and 2 per thousand admitted suffering from a puerperal psychosis. Once the birthrate of a health district is known the local psychiatric morbidity is easily estimated. Even in the smallest health district there will be sufficient workload to justify special interest consultant sessions. The clinical characteristics, health needs and patterns of service usage are sufficiently distinctive to justify a specialist service.

Despite this few centres in the UK offer even mother and baby admission and even fewer comprehensive and integrated care.

The information needed for a local health needs assessment exercise and the formula for estimating the necessary resources is given. Different models of service delivery appropriate to local circumstances are described.

The General Psychiatry Section Working Party on postnatal mental illness recommends that all suffering from psychiatric disorder following childbirth should have access to a consultant with a special interest in their condition and specialist community psychiatric nurses. When necessary such patients should have access to specialist inpatient mother and baby beds.

PERINATAL CARE AND MATERNAL WELL-BEING IN THE NETHERLANDS

V.J. Pop. *Department of Social and Behavioural Sciences, University of Tilburg, PO Box 90153, 5000 LE Tilburg, The Netherlands*

Generally speaking, in The Netherlands, there are three patterns of peripartum care: antenatal consultations and birth at home with the aid of a community midwife (or occasionally a general practitioner); a '24-hour confinement' (parturition in hospital with the aid of the person who provided the antenatal care — community midwife, general practitioner or obstetrician — with the mother leaving the hospital within 24 hours); and a 'clinical' confinement (parturition in hospital with the mother remaining for more than one day — generally 5 to 7 days — when there is a medical indication). Up to 35% of the women deliver their baby at home. After parturition, a 'perinatal' health nurse stays with the mother during the day for one week teaching the (new) mother how to cope with the newborn. At six weeks' postpartum there is a final consultation with the person who provided antenatal care. There is, however, a lack of inpatient facilities for admitting mothers and babies jointly when mothers are psychotic.

This system of clinical care allows one to examine psychiatric outcome in dyads with elective normal deliveries in hospital and at home. Although no differences in outcome were found assessing mood at 4 weeks' postpartum, recently, assessing mood during the first postpartum week, the occurrence of blues and depression (EPDS) was found to be related to deliveries at home or in hospital.

S10. Attitudes towards antipsychotic medication

Chairmen: E Hoencamp, J Gerlach

PATIENTS SUBJECTIVE EXPERIENCES ON ANTI-PSYCHOTIC MEDICATIONS — IMPLICATIONS FOR OUTCOME AND QUALITY OF LIFE

A.G. Awad. *The Clarke Institute of Psychiatry, University of Toronto, 250 College Street, Toronto, Ontario M5T 1R8 Canada*

Clinicians have frequently observed that some of their schizophrenic patients experienced a change in subjective state often following only a few doses of a neuroleptic. Complaints ranged from "feeling like a Zombie", the inability to think straight, and the notion that the medications are worsening their condition. Such phenomena have been invariably labelled as neuroleptic dysphoria, akinetic depression, behavioral toxicity, neuroleptic decompensation, etc. Not surprisingly, a number of patients experiencing such negative subjective responses to neuroleptics continually complain about the medications, and place pressure on their clinicians to frequently change them. It is not uncommon for many to discontinue their medication themselves, leading to relapse and frequent hospitalizations.

This presentation will review the concept of subjective response to neuroleptics, the validity of the construct, its measurement as well as its relevance to therapeutic outcome. Data will be presented to link negative subjective response to compliance, less favourable clinical outcome, to concomitant illicit drug abuse (comorbidity) as well as its association with some cases of suicide. The predictive value of early subjective response in treatment outcome has been validated in a number of studies.

In schizophrenia, as in any other chronic illness that requires long-term therapy, what is important for patients is how they feel and function on medications. In that sense the impact of neuroleptics on the functional status becomes an important consideration, not only from the clinical aspect but also for the development of new neuroleptics. Data will be presented to confirm the contribution of negative subjective responses to the construct of quality of life in medicated schizophrenics.

NEUROLEPTIC-INDUCED DEFICIT SYNDROME, DEPRESSION AND NEGATIVE SYMPTOMS IN SCHIZOPHRENIA

Thomas R.E. Barnes, Michael McPhillips. *Department of Psychiatry, Charing Cross and Westminster Medical School, St. Dunstan's Road, London W6 8RP, UK*

The differentiation between depressive features, negative symptoms, and neuroleptic side-effects, such as the putative neuroleptic-induced deficit syndrome (NIDS), in patients with schizophrenia may have significant implications for treatment and management. The problems in assessment include the degree of phenomenological overlap, particularly with regard to dysphoric symptoms, and the lack of precise operational definitions, particularly for negative symptoms and the NIDS. The NIDS incorporates adverse subjective experiences as well as objective measures, such as cognitive impairments, and behavioural deficits such as apathy and lack of initiative. The diagnostic process is further confounded by the need to distinguish between primary negative symptoms as persistent, enduring deficits, and social and emotional withdrawal secondary to positive symptoms, or related to depressive features or drug-effects such as sedation and the bradykinesia component of parkinsonism.

Clinical discrimination between these elements is likely to require careful observation of patients with schizophrenia, over time, by trained raters using appropriate rating scales for depression and negative symptoms that are sensitive to change. Ratings of patients' subjective experiences regarding mood may have discriminatory value in clinical practice. Patients' awareness of behavioural and cognitive deficits, should also be included in view of their possible relationship with social functioning and vulnerability to depression. The associations between the subjective data and the objective ratings of depression, negative symptoms and drug side-effects may help in the clinical discrimination of these areas of dysfunction and also the refinement of their phenomenological descriptions.