symptoms and health related quality of life (HRQOL). The HADS scale was used to define caseness: non-cases (scores 0-7); doubtful cases (scores 8-10) and probable cases (scores >=11).

Results: There were 3468 eligible patients as per clinical diagnosis. Of those, 66.3% and 74.1% qualified as probable cases of depression and anxiety respectively. Mean (SD) HADS-D and HADS-A scores were 12.3[4.5] and 13.0[4.0] respectively. 55.9% of sample population had overlapping depression and anxiety ''caseness'', whilst 15.3% were ''no or doubtful caseness'' for both depression and anxiety. HRQOL as measured by mean (SD) SF-36 scores showed a descendent trend for HADS depression subgroups particularly for the mental component (33.5[10.3] ''non cases''; 26.3[8.1] ''doubtful cases'' and 18.4[7.9] ''probable cases''). This trend was also found for the HADS anxiety subscale.

Conclusion: Findings will be discussed in light of contextual differences between depression diagnosis as per clinical judgement and self-reported measures in outpatient care.

S32.03

Pain in depression

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Introduction: The objective is to describe the prevalence and nature of painful symptoms among depressive outpatients and how are they related with depressive symptoms and somatic non painful symptoms at baseline.

Methods: The FINDER study, conducted in 12 European countries in depressed outpatients in routine primary and specialist care settings provides a unique opportunity to answer these questions.

Painful symptoms were evaluated among 3468 patients enrolled by 437 investigators, using the 28-item Somatic Symptom Inventory (SSI-28) and 6 Visual Analogue Scales (1 item on overall pain and 5 items on pain characteristics: headaches, back pain, shoulder pain, interferences with daily activities and pain while awake). There was a strong correlation between the VAS overall pain score and the pain sub score of the SSI-28. The threshold score of 30 mm on the overall pain severity in combination with selected comorbidities was used to divide patients in three pain cohorts: (1) those with no/mild pain; (2) those with moderate/severe œmedically explained pain and (3) those with moderate/severe medically unexplained pain.

Results: Results showed that 1447 (43.7%) patients had no/mild pain, 550 (16,6%) had moderate/severe medically explained pain, and 1311 (39,6%) had moderate/severe medically unexplained pain. Of the different locations of pain symptoms (from the SSI-28), headaches were the most common, followed by muscle soreness and lower back pain. The mean depression score (HADS-D) was higher in patients with pain-related symptoms.

Conclusion: We studied the correlations between the measures of pain and depression. These results and their implications will be discussed.

S32.04

Prescribing patterns in the Finder study

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Introduction: The objective is to describe antidepressants prescribed at baseline and associated physician and patient characteristics.

Method: Physicians in 12 European countries collected data on the medication history of the patient -antidepressants, analgesics, psychotherapy- for the 24 months prior to joining the study. Information on the daily dose and start and stop dates for antidepressants and reasons for discontinuation was recorded. Data were also collected on the antidepressant being prescribed at baseline and the daily dose recommended. Descriptive baseline data and statistical associations between variables were examined to evaluate key factors influencing the choice of treatment.

Results: Out of 3468 eligible patients for analysis, 38.2% had taken an antidepressant in the previous 24 months. At baseline, patient characteristics were very similar between groups prescribed SSRI, SNRI, TCA, other drugs and combination treatments although TCA and Combination groups showed a somewhat different profile. Indeed, patients with a higher HADS depression score were more likely to receive a combination of antidepressants (Combination-13.4[5.0] vs. SSRI-12.4[4.4]; TCA-12.3[4.5]; SNRI-12.1[4.6] and Other-12.2[4.5]). At baseline, 63.3% of patients were prescribed an SSRI, 9.2% a TCA, 13.6% an SNRI, 9.3% Other and 4.6% a Combination of antidepressants. Mean (SD) doses (mg) for the five most prescribed antidepressants were: fluoxetine (20.7[7.5]), citalopram (20.9[7.9]), escitalopram (11.2[4.5]), venlafaxine (95.6[44.3]), paroxetine (21.5[7.1]).

Conclusion: Analysis of treatment selection considering investigator and patient characteristics will provide more insight of factors influencing antidepressant choice for individual patients. Findings will be discussed in light of contextual differences in various countries and other work in the area.

W10. Workshop: THE USE OF LEGAL SUBSTANCES BY PERSONS WITH SCHIZOPHRENIA

W10.01

The use of legal substances by persons with schizophrenia

R.G. McCreadie [1], A. Dervaux [2], J. de Leon [4], M. Gurpegui [3]. [1] *Crichton Royal Hospital, Dumfries, United Kingdom* [2] *Department of Substance Abuse, CH Sainte-Anne, Paris, France* [3] *Department of Psychiatry and Institute of Neurosciences, University of Granada, Granada, Spain* [4] *UK MHRC Eastern State Hospital, Lexington, KY, USA*

Poor diet habits and a more sedentary life may contribute to a worse physical health outcome of persons with schizophrenia, who are subjected to an increased risk of diabetes mellitus and other metabolic complications. These patients report greater euphoria and stimulatory effects in response to alcohol that may contribute to the increased risk for alcohol use disorders, which complicate the functional outcome of schizophrenia. Among subjects in this diagnostic group, those exposed to caffeine consumption tend to drink heavier amount of it, although the psychobiological implication of this finding has not been

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elucidated. Finally, there is worldwide a greater prevalence of tobacco smoking, heavy smoking and high nicotine dependence; and the available date support a theory of shared vulnerability to both smoking and schizophrenia rather than a self-medication hypothesis. The authors, all of whom have been contributors in this area, will discuss each other presentations

W10.03

Who are the patients with schizophrenia who drink alcohol?

