recipients and the priority target of this significant change. While the fate of a person with schizophrenia was almost unavoidably a long-term instituzionalization, nowadays the bulk of care to patients with this disorder is provided, inter alia, in a variety of outpatient and non-hospital settings. In parallel with the institutional change, our knowledge of the disorder and of the effectiveness of different treatment options has dramatically improved. All these transformations are reflected in substantial changes in several indicators affecting the life of people of schizophrenia: general mortality rates, suicide rates, life expectancy, comorbidity rates, average length of hospitalizations, quality of life, employment opportunities, etc. All these changes on turn have challenged the 'social' (as opposed to the 'natural') history to the disorder. This paper will provide an overview of the main institutional changes occurred in the course of this century, will show how they have affected the life of people with schizophrenia and will point to the most sensible and reliable indicators of this global transformation.

S26-2
WHEN AND HOW DOES SCHIZOPHRENIA LEAD TO SOCIAL DEFICITS?

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We studied the course of schizophrenia in a population-based sample: 1) 232 first episodes of schizophrenia of a broad diagnosis retrospectively from onset to first admission, 2) in a representative subsample of 115 first episodes prospectively from first admission on at 5 cross-sections over 5 years. 3/4 of the cases began with a prodromal phase lasting 5 years on average and free of positive symptoms. Only 18% had an acute onset within 4 weeks before first admission, and only 7% began with purely positive symptoms. In 57% of the sample social disability (Disability Assessment Schedule score ≥ 2) emerged before first admission (on average 2 to 4 years before). Schizophrenics at onset did not differ significantly from healthy controls in social status. Before first admission, however, they suffered considerable deficits in social ascent.

75% of schizophrenics fell ill before age 30, men 3 to 4 years earlier than women. The proxy variables of the disorder – initial symptoms, type of onset etc., showed no significant sex differences. Socially negative behaviour and substance abuse were considerably more frequent among schizophrenic men than women. Even the sex difference in age of onset meant slightly better social conditions at onset for women than men. By logistic regression we could show that an earlier age of onset and socially negative behaviour of young men at the time of the first episode had a significantly unfavourable impact on 5-year social outcome.

The symptom-related course showed great interindividual variability, but stability without any clear-cut improvement or deterioration of group means. As a whole, social outcome was clearly better for schizophrenic women than men because of women's slightly higher level of social development at onset and better adjusted illness behaviour. Considering their high level of social development at onset, late-onset patients, however, showed considerable downward drift. Nevertheless, their social outcome was better than in the early-onset group. The most important implication of these findings is a need for early detection and intervention.

S26-3
THE INFLUENCE OF DISCRIMINATION AND STIGMA ON THE LIFE OF PATIENTS AND THEIR RELATIVES

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The heavy stigma attached to mental illness, particularly schizophrenia, by the public affects patients and their families. Patients find it very hard to gain employment once their history of illness is known. They also meet difficulties in being accepted in social situations. Relatives feel embarrassed to reveal the illness to other family members and friends, and as a result they lose the support of their natural social networks.

Two surveys of neighbours in streets with sheltered housing for the mentally ill showed that there was a great deal of ignorance about schizophrenia. In particular people confused mental illness and learning difficulties. They saw the mentally ill as being unpredictable, difficult to communicate with, and dangerous, although the latter was mentioned by less than a quarter of the respondents.

An encouraging feature was that there was a great deal of goodwill expressed towards the mentally ill and a desire for information.

These surveys were followed by a controlled trial of a campaign to educate the neighbours in one of the streets. The campaign included an educational meeting with a video and leaflets, social activities in the sheltered house, and door-to-door discussions with the residents. Compared to residents in the control street, neighbours exposed to the campaign showed a reduction in fear of the mentally ill, an increase in intentions to socialize with the patients, and a fair amount of social contact with them. Experimental patients had significantly more contact with their neighbours than control patients.

S26-4
DO MODERN CARE AND TREATMENT IMPROVE THE QUALITY OF LIFE OF SCHIZOPHRENICS AND THEIR RELATIVES?

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Background: This paper reports the impact on the quality of life (QOL) of patients with psychosis of an intensive compared to a standard model of community care.

Method: An epidemiologically representative sample of 514 patients was identified all of whom had an ICD 10 diagnosis of psychosis, and were living in two geographical sectors in South East London. A random sample of these from each sector were interviewed with a variety of research measures at baseline, and at a two year follow up point. Between baseline and follow up services within the intervention sector were reorganised. Quality of life was measured using the Lancashire Quality of Life Profile. 138 patients had QOL data at both time points.

Results: The two overall QOL measures - global QOL and the average of the domain specific scores, were remarkably stable over time. There were no within sector significant changes on these overall measures, nor was there any evidence of an effect of the intervention of these QOL measures. For individual QOL domains there was weak evidence for an improvement in living situation domain in the intensive sector, and it is suggested that this may be accounted for by the large drop in inpatient admissions in the intensive sector. In both sectors objective QOL was poor, and there was little change over time in any of the objective indicators except