not be confined to models of face-processing, but be extended to models of visual recognition in general.

AMISULPRIDE IN THE TREATMENT OF ACUTE EXACERBATIONS OF SUBCHRONIC OR CHRONIC SCHIZOPHRENIA: A DOSE RANGE FINDING STUDY

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Amisulpride (AMI) is an antipsychotic agent with highly selective affinity for dopamine D_2 and D_3 receptors, devoid of affinity for other neurotransmitters. In animal studies AMI preferentially binds to receptors in the limbic area. This profile suggests antipsychotic activity with a low risk of associated extrapyramidal symptoms. The short-term (4 weeks) efficacy and safety of AMI were evaluated in this study comparing four fixed doses of AMI (100, 400, 800 and 1200 mg/d) and 16 mg/d of haloperidol (H). All other AMI doses and H were compared with AMI 100 mg/d as potentially subtherapeutic dose. After a washout period of 3 to 7 days, patients fulfilling DSM III-R criteria for schizophrenia (paranoid, disorganized or undifferentiated type) could be included into the study. Efficacy was evaluated using the BPRS (main criterion), the PANSS Positive and Negative Subscales and the CGI. Safety evaluation included the UKU side effect scale, the Simpson-Angus (SAs) scale (parkinsonism), the Barnes Akathisia Scale (BAS) and the AIMS (tardive dyskinesia). A total of 319 patients (mean age 36 yrs, sd 11, mean duration of illness 10.1 yrs, sd 8.3) were included in the study. About half of the patients (46%) were pretreated with neuroleptics in the month before inclusion into the study. The mean BPRS total score (1 to 7 scoring) at inclusion was 61.2 (sd 11.4), the corresponding PANSS Positive and Negative scores were 25.9 (sd 6.0) and 27.3 (sd 8.1). 237 patients (74%) completed the study. The AMI 800 mg group had the lowest dropout rate for inefficacy (2/64 patients, $p < 0.05$ vs AMI 100 mg), whereas the H group had the highest dropout rate for safety reasons (10/64 patients, $p < 0.05$). The highest improvement (BPRS total score) was found in the AMI 400 and 800 mg groups (24.9 sd 18.4 and 26 sd 14.9, unadjusted $p < 0.05$). The corresponding response rates (CGI) were 66% and 78% respectively, ($p < 0.01$ for AMI 800). PANSS positive scores also improved significantly in the AMI 800 group (12 sd 6.9, $p < 0.05$). PANSS negative scores improved most in the AMI 400 and 800 groups (8.4 sd 7.9 and 9.6 sd 8.7) but this difference failed to reach significance. Extrapyramidal symptoms (parkinsonism) did not increase significantly in the AMI 400, 800 and 1200 mg groups compared with AMI 100, whereas increase was significantly higher in the H group ($p < 0.002$). Akathisia and tardive dyskinesia scores did not change significantly during treatment. Vital signs and biological tests showed no clinically relevant abnormalities in the different treatment groups. Overall, Amisulpride at daily doses of 400 and 800 mg proved to be highly effective on productive symptoms in acutely exacerbated schizophrenic patients with an additional effect on negative symptoms in these patients and significantly better extrapyramidal safety compared with haloperidol.

CLOZAPINE AND RISPERIDONE IN THE TREATMENT OF THERAPY-RESISTANT SCHIZOPHRENIA: A PRELIMINARY REPORT ON TWO ONGOING CLINICAL TRIALS

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Background: Clozapine proved to be effective in patients not responding to other neuroleptics. This effect has been known for years. More recently it has been shown that also Risperidone can effectively be used in these patients. We present preliminary results of two uncontrolled trials evaluating the effects of Clozapine and Risperidone on schizophrenic patients non-responding to other neuroleptic agents.

Methods: We performed two clinical trials in a parallel research design. 26 schizophrenic patients (ICD 10, mean age 46 y.) who had failed to respond to two or more different neuroleptics — each given for three weeks at least — were assigned by their individual psychiatrist to either Risperidone (n = 14) or Clozapine (n = 12). In both studies sociodemographic data were recorded, psychopathology and extrapyramidal symptoms were assessed by the same independent blind-observer in the washout period (week 0), after week 2 and after week 6 of treatment, using PANSS, BPRS, CGI, NOSIE and EPS rating scales. Statistic analysis was performed comparing rating scores between weeks 0, 2, and 6 using Students-t-test in each study separately.

Results: BPRS total score in the Clozapine Study decreased from 54.3 to 52 (−4.2%, week 2) to 50.1 (−7.7%, week 6). The corresponding score in the Risperidone Study was 52.9 (week 0), 47.9 (−9.5%, week 2) and 40.7 (−23.1%, week 6). PANSS total score in the Clozapine Study could be reduced from 84.1 to 80.3 (−4.5%, week 2) to 77 (−8.4%, week 6). Only the decrease in the positive syndrome scale was significant ($p = 0.01$). PANSS total score in the Risperidone Study was 81.2 (week 0), 72.4 (− 10.8%, week 2) and 61.0 (−24.9%, week 6). The decrease on positive syndrome scale (week 6), general psychopathology scale (week 6) and on total score of PANSS (week 2 and 6) was nearly significant ($p = 0.05$). Extrapyramidal symptom scores were remarkable low and decreased during treatment in both studies.

Conclusions: In this intermediate analysis we observed an effect of both drugs in the treatment of initially pharmaco-resistant schizophrenia which reached statistic significance in the so far small samples. However there was a difference in the magnitude of observed treatment effects favoring Risperidone. The observed differences may be due to the uncontrolled study design, unmeasured confounding risk factors, chance or a true difference between both drugs.

PSYCHOPATHOLOGY AND COGNITIVE (EXECUTIVE) DYSFUNCTION IN RELATION TO DURATION OF INITIALLY UNTREATED PSYCHOSIS IN SCHIZOPHRENIA

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While determinants of the course of schizophrenia are unclear, emerging evidence suggests that the longer psychosis proceeds unchecked before initiation of anti-psychotic therapy, the poorer may be long-term outcome. We have examined current psychopathology using the Positive and Negative Syndrome Scale (PANSS), general cognitive function using the Mini-Mental State Examination (MMSE) and executive/frontal function using the Executive Interview (EXIT) in 48 older patients with schizophrenia, many of whom were admitted in the pre-neuroleptic era. After controlling for age and for the duration and continuity of subsequent neuroleptic treatment, increasing duration of initially untreated psychosis was associated with greater severity of negative ($p < 0.005$) but not positive (NS) symptoms, and with lower scores on the MMSE ($p < 0.05$) but not with EXIT performance: duration of illness following initiation of treatment was not associated with psychopathology. Overall performance on the MMSE decreased prominently with age/duration of illness, while EXIT performance changed consid-

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erably less prominently, particularly in male patients. These data indicate that increasing duration of initially untreated psychosis is associated