Background: Effectiveness of medication treatment is determined by three components: treatment efficacy (symptom reduction), tolerability/safety, and adherence. Compared with efficacy and safety, research into adherence has been lacking. Nevertheless, medication non-adherence is a risk factor for relapse and for aggressive behavior in association with substance abuse in schizophrenia patients. Non-adherence has been estimated to cause approximately 40% of relapses in patients with schizophrenia. High rates of treatment discontinuation in all arms of the CATIE study illustrate the widespread nature of non-adherence. Most of previous research has defined non-adherence as a complete discontinuation of medication. However, many schizophrenia patients show partial adherence: they do not completely discontinue their medication, but they do not take all that has been prescribed. Partial adherence is more difficult to define and study than complete non-adherence.

Methods: We had the opportunity to study partial adherence in the context of a randomized, double-blind, 8-week, fixed-dose study comparing olanzapine 10mg/d, 20 mg/d and 40 mg/d for patients with schizophrenia or schizoaffective disorder (N=599). Medication non-adherence was measured by pill counts. Baseline characteristics including demographics, illness history and symptom severity were investigated as potential risk factors for treatment non-adherence.

Results and conclusion: Approximately 1/3 of patients were non-adherent with their medication at least once during the 8-week study. These non-adherent patients had significantly less improvement compared to adherent patients. Adherent patients had greater weight gain than the non-adherent ones. Among the available baseline measures, greater baseline depression severity appeared to be a significant risk factor for non-adherence.

S34.02

Long-term outcomes of schizophrenia: Does psychosocial treatment make a difference?

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Successful schizophrenia management should concentrate on treatment non-adherence, lack of information about the disease, poor insight, depressive symptoms, cognitive decline and stressful family atmosphere. We introduce clinically-based 6-week structured comprehensive program for out-patients with schizophrenia-spectrum disorders in the stabilization phase of the treatment. The group program consists of individual and family psychoeducation, life style improvement intervention, social skills training, cognitive rehabilitation and information technology aided relapse prevention program (ITAREPS). To assess the feasibility and effectiveness we designed one-year prospective follow-up field study. Data on psychopathology (PANSS) and quality of life (Schwartz Outcomes Scale, WHO-QOL-BREF and Social Integration Survey) will be presented. Preliminary analyses (N=58) show statistically significant improvement in total PANSS scores and in quality of life (psychological domain, WHO-QOL-BREF). Patients and their relatives welcome the opportunity to participate in such a comprehensive program.

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S34.03

Large pragmatic long term clinical trials in schizophrenia

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Antipsychotics have for half a century been the mainstay for the pharmacological management of schizophrenia patients. While efficacy has been the primary outcome variable in short term clinical trials many additional variables need to be accounted for when judging the usefulness of these medications over longer periods of time. Classic continuation studies and relapse prevention trials have mostly focused on symptom control, while safety/tolerability and subjective acceptance of these medications have generally been seen as secondary outcome measures. The concept of effectiveness attempts to provide a comprehensive outcome variable which encompasses all the relevant issues that determine longer term treatment success. Lately a number of large scale effectiveness trials, sometimes called large pragmatic clinical trials, have been undertaken, especially in the context of the attempt to evaluate differential drug effects. CATIE and CUTLASS have already been published, CAFE data have been presented in rough outlines and EUFEST results are still pending. While the first two studies have included patients with chronic schizophrenia, first episode patients have been allocated to the latter two trials. Although the available results from these trials are discussed very controversially, they unquestionably present an important addition to the traditional randomized controlled clinical trial design. Information from all types of research will have to be amalgamated in order to allow a rational choice for the long term management of schizophrenia patients. Unfortunately, the results available so far do not allow generalizable statements with regard to differential efficacy/effectiveness of antipsychotic drugs in the long term management of schizophrenia.

S34.04

Real-world effectiveness of pharmacological treatments in schizophrenia

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Background: Guidelines for treating schizophrenia are mainly based on randomized controlled trials of highly selected patients and limited follow-up. It is unknown how well these data can be applied to representative community settings, nor how the choice of antipsychotic medication affects the long-term outcome.

Methods: We evaluated a nation-wide cohort of consecutive subjects (n=2230) hospitalized in Finland for the first time due to schizophrenia or schizoaffective disorder between January 1995 and December 2001. National central registers were used to study all-cause discontinuation rates, re-hospitalization rates, and mortality associated with monotherapy with the 10 most frequently used antipsychotic medications.

