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.

Wed-P16

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.

Wed-P18

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 ($\pm$ 11.4), mean BPRS-Score 43.7 ($\pm$ 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 ($\pm$ 1.3) clinical and 1.6 ($\pm$ 2.3) social NCA-areas (esp. concerning negative symptoms, psychosocial distress, social interaction skills,

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legal capacity). At the end of the year there was a slight decrease of current clinical (1.96 (± 1.5)) and social (1.46 (± 2.1)) problems. Analyzing patients' individual courses during the 1 year-period the level of social skills and abilities is much more stable than the clinical level of functioning with its considerable fluctuations (esp. concerning neuroleptic side-effects, destructive and socially embarrassing behaviour). Studying the contents of the normative needs for care rated by professionals with a factor analysis the main field during the 1 year-period shiftes to items of care resulting from disabled social competences. On the other hand the part of psychiatric needs for care growing from schizophrenic disorders' typical symptoms loses a great deal of its significance. - Besides correlations with data on former hospitalizations (r = .28 to .39) and psychopathological characteristics (r = .34 to .61) the needs of care especially in the social sector are higher for men and for patients living in their family of origin and in sheltered homes (p = .011 resp. p = .000). - The general level of unmet needs and not meetable needs in the examined group of patients ranges from 5–11% in the community psychiatric care structure of the Dresden area. The main fields here are: leisure-time activities, occupation/employment and social interaction skills. In each of these this is partly due to not yet established community-orientated institutions of care.

Wed-P19

UTILITY OF AN ACCURATE ASSESSMENT OF THE AGE OF ONSET IN SCHIZOPHRENIA

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Aims: An accurate assessment of the age of onset in schizophrenia could be necessary in research, in particular in studies on premorbid adaptation, premorbid personality disorders or anticipation. The aim of this study was to assess the interest of using a standardized interview to determine the age of onset in schizophrenia.

Methods: 65 schizophrenic patients aged between 18 and 42 were included. We elaborated an original interview based on DSM-IV criteria which enabled us to determine retrospectively the date of onset of the first psychotic symptom present for at least one month, or of a marked socioprofessional deterioration. Patients and their mothers were interviewed separately and we examined the medical records. To determine the age of onset in schizophrenia, we took into account the earliest age of onset of psychotic symptoms or socioprofessional deterioration mentioned by the informants and the medical records.

Results: Reliable assessments were realisable for 96.9% patients (63/65). The age of onset of schizophrenia was consistent with patients answers in 79.2% of cases, with mothers answers in 73.0% of cases, and with medical records in only 39.6% of cases. The mean age of onset assessed by the interview was significantly lower than the mean age of first hospitalisation (19.6 +/– 4.9 vs 23.0 +/– 4.7 years; $p < 0.001$). The difference between age of onset and age of first hospitalisation was significantly greater in progressive than in acute onsets (4.6 +/– 3.0 vs 1.3 years +/– 2.4; $p < 0.001$).

Conclusion: the use of a standardized interview to determine the age of onset of schizophrenia seems to bring more reliable and more accurate results than a simple examination of medical records particularly in progressive onsets.

Wed-P20

CLINICAL DIMENSIONS OF AUDITORY HALLUCINATIONS: A FACTOR ANALYTIC STUDY

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Material-Methods: One hundred psychotic psychiatric inpatients with active auditory hallucinations were rated at admission on 20 item scales representing several important clinical features of auditory hallucinations, tested for their interrater reliability. Patients were also rated on the Brief Psychiatric Rating Scale (BPRS), the Hamilton Depression Rating Scale (HDRS) and the Mini-Mental State Examination (MMSE).

Results: A Principal Component Analysis of patients' scores on the 20 item-scales resulted in the extraction of eight factors, jointly accounting for 63.3% of the variance. These factors were interpreted as representing the dimensions of length of hallucinatory occurrences (F_1), emotional and behavioral concern (F_2), changeability (F_3), rate of hallucinatory occurrences (F_4), delusional elaboration (F_5), similarity to normal auditory perception (F_6), verbal comprehension (F_7) and volitional dyscontrol (F_8). Most of the factors were found to exhibit distinctive profiles of anamnestic and clinical correlates. Thus, F_1 was correlated with longer duration of illness and lower score on the BPRS, F_2 with higher BPRS score and shorter duration of illness, F_3 with higher and F_4 with lower number of hospitalizations respectively, F_5 with longer duration of illness, lower number of hospitalizations and lower BPRS score and, finally F_6 with lower score on the MMSE.

Conclusions: Our results provide for the first time supportive evidence for the multidimensionality of auditory hallucinations at the factor analytic level as well as for the partial external validity of the factorial solution obtained. Furthermore, they are in agreement with those of other studies showing the differential response of various components of auditory hallucinations to treatment with antipsychotic drugs as well as their distinctive course over time.

Wed-P21

CLINICAL DIMENSIONS OF DELUSIONAL BELIEFS: A FACTOR ANALYTIC STUDY

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Material-Methods: We studied 12 formal clinical characteristics of delusional beliefs in 127 psychiatric inpatients with delusions at admission by means of 3-point ordinal rating scales, tested successfully for their interrater reliability. Patients were also rated on the Brief Psychiatric Rating Scale (BPRS), the Hamilton Depression Rating Scale (HDRS), the Global Assessment Scale (GAS) and the Mini-Mental State Examination (MMSE).

Results: A Principal Component Analysis of patients' scores on the 12 item scales yielded five factors which jointly accounted for 62.7% of the variance. These factors were interpreted as representing the dimensions of cognitive disintegration (F_1), doxastic strength (F_2), subjective concern (F_3), referential and affective inconguence (F_4) and delusional expansiveness (F_5). Moreover these five factors were found to exhibit to a large extent distinctive profiles of demographic, anamnestic and clinical correlates. Thus, F_1 was associated with male gender, longer duration of illness and lower MMSE score, F_2 with shorter duration of illness and lower number of hospitalizations, F_3 with higher BPRS scores, F_4 with

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