Wed-P12

STRATEGIES FOR ENHANCING SELF-ESTEEM AND SOCIAL INTEGRATION OF PATIENTS WITH SCHIZOPHRENIA

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Objectives: Investigation of illocutionary and perlocutionary effects of linguistic presentations of the diagnosis of schizophrenia, on the patients' self-concept, which may have significant effects on the prognosis of schizophrenia.

Methods: 200 patients with schizophrenia in remission were asked how they wished people to refer to them if they (the patients) develop or have already developed schizophrenia (schizophrenia sufferer; schizophrenic; person with schizophrenia, or any other alternative). This led to self-reports which indicate the impact of the diagnosis on patients' self-concept. A separate questionnaire assessed any stigmatising social response towards each of the designations and towards the concept of schizophrenia.

Results: About 15% of patients fully internalise the stigmatising social response into their self-concept or use it as a compensatory mechanism. Twenty percent totally resist accepting the diagnosis. Twenty per cent accept the diagnosis but reclaim positive attributes for it or use it as a means of declaring their solidarity with other patients. Ninety per cent accept the diagnosis but propose alternative linguistic formulations to reduce stigmatisation.

Conclusions: Patients with schizophrenia employ Linguistic Intervention, Solidarity and Reclaiming as defence strategies against stigmatisation. The latter should be encouraged to enhance the patients' self-esteem and cooperation with treatment.

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SELF-AWARENESS IN CHRONIC SCHIZOPHRENIA: BILATERAL ASSESSMENT OF NEGATIVE SYMPTOMS (BAINSA)

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Self assessment of psychopathological symptoms in schizophrenia is restricted by the disturbance of self-awareness. There exists no generally applicable operationalization for a quantitative measurement of unawareness of negative symptoms. In the present study 33 chronic schizophrenic out-patients were examined by the 'Scale for the Assessment of Negative Symptoms' (SANS, Andreasen 1984) and an analogously scaled 'Questionnaire for Negative Symptoms'. Differences between item scores were taken as item values constituting a new scale of the 'Bilateral Assessment of Impairment of Negative symptoms' Self-Awareness' (BAINSA). No significant correlation was found between SANS and QNS scores. BAINSA scores significantly correlated to SANS scores ($R = 0.69$; $p < 0.000008$). The results confirm a disruption of self-awareness and indicate that schizophrenic patients with a high extent of negative symptoms underestimate and less impaired patients overestimate their negative symptoms. It is proposed to introduce SANS-QNS differences as BAINSA scores for the quantitative measurement of the self-awareness of negative symptoms in schizophrenia.

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VALIDATION OF THE BEHAVIOURAL ACTIVITY RATING SCALE: A MEASURE OF ACTIVITY IN AGITATED PATIENTS

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The rapid-acting, intramuscular (IM) formulation of the novel antipsychotic, ziprasidone, reduces symptoms of acute agitation in patients with psychosis but is not profoundly sedating. For the Phase III clinical trials of IM ziprasidone an objective measurement that accurately characterized the effect of ziprasidone IM on activity levels in patients with psychosis and acute agitation was required. The seven-point Behavioural Activity Rating Scale (BARS), a novel measure of agitated behaviour, ranging from 1 (difficult or unable to rouse), through 4 (quiet and awake/normal level of activity), to 7 (violent, requires restraint) was developed. Data from a Phase III clinical trial were used to validate the BARS. Convergent validity was assessed using Spearman's correlation coefficient between BARS scores and the sum of a PANSS agitation grouping (hostility, excitement, anxiety and tension) and between BARS and CGI-S scores. Divergent validity was assessed by using Spearman's correlation coefficient between BARS and PANSS negative subscale scores. Effect sizes of the BARS, PANSS agitation grouping, and CGI-S were compared to measure the responsiveness to treatment differences. The discriminant validity of the BARS between two different patient populations (one from another study) at baseline was evaluated with the Wilcoxon rank sum test. Inter- and intra-rater reliability were examined using investigator training data. The correlation coefficients between the baseline BARS and the PANSS agitation grouping (0.33) and CGI-S scores (0.40) were statistically significant, whereas the coefficient between the BARS and PANSS negative subscale scores (0.16) was not. The effect size was larger for the BARS (0.83) than for the PANSS agitation grouping (0.52) and the CGI-S (0.60). A significant difference in BARS scores at baseline was found between the two distinct populations ($P < 0.05$). Perfect inter- and intra-rater reliability were achieved. The BARS is a psychometrically valid and reliable scale to objectively measure the level of activity in acutely agitated patients with psychotic disorders treated with rapid-acting, IM ziprasidone.

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ARE THE COSTS OF TREATMENT IN SCHIZOPHRENIC PATIENTS RELATED TO PSYCHOPATHOLOGY, SOCIAL DISABILITY AND SUBJECTIVE CONCEPT OF ILLNESS?

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Objective: It should be examined whether the use of medical and social support in chronic schizophrenic patients - summarized in the total costs of treatment - is correlated to the subjective concept of illness and outcome variables as psychopathology and social disability.

Method: Out of a sample of 138 patients with diagnosis of schizophrenia or schizoaffective disorder (ICD-10) first time hospitalized between 1990 and 1993, 31 patients rehospitalized between 1994 and 1996 were prospectively investigated (t1, index admission; t2, one-year-follow-up). Both times, psychopathology was recorded by the Positive and Negative Syndrome Scale (PANSS), social disability by the german version of the Disability Assessment Schedule (DAS) and subjective concept of illness by the illness

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concept scale (KK Scale). The total costs of treatment in the past year were estimated including all outpatient services used within the last year.