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Results: Initial use of clozapine (propensity score adjusted relative risk 0.17, 95% confidence interval 0.10 to 0.29), perphenazine depot (0.24, 0.13 to 0.47), and olanzapine (0.35, 0.18 to 0.71) were associated with the lowest rates of discontinuation for any reason when compared with oral haloperidol. Current use of perphenazine depot (0.32, 0.22 to 0.49), olanzapine (0.54, 0.41 to 0.71), and clozapine (0.64, 0.48 to 0.85) were associated with the lowest risk of rehospitalisation. Mortality was markedly raised in patients not taking antipsychotics (12.3, 6.0 to 24.1) and the risk of suicide was high (37.4, 5.1 to 276).

Conclusions: The effectiveness of first and second generation antipsychotics varies greatly in the community. Patients treated with perphenazine depot, clozapine, or olanzapine have a substantially lower risk of rehospitalisation or discontinuation of their initial treatment than do patients treated with haloperidol. Excess mortality is seen mostly in patients not using antipsychotic drugs.

S35. Symposium: INSIGHTS IN LATE-LIFE FUNCTIONAL PSYCHOSIS (In Spanish)

S35.01

Treatment strategies for psychotic geriatric depression

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Psychotic depression is subject to many controversies. Geriatric psychotic depression has even more, and will be addressed in the presentation. The first controversy relates to whether depression with psychotic features is more frequent in elderly patients. Another controversial issue is the possibility that psychotic depression might be a different entity from the non-psychotic counterpart. The role of an organic component will be discussed as well as the possible presence of cognitive impairment. Differential diagnosis can be difficult in elderly patients that may deny symptoms, have medical conditions or dementia.

Treatment options for psychotic depression include the use of antidepressants, antipsychotics and electroconvulsive therapy among others. The preference of those treatments or its combinations is also controversial and will be discussed and put into context. In addition, current and novel treatment options for treatment resistant or partially responsive psychotic depression will be reviewed. These strategies include optimization, substitution, combination, or augmentation of antidepressants and other agents and different non-pharmacological techniques, all of which will be explained and related to the specificities of the geriatric patient

S35.02

Care needs of functional psychotic patients in late life. the situation of elderly patients at psychiatric hospitals versus nursing homes

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The reforming process of Psychiatric care carried out in Spain over the last decades brought about the relocation of many psychotic patients in different nursing homes whilst some of them stay at Psychiatric Hospitals. Those people's real needs, formerly widely debated among psychiatric professionals, are scarcely known.

This paper assesses the situation of elderly psychotic patients received at a Psychiatric Hospital; its data are compared with those arising from other papers by our group which have been carried out in different nursing homes located in Galicia, Spain.

Nineteen patients over 60 years are residing at the Rebullón Psychiatric Hospital. A comprehensive evaluation of their health, functional capacity and social situation has been carried out. The Camberwell Assessment of Needs of the Elderly (CANE) has been used to systematize the met and unmet needs. The CANE distinguishes between 24 areas of needs and they are assessed by the patient and a carer.

Preliminary results: a) their basic material and health needs are met; b) the most important unmet needs are those related to recreational and leisure activities, as well as the existence of intimate personal relationships.

Moreover, the evaluation of psychotic patients living at nursing homes has showed they lack accurate psychiatric assessment and treatment; many centres are not the adequate ones to fulfil their needs.

In conclusion, these patients suffer the double stigma the WHO is alerting about: because of their mental disease and because of their advanced age.

S35.03

The paraspectrum study: searching for a valid paranoid psychotic phenotype

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Paranoid Schizophrenia (PS), yet included within the same nosological category than Non-Paranoid Schizophrenia (NPS), may in fact constitute a different disorder. In this study, the above both schizophrenia subtypes are compared with Delusional Disorder (DD). We hypothesized that, phenomenologically PS could either be a halfway category between DD and NPS or part of a phenomenological continuum of psychotic and cognitive symptoms between these three psychotic categories.

102 patients fulfilling DSM-IV-TR criteria of schizophrenia (with 56 PS and 46 with NPS) and 80 DD patients were included in this study (n=182). We compared outcome groups (DD vs. PS vs. NPS) on clinical dimensions, global functioning and sociodemographics. Clinical dimensions were extracted from the PANSS and neuropsychological scales using Principal-Component-Analysis and, subsequently, cluster analysis to assign subjects to empirically emerging clinical groups. The associations between such groups and DSM-IV-TR groups were explored using polynomial regression.

We found lineal associations demonstrating empirically that, from the psychopathological, neuropsychological and functioning perspectives, it is reasonable to consider PS as an intermediate and independent category right in between DD and NPS. Thus, the distribution of subjects assigned to three empirically emerging clinical groups (Paranoid-Affective, Paranoid-Hostile and Negative) associated, significantly and preferentially, with DSM-IV categories along the following fashion: The proportion of paranoid-hostile and, particularly, paranoid-affective subjects decreased progressively

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