

FC36 Health services and epidemiology**SUICIDAL ATTEMPTS AMONG CHILDREN UNDER 15 YEARS OF AGE**

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Suicide and suicidal attempts are infrequent among children. Nevertheless, suicide rates and suicidal attempt rates are increasing in European countries and these rates are even higher in Brittany. Clinical assessment of child population after recovery from a suicidal attempt may shed light on this growing public health problem. To determine demographic, family and school-related risk factors and immediate pre-suicidal conditions presented by children after committing a suicidal attempt and being admitted in a hospital emergency room serving the majority of an urban community: e.g. 70 consecutive emergency room visits for children younger than 15 years of age over a 5-year period were assessed from paediatric and psychiatric clinical records. For each visit at the emergency room unit, a questionnaire used in previous studies on suicidal attempts among adolescents was filled in by a clinician from the clinical files. The demographic, family, school and health history data for the child and his family were gathered. 86% of the children who commit a suicidal attempt were over 12 years of age with a sex ratio boy/girl of 0.80. There is a strong shift of the sex ratio after 12 years of age. The major diagnosis is adjustment disorders (41%) and personality disorders (22%). 28.5% of the children had a previous history of personal psychiatric disorders. A quarter of the fathers/mothers had a previous history of psychiatric disorders and the rate of alcoholism was of 43% for the fathers and 15% for the mothers. 56% of the children had separated parents, three quarters of these children live with a single parent. 93% used medication ingestion. 46% patients had suicidal ideation before they committed the suicidal attempt and the majority of them (86%) had suicidal ideation for at least 2 weeks. The rate of suicidal attempts seems to increase. The children committing suicidal attempts have no severe psychiatric disorders and have suicidal ideation several weeks before the attempt. The fact should enable parents, teachers, paediatricians and general practitioners to prevent these children from committing suicidal attempts.

FC37 Health services and epidemiology**A COMPARATIVE STUDY OF PSE-10/CATEGO-5, OPCRIT-CHECKLIST/QUICK-BASIC: TWO PSYCHIATRIC COMPUTER ASSISTED DIAGNOSTIC SYSTEMS**

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Objective of computer-assisted diagnosis and its advantages are well noted in different relevant literature. It has been factalized that computers can be used for various tasks in the diagnosis process because of well-known limitations of clinical methods. Computer-assisted diagnostic systems had been recently developed. We compare outputs from 2 computer-assisted diagnostic generating psychiatric diagnosis to observe the variability of computer-assisted diagnosis outcomes: E.g. 40 adolescent psychotic inpatients of age 16 to 19 years in a university psychiatric unit. Standardized interview with the diagnostic instrument SCAN (Schedules for Clinical Assessment in Neuropsychiatry) were carried out on 40 adolescent psychotics. Interrater reliability were done on videoscoped interviews by 2 independent psychiatrists trained on SCAN. Data were put on the computer through computer data sheets to have the CATEGO5 diagnosis (DSM-III-R and ICD-10). OPCRIT checklist was used from the observed SCAN interview. Sometimes, clinical files were consulted for certain OPCRIT checklist items. Interrater reliability was carried out which was quite satisfactory (Kappa = 0.66). On one hand computerized ICD-10 diagnostic outputs from the two systems are in the average (Kappa = 0.429). On the other hand, DSM-III-R computerized diagnosis are quite different between Catego and Quickbasic (Kappa = 0.108). Hypothesised origins of these discrepancies are screened and analysed.

FC38 Health services and epidemiology**WORK AND QUALITY OF LIFE OF THE CHRONICALLY MENTALLY ILL**

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Different studies have demonstrated the ambivalence of people with chronic mental illness with regard to the meaning of work in their lives. The present study aims at throwing more light on this ambivalence and to enquire about its causes. Since quantitative studies do not allow for making statements regarding the evaluation processes at the root of ambiguous meanings assigned to important dimensions of people's quality of life, we chose to investigate these aspects using both a semi structured interview and the German version of the Lancashire Quality of Life Profile. The sample consists of 50 chronically schizophrenic patients in out-patient treatment in a city in the eastern part of Germany. A particular ambivalence became apparent with regard to illness-related early retirement. On the one hand the latter is conceived as a form of protection and social security. On the other hand, however, it is felt as an additional disablement. The fact that with an early pension, the person in question is not allowed to work or seek employment is reflected in various dimensions of his/her quality of life. Following from our results it is recommended that illness-related early retirement should not preclude the opportunity to engage in paid work but that it should also be available as an interim solution for re-integration after acute illness phase.

FC39 Health services and epidemiology**FAMILY BURDEN AND PATIENTS' SOCIAL FUNCTIONING IN SCHIZOPHRENIA: PRELIMINARY RESULTS OF THE EUROPEAN COMMUNITY STUDY**

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Most countries of the European Community have recently developed or are developing mental health programmes whose outcome will depend to a large extent on the degree of collaboration of patients' families. However, only few studies have been carried out in these countries on the emotional, practical and economical burden that care for psychiatric patients involves for their relatives. Under the auspices of the European Community, an international study has been carried out in order to assess the burden on the families of schizophrenic patients in centres selected in five different European countries. Information has been collected on the different aspects of subjective and objective burden on the key-relatives of schizophrenic outpatients in relation to a) the coping strategies adopted by these key-relatives; b) the patients' degree of disability and severity of psychiatric symptomatology; c) the pattern of psychiatric care provided in the centres. Here we report data concerning the relationship between family burden and patients' disability and discuss their implications for the planning and assessment of rehabilitative programmes.