the Regional Office, so techniques are available for relevant inquiries.<sup>a</sup> Thirdly, their significance has emerged from the findings of study centres in various ways. Thus the third working group on mental health services in pilot study areas (Trieste, 1975) emphasized that the pattern of mental health services required for an area is partly determined by the proportion of elderly persons in the population - a group which tends to have high dependency needs, and may absorb a considerable share of mental health resources, particularly if family and community support is limited. It was pointed out that the Trieste and Oslo centres contained a comparatively large percentage of elderly and might need to place particular emphasis on psychogeriatric services (Third Working Group on Mental Health Services in Pilot Study Areas, Trieste, 1975). It was also noted that several centres had commented on the large groups of long-term patients, who are growing old in the mental hospitals and eventually passing into the psychogeriatric category. Moreover, one centre had reported that the opening of a number of community-based homes for psychogeriatric patients, coupled with the provision of a day-patient service, had actually increased the demand for psychogeriatric beds in the area, although the workload for the mental hospital had been reduced. Discussion of the social and demographic data also pointed to the significance of poor housing and overcrowding which were deemed so severe that it might prove virtually impossible to care for impaired elderly at home, thus increasing still further the pressure for admission to geriatric or psychogeriatric facilities.

The design of a phase IV study conceived as an evaluative research project rather than a monitoring exercise should, if possible, make use of as much information as is already available. The data collected make it clear that there already exists a good picture of inpatient services and that future phases should give priority to the study of extra-mural services (Fourth Working Group on Mental Health Services in Pilot Study Areas, Copenhagen, 1978). This would point to the need to

---

<sup>a</sup> Psychogeriatric care in the community. Copenhagen, WHO Regional Office for Europe, 1979 (Public Health in Europe, No. 10).

focus on such services, but to do so after referral makes retrospective analysis, with all its attendant problems, unavoidable. To ascertain the antecedents of these patients and their paths to treatment would involve the setting up of large-scale surveys which seem to be beyond the capacity of the centres. To concentrate on patients after detection, however, would seem feasible and important. Accordingly, it is proposed that a prospective study be mounted on discharged psychogeriatric patients whose subsequent fate could be traced through the extra-mural services of the various pilot studies. The basic demographic and epidemiological information already collected would enable an estimate to be made of the role of the mental health facilities in the management of declared psychogeriatric cases.

It is appreciated that any such sample of patients cannot be representative. It comprises the "survivors" of a cohort of admissions whose intra-mural fate will have varied and can be assessed independently. The discharged patients would be used primarily to render feasible an assessment and evaluation of the community services in terms of their effectiveness and efficiency. Effectiveness, it may be recalled, relates to the planned results and is defined as the extent to which the defined objectives are achieved. Efficiency, on the other hand, relates to the cost of achieving these objectives and it can be defined as the output or end result achieved in relation to cost in terms of resources, manpower or money.<sup>a</sup>

The essential components required for the assessment of effectiveness and efficiency in this context are the following:

- (1) clinical and social assessment of the patients at the time of discharge from hospital;
- (2) a further clinical and social assessment of the patient at the end of the follow-up period (possibly 12 months) or at the point of readmission to hospital;
- (3) the recording of all contacts with the medical and social services during the follow-up period;
- (4) an independent assessment of the family "burden" imposed by the discharged patient if he or she lives at home after leaving hospital.

Data derived from (1) and (2) will make it possible to assess "effectiveness". Data derived from (3) and (4) can be used to assess "efficiency", including indirect cost. Together they will furnish information necessary for the evaluation process, which can be rendered more informative by the availability of comparative data derived from different systems.

This information would also relate to the WHO headquarters programme for the monitoring of mental health needs.

---

<sup>a</sup> Holland, W.W. & Karhausen, L., ed. Health care and epidemiology. London, Kimpton, 1978

Annex IV

PROVISIONAL TIMETABLE FOR FUTURE WORK

- 31 August 1980      The Regional Office to send areas the report on the seventh meeting, including amended data sheets for the cohort study
- 31 October 1980    1. Areas to send to the Regional Office in checked, final form:
- social demographic data
  - services inventory
  - patient censuses
2. Areas to inform the Regional Office whether they are doing a prospective or a retrospective cohort study in accordance with the definition of the cohort, and when they have started
- 31 December 1980    The Regional Office to send areas a final simplified tabulation programme for the cohort study
- 30 April 1981      End of data collection for the retrospective cohort study
- 18-22 May 1981  
Eighth meeting    1. Reports to be presented by areas on:
- social demographic data
  - services inventory
  - patient censuses
2. Strategy of analysis of cohort study data
3. Direct cost study
4. Research protocol on effectiveness and efficiency
- 31 March 1982      End of data collection for prospective or combined cohort study
- October 1982  
Ninth meeting    1. First draft report on retrospective cohort study
2. Report on direct cost study
3. Plan for final publication on phase III to be agreed upon
4. Progress report on effectiveness and efficiency study
- October 1983  
Conference      Final publication to be presented in draft form

