two patients, zuclopenthixol in combination with chlorprothixene in one, haloperidol alone in one and chlorprothixene and clozapine in one patient) severe dystonic reactions appeared in all patients with lateralization in four of them. The observed dystonic reactions lasted up to 30 days and did not improve with anticholinergics. One of the patients died suddenly three days after the appearance of the dystonic reaction and the post mortem did not reveal an obvious cause for this fatal outcome. The reported cases underline the high risk of the occurrence of manic symptoms shortly after lithium withdrawal. Moreover, they are an indication of a heightened risk for severe side effects of neuroleptic treatment in patients after abrupt lithium withdrawal.

THE PATIENT UNDER NEUROLEPTIC TREATMENT

B. Lachaux, C. Gaussares. *Hôpital Saint Jean de Dieu, 290, Route de Vienne, 69373 Lyon Cedex 08, France*

The patient under neuroleptic treatment.

This study treats:

- Neuroleptic prescription practice in the field of psychiatry in the French public health services.
- according to a naturalistic method which respects the usual modes of prescription
- in the context of the organisation of psychiatry in the French public health service in sectors which allow a coherent network of the different investigators involved.

The results presented concern more than 4,000 files of patients gathered by a network of 85 public health service psychiatrists from all over France and working under the same conditions. These patients' files which follow up hospitalisation and consultation have been collected over a nine-month period at three intervals (M0, M4 and M9).

This at the same deadline and under the same conditions of place for each of the investigators.

All analysed files are exhaustively documented on clinical particularities as well as on the drug and non-drug treatments.

This approach is a research method on prescription modes but also an excellent method of training since the different investigators receive, in return, their personal data accompanied by global results to which they can compare. They also receive the main elements which are the consensus in this field.

SEVERE DEPRESSION: RECOGNITION AND TREATMENT

Y. Lecrubier, J.C. Bisserbe. *Unité INSERM 302, Hôpital La Salpétrière, Paris Cedex, France*

There is no single definition of severe depression, however, all the following variables should be considered in patient assessment: intensity of specific symptoms; diagnostic subgroups (eg, bipolar depression); stage of evolution (chronic or recurrent); comorbidity; and resistance to treatment. Elderly patients are more likely to have severe depression because of the high incidence of chronicity, recurrence and comorbidity in these patients. Severe depression is mainly treated with tricyclic antidepressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs). Comparative studies have shown that TCAs and SSRIs are effective in patients with a baseline HAM-D score > 25 and/or melancholia; a meta-analysis in 244 patients with melancholia showed that paroxetine was significantly more effective than placebo. As maintenance therapy may be necessary for many years, the tolerability of agents is of major importance. SSRIs appear to be better tolerated than TCAs, with fewer patients stopping treatment because of adverse events; pooled comparative data of paroxetine, placebo and active comparators (mainly TCAs) in almost 5000 patients showed a lower incidence of anticholinergic, neurological and cardiovascular effects with paroxetine. However, SSRIs are associated with a higher incidence of nausea although few patients discontinue treatment. Numerous long-term studies also demonstrate the efficacy of TCAs and SSRIs in prevention of relapse and recurrence and the superior tolerability of SSRIs compared with TCAs.

COMPULSIVE BUYING IN DEPRESSED PATIENTS

M. Lejoyeux, J. Adès. *Departement of Psychiatry, Hopital Bichat-Claude Bernard, 75877 Paris Cédex 18, France; Hopital Louis Mourier, 92700 Colombes, France*

Compulsive buying is defined by the presence of repetitive impulsive and excessive buying leading to personal and familial distress. Patient presenting this disorder also suffer from mood disorder in 50 to 100% of the cases and antidepressants help to decrease the frequency and the severity of uncontrolled buying. In order to precise the correlation between compulsive buying and depression, we assessed this behavior among 119 inpatients answering to DSM-III-R criteria of major depressive episode. We also evaluated the comorbidity in the patients suffering from compulsive buying (CB+) and in those who were free from this disorder (CB−). In addition, impulsivity and sensation seeking were compared in the two groups.

