and 1998 the time consulting requested were 100% respected. A few innovations have been introduced: morning meetings, mobile phones, list of the primary care physicians in our district and the data base. QM is related to need of producing documents for accreditation in accordance with Italian law. At the moment we are on the way to obtain certification according to ISO 9002 laws, by an improvement of documents for accreditation: Quality Assurance Plan, organisation chart, job description, responsibility matrix, product standard, consulting request procedure, guidelines (for attempted suicide, delirium, abortion), special services (diagnosis and therapy for psychiatric comorbidity, psychosomatic diagnosis for patients with cardiovascular diseases). This experience contributed in giving importance and recognition to the Service, both locally and nationwide (e.g. gave rise consulting requests by other Italian C-L Services).

S46.03
CONSULTATION-LIAISON PSYCHIATRY IN EUROPE: CURRENT ISSUES – THE IMPORTANCE OF COST-EFFECTIVENESS STUDIES

F. Creed. *School of Psychiatry & Behavioural Sciences, Rawnsley Building, Manchester Royal Infirmary, UK*

Background: Consultation-liaison psychiatry services are unlikely to be commissioned across Europe unless we can demonstrate their cost-effectiveness. We have previously demonstrated the effectiveness of psychological treatment for irritable bowel syndrome. The aim of the present study was to establish whether these treatments could be generalised and, if so, whether they were cost-effective.

Methods: Patients with moderate to severe irritable bowel syndrome were randomly allocated to either seven sessions of individual psychotherapy or 20 mgs of paroxetine daily for three months or routine care by gastroenterologist and general practitioner. Abdominal pain, bowel symptoms and health-related quality of life, healthcare and other costs were assessed after the three month treatment period and at follow-up one year later.

Results: 257 (81% of eligible subjects) from seven hospitals were recruited to the trial. 69% of psychotherapy and 50% of the antidepressant group completed the course of treatment. Abdominal pain and bowel symptoms improved slightly in all groups; there was no significant difference between the groups at 12 months follow up. Both psychotherapy and antidepressants were superior to treatment as usual in improving the SF-36 physical component score ($p < 0.0005$). The same pattern was recorded at 3 months for the mental component score ($p = 0.007$), but not at follow-up. Psychotherapy, but not antidepressant treatment, was associated with significant lower total costs during the follow-up compared to treatment as usual year [$1,674 (sd = 1,798) v $2,361 (sd = 3636)]. Psychotherapy also led to a significant reduction in the number of people on sickness benefit.

Conclusions: Patients with moderate to severe IBS, which has not responded to conventional therapy, attend all gastroenterology clinics. Their number is greatest in tertiary referral clinics. A significant improvement in health-related quality of life can be offered by psychological treatments but these do not improve bowel symptoms.

S46.04
CONSULTATION-LIAISON PSYCHIATRY AND PSYCHOSOMATICS: QUALITY MANAGEMENT AND GUIDELINE DEVELOPMENT – A EUROPEAN PERSPECTIVE

T. Herzog

No abstract was available at the time of printing.

S47. Neuropsychiatry of brain injury

Chair: S. Fleminger (UK)

S47.01
ABULIA FOLLOWING BRAIN INJURY

K. Barrett

No abstract was available at the time of printing.

S47.02
TREATMENT OF AFFECTIVE DISORDERS AFTER BRAIN INJURY

P. Eames. *Grafton Manor Brain Injury Rehabilitation Unit, Grafton Regis, Northamptonshire, UK*

Brain injury can disturb affect in a number of quite distinct ways; before rational treatment can be planned, it is essential that the particular individual's disorder be analysed carefully, so that appropriate steps can be taken. The least common disorders are those that closely resemble (and sometimes are) 'typical' depressive illness or hypomania: these require traditional treatments, though there are some necessary caveats related to potential adverse effects that are particularly likely in the already injured brain. Probably the most common disorder is depression of mood reactive to the person's changed circumstances as a result of the injury, though most often this can be dealt with simply by giving adequate support and information to both the person and his or her family. The most important disorders to learn to recognise, because they are not widely enough known and need very specific treatment, are the quite common episodic mood disorders. The characteristics of the various forms of affective disorders will be presented and details of treatment regimes will be discussed.

S47.03
PHARMACOTHERAPY OF NEUROPSYCHIATRIC DISORDERS FOLLOWING BRAIN INJURY

U. Müller. *Department of Psychiatry, University of Leipzig, 22 Liebigstr., 04103 Leipzig, Germany*

Background: Neuropsychiatric disorders like depression, apathy, anxiety and post-traumatic stress disorder, sleep disturbances, aggression and agitation are common findings after traumatic brain injury (TBI). The correct diagnosis and optimal treatment of psychiatric complications has a strong impact on the outcome of patients with both mild and severe forms of TBI. Cognitive deficits like aphasia, amnesia, working memory and attentional deficits have recently become a new focus of pharmacotherapy after TBI.

Methods: A literature search in MEDLINE and PsychINFO databases was performed, specialized journals and textbooks were screened to retrieve relevant publications. Proposals for pharmacological treatment are also based on the author's own clinical experiences.

