ported this view. In healthy volunteers, anterior paralimbic activation has been noted during pharmacological (procaine) & neuropsychological (transient self-induced sadness) induction of affective arousal. Moreover, in primary mood disorders, abnormal anterior paralimbic activation has been noted with these probes. Most functional imaging rest studies in both primary and secondary depression have reported decreased prefrontal and anterior paralimbic activity, with this hypofrontality often correlating with the severity of depression & resolving with symptom remission. A few studies of primary mood disorders have noted increased activity in these same regions, which may reflect heterogeneity due to particular illness subtypes.

Preliminary evidence suggests that baseline prefrontal and anterior paralimbic functional abnormalities may even provide differential markers of therapeutic responses. Taken together, these findings indicate that prefrontal and anterior paralimbic structures may be common neural substrates for both primary and secondary mood disorders. Future studies of the function of these structures may yield further insights into the neurobiology of normal emotion in health, subtypes of primary and secondary affective disorders, and perhaps even improved targeting of therapeutic interventions.

DEPRESSION AND THE POSTPARTUM PATIENT

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The prevalence of non-psychotic depression postpartum is between 10% and 15% in first-time mothers. The risk is even higher in women with a previous history of a mood disorder and in women with a higher prevalence of mood-related disorders in their families. Other risk factors such as psychosocial stressors, obstetric complications and marital relationships have all been studied but the data are inconclusive. Laboratory findings and in particular neuroendocrine studies have so far yielded only very limited support to the hormonal theories concerning the etiology of postpartum mood disorders. The recurrent nature of postpartum depression has nevertheless prompted studies into prophylactic measures and preliminary results from successful interventions seem to indicate that dysregulation of central neurotransmitter systems may be relevant in these patients.

S15. Liaison psychiatry across Europe: setting clinical standards

Chairmen: F Creed, T Herzog

GUIDELINES FOR C-L INTERVENTION IN INTENSIVE CARE UNITS

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Intensive Care Units (ICU) have been described as a unique setting where high rates of psychiatric morbidity are expected. The seriousness of somatic conditions and the strange technological environment no doubt help create this situation. These conditions make ICUs a particular setting for a specific intervention in C-L psychiatry. The European Consultation-Liaison Workgroup Collaborative Study, aiming at the assessment of health care delivery in C-L psychiatry across Europe, has presented results which enable us to formulate guidelines for ICU intervention.

The main results are the following: Psychiatric referrals from ICUs constitute 6.3% of the total referrals (14717) and come mainly from Medical units. The main reasons for referral are: 1. attempted suicide, 2. current psychiatric symptoms, including anxiety, depression, confusion/agitation and 3. substance abuse. Referral is more often urgent or very urgent and more often within 24 h. of admission when compared to non-ICU (51.5 against 32.9%). 80% of patients in ICU are seen on the day of referral against 57% of non-ICU. There is a higher percentage of contract and liaison articulations with ICUs then with other departments. C-L intervention in ICU has a higher rate of staff interventions and of combined patient, staff and family approaches when compared to non-ICU.

The following guidelines can be drawn from these results: 1. C-L services to ICUs are urgently needed. 2. These services must be easily accessible and answer referrals within 24 hours. 3. Their organization must include specific programmes for suicide attempts. 4. The C-L team must work in strong coordination with the medical staff 5. Furthermore, it must include families in their intervention.

THE U.K. RESULTS OF THE EUROPEAN CONSULTATION LIAISON WORKING GROUP STUDY

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The European C.L. workgroup collaborative study included 1375 referrals within the U.K. across 7 hospitals.

The proportion of deliberate self-harm referrals in the U.K. (34.6%) was significantly greater than 4 the E.U. as a whole (17%). The reason for referral, other than deliberate self-harm, was similar between the U.K. and other E.U. countries.

There was very considerable variation between the U.K. centres, including duration of consultation — a potential quality measure. Both the results of multi-variate analyses will be presented in this paper. Variables relating to the nature of the service (e.g. discipline of C.L. staff) were prominent for deliberate self-harm patients but for the remainder, additional variables relating to severity or/and nature of physical and psychiatric disorders were important, thus indicating the needs of the patient.

EUROPEAN STANDARDS FOR CONSULTATION LIAISON (CL) PSYCHIATRY AND PSYCHOSOMATICS?

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Objective: 1) To increase awareness of the meanings and implications of terms like "standards", "guidelines", "options". 2) To involve the audience in a process of priorization regarding the choice of aspects of CL care delivery ready for European consensus. 3) To prepare a European consensus conference on CL care delivery.

Method: After a clarification of terms [1] selected structural and process data from the largest international multi-centre naturalistic study of CL service delivery [2,3] are contrasted with some existing recommendations (e.g. [4]). Size of the audience and time permitting, an abbreviated nominal group process method will be used to collect and prioritize specific areas in need of consensus.

