Conclusions: High rates of readmission may adversely impact healthcare spending. This study suggests a need for focused health policies to address readmission factors and improve community-based care.

Disclosure of Interest: None Declared

EPV0581

MULTIDISCIPLINARY COLLABORATION AS A IMPROVEMENT IN PROVIDING QUALITY USER-ORIENTED SERVICES

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Introduction: As one of main aim of broad mental health (MH) reform in Bosnia and Herzegovina (BH), quality of services and continuous improvement are priorities. In last decade network of community services-community mental health centers (CMHC) covered all the parts of the country and is connected with secondary and tertiary medical institutions as well as with broad network of centers for social welfare and growing number of user organizations.
Objectives: As a novel practice that will be involved in standards of quality for all MH services is joint planning of hospital discharge people with mental illnesses, supported by legislative and connected with other positive results of mental health reform in BH
Methods: Review of implementation of results of MH reform in BH with focus on joint planning hospital discharge.
Results: In BH in last decade has been established broad spectrum of services that improved quality of care through multidisciplinary collaboration between sectors. Important role has given to users' organization. Quality standards are defined trough certification and accreditation. New services were developed or renewed and implemented (such as case management, occupational therapy). Entities' policies and strategies involved new services and improved MH legislative following the course of more involvement of patients as well as their families, representatives or persons of their trust in decision making and planning of multidisciplinary treatments in the CMHCs. Joint Planning of discharge from the hospital fund as important step in further improvement of quality of care for people with MH disorders, especially for those with severe mental illnesses.
Conclusions: Last decade in BH gave important results in the better quality of MH care. Further plans will be focused on implementation of new MH user-oriented services.

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Difficult patients in mental health care–who are they?

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Introduction: Difficult patients are not something new and we can find innumerous definitions for this concept. However, they form a very heterogenous group and we need a less abstract definition focused more on the clinical reality and the difficulties experienced by patients and mental health professionals.
Objectives: Our goal was to find a more precise and clinical definition of the difficult patient based on quantitative measures using a statistical analysis of a series of hospitalizations.
Methods: A cluster analysis of our hospital's in-patient treatment from the last 5 years was made concerning the duration of the stay and the number of previous hospitalizations.
Results: A sample of 8576 inpatient treatment episodes was used. 52.4% were male and 47.6% female patients between the age of 15 and 103 years old. The length of the treatment varied from 0 to 1007 days and the number of previous hospitalizations from 0 to 109; excluding the outliers the means were, respectively, 21 days and 2 previous hospitalizations.
The cluster analysis excluded 85 episodes and it found the presence of 3 clusters, being the number 1 the wider one (n=5861 episodes) and the other quite similar.
The Cluster 1 was characterized by a smaller length of hospital stay and number of hospitalizations; the Cluster 2 was defined by the episodes with the highest number of previous hospitalizations (`x =8.77) and the Cluster C by the longest hospital stays (`x =58.09 days). With a Kruskal-Wallis test we found both variables statistically different between all clusters ($p<0.001$). In Cluster 2 and 3, respectively, we found that 40,24% and 34.61% was taking the medication before being hospitalized, 6.42% and 3.15% were compulsive hospitalizations, and 40.5% and 21.89% had LAI prescribed.
Concerning the diagnosis, Cluster 1 had more Depression, Neurotic and Somatoform disorders; Cluster 2 more Bipolar and Intellectual disability disorders and Cluster 3 more Dementia and Delusional disorders. Substance use disorders and Personality disorders were found more common in both Cluster 1 and 2, Schizophrenia in Cluster 2 and 3 and Psychosis non specified in Cluster 1 and 3.
Conclusions: We can say Cluster 1 comprises the non-difficult patients and it's not surprising that it includes more Depression and Neurotic and Somatoform disorders. The other diagnostic distributions among clusters were also expected and we can also theorize that Cluster 3 had higher percentages of social cases. Treatment with LAI is linked to a decrease in rehospitalizations and we found that in the majority of these episodes it wasn't been applied. This research is important in order to identify the difficult patients and what challenges they can bring to the mental health services. Creating these patients' profile will allow us to better understand their needs to create guidelines for a personalized inpatient treatment and to improve community services to prevent the rehospitalizations and prolonged hospital stays.

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