symptoms is presented, as a potentially more pragmatically useful and theoretically more consistent framework for classification of schizophrenic symptomatology.

S46-2
QUALITY OF LIFE: SYMPTOMS - SIDE EFFECTS - SOCIAL PERFORMANCE - MOOD

P. Bech. *Psychiatric Research Unit, Frederiksborg General Hospital, DK-3400 Hillerød, Denmark*

Quality of life is often measured in terms of social disability or social adjustment. In contrast to stress, quality of life is a measure of outcome rather than cause of illness. In chronic disorders like schizophrenia, the WHO Classification of impairments and disabilities is very useful. The disability is a measure of performance of social roles. Quality of life goes beyond the WHO concept of handicap when defining the consequences of chronic illness. It is the subjective dimension on the sequence underlying impairments and disabilities. In clinical trials with antipsychotics in schizophrenia, quality of life is considered as the outcome measure capturing the balance between efficacy and safety from the patient's point of view. Schizophrenia-specific quality of life scales have been developed, but also generic scales have been used. Among the generic scales the Psychological General Well-Being Scale has obtained an acceptable applicability in schizophrenia. This scale measures both positive and negative well-being.

(1) Bech P: Quality of life in the psychiatric patient. London: Mosby-Wolfe, 1998.

S46-3
ANTIPSYCHOTICS: WILL THE ATYPICALS IMPROVE THE PATIENTS' QUALITY OF LIFE?

Dieter Naber. *University of Hamburg, Hamburg, Germany*

The benefit of neuroleptic drugs in the treatment of schizophrenic patients is beyond doubt. However, most patients discontinue these drugs within a few months. This low compliance may be caused by a lack of insight into the disease and the necessity of therapy. Also of major importance are adverse effects, which are not restricted to motor symptoms but markedly affect drive and emotion. They are often too subtle to be detected by objective examination but are reported by patients, who complain of a reduced quality of life (QOL) with restrictions in emotionality, straight thinking, and spontaneity. This syndrome, similar to the negative symptoms of schizophrenia, has been namend pharmacogenic depression or neuroleptic-induced deficit syndrome.

The patients' perspective in the treatment of schizophrenia has largely been neglected, perhaps because of the lack of agreement on a definition of QOL and its essential components or the lack of a specific model for QOL in schizophrenic patients under neuroleptic treatment. To date, there is no practical and therapy-sensetive scale to measure subjective QOL in schizophrenic patients. Another reason for the low scientific interest in QOL with neuroleptic treatment may be the misconception that schizophrenic patients are not able to evaluate their well-beingor QOL.

However, numerous studies have demonstrated that between 63% and 95% of schizophrenic patients, most of whom were in remission, were able to self-rate their affective state or their QOL. The relationship between the subjected evaluation of QOL and expert-rated psychopathology is not strongly correlated. Most studies found significant correlations to only negative symptoms. The few studies in which the effect of atypical neuroleptic drugs on QOL was investigated show that these drugs - namely clozapine, olanzapine, risperidone, and sertindole - are superior to typical neuroleptics.

Owing to the lack of relevant motor or affective side effects with atypical neuroleptics, compliance is relatively high, and patients are less often rehospitalized. Therefore, they are able to participate in long-term, psychosocial rehabilitative treatment, which finally leads to improvement of negative symptoms, subjective well-being, and QOL.

Moreover, numerous studies indicate that early and continous neuroleptic treatment is of major importance for long-term prognosis. It might be possible that the broad use of effective, tolerable, and socially accepted atypical neuroleptics also results in a markedly better long-term prognosis.

S46-4
COMMUNITY PSYCHIATRY: THE CHALLENGE OF CO-ORDINATION AND FOCUS

Tom Burns. *St. George's Hospital Medical School, London, SW17 0RE, UK*

The management of long-term and disabling disorders such as schizophrenia in the community present major challenges for European teams. The general principle of sectorisation has the advantage of ensuring a prompt and usually multiprofessional response. It has inherent problems, however, in co-ordination (in particular between health and social care) and maintaining a focus on prioritising the needs of severely mentally ill individuals.

In the US case-management has been developed for co-ordination of care and published studies are encouraging. In Europe case-management studies have yielded mixed results. Maintaining a clinically appropriate focus has not been so widely written about or researched.

The Care Programme Approach in the UK has been an attempt to control both co-ordination and focus through central legislation. Current evidence suggests that such hybrid legislation achieves neither of its goals very well. Failing to recognise the vast range of levels of disability and needs in schizophrenia is the clearest example. It is proposed that the two are best separated so that the essentially more clinical nature of prioritisation can be recognised without down-playing the importance of management structures in co-ordination

S46-5
THE ASSESSMENT OF THE QUALITY OF CARE USING SOME PHARMACOECONOMIC PARAMETERS

A.C. Altamura[1] *, M. Percudani[2]. [1]*Istituto Scienze Biomediche, Università di Milano, Ospedale "L. Sacco"*; [2]*Dipartimento di Psichiatria, Ospedale "G. Fornaroli", Magenta (Mi), Italy*

