

in Coventry, a large multicultural city in the West Midlands. It is a response to the UK's new National Service Framework for Mental Health (Sept 99) and was formed by amalgamating staff from the Community Mental Health Teams, Social Services and the 24 hour Psychiatric Assessment Unit (PAU). It offers a fast community-based assessment service round the clock as well as crisis support and short-term treatment. It also follows up patients discharging against medical advice and going absent without leave where there is cause for concern and it provides a Psychiatric Casualty allowing clients to self-refer at all hours. Referrals come from any health care professional as well as local agencies. Assessments are multidisciplinary, with nursing or social worker assessment followed by a psychiatrist in most cases. Pairs of staff undertake community assessments. When fully staffed, the Team will include occupational therapy and psychology input as well as clerical support. Support workers are also employed to assist in the assessment process and staff the helpline. Using this approach it is hoped patient care will improve and admission to inpatient services can be reduced. We undertook an audit of admissions to the inpatient services in September 1993 prior to the PAU and compared this to September 1999: a reduction in acute admissions of 55% was found. The audit is to be repeated in September 2000 to compare the impact of the A&TT to previous approaches. A further audit into the assessment process and location of assessments is being carried out in June 2000. Results of both these audits will be presented.

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AL AIN COMMUNITY SURVEY OF PSYCHIATRIC MORBIDITY III: THE NATURAL HISTORY OF PSYCHOPATHOLOGY AND THE UTILIZATION RATE OF PSYCHIATRIC SERVICES IN AL AIN

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Background: We evaluated the natural history of psychopathology of a stratified sample (n = 250) comprising subjects with no ICD-10 psychiatric disorder over 12 months period using SCID as assessment tool.

Methods: A representative sample categorized earlier (one year before) as: ICD-10 psychiatric disorder, subthreshold disorders and no ICD-10 psychiatric disorders were reassessed with SCID one year after. The incidence, recovery rates and the percentage of subthreshold disorders which become DSM-III-R disorder were calculated. The utilization rate of psychiatric services was also assessed.

Results: The incidence rate of new case was 10.2%. The recovery (remission) rate was 48% and approximately 20% of subthreshold disorders became definitive disorders (DSM-III-R) after one year. Male sex and contact with psychiatric services were found to affect the recovery rate. Approximately 13% of the sample made contacts with psychiatric services with no gender differences but males were significantly more hospitalized than females.

Conclusion: Our findings indicate that mental disorders are relatively common. Approximately 50% of psychiatric disorders in the community are persistent and patients with emotional disorder under-utilize existing services.

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DEPRESSION AND ANXIETY IN CORONARY ARTERY BYPASS GRAFTING PATIENTS

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Background: Mood disorders and anxiety are reported as a consequence of coronary artery bypass grafting (CABG) and cardiac surgery in general. Depression is an independent risk factor for increased mortality and morbidity in cardiovascular patients. Heart surgery is a strong stressful event that triggers specific emotional and physiological responses of a patient. In spite of positive somatic effects of surgery, depression and anxiety can persist or appear for the first time after the operation worsening patient's psychosocial functioning and quality of life. The aim of this study is to offer a prospective view on the incidence and course of self-reported depression and anxiety in CABG patients.

Methods: After informed consent, 53 patients, who submitted CABG, were examined few days before and after the operation and 3 months after CABG. They completed the Spielberger State-Trait Anxiety Questionnaire and the Beck Depression Inventory.

Results: Approximately 55% of the patients had high level of anxiety preoperatively. Shortly after the surgery 34% of the patients and after 3 months 32% of them had clinically relevant level of anxiety. 32% of the patients before the surgery, 28% immediately after CABG and 26% at follow-up were depressed.

Conclusions: High preoperative depression, state and trait anxiety scores appear to be predictors of postoperative psychological outcome. Preoperative assessment can identify patients at risk for clinical levels of postoperative anxiety and depression. Psychological preventive counseling and psychiatric intervention can reduce patients' emotional distress, medical and economic costs.

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RELATIONSHIP BETWEEN COGNITIVE FUNCTION AND INTERPERSONAL PROBLEM-SOLVING SKILLS IN SCHIZOPHRENIC PATIENTS COMPARED TO HEALTHY SUBJECTS

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Background: Subjects with schizophrenia feature neurocognitive alterations. The functional consequences of these deficits need to be fully determined, in order to define more effective rehabilitation programmes. We tried to determine the relationship between neurocognitive function and social problem-solving skills, both among schizophrenic patients and healthy subjects.

Methods: Twenty-seven outpatients with DSM-IV schizophrenia and twenty-six healthy subjects underwent a neuropsychological assessment on the domains of auditory-verbal and visuo-spatial memory, executive functioning, attention and visual reasoning. Social problem solving skills were assessed by a video-based test, the Assessment of Interpersonal Problem-Solving Skills (AIPSS). The AIPSS measures the subject's ability 1) to describe an interpersonal social problem, 2) to derive a solution to the problem, and 3) to enact what he or she would say and do in an actual situation.

Results: The schizophrenic and control groups differed significantly on all but one neurocognitive measures and on AIPSS scores. Among schizophrenic patients, correlations between AIPSS subscales and neuropsychological tests were observed for executive functions, attention and visual reasoning. These associations were not replicated in healthy subjects.

