

of the patient's prognosis. It helps to reduce the whole family burden represented by the illness. Basic questions are: How can we measure these effects? Are there any differences among different types of programs?

To measure the effects of psychoeducation in terms of the quality of life improvement the Czech version (SQUALA-CZ) of the French instrument SQUALA (Subjective Quality of Life Analysis) was used (Zannotti 1992). This questionnaire was selected for this study for several reasons: (1) it is well theoretically based on a definition very similar to our concept; (2) it measures subjective quality of life defined as the difference between the wish and expectations on one side and the person's situation on the other, taking into account the individual hierarchy of values and (3) it includes 23 domains of life functioning, covering the health status, everyday activities, social interactions and inner reality. Respondents were asked to use a five-level scale to assess subjective importance (0 = irrelevant; 4 = essential) and personal satisfaction (1 = disappointed; 5 = completely satisfied) with each of the 23 life domains. Patients with schizophrenia and their relatives were randomized into one of the two parallel group programs (relatives and patients participating in programs separately): (1) 8 weeks program, two hours sessions once in a 14 days for relatives and one hour session once a week for patients and (2) one day 8 hours program. Until now we have data from 30 participants, 20 relatives and 10 patients. They completed SQUALA questionnaire before the entry into the study and 3 months later. First preliminary data analysis showed that there is a significant improvement of satisfaction with the domain "Family" ( $p < 0.05$ ). During the next course/duration of the program we are expecting more answers about relevant methods of "measuring" the effects of psychoeducation, advantages and disadvantages of the both types of programs, relaps frequency and duration of possible re-hospitalization in comparison with noneducated control groups of patients and their relatives.

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#### YRP.14

Service and non-service costs of psychiatric patients attending a community mental health centre in Italy

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**Objective:** This study estimated service and non-service costs in a random sample of patients attending a community psychiatric mental health centre (CMHC) in Italy. Costs of different diagnostic subgroups and variables associated with service and non-service costs were calculated.

**Methods:** A randomly selected sample of patients identified during one week of routine clinical activity of the Magenta CMHC. Information was collected using the Economic Questionnaire for routine clinical practice of Psychiatric Services (QESP). The QESP includes the following domains and variables: sociodemographic data, information related to the psychiatric illness, accommodation, employment and income, caregiver, service receipt and patient / caregiver burden. Costs were classified in two categories: service costs (from the provision of services) and non-service costs (loss of productivity and informal care)

**Results:** One hundred-twenty patients were included. In patients suffering from schizophrenia service cost per month per patient was

nearly double than for patients with other diagnoses. Non-service costs associated with patient's lack of job opportunities were more than three times higher in patients with schizophrenia, accounting for an overall non-service cost per month per patient more than three times higher than that for patients with other diagnoses. Non-service costs associated with patient's and caregivers' time off work were similar in the two groups. In the multivariate analysis length of illness and being not employed, but not diagnosis, were associated with higher service costs. Young age and length of illness were determinants of higher non-service costs. The latter two independent variables resulted in addition associated with overall (service and non-service) costs.

**Conclusion:** This study of an Italian community psychiatric service showed that monitoring within routine conditions was successful and could generate useful information on the costs to psychiatric services, patients and care-givers.

#### YRP.15

Depression, anxiety, aggression, impulsivity and suicidal behavior

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**Objectives:** The study of clinical suicide risk factors should involve the simultaneous assessment of dimensions such as depression, anxiety, aggression, and impulsivity that should be integrated in the relatively large concept of comorbidity. The purpose of the study was: 1) to assess the interrelations between all these factors in a sample of affective disorder patients; 2) to test the hypothesis that a high level of anxiety could be a protective factor against suicide acts; 3) to further assess the validity and clinical interest of the Suicide Risk Scale (SRS) of Plutchik.

**Methods:** We assessed a sample of 49 inpatients with an axis I diagnosis of affective disorder (major depression, dysthymia, adjustment disorder). Patients were subgrouped into suicide attempters (SA,  $n = 25$ ) and non-attempters (NSA,  $n = 24$ ). Both groups were compared on measures of depression, impulsivity (Impulsivity scale, Plutchik), anxiety (State and trait anxiety scale of Spielberger), aggressiveness (Buss-Durkee Hostility Inventory and suicide risk (SRS).

**Results:** SA and NSA differed significantly on the suicide risk scale ( $p < 0.0005$ ) and the impulsivity scale ( $p < 0.001$ ). We did not observe any differences in BDHI scale scores, and state or trait anxiety scores between SA and NSA. However, several aspects of aggressiveness were correlated with the current suicide risk. Our results did not confirm the protective value of a high anxiety level.

**Conclusions:** Taking account of some methodological limitations, we can consider that impulsivity is an important risk factor (a trait factor) of suicidal behavior in patients suffering from an affective disorder. Dimensions such as aggressiveness, anxiety and severity of depression tend to play a more minor role. Our results also suggest the potential interest of the suicide risk scale of Plutchik in clinical practice.

#### YRP.16

Brain glucose metabolism after dextromethorphan challenge in alcohol dependent males and controls

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**Introduction:** Pre-clinical studies indicate that acute and chronic effects of alcohol are mediated by NMDA receptor. NMDA re-