Results: There is only a limited number of randomized controlled trials, most publications are open studies, case series or single case reports. Some evidence-based recommendations can only be given for the treatment of depression and agitation after TBI.

Conclusions: (1) The first principle in pharmacotherapy of neuropsychiatric disorders following TBI is to avoid neurotoxic medications. Cognitive, epileptogenic, and neuroplasticity-decreasing

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side-effects especially critical. (2) Deficit symptoms after TBI can be treated with drugs that mimic major neurotransmitters, like dopamine agonists, psychostimulants, non-tricyclic antidepressants and cholinesterase inhibitors. (3) Antidepressive drugs might also help to reduce the (hippocampal) toxicity of hypercortisolism related to intensive-care treatment, rehabilitation stress and depression. (4) Positive neuropsychiatric symptoms after TBI can be treated with a number of sedative and antipsychotic drugs. (5) Finally, the ethical and legal aspects of compassionate drug use in rehabilitation of patients with TBI will be discussed.

S47.04
PSYCHOPATHOLOGY FOLLOWING BRAIN INJURY; IMPACT ON RETURN TO WORK

P. North

No abstract was available at the time of printing.

S48. Quality assurance, accreditation and costs in mental health

Chairs: R. Bosio (I), F. Ramacciotti (I)

S48.01
QUALITY IN ACCREDITATION TO THE EXCELLENCE

G.V. Rossi*, A. Erlicher, C. Barbini, A. Righi. *Department of Mental Health, Azienda USL Modena, 79 Via del Pozzo, c/o Distretto 3, 41100 Modena, Italy*

Background: In order to implement peer accreditation programmes between mental health services, it is necessary to develop standardised assessment instruments which are user-friendly, reliable and based on a large consensus.

Objectives: A) To devolop a consensus methodology including a set of criteria, indicators, standards and procedures for accreditation visits. B) To promote the training of both in-house and external visit facilitators. C) To carry out peer accreditation visits aimed to promote the total quality approach in the Departments of Mental Health (DMH).

Metods: A) Enrolment of DMHs on a voluntary basis. B) Consensus definition of evaluation criteria, indicators and standards; consensus definition of operational procedures for accreditation visits. C) Realisation of peer accreditation visits to DMHs and preparation of detailed visit reports, with feed-backs from the visited DMHs. D) Final evaluation.

Results: A "DMH Accreditation Manual", 2000 second version, has bee developed; it includes five sets of quality requirements in the area of: Department Organisation, CMHC, day-center, residential facilities, hospital facilities. Moreover, specific visiting procedures have been finalised, and visit reports of DMHs have been made available. Some DHMs are already using the visit reports for the planning of activities and preparation of the new year budget. A specific software linked to the accreditation manual has been produced, to be used for self-evaluation and training activities.

Conclusions: It is possible to apply accreditation procedures with DMHs, although they need an ongoing update and improved degrees of reliability.

S48.02
HOW TO STATE PROCEDURES IN MENTAL HEALTH: THE GENOA DEPARTMENT OF MENTAL HEALTH EXPERIENCE

L. Ferrannini*, G. Boidi, P. Ciancaglini. *Via S. Vincenzo 8516, Genova 16121, Italy*

In Italy, the recent reorganization of psychiatric services, that led to institution of the Department of Mental Health, went on together with the changing in the management of the total health system.

Psychiatry itself already needed to overtake too many differences arisen in the services in the last twenty years, with the aim of confronting and selecting more useful practices.

It wouldn't have been easy, because the ways of psychiatric practice aren't so straight, because the staff was trained not always according to the needs, and because in Italy there wasn't a system of standards and organization in treatments.

We verified how the different services were proceeding about the following problems: meeting the demands, taking care, emergencies and planned treatments, liaison psychiatry, residentiality, social interventions. By confronting the differences it was possible to identify the more used ways of proceeding, that were collected in a Handbook of the D.M.H.

In this work, the Authors describe the process for the construction of a Handbook for Quality, pointing out the obstacles they met and the methodologies they chose to face them.

People working, also in teams, were involved and the outcomes can be used for the development, the revision and the evaluation of the clinical practice and the taking care.

S48.03
IDEOLOGIES AND ACCREDITATIONS

F.A. Jenner

No abstract was available at the time of printing.

S48.04
STANDARDISED DESCRIPTION OF PSYCHIATRIC CARE. THE NEED TO PLACE EVERY SERVICE IN ITS SPECIFIC CONTEXT

G. Tibaldi, C. Munizza

No abstract was available at the time of printing.

S49. Treatment spectrum of atypical antipsychosis

Chairs: S. Kasper (A), J.Svesttka (CZ)

S49.01
ATYPICAL ANTIPSYCHOTICS IN SCHIZOAFFECTIVE DISORDERS

S. Montgomery

No abstract was available at the time of printing.

S49.02
ATYPICAL ANTIPSYCHOTICS IN BIPOLAR DISORDER

Goodwin

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