Results: The presentation and participants' input will contribute to ongoing multi-centre studies on quality management in CL psychiatry and psychosomatics [5,6].

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https://doi.org/10.1016/0924-9338(96)88457-4 Published online by Cambridge University Press

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IMPROVEMENT OF C-L SERVICES IN EUROPE

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Past: There has been a heated debate whether or not C-L psychiatrists should focus on a consult or a liaison model. Most literature has been produced by university hospitals and is not representative for the field.

Current state: The European C-L Workgroup Collaborative Study (ECLW CS) — a health service study in 56 European hospitals (both university and non-university hospitals) across 11 countries (MR4*-340-NL)- reported an average consult rate of 1% and almost non liaison activities. Consequently, C-L psychiatrists did not get their message across. From a quality perspective, this needs improvement.

Future directions: In the framework of the Biomed program there is a study focusing on the development and testing of a quality management system for C-L services (BMH1-CT94-1706), another one will produce a risk prediction instrument for complexity of medical, nurse and organisational care during hospital admission allowing for a more appropriate referral mechanism (BMH1-CT93-1180). In the Netherlands the national development of general hospital psychiatry has been supported by the government through a report called: "Beyond borders." It includes recommendations for hospital-wide guidelines for the approach towards for instance attempted suicide, confusion and alcohol abuse to be implemented through active participation of psychiatrists in general hospital staffs. This program has been inspired by guidelines of the UK Royal College of Physicians and Psychiatrists joint workgroup on the psychological care for the medically ill. Currently the feasibility of specific teaching programs for ward staffs provided by and supported with clinical C-L nurse services. All these efforts have been the result of national and international collaboration. These programs will improve the future quality and effectiveness of C-L service delivery. This will be reported in detail.

GUIDELINES FOR MANAGEMENT OF DELIRIUM: A CRITICAL REVIEW OF CLINICAL PRACTICE

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Delirium is defined as a transient and fluctuating organic mental syndrome of acute onset, characterized by a global impairment of cognitive functions, a reduced level of consciousness, attentional abnormalities, increased or decreased psychomotor activity, and a disordered sleep-wake cycle. Abnormalities in every aspect of the mental state have been found. The clinical presentation of delirium may vary considerably from patient to patient and in a given patient over a 24-hour period. Delirium is associated with higher mortality and complication rates, poor functional recovery and longer lengths of stay. The management of delirium is twofold: first, adequate treatment of the underlying causal factor(s) and second, symptomatic measures including psychological interventions, good nursing care and psychotropic medication. Of course, a correct diagnosis of delirium and its etiology is crucial. Symptomatic management of delirium is particularly based on clinical experience, since no systematic research has been done on the effectiveness of different interventions. Psychological measures and good nursing care include: providing a quiet, familiar, safe and supportive environment; avoiding extremes of sensory stimulation and information inputs; reorienting the patient on a regular basis; treating the patient in a calm, clear and reassuring way; close monitoring of the patient's mental state and behavior; and, in case continuous nursing care or attendance of a familiar person cannot be provided, employing physical restraints may be necessary to prevent (self) damaging behavior. The use of psychotropic medication in delirium is often necessary. Short-acting benzodiazepines are effective in the treatment of alcohol withdrawal delirium and hepatic encephalopathy, and may be used to ensure sleep in delirious patients. Haloperidol is the drug of choice for the treatment of agitation, psychotic symptoms and anxiety in delirium. It is advisable to provide adequate information and aftercare for the patient and his family and prevent posttraumatic (= delirium) stress symptoms.

S16. Continuum of spontaneous 'tardive' dyskinesia in schizophrenia

Chairmen: S Lewis, E O'Callaghan

THE RELATIONSHIP BETWEEN NEGATIVE SYMPTOMS AND TARDIVE DYSKINESIA IN SCHIZOPHRENIA

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Much of the efforts to determine the aetiology of tardive dyskinesia have been aimed at elucidating the relationship with symptomatology and drug treatment. Review of the literature demonstrates evidence of relationships with many clinical symptoms of schizophrenia but the most consistent findings have been with the 'negative' symptoms of the illness. Many studies, however, report associations with overall negative symptoms whereas the relationship may be more complex.

Results of a study of 185 patients with schizophrenia demonstrate an increase in overall negative symptoms in patients with dyskinesia compared to those without. This finding is confirmed by a stepwise regression procedure incorporating the effects of other parameters, such as drug treatment. However, the relationship does not appear to hold for certain aspects of what are assessed as negative symptoms, in particular affective blunting. The data from this study do not suggest a relationship with overall cognitive function. Thus the relationship seems to lie more with aspects of social dysfunction.

ABNORMAL MOVEMENTS IN NEVER MEDICATED NIGERIAN AND INDIAN SCHIZOPHRENIC PATIENTS

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242 Nigerian schizophrenic patients, mean age 42 years, were examined for dyskinesia, using the Abnormal Involuntary Movements