Diagnosis of compulsive buying was made using standardized criteria and a specific rating scale. Diagnosis of depression and assessment of comorbidity was investigated using the Mini International Neuropsychiatric interview. The prevalence of the disorder was 31.9%, 38 of the 119 depressives being diagnosed as compulsive buyers. Patients from the CB+ group were younger, more often women and unmarried. They had experienced irresistible urges, uncontrollable needs, or mounting tension that could be relieved only by buying. For all patients, compulsive buying had tangible negative consequences. Postpurchase guilt was present in 21 (55%) patients. 24 (63%) of compulsive buyers described attempts to resist urges to buy.

Patients with compulsive buying presented more often than others recurrent depression (relative risk = 1.4), impulse control disorders as kleptomania (RR = 8.5) or bulimia (RR = 2.8), benzodiazepine abuse or dependence disorder (RR = 4.68), associations of dependences (RR = 1.99). Compulsive buying was thus frequent among depressives and associated with other impulse control disorders or dependence disorders.

ROUTINE ASSESSMENT OF PATIENT HEALTH: A WORST CASE SITUATION WITH REGARDS TO INTER-RATER RELIABILITY

H. Loevdahl, S. Friis.

Global Assessment of Functioning (GAF) has been selected as the variable for routine assessment of patient health in the Norwegian national Minimal Basis Data Set for Psychiatry. The objective is to obtain reliable data on patient status at the beginning and the end of every treatment episode for all psychiatric patients. High quality routine data provide a new and fascinating possibility: To be able to perform retrospective longitudinal studies, and thus avoid the major problems associated with such prospective studies. However, this can only be achieved if good reliability of the data is ensured.

In order to test the reliability of GAF-scores in routine settings, we let more than one hundred persons rate the same clinical case-vignettes. Reliability is generally better with case-vignettes than with patients, due to a restricted variance of information. But this only means that any shortcomings demonstrated in this "in vitro" situation represents understatements of actual problems in clinical settings.

Our study demonstrated that normal therapeutic responses to psychiatric treatment could not be reliably identified in routine settings using the GAF-scale. We therefore suggest a structured scheme for enhancing the interrater reliability of GAF-scores, and demonstrate it's profound effect on the variance of scores.

THE LONG-TERM OUTCOME OF DEPRESSED MOOD AND MAJOR DEPRESSIVE DISORDERS IN THE COMMUNITY [1980–1994]

M.G. Madianos, M. Economou, E. Rogakou, C.N. Stefanis. *Social Psychiatry Unit, C.M.H.C., Dept. of Psychiatry, University of Athens, 14 Delou Str. Kessariani, 161 21, Athens, Greece*

In this report results concerning the outcome of depressive mood cases and major depressive disorders over a thirteen year period (1980–1994) are presented.

In 1980 a two stage cross-sectional study on the prevalence of mental disorders was carried out in a probability community sample of 1,574 adults. After completion of interviews a "case" identification procedure was applied by the use of clinical criteria allocating each respondent to one of five categories, from "well" to "definite case" (Stage A). In stage B (1981) two psychiatrists interviewed a sample of 360 respondents comprised all the identified probable and definite "cases" together with randomly selected individuals for the other three mental status categories.

In 1994 a follow-up study was conducted to reinterview the above sample of 360 respondents by the use of SCID. The follow up search ended with 182 baseline respondents located alive plus 38 certificated as dead and residual (140 of the baseline sample) categorized as definetely unlocateable.

According to the diagnostic classification of mood disorders in 1980/1981 90% of the previously diagnosed residents as suffering from major depressive episode were found to be "non cases". However only 20% of the cases diagnosed in 1981 as dysthymic, were identified as "non cases" in 1994.

The results are discussed within the context of other clinical and social characteristics of the sample.