Results: The costs of treatment amounted on average 31000 DM/year in the year before index admission and 43000 DM/year in the following year (including index admission). The costs were highly correlated with social disability (t2) ($p < 0.0001$) and moderately correlated with negative symptoms (t1, t2) ($p < .05$), but not with positive or general symptoms. Negative symptoms were highly correlated with social disability (t1, t2) ($p < .01$), positive and general symptoms only moderately (t2) ($p < .05$). The t1-t2-correlation of the KKS was pretty good with mean $r = .4$ in the 7 subscales. A negative correlation was found between drug confidence and the costs of treatment in the following year ($p < .001$).

Conclusions: The use of medical and social support in chronic schizophrenic patients is highly determined by illness-related factors as negative symptoms and social disability. This supports the assumption that the inpatient and outpatient care system meets the needs of patients.

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A LONGITUDINAL EVALUATION OF TWO PSYCHIATRIC INPATIENT UNITS ATTACHED TO A COMMUNITY MENTAL HEALTH CENTRE. OUTCOMES AND COSTS

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Background: The inpatient care of those with psychiatric disorder is little evaluated despite the central role of inpatient units in catchment area services. Two innovative 8-bedded psychiatric inpatient units attached to two Community Mental Health Centres (CMHCs) were evaluated. These units have potential advantages for the assessment and after care of those recovering from severe mental illnesses.

Method: All patients admitted to the acute psychiatric wards serving the two CMHCs were assessed for suitability for inclusion. Those transferred to the community beds or admitted directly to these beds constituted the experimental group. A control group consisted of those patients admitted to the acute wards serving two demographically similar catchment areas but whose community services did not have associated community beds. Clinical and social measures were made during the first week of admission and repeated 6 and 12 months later. Public and private resource consumption was also measured.

Results: 177 individuals met the inclusion criteria. The experimental and control groups were matched on demographic and clinical preliminary variables. The experimental group made significantly greater improvement on most outcome measures including symptom and social measures, user satisfaction, length of acute inpatient stay, number of readmissions, improved after care contact. The overall costs of the community units were greater than that of traditional inpatient units but there was significant variation of costs between the two community units.

Conclusions: The attachment of community inpatient units to Community Mental Health Centres has theoretical and practical advantages. The use of such community beds may have significant benefits for clinical and social outcomes for the patients with severe mental illnesses. Higher costs of the units were not inevitable and may depend on the way in which such units are integrated into existing care provision. The model of provision of inpatient services within a Community Mental Health Centre may be worth adopting more widely.

Wed-P17

REPROVISION OF 'REMNANT' SCHIZOPHRENIC PATIENTS: CAN ALL PATIENTS LEAVE HOSPITAL?

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Several studies on deinstitutionalisation of long-stay patients have brought attention to a group of 'remnant' patients, apparently difficult to move into the community. This has led to pessimistic conclusions about the chances of fully closing long-stay wards of psychiatric hospitals. A remarkable reduction of hospital beds in the 70s and 80s in the German state of Hessia was followed by a political decision in 1992 to close long-stay wards of mental hospitals. The object of this study is (1) to display the characteristics of a remaining population of schizophrenic patients ($n = 266$) that had not been deinstitutionalised despite an ongoing reprovision-program until 1995. (2) Moreover, selection criteria for community reprovision within this 'remnant' group of patients should be identified.

(1) Patients were found to be extremely disabled. Mean duration of stay was 30 years. (2) Only 50 of the 'remnant' patients have been moved into the community since 1995. Significant differences between discharged and remaining 'remnant' patients were found regarding gender, age, and duration of hospitalisation at baseline (1995), while the age of onset of illness was equal in both groups. The patients left in hospital had been less engaged in spare-time activities and less likely to want to leave hospital at baseline. No differences could be found with regard to psychopathology and quantitatively assessed quality of life. However, results of content analysis of open-ended quality of life interviews indicate differences regarding the internal orientation to various life domains between the newly discharged patients and the still remaining patients.

Results indicate that even within this 'remnant' group of patients a selection bias for community reprovision operates. It is discussed whether the 'hard core' of remnant patients could be resistant to re-provision or possibly needs a special intensive care in the community.

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SCHIZOPHRENIC PATIENTS' NORMATIVE NEEDS FOR CARE IN THE YEAR AFTER DISCHARGE FROM THE HOSPITAL

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Introduction: As part of a public health research project that evaluates restructured psychiatric community care for chronic patients after the German reunification in Saxony a group of ICD-10 schizophrenic patients limited to the Dresden area was examined.

Methods: Data were collected 1, 6 and 12 months after discharge from the hospital using the MRC Needs for Care Assessment.

Characteristics of the Study's Clientele: ($n = 112$): sex-ratio 1:1; mean age 42 y; 60% unmarried; 75% recipients of a pension; mean duration of disorder 14.4 y; mean GAF-Score 41.8 (± 11.4), mean BPRS-Score 43.7 (± 12.5).

Results: 1 month after discharge normative psychiatric needs for care (mainly based on informations of psychiatrists, social workers and relatives) with current clinical significance were rated in 2.1 (± 1.3) clinical and 1.6 (± 2.3) social NCA-areas (esp. concerning negative symptoms, psychosocial distress, social interaction skills,

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