between impulsive acts (previously conceptualized as impulsions), whose paroxysmal, automatic psychomotoric and internally generated nature could be close to catatatonic behaviour or immediate reflexive actions, and from other type of aggressive impulsivity, secondary to delusions or hallucinations with a strong self- implication. Quite a different phenomenon is observed in Bipolar patients (phase dependent) in which goal-directed impulsivity can assume two expressions: a ''pure'' appetitive impulsivity form connected with euphoric or dysphoric mood and a desinhibited impulsivity one close to a more labile mood. The later expressive behaviour is distinct from reckless and desinihibited impulsivity common to ADHD and hypertimic bipolar patients.

In schizophrenic psychotic patients, impulsive acts can be understood as psychopathological expressions of a morbid process at the same level of other psychotic symptoms. On contrary, in mood psychotic disorders the main emphasis is both on the role of self awareness and control, as well as on the understating of several types of impulsivity in a continuum between normal primary emotions and excessive emotional experiences and drives.

S22.03

Loss of control in personality disorders

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Abstract not available at the time of printing.

S22.04

Pathological gambling: Addiction or impulse control disorder

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In ICD-10 we find pathological gambling in the rest-category ''Habit and Impulse Disorders'' together with pathological fire setting (pyromania), pathological stealing (kleptomania), trichotillomania and other habit and impulse disorders. In DSM-IV the same disorders have to be attributed to the rest-category named ''Impulse control Disorders''. In ICD-10 as well as in DSM-IV the diagnosis impulse (control) disorders should be used for kinds of persistently repeated maladaptive behaviour that are not secondary to a recognized psychiatric syndrome, and in which it appears that there is repeated failure to resist impulses to carry out the behaviour and the patients report a prodromal period of tension with a feeling of release at the time of the act. Without any doubt, pathological gambling cannot be reduced to mere maladaptive behaviour. As we know from clinical praxis, patients suffering from pathological gambling show a much more complex psychopathology. Beside the signs of a strong desire or sense of compulsion to gamble and an impaired capacity to control gambling in terms of its onset, termination, or levels of gambling (which may seem similar to symptoms of impulse control disorders) all other signs of a dependence syndrome (e.g. evidence of tolerance with a need for significantly increased frequency of gambling, preoccupation with gambling, persistent gambling despite clear evidence of harmful consequences, physical withdrawal states) can be observed in patients suffering from pathological gambling. Concluding we may say that pathological gambling is a much more complex disorder than impulse control disorders. Beside phenomenological analyses also comorbidity studies indicate similarities of pathological gambling to substance-related addictions. Therefore we propose for DSM-V that pathological gambling should not longer be part of the rest-category ''impulse control disorders'' but should be attributed as gambling addiction (or gambling dependence syndrome) together with other substance-related and non-substance related addictions (e.g. internet addiction, buying addiction, working addiction) to a new group of dependence disorders.

S23. Symposium: NEW ADVANCES IN MENTAL ILLNESS SUBSTANCE MISUSE (Organised by AEP section on Alcoholism and Drug Addiction)

S23.01

Comorbidity across the life span

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Over the last decade there has been an increasing awareness of comorbidity in the adult population. It is also increasingly recognised that substance misuse is increasing in young people and the older population is increasing. Prevalence estimates and clinical experience point to more younger and older addicts attending clinical services. Substance problems are associated with psychological and physical comorbidities and social difficulties across the lifespan. This leads to poorer outcome. Inadequate assessment of substance problems, prescription and over the counter medication, including interactions and compliance, in younger and older age groups leads to ineffective management. The key principles which inform the implementation of effective pharmacological and psychological treatment interventions for nicotine, alcohol and illicit drugs treatment options in adults is well established. Outcome studies in the adult population suggest patient benefit. Although limited, studies of substance misuse treatment interventions that have been carried out in younger and older age groups demonstrate improvement. Although outcome studies that have been undertaken in comorbid groups do not yet point to a particular type of intervention or service model, administration of effective interventions for substance misuse may lead to improvements, which has policy ramifications. Most of the scientific research has been carried out is in the United States which has a very different health care system and there is need for a focus on neurobiological and social research in particularly vulnerable populations.

S23.02

Policy and dual diagnosis

A. Baldacchino. *Stratheden Hospital, Bycooper, Fife, Scotland, United Kingdom*

Despite legislation to harmonise mental health practice and convergence in systems of training there remains an extraordinary diversity in mental health practice in Europe. Approaches to tackling substance misuse and attitudes towards substance misuse and mental illness also show definite international differences.

Whilst mental health services are organised and financed in very different ways there are nevertheless a number of common trends and issues. The most obvious trend has been the run-down of psychiatric beds, giving rise to the problem of providing alternative services. Throughout Europe people are striving, with mixed success, to establish new community-orientated services, providing reasonable levels of clinical care, some continuity and co-ordination, and appropriate accommodation and day-time activities.