THE PRACTICE OF CO-ADMITTING RELATIVES OF PATIENTS IN AN OPEN GENERAL HOSPITAL UNIT — EFFECTS ON RELATIVES

Chr. Mantas, M. Carteri, A. Liakos. *Psychiatric Clinic of General Hospital of Ioannina, University of Ioannina, Medical School, 451 10 Ioannina, Greecce*

The practice of co-admitting a relative during hospitalization, developed by Psychiatric University Clinic of Ioannina, is the subject of the present investigation.

By instituting this practice, 93% of the patients who need hospitalization are voluntarily admitted to our clinic, a 30 bed Open Unit in the University General Hospital of Ioannina. In this pilot study the group of co-admitted relatives (N = 21) were compared to relatives of the patients who were admitted alone (N = 14). Evaluation included the relatives attitude towards mental illness and their feelings for their patients, on admission and discharge. All relatives completed, on admission and discharge, the OMI (J Cohen and E Struening, 1962) and the FAF (Family Attitude Form — D Kreisman), which includes the Patient Rejection Scale and Patient Overprotection Scale. The analysis of data shows that the patients with co-admitted relative are more disturbed and reside further away from the Hospital. The changes of the OMI and FAF scores from admission to discharge were investigated in the two groups of relatives. There was a tendency for a significant decrease in the Overprotection subscale of the FAF in the group of co-admitted relatives.

We conclude that our practice permits the informal admission of disturbed patients in an Open Unit. Additionally it helps co-admitted relatives to change their attitudes towards their patients.

ISSUES IN CONDUCTING COST OF ILLNESS STUDIES FOR SCHIZOPHRENIA

C. Martin, L. Genduso. *Lilly Research Center, Erl Wood, Windlesham, UK and Lilly Corporate Center, Indianapolis, USA*

The purposes of a cost of illness (COI) study for schizophrenia (S), an evaluation of direct and indirect costs in a specified population, are many fold: increase awareness regarding the costs of S to a society or government, determine policies for better mental health programs, and provide a baseline to measure clinical practice as well as the cost-effectiveness of certain interventions. Prevalence estimates (assessment of the total cost for a given year) are better suited for cost control measures and as a budget planning tool for the next years. Incidence studies (assessement of the lifetime costs for a given cohort) are more useful for overall program evaluation, and as a baseline for new treatment interventions. Planning a COI study involves several steps before data collection begins: i) determine if the study will be retrospective or prospective, ii) define criteria for inclusions (ICD codes or DSM IV classification), iii) obtain an appropriate sampling matched to the demographics of the overall schizophrenic population for relevant variables (eg age, socio-economic status, severity of illness, type of institution), iiii) state the perspective of the study (eg societal perspective, government perspective), iiiii) define sample size. Reporting of resources used, costs per service utilization item and average costs per patient lead to greater transparency. Sensitivity analysis should be done on key variables (eg prices, patient mix, type of treatments). If the sample is representative and of sufficient size, the results can be extrapolated, with caution, to the population. COI studies have been conducted in Australia, UK and the US and we are aware of ongoing studies in Belgium, France, Germany and Spain. Comparing COI studies over time, even with adjustments for inflation, is difficult because of various changes including an improvement in cost measurement techniques, a narrowing of the definition of S and a shift from hospital care to community care that has impacted costs. COI studies can assist in the needs to serve the patient while being mindful of the government, private insurer, and patient payments. As more and more studies are conducted, research techniques are improving and becoming more rigorous.

PSYCHIATRIC REHABILITATION IN POLAND — CURRENT CONDITION AND PERSPECTIVES OF DEVELOPMENT

J. Meder, K. Muskat, A. Stołowska.

On 19th August, 1995 Seym of Polish Republic passed the Mental Health Act, which should strongly influence the development of modern psychiatry. At the present moment there are mainly big, old psychiatric hospitals, little number of wards at general hospitals and several dozen of unequally collocated day centers in Poland. 20% of patients currently treated in psychiatric hospitals stay there only on social account. In these cases we employed Liberman behavioural program in order to activate and prepare them to independent life. We lay stress on best training, enlargement of medical staff number and making cooperation between psychiatrist, GPs and social workers efficient. Besides it is important for us to initiate and develop our collaboration with various organizations.