on outcome of psychosis, and its impact on psychiatric services

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There is little doubt that a person with schizophrenia in remission who then returns to abusing substances can be precipitated into a relapse of his/her psychosis. This may be through a direct effect on psychotic symptoms (eg dopaminergic effects), indirectly (eg by an increase in depression and anxiety), or with resultant treatment uncompliance and/or resultant social crises acting as a trigger. Thus substance abuse is one of the risk factors for poor prognosis in patients suffering from schizophrenia. Our research (Grech et al. 1999), showed this phenomenon occurring with cannabis abuse. But this is also associated with abuse of other substances, thus resulting in patients with both schizophrenia and substance abuse, making more use of services and are more likely to be violent and imprisoned. (Murray et al, 2003). This results in these patients posing a big and complex demand on the psychiatric services, a phenomenon that is becoming more evident in Malta as well.

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O-073

Anxiety, depression and spiritual-well being in Maltese patients with first myocardial infarction

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Through research findings and nursing experience, it could be said that the spiritual dimension has been underestimated in patient care. A longitudinal research study was conducted on a sample of 70 patients with first MI in the main general teaching hospital in Malta. One of the aims was to identify relationships between patients' anxiety and depression and spiritual well-being across the first three months after MI. Anxiety and depression were measured by the Hospital Anxiety and Depression scale (Zigmond and Snaith 1983) whilst SWB was investigated by the JAREL SWB scale (Hungelmann et al. 1989).

Findings revealed that anxiety was more prominent than depression. Negative significant relationships were identified between anxiety and SWB during the early stage of recovery. In contrast, depression was found negatively related in the later stages of the recovery period. Several coping strategies were used including the religious. Hence, in their struggle to find meaning and purpose in life, individuals cope by the use of both religious and non-religious strategies (Baldacchino 2003). This implies that the multidisciplinary team need to give attention to the religious perspective to enhance holistic care.

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O-074

The development of an interface between Primary and Secondary Care in Mental Health

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The interface between primary and secondary mental health care is crucial to the development of Mental Health services generally, and in particular to establishing a seamless system of care whereby each patient receives an appropriate level of care and whereby care is delivered effectively to those who need it [1].

Primary care accounts for 95% of all mental health care, so that 95% of patients never get referred to secondary care. Surprisingly, it took a great deal of debate before Goldberg and Gournay stated that it was appropriate to refer to secondary care those patients which could not be treated by primary mental health care [2].

Thus, logically, if mental health care is to be adequately delivered to the large number of cases who require it, without excessive numbers of referrals to secondary care, there requires to be an increase in the capacity of primary care to deal with simple mental health problems, an increase in supervision of primary care staff who are using their newly acquired Mental Health Skills, and an increased liaison between primary care teams and community Mental Health Teams [3].

The paper describes how we developed in Luton, Bedfordshire, a theoretical model which suggested that the best way of achieving this development of primary care psychiatry was by a combination of training of primary care team staff, and the use of a special team of experienced Community Mental Health Practitioners who acted as liaison between the primary care and secondary [or community mental health teams], and were also available to the primary care staff for advice and supervision [4]. Furthermore, protocols were devised for the management of simple mental health problems in primary care.

The training was offered to Primary Care Staff along the lines suggested by Tylee [5].

Outcomes of this initiative over the last few years and the process of protocol development will be discussed.

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O-075

What do Maltese psychiatric patients think of their outpatient care? A preliminary study

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Aims and Objectives: Patient views are increasingly being used as part of service improvement methodology. This study explores psychiatric

patient perceptions regarding outpatient care including accessibility, responsiveness, and whether it meets their needs. It assesses patient satisfaction with current service, respect for their dignity and well-being.

Methodology: review of literature and National Policy on Mental Health Service (Ministry for Home Affairs and Social Development,1995); parameters identified included *referral, treatment, information, emergency care, provision of care by healthcare professionals, standards; support, discrimination within the rest of the service*. Other aspects included *primary/secondary interface*, and *general outpatient service domains*. Qualitative study using focus group methodology was used to obtain patient perspectives.

Results: Content analysis revealed general satisfaction with professional care; staff were perceived to do their best in spite of pressure of workload, frequent interruptions, and missing notes. Dissatisfaction was expressed with: lack of properly timed appointments; lack of information (treatment, side effects, illness, prognosis); access to care and communication with outpatients were difficult in crisis situations; lack of interaction with Social Services Department; little community support; lack of 'joined-up' care. There was no perception of discrimination within the rest of the service. Privacy and dignity are an issue in the waiting and common areas-though not in the consultation areas. Findings are being used to refine semi-structured interviews with individuals. A qualitative approach is very suitable for psychiatric patient survey and is being used as part of a quality improvement project currently under way using feedback.