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Background: Alcohol use disorders (AUD) comorbidity has a high prevalence in schizophrenia: 21% to 51% of patients with schizophrenia had a lifetime history of alcohol abuse or dependence.

Methods: Systematic search of Medline from January 1966 to October 2006.

Results: Patients with AUD are more likely to be male and to present cannabis dependence. Conduct disorder, antisocial personality disorder, greater impulsivity and sensation seeking are established risk factors for AUD among patients with schizophrenia. Patients with schizophrenia reported greater euphoria and stimulatory effects in response to alcohol that may contribute to the increased risk for AUD (D'souza et al., 2006).

AUD have a negative impact on the course and outcome of schizophrenia, in particular, alcohol use may worsen the positive and cognitive symptoms of schizophrenia (Bowie et al., 2005). AUD are associated with depression and suicide behaviors in patients with schizophrenia. Patients with dual disorders have higher rates of medication nonadherence or number of hospitalizations. Despite lower alcohol exposure than in pure alcohol dependence, the comorbidity of schizophrenia with AUD compounds or accounts for brain volume abnormalities of schizophrenia in cortical prefrontal (Mathalon et al. 2003), cerebellar (Sullivan et al. 2000), pontine and thalamic (Sullivan et al. 2003) sites.

A number of theories have been proposed to explain the frequecy of the comorbidity. Dopamine-mediated mesocorticolimbic brain reward circuitry dysfunction in schizophrenia may explain the increased sensitivity to alcohol (Chambers et al. 2001, Green 2005). Atypical antipsychotics, particularly clozapine treatment, could be associated with reduced substance abuse.

S33. Symposium: MORTALITY AND MENTAL DISORDERS: SUICIDE AND BEYOND (Organised by the AEP section on Epidemiology and Social Psychiatry)

S33.01

Does duration of depression predict suicidality?

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Background: To describe the associations between depression and suicidality in the general population.

Methods: Data were derived from the Netherlands Mental Health Survey and Incidence Study (NEMESIS), a prospective epidemiologic study of a representative sample of 7076 adults aged 18-64, interviewed in three waves (baseline, one year and three years after baseline) with the CIDI.

Results: 3% of the population reported suicidal thoughts and 1% a suicidal act in the past year. women were more at risk then men (RR=1.83). Suicidal thoughts were associated with mood disorders (RR= 12.09), especially dysthymia (RR = 26.42). The same associations were found for suicidal acts (mood disorders RR= 11.9; dysthyma = 45.6). Incident suicidal thoughts (in three years time) were reported by 2.7% of the population and new suicidal acts by 0.8%. Bipolar disorder was strongly related to new suicidal acts.

Suicidality is persistent for almost 30% of those affected over a period of one year.

Conclusions: From the mood disorders, dysthymia is mostly correlated with suicidality. This raises the question whether suicidality is more related to duration of the depressive disorder than severity.

S33.02

Transition probability form attempted to completed suicide: A thirty year follow-up study

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Background and Aims: Since suicide is a rare event, the much more frequent suicide attempts are often used as a "proxy measure" - in such diverse fields as the ongoing debate about the potential increase of "suicidality" by SSRIs and the public health challenge of suicide prevention. Most authors dealing with these topics implicitly assume that there is a continuity between suicidal ideation > first suicide attempt > repeated suicide attempt and > completed suicide. They obviously take no notice of an important literature casting doubt on this unitarian process model of "suicidality". The pooled findings of studies show that the risk of suicide is raised after an attempted suicide, but generally not very much – in fact most people who "attempt a suicide", never commit suicide.

Methods: A thirty year prospective population based actuarial follow up study of 261 persons who had attempted suicide in 1971.

Results: (1) the risk of suicide was 9 times higher than in a comparable sample of the general population, but with 8% rather small in absolute figures; (2) most of the suicides occurred in the 5 to 10 years immediately following the attempt; (3) general mortality was slightly increased in men but not in women.

Conclusion: Given the rather low transition probability from attempted to completed suicide, the above mentioned debates should become more differentiated. It will also be discussed, whether subtypes of suicide attempts have different prognostic implication with regard to completed suicide.

S33.03

Mortality and mental disorders

C. Lauber, V. Ajdacic-Gross, W. Rössler. *Psychiatric University Hospital, Zurich, Switzerland*

Background and Aims: People with mental illness are at a high suicide risk. About 5% of these suicides occur during psychiatric inpatient treatment. Few data are available on demographic and risk factors for this population. Therefore, we analysed all psychiatric inpatient suicides from 1992 – 2004 in a catchment area of about 1.2m population in Switzerland.

Methods: Charts review.

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