There is a need for researchers and policymakers in the area of co-morbid mental health and substance misuse to collaborate and develop shared methods of approach to evidence and research based policy. Although much is known about the prevalence and multiple needs of co-morbid individuals, there are a number of research questions that remain unanswered. By collaborating with colleagues in other European countries and encouraging generalization of results an understanding of the effect health and social care systems on the level and intensity of complexity dual diagnosis presentations will develop. Similarly, while previous research highlighted the complex needs of co-morbid individuals, future research should concentrate on factors that may help prevent the 'ping-pong' effect, resulting in co-morbid people being bounced around various organisations and agencies, most notably among mental health and substance misuse services.

S23.03

Innovations in pharmacological treatment of addiction

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Addictive behaviour associated with alcoholism is a brain disease characterized by craving for alcohol, loss of control over consumption, development of tolerance and dependence, while simultaneously the repertoire of social functioning not related to intake behaviour declines dramatically. To understand the factors that compel some individuals to drink excessively and to identify targets for pharmacological intervention, addiction research has focused on the identification of brain mechanisms that support reinforcing actions of alcohol and the progression of changes in neural function induced by chronic drug or ethanol intake. Cellular and molecular mechanisms of tolerance, sensitization, and dependence have been investigated intensively. The ability of most drugs to enhance dopamine neurotransmission particularly within the mesocorticolimbic dopamine (''reward'') system was demonstrated repeatedly. However, the past decade has placed the dopamine system within a broader context of neuronal circuitry involved in drug seeking, drug taking, and recovery. Specific effects on other receptors symptoms provide particular challenges given the almost ubiquitous expression of these receptors throughout the CNS. Additionally, new emphasis on various neuropeptide systems has reemerged, including opioid peptides and the stress-related peptides of the hypothalamus-pituitary-adrenal axis. Continued research is warranted on the various neurobiological based components that underlie the transition from drug intake to addiction to define drug targets for innovative pharmacological treatment options.

S23.04

Hidden comorbidity

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Attention-deficit/hyperactivity disorder (ADHD) is a chronic disease that is well accepted as a childhood condition. Despite increasing evidence of its clinical relevance in adults, it would appear that adult ADHD is underdiagnosed. This is particularly the case when comorbid with another mental disorder. Comorbidity across the life-span runs as high as 70% amongst adults diagnosed with ADHD. One of the most frequently occurring comorbidities in adult ADHD are substance use disorders (SUDs), which show a bi-directional relationship. ADHD is a risk factor for the development of later SUD to the extent that 9%-30% of adults with ADHD have a substance use problem. On the other hand, prevalence studies have shown that between 15% and 25% of patients with a SUD also have ADHD. The bi-directional relationship between ADHD and SUD can modify the clinical expression of symptoms, thus rendering difficult both correct diagnosis and appropriate treatment. ADHD is a strong risk factor for the subsequent development of an SUD and can jeopardize drug treatment. Assessment for ADHD is highly recommended amongst SUD patients as is a drug evaluation for those adults diagnosed with ADHD. An undiagnosed comorbidity can result in poor results as only part of the problem is treated. More research is needed to clarify relationship between adult ADHD and substance abuse, as well as to explore new psychopharmacological and psychotherapeutic treatments for this comorbidity.

S24. Symposium: QUALITY OF LIFE AND SUICIDE IN THE GERIATRIC PSYCHIATRY–THE RIGHT TO DIE, AN ETHICAL POINT OF VIEW (Organised by the AEP section on Geriatric Psychiatry)

S24.01

The concept of quality of life in dementia in the different stages of the disease

J.W. Leszek, R. Wojtynska. *Department of Psychiatry, University of Wroclaw, Wroclaw, Poland*

Dementia is progressive, age related, chronic condition and can profoundly affect the lives of patients and their families.The main question in care becomes how to promote well being and maintain an optimal Quality of Life QOL. But is not always clear what QOL means.The conceptualizations of QOL vary because most instuments are developed for patients in different stages of dementia, and the relevant life domains for QOL vary with the progression of the disease. As a consequence most instruments are unsuitable for assessing QOL in the whole range of mild to severe dementia.This presents a problem for the daily care for people with dementia and for the evaluation of interventions aimed at improving QOL, as changes in QOL with the progression of the disease are difficult to detect and assess with existing instruments.This presentation following conceptual definition offered. Dementia specific QOL is the multidimensional evaluation of the person environment system of the individual, in terms of adaptation to the perceived consequences of the dementia.

S24.02

Suicide and attempted suicide in the elderly. Should the physician give support to patient's wish to die?

I. Icelli. *Department of Psychiatry, Celal Bayar University Faculty of Medicine, Manisa, Turkey*

Suicide is a major cause of death of older people. The most reason cited by older adults who consider suicide is loneliness. Feeling alone, worthless, helpless and hopeless are symptoms of depression which carries a high risk for suicide. The suicide risk in the elderly depends on the societies, communities and religious beliefs.

