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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