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]

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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

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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

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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

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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.