Annex V

LIST OF PARTICIPANTS

TEMPORARY ADVISERS

- Dr E.E. Anttinen  
Professor of Social Psychiatry, Institute of Public Health Sciences, University of Tampere,  
Finland
- Dr P. Bailly-Salin  
Chief, Mental Health Service for the 7th District, Vaucluse Special Hospital Centre,  
Epinay-sur-Orge, France
- Dr M. Bille  
Head, Psychiatric Department, Randers Hospital, Denmark
- Dr E. Bjarnar  
Trøndelag Psychiatric Hospital, Trondheim, Norway
- Dr J. Casselman  
Heverlee-Leuven, Belgium
- Dr P. Chanoff  
Director, Marcel Rivière Institute, Paris, France
- Professor R. Diatkine  
Alfred Binet Centre, Paris, France
- Dr J. Eskola  
Medical Officer, Mental Health Department, Directorate of Health, Helsinki, Finland (Chairman)
- Dr D. José Martín García  
Director, Mental Health Area and Biostatistical Research Department, Leganes National  
Psychiatric Hospital, Madrid, Spain
- Ms M.G. Giannichedda  
Sociologist, Andrea di Sergio Galatti Psychiatric Hospital, Trieste, Italy
- Dr R. Giel  
Professor of Social Psychiatry, University Hospital, Groningen, Netherlands
- Dr A. Harenko  
Medical Director, Central Mental Hospital, Pitkänniemi, Finland
- Dr P. Hermann  
Chief, Clinical Research Unit, University Psychosocial Centre, Geneva, Switzerland
- Ms I. Järventie  
Institute of Public Health Sciences, University of Tampere, Finland
- Dr H. Katschnig  
Director, Ludwig-Boltzmann Institute for Social Psychiatry, Vienna, Austria (Rapporteur)
- Dr J. Klug  
Central Institute for Mental Health, Mannheim, Federal Republic of Germany
- Dr N.J. Lavik  
Associate Professor, University Psychiatric Institute, Oslo, Norway
- Ms V. Lavondes  
Alfred Binet Centre, Paris, France

- Dr E. Malapert  
Mental Health Service for the 7th District, Vaucluse Special Hospital Centre, Epinay-sur-Orge,  
France
- Dr G. Moschel  
Chairman, Department of Medical Sociology, Central Institute for Mental Health, Mannheim,  
Federal Republic of Germany
- Ms H. Nieminen  
Institute of Public Health Sciences, University of Tampere, Finland
- Dr A. Riedl  
Behindertendorf, Altenhof, Austria
- Dr M. Schimek  
Statistician, Ludwig-Boltzmann Institute for Social Psychiatry, Vienna, Austria
- Dr R. Schwarz  
Central Institute for Mental Health, Mannheim, Federal Republic of Germany
- Professor M. Shepherd  
Institute of Psychiatry, London, United Kingdom
- Dr C. Stefanis  
Professor of Psychiatry, Eginition Hospital, Athens, Greece
- Ms R. Tuovinen  
Institute of Public Health Sciences, University of Tampere, Finland
- Mr K. Vinni  
Institute of Public Health Sciences, University of Tampere, Finland
- Dr D. Walsh  
Director, Mental Health Department, Medico-Social Research Board, Dublin, Ireland

OBSERVERS

- Ms K. Nojonen  
Central Mental Hospital, Pitkänniemi, Finland
- Ms T. Pukuri  
Central Mental Hospital, Pitkänniemi, Finland

WORLD HEALTH ORGANIZATION

Regional Office for Europe

- Dr A.E. Baert  
Regional Officer for Mental Health (Secretary)
- Mr J.U. Hannibal  
Technical Officer for Mental Health (Co-Secretary)
- Dr M. Postiglione  
Director, Disease Prevention and Control
- Dr H. Zöllner  
Regional Officer for Health Economics