Conclusions: For the schizophrenic patients, social problem-solving efficiency relies mostly upon attention and executive functions. This correlation is restricted to this group. The link between neurocognitive performances and social skills may be due to the impairment associated with the schizophrenic process, rather than to a non-specific relationship between cognitive variance and social competence. This issue is important regarding schizophrenia and its functional outcome. Also, support is given to the usefulness of the combination of neurocognitive training with social skills training in social rehabilitation, at least for the training of the kind of skills involved in social challenges as featured by the AIPSS.

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ANNOUNCEMENT OF DIAGNOSIS OF SCHIZOPHRENIA

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The announcement of diagnosis in psychiatry is more and more widespread. But in France, it still remains a controversial practice in the patient's care. Following the example of other medical disease, we hope that patients, knowing more about their illness, will better observe and participate to the medical attention. Consequently, a better observance and less frequent and less severe relapses are waited for. Clinically, the announcement of diagnosis may come up against anosognosia, which is an inherent symptom in the illness, and often a worsening factor, hindering the good proceed of care.

The announcement can help the patient to limit the baneful effects of this symptom. This study proposes to evaluate the announcement of diagnosis's impact, whose information elements will be formalised Day1, Day7, Day28 after on a population of 30 schizophrenic patients. 3 supervised interviews and evaluation of patients with avisual analogical scale will be performed. It will permit to appreciate the persistence of the given information about the illness and the potential psychopathological consequences on the short and middle-term.

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COMEDICATION IN PSYCHIATRIC ILLNESES

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Several reasons stand behind the rationale for the use of combination therapy. It has been hypothesised that this strategy likely target the different neurotransmitter systems involved in the pathophysiology of psychiatric disorders. Indeed, neurotransmitter imbalances in some areas of the CNS as well as neuroanatomical and neurophysiological abnormalities may coincide for different nosological entities and therefore, monotherapy is usually insufficient to adequately treat an individual nosological category. Additionally, augmentation strategies, when residual or recurring symptoms are not controlled with a single primary agent, or when the disease is resistant to one or more monotherapies has also been advocated. There are reports in the literature which associate combination therapy with better clinical outcome. However, controlled clinical trials with enough number of patients are lacking to support the use of this polypharmacy and the risk for the appearance of potential pharmacokinetic and pharmacodynamic drug interactions that frequently lead to the increase incidence of severe side effects is not null. In our presentation the rationale behind the proposed combination therapies (especially in the treatment of schizophrenia, major depression and bipolar disorders), their clinical outcome and their potential for the development of side effects as reported in the literature will be reviewed.

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MENTAL HEALTH SUPPORT FOR WAR REFUGEES

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During spring 1999 more than a million had to flee from Kosovo. 300000 escaped to FYR Macedonia, 700000 to Albania. The influx of refugees was enormous, thousands crossed the border daily. This caused an enormous turbulence, because the refugees were continually transferred to other camps.

The refugees arrived scared and in chock after a few days of travel. The immediate needs were protection and shelter, the next food and information. After a few days the impact of the trauma became more obvious, with denials, repeating of memories, dissolving or hiding emotions and behavioral symptoms.

Medical services were arranged in the camps with mental health. The services were mostly individual visits to a health worker, usually a health worker among the refugees – hired by an organization. The patients sought relatively often help for somatization. The treatment was usually pharmacological.

The refugees shared their experiences first with their family, relatives or people from the same villages. The refugees searched very actively for people they knew from before, with the same cultural background. This network was clearly the most important source of comfort and support. Non therapeutic activities as sports or different leisure activities were important as also domestic tasks.

The coordination task of the organizations and activities in the camps was enormous. More than 100 different international organization participated. Local Macedonian and Albanian professionals were not properly involved in the services.

A guideline of the mental health and psychosocial services needed by war refugees in should be prepared. Local professionals should be involved. Other forms of support than individual visits must be arranged. The observations above were collected by WHO-EURO during the Kosovo crises 1999.

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COMPARISON OF THE TREATMENT OUTCOME MEASURES IN PANIC DISORDER

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Background and Objective: The monitoring of the outcome of treatment of panic disorder (PD) has recently been improved by introduction of Panic and Agoraphobia Scale (PAS) and Panic Disorder Severity Scale (PDSS). The goal of this study was to compare the efficiency of these instruments for measuring the outcome of treatment of PD.

Methods: 96 patients with PD were treated with cognitive-behaviour therapy (CBT) and pharmacotherapy. CBT was performed over the course of 16 sessions, followed by "booster" sessions once a month. Pharmacotherapy involved an 8-month course with an SSRI plus a 6-week initial treatment with a high-potency benzodiazepine. The scores on the PAS and PDSS were obtained at baseline and after 8 months of treatment.

Results: Patients showed a significant improvement on both the PAS and PDSS scores. However, the magnitude of the improvement ($p = 0.002$) was greater when the PAS scores at baseline and posttreatment were compared with the PDSS scores at baseline and posttreatment ($p = 0.03$). The improvement demonstrated by the PAS correlated more closely with clinical observations.