Recommendations: A number of areas identified can be solved easily (e.g. providing locks on toilet doors and publicizing Richmond Foundation information in the outpatient waiting area), others will require more planning and new resources (e.g. better coordination for social services and community care, better information provision, clerk receptionist to coordinate appointments and control telephone interruptions). There emerges a general need to make patients and caregivers more aware that they can register their concerns with outpatient staff or with customer care services, with a view to improving services.

o-076

The communication skills courses in the behavioural sciences programme: an evaluation

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The World Health Organisation, the World Federation of Medical Education and the World Psychiatric Association have jointly recommended the development of Behavioural Sciences Courses for medical students.

The Faculty of Medicine and Surgery in a collaborative interdepartmental project has promoted the development of these courses.

Academic Year 2002 – 2003 has seen the introduction of courses in Psychology and Sociology in relation to health care for clinical students and Communication Skills Courses for the pre-clinical years.

The four communication skills courses are aimed at improving the acquisition of skills and professional attitudes that facilitate effective and appropriate interaction with patients, families and colleagues. They focus on interpersonal communication, self-awareness, coping with stress, doctor-patient relationship and teamwork.

These four courses are each three-day residential. Learning is in small groups, interactive and experiential. Didactic teaching is avoided.

One year after their inception, two evaluation seminars have already been held. Students and group facilitators are also being requested individual feedback.

A thematic analysis of the evaluation results will be held and this will be presented at the Conference.

o-077

Transcatheter closure of post-infarct ventricular septal defects

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Ventricular septal rupture causing a ventricular septal defect (VSD) occurs in around 1% of patients who sustain a myocardial infarct. The mortality is high both for those managed medically as well as those repaired surgically; conservatively, the surgical results claim 50% mortality and some of these patients would have had to survive a trial of life for several weeks before surgery is offered. We present a small group who had transcatheter closure of the VSD using an Amplatz VSD device, all of whom survived the procedure.

Between September 2001 and August 2003, 14 patients with post-infarct VSD were considered for the procedure and of these, 10 underwent closure; of the remaining 4, one was moribund at the time of referral and died within a few hours, one developed an acute abdomen possibly related to bowel infarction/perforation (pt on balloon pump), one was considered too old at 89 years of age and one was refused the procedure by the medical director. Thirteen devices were implanted in the 10 patients, 6 of whom were female. Six were carried out in the acute phase, all were on a balloon pump and most on inotropic support and had been turned down by the surgeons; two of these had coronary stent implantation in addition to the VSD closure. Of the remaining 4 patients who had the procedure late after the infarct and who had bypass grafts after the infarct, 2 had had surgical repair of the VSD (one patched and one sutured), 1 had had resection of a left ventricular aneurysm and in the final one the defect was not touched at surgery. A total of 13 devices were implanted in the 10 patients, 1 receiving 2 additional devices and 1 an additional device late after the infarct and having had a device implanted in the acute phase.

All the procedures were carried out under general anaesthesia using fluoroscopy and transoesophageal echocardiography. The approach was from the internal jugular vein using a catheter circuit from the femoral artery. All were sized with a balloon and the device size was based on this. There were no deaths related to the procedure but one patient died 10 days later from persistent sepsis (likely source being the balloon pump catheter) and major metabolic problems due to capillary leak; the rest are alive. Complications were uncommon; transient arrhythmias and hypotension were common usually when the sheath was placed across the VSD. There was one significant complication, namely, a pericardial effusion; although this was small, it was decided to drain it as it was in an acute infarct and anticoagulation was essential for the balloon pump.

Transcatheter closure of post-infarct VSD with the Amplatzer VSD device is feasible and the results are very encouraging even for those carried out during the acute phase. In the latter, some may also benefit from concomitant stent implantation. Although some residual shunts will remain, these are sometimes insignificant or can be closed later with another device or surgery. Timing of intervention is important with some cases benefiting from early closure even if supported with a balloon pump.

o-078

Risk adjusted effect of bypass on mortality and morbidity in CABG

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Introduction: Risk stratification systems such as Parsonnet or UK Bayes have been devised to predict the risk of any individual patient dying after coronary artery bypass surgery (CABG). In certain instances they can be used to predict morbidity.

Traditionally, CABG has been performed using cardiopulmonary bypass. Recently published randomized controlled studies, which have only shown a marginal benefit of 'off pump' (without cardiopulmonary bypass) CABG, have only included patients whose risk of mortality/morbidity after CABG is low. We have used risk-stratified methods to compare mortality and morbidity outcomes in all patients undergoing on pump and off pump CABG.