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There is a need for researchers and policymakers in the area of co-morbid mental health and substance misuse to collaborate and develop shared methods of approach to evidence and research based policy. Although much is known about the prevalence and multiple needs of co-morbid individuals, there are a number of research questions that remain unanswered. By collaborating with colleagues in other European countries and encouraging generalization of results an understanding of the effect health and social care systems on the level and intensity of complexity dual diagnosis presentations will develop. Similarly, while previous research highlighted the complex needs of co-morbid individuals, future research should concentrate on factors that may help prevent the 'ping-pong' effect, resulting in co-morbid people being bounced around various organisations and agencies, most notably among mental health and substance misuse services.

S23.03

Innovations in pharmacological treatment of addiction

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Addictive behaviour associated with alcoholism is a brain disease characterized by craving for alcohol, loss of control over consumption, development of tolerance and dependence, while simultaneously the repertoire of social functioning not related to intake behaviour declines dramatically. To understand the factors that compel some individuals to drink excessively and to identify targets for pharmacological intervention, addiction research has focused on the identification of brain mechanisms that support reinforcing actions of alcohol and the progression of changes in neural function induced by chronic drug or ethanol intake. Cellular and molecular mechanisms of tolerance, sensitization, and dependence have been investigated intensively. The ability of most drugs to enhance dopamine neurotransmission particularly within the mesocorticolimbic dopamine (''reward'') system was demonstrated repeatedly. However, the past decade has placed the dopamine system within a broader context of neuronal circuitry involved in drug seeking, drug taking, and recovery. Specific effects on other receptors symptoms provide particular challenges given the almost ubiquitous expression of these receptors throughout the CNS. Additionally, new emphasis on various neuropeptide systems has reemerged, including opioid peptides and the stress-related peptides of the hypothalamus-pituitary-adrenal axis. Continued research is warranted on the various neurobiological based components that underlie the transition from drug intake to addiction to define drug targets for innovative pharmacological treatment options.

S23.04

Hidden comorbidity

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Attention-deficit/hyperactivity disorder (ADHD) is a chronic disease that is well accepted as a childhood condition. Despite increasing evidence of its clinical relevance in adults, it would appear that adult ADHD is underdiagnosed. This is particularly the case when comorbid with another mental disorder. Comorbidity across the life-span runs as high as 70% amongst adults diagnosed with ADHD. One of the most frequently occurring comorbidities in adult ADHD are substance use disorders (SUDs), which show a bi-directional relationship. ADHD is a risk factor for the development of later SUD to the extent that 9%-30% of adults with ADHD have a substance use problem. On the other hand, prevalence studies have shown that between 15% and 25% of patients with a SUD also have ADHD. The bi-directional relationship between ADHD and SUD can modify the clinical expression of symptoms, thus rendering difficult both correct diagnosis and appropriate treatment. ADHD is a strong risk factor for the subsequent development of an SUD and can jeopardize drug treatment. Assessment for ADHD is highly recommended amongst SUD patients as is a drug evaluation for those adults diagnosed with ADHD. An undiagnosed comorbidity can result in poor results as only part of the problem is treated. More research is needed to clarify relationship between adult ADHD and substance abuse, as well as to explore new psychopharmacological and psychotherapeutic treatments for this comorbidity.

S24. Symposium: QUALITY OF LIFE AND SUICIDE IN THE GERIATRIC PSYCHIATRY–THE RIGHT TO DIE, AN ETHICAL POINT OF VIEW (Organised by the AEP section on Geriatric Psychiatry)

S24.01

The concept of quality of life in dementia in the different stages of the disease

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Dementia is progressive, age related, chronic condition and can profoundly affect the lives of patients and their families.The main question in care becomes how to promote well being and maintain an optimal Quality of Life QOL. But is not always clear what QOL means.The conceptualizations of QOL vary because most instuments are developed for patients in different stages of dementia, and the relevant life domains for QOL vary with the progression of the disease. As a consequence most instruments are unsuitable for assessing QOL in the whole range of mild to severe dementia.This presents a problem for the daily care for people with dementia and for the evaluation of interventions aimed at improving QOL, as changes in QOL with the progression of the disease are difficult to detect and assess with existing instruments.This presentation following conceptual definition offered. Dementia specific QOL is the multidimensional evaluation of the person environment system of the individual, in terms of adaptation to the perceived consequences of the dementia.

S24.02

Suicide and attempted suicide in the elderly. Should the physician give support to patient's wish to die?

I. Icelli. *Department of Psychiatry, Celal Bayar University Faculty of Medicine, Manisa, Turkey*

Suicide is a major cause of death of older people. The most reason cited by older adults who consider suicide is loneliness. Feeling alone, worthless, helpless and hopeless are symptoms of depression which carries a high risk for suicide. The suicide risk in the elderly depends on the societies, communities and religious beliefs.

On the other hand the patients who believe that their quality of life would be disturbed by the continued treatment, have the right to ask

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