one hand more of 3,000 and on the other hand more of 6,000 case of prescription that are analyzeed.

This database on practices allows to better surround characteristics of drug psychotropic processings in schizophrenic pathology notably as compared to history of the pathology and the coprescriptions.

FC14-5

THERAPY OF RESISTANT PSYCHOSES: COMBINED TREATMENT WITH CLOZAPINE

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According to the actually valid treatment guidelines the combined application of clozapine and other neuroleptics, also with high potent neuroleptics, is not admissable.

A retrospective data analysis with 27 chronically productive schizophrenic patients, who had been hospitalized in many cases for several years, showed that after complete treatment failure of classical neuroleptic therapy and treatment failure of a high dosage clozapine monotherapy these patients profited from a combined application of clozapine and high potent neuroleptics.

19 patients improved to an exent that they clould leave the hospital, 4 patients experienced an essential improvement of their complaints. Only 4 patients under this combined treatment did not show a treatment success. In the course of this treatment no severe side effects were recorded, especially there were no changes of blood picture.

Since the good response to this combined application of clozapine and high potent neuroleptics is possibly hard to explain due to the still limited knowledge of action, controlled experimental investigations should be carried out in order to eventually correct the actual treatment procedures.

FC14-6

CARE PATHWAYS FOR PSYCHOSIS & AFFECTIVE DISORDER

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Background: Care Pathways (CPs) cover a patient's experience from the onset of symptoms, to arrival at specialist services, as well as subsequent management. This study constructs CPs for patients admitted with psychosis or major affective disorder using routine contracting data from hospitals

Design: Patients admitted under general adult & forensic psychiatrists in Birmingham, completing inpatient treatment in the financial year of 1996–7, were identified using the Contract Minimum Data Set (CMDS)

Results: 1231 patients were identified. The vast majority were admitted as an emergency (85%) from their usual place of residence (80%). Another 10% were admitted from general medical wards and 6% from prisons. Patients of Afro-Caribbean or other black backgrounds were over three times as likely to be admitted from prison than any other group ((Odds ratio (OR) = 3.6 (95% CI = 2.1–6.3)). 85% of individuals were discharged to their usual place of residence. Approximately 6% were admitted to a further health service facility and just over 0.5% to local authority accommodation. Factors associated with discharge to a usual place of residence included younger age (OR = 2.5 (95% CI = 1.6–3.3)), admission from home (OR = 2.6 (95% CI = 1.7–3.8)), and affective as opposed to non-affective disorder (OR = 1.6 (1.1–2.5)). Patients admitted from institutional care were half as likely to be discharged to a non-institutional setting (OR = 0.4 (95% CI = 0.2–0.6)). Just under 1% died (n = 15), and these were more likely to be of older age (OR = 13.8 (95% CI = 3.4–48.8)), and have come from health service institutional care (OR = 3.6 (95% CI = 1.2–10.6)) or a general hospital (OR = 3.4 (95% CI = 1.1–10.8))

Conclusions: Data collected for contracting can be converted into patient-based records to study service delivery. This reveals that the treatment experience & outcome of patients is associated with socio-demographic & social characteristics as well as clinical diagnosis.

FC14-7

COMPARISON OF FACTOR-ANALYTICAL DERIVED CONSTRUCTS OF SUBJECTIVE QUALITY OF LIFE IN SCHIZOPHRENIC PATIENTS AND HEALTHY CONTROLS

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Instruments assessing the subjective component of quality of life (S-QL) in schizophrenic patients have traditionally been adopted from the normal population or additionally been modified according to the researcher's view on S-QL. It is not clear, however, whether the construct of S-QL is represented by different frames of reference in healthy subjects and schizophrenic patients. Since there are by definition no external criteria to validate subjective assessments, the present study investigated the internal validity of S-QL.

The internal structure of S-QL-data was compared between long-stay schizophrenic patients (LSP) and healthy controls (HC). S-QL was assessed by means of the Munich Quality of Life Dimensions List in 168 LSP and 316 HC. Two separate factor-analysis were conducted (PCA, eigenvalue >1, VariMax rotation). Subjects with definite response sets were eliminated prior to analysis.

Four factors could be found in both LSP and HC. Although similar in certain aspects, the solutions differed remarkably with regard to the components of the factors. The factor structure of HC is similar to the factors postulated by the authors of the MLDL.

Results indicate that the construct of S-QL, although similar to HC to some degree, is represented in a different manner in LSP. The factor structure of the S-QL in LSP implies a different perspective of S-QL. It seems necessary to investigate this specific perspective more thoroughly.

S15. Presentation of scientific issues from ECCAS

Chairs: AH Ghodse (UK), C Rösinger (D)

S15-1

A MODEL FOR MULTICENTRE COLLABORATION IN ADDICTION RESEARCH ACROSS EUROPE — EXPERIENCES FROM ECCAS (EUROPEAN COLLABORATING CENTRES IN ADDICTION STUDIES)

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In Article 129 of the Maastricht Treaty (1992) which gave the European Union a mandate to help prevent major health scourges,

https://doi.org/10.1016/S0924-9338(99)80065-0 Published online by Cambridge University Press