On the other hand the patients who believe that their quality of life would be disturbed by the continued treatment, have the right to ask

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to stop the treatment. The further extention of this issue involves the wish to die and physician-assisted suicide. The physician-assisted suicide raises several ethical questions beside the conflicting roles of physicians in preseving life versus ending suffering. In the Hippocratic oath, physicians swear not to precribe a deadly drug or give advise to a patient that may cause death. Or, nowadays euthanasia and physician-assisted suicide have become sources of continuing controversy and are likely to be so far forseeable future.

Once a physician swears to keep the patient alive, is it ethical when he / she administers a lethal dose of medication or another agent to a hopelessly ill or injured patient?

The achivement of modern medicine in terms off technology and treatment, enable physicians to prolong life and to delay that even the presence of severly debilitating conditions. However, benefical medicine technology may be harmful when used as a life-sustaining measure, in terminally ill patients. Elderly people themselves often fear and believe a zealous aplication of that kind of life-sustaining procedures will just prolong their suffering.

What the physician should do? To undertake the treatment and the life-support systems or follow the ''do not resuscitate'' order?

S24.03

Sanctions and suicide in the elderly

A. Milicevic-Kalasic. *Institute of Gerontology, Home Treatment and Care, Belgrade, Serbia*

Objective: In the process of defining the most accurate and sensitive indicators for humanitarian conditions and impact of sanctions against FRY, the number of committed suicides was followed up with particular interest in group of people aged 60 and more.

Design: Retrospective Study used data from Municipal Statistical Office in 4 year period meaningful for certain changes in Yugoslavia (economic mismanagement, state break-up, war and economic sanctions).

Materials and Methods: The number of committed suicides obtained from records of Municipal Statistical Office was followed up. Statistical evaluation encompassed calculation by absolute and relative numbers, as well as suicidal trends in Belgrade. Age, gender and occupation were analyzed parameters.

Results: ''J curve'' obtained by analyzed data represented suicidal trends in Belgrade in period 1988-1992. The lowest point of ''J curve'' was in 1989. Relative number of elderly who committed suicide remained approximately the same.

Conclusion: In particular situation of established Sanctions against FRY, suicidal rate generally increased but the elderly wasn't the most vulnerable population.

S24.04

Quality of life in the elderly mentally ill and the right to dye with dignity

N. Tataru. *Forensic Psychiatry Hospital, Stei Bihor, Romania*

There appeared serious ethical challenges for psychiatry: to cut mental health costs and to provide care to as many as possible. The psychiatrists have to face these challenges and treat the elderly with or without mental disorders, assuring them the best quality of life as it is possible.

Multiple loses in old age are important in decreasing of quality of life and increasing of mental health problems in the elderly. Suicide and attempted suicide are one of the major health problems in the world. We discuss about the wish of die in elderly persons and about 'the right to die'. We are questioning: whether it is natural for the elderly to wish to die, and whether the right to eventually kill oneself should be respected or whether suicidal intentions in old people are expressions of mental diseases.

To find predictors of suicide in old age is an urgent task for prevention. In more of the controlled studies depression and personality disorders are potentially important predictors of suicide in the elderly. The prevention of suicide in later life must account the educational program for primary care to enhance knowledge regarding the treatment of mental illnesses and recognize them. Thus we must use the newer antidepressants and community care to avoid the suicidal behaviour in the elderly, because the depression is under-diagnosed and often under-treated. We try to improve the quality of life of all elderly mentally ill patients, also solving the stigma and discrimination against the elderly with mental problems.

S25. Symposium: TREATING DEPRESSION IN SPECIAL POPULATION (In Memory of Manfred Ackenheil)

S25.01

Treating depression among HIV/AIDS patients: recent advances

P. Ruiz. *Department of Psychiatry, University of Texas Health Science Center, Houston, TX, USA*

The number of persons affected with HIV/AIDS continues to increase dramatically. This epidemic, while being very devastating in Sub-Saharan Africa, is also rapidly spreading to other parts of the world; in particular, South East Asia. Recent data has shown that currently there are about 50 million people already suffering from AIDS. Of this number, one million alone are residents of the United States. It is, therefore, imperative that we advance the profession and field in all model and treatment approaches vis-à-vis psychiatric disorders and conditions that could affect people suffering from HIV/AIDS.

Among the illnesses affecting persons with HIV/AIDS, either independently or as a comorbid condition, mood disorders are very prominent. Major depression among them is oftenly observed in this patient population. In this presentation, focus will be given to the most advance methods of intervention for the treatment of HIV/AIDS patient who suffer from depression.

Educational Objectives:

At the end of this presentation, participants should be able to:

1. Recognize the symptoms of depression among HIV/AIDS patient.
2. Treat depression among HIV/AIDS population in accordance to the most far advance methods of intervention.
3. Help to prevent relapse and complications, including suicide, in the HIV/AIDS patient population.

Literature References

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