Schizophrenia is the most serious illness that psychiatrists treat. It is an expensive illness, costly in both social and financial terms. It begins early in life, produces maximal morbidity and lacks a comprehensive efficacious treatment. Most patients with schizophrenia experience a profound decrement in quality of life in all areas of functioning. The reduced quality of life is due to the manifestations of schizophrenia itself as well as to the side effects of classical antidopaminergic neuroleptic therapy. Major cost items are inpatient care as well as other types of residential and day care. The cost of pharmacological treatment contributes only a small percentage of the total costs of treating schizophrenia (1–5% of the total costs of care). In addition to direct treatment costs, 70–80% of patients are likely to be unemployed, resulting in costs of

lost production as well as social assistence costs. Other indirect costs include the results of premature mortality and negative effects on the family. Cost-outcome evaluations are particularly important because they allow comparisons of the potential costs and consequences of various strategies of treatment. The best estimates of outcome use batteries of instruments to score the well-being of patients and their caregivers. Dimension of well-being include clinical status, functional status, access to resaources and opportunities, subjective quality of life, family well-being, and patient satisfaction with services.

Modern-day health care is driven by cost-consciousness and pervasive pressures to provide cost-effective treatment. The introduction of newer antipsychotic drugs has had a profound impact on the treatment of schizophrenia. Clozapine and others atypical antipsychotics can improve a broad range of outcomes and result in cost savings.

SEC47. Personality disorders: clinical, forensic and research aspects

Chairs: A Dahl (N), E Simonsen (DK

SEC47-1
EXPERIENCES WITH SCREENING INSTRUMENTS FOR PERSONALITY DISORDERS

Lisa Ekselius. *Department of Psychiatry, University Hospital, Uppsala, Sweden*

Since the publication of the DSM-III personality disorder criteria a number of structured interviews have been developed, resulting in improved diagnostic reliability for the axis II disorders. However, there are limitations as concerns the use of time-consuming structured interviews in clinical practice. In this situation, there are advantages with self-report questionnaires as they are time-saving and easy to administer.

Based on our previous experiences from the Swedish version of the SCID screen questionnaire, a new self-report instrument was developed, the DSM-IV and ICD-10 Personality Questionnaire (DIP-Q). The DIP-Q is a 140 item true/false self-report questionnaire, 135 items reflect major aspects of the diagnostic criteria for the separate personality disorders in the DSM-IV and ICD-10 and five items constitute the impairment/distress scale corresponding to the general diagnostic criteria. A self-report version of the Global Assessment of Functioning (GAF) Scale is also included.

The DIP-Q was validated by comparing results obtained from the questionnaire to results obtained from a structured clinical interview in a clinical sample comprising 138 psychiatric patients. On the DSM-IV cluster level agreement was acceptable (Cohen's Kappa 0.45–0.61), as well as on global level for ICD-10 (Cohen's Kappa 0.56). In examining the overall sensitivity and specificity of the DIP-Q, a surprisingly good sensitivity (for DSM-IV 0.84 and for ICD-10 0.85) and a moderate specificity (0.77 and 0.70, respectively) were demonstrated. When dimensional scores for each personality disorder were compared, self-report and interview correlation was high for most personality disorders.

Our results indicate that the DIP-Q is useful in screening for personality disorders, and it can also be used as an independent diagnostic tool in epidemiological studies.

SEC47-2
No abstract received

SEC47-3
PERSONALITY DISORDERS — WHAT IS THE EXPERIENCE AND PREFERRED TREATMENT AMONG NORWEGIAN SPECIALISTS

K. Narud. *Research Unit, Aker Hospital, Division of Psychiatry, Oslo, Norway*

Personality disorders (PD) are difficult to treat. Today we have some knowledge about what kind of treatment is to be preferred when it comes to the different PDs. The view among specialists are quite variable. A questionaire was sent to Norwegian psychiatrists and psychologists in order to survey what kind of experience and knowledge skilled professionals was holding when it came to PD. The questionaire also surveyed what ideals the skilled professionals had in the treatment of PDs, and what they preferred as treatment of choice in their daily practice. Their professional background, field of activity, occupational title, postgraduate courses as well as their experience with PDs was surveyed. 42 main items with subordinate items were to be answered by the 758 psychiatrists and 1251 psychologists living in Norway. The questionaires are returning these days. Results from the investigation will be presented at the symposium.

S48. Recognition and treatment of alcohol- and drug-related disorders in primary care

Chairs: F Poldrugo (I), J Adès (F)

S48-1
No abstract received

S48-2
GENERAL PRACTITIONERS' BARRIERS ON TALKING ABOUT ALCOHOL WITH THEIR PATIENTS

S. Barfod. *Central Research Unit of General Practice, University of Copenhagen, Denmark*

An investigation of questionnaires answered by 304 GPs shows that GPs are interested in doing more preventive work. Alcohol problems are considered important but are the most difficult problems to deal with, too. There are several barriers but most important is lack of convincing documentation. The GPs think this documentation could change their attitudes towards drinking problems.

They do not accept the governmental recommendation of drinking limits ('safe limits').

If the GPs find the effectiveness of brief intervention well documentated they believe they will treat more alcohol problems.

The study is a part of a WHO Collaborative Study.

https://doi.org/10.1016/S0924-9338(99)80211-9 Published online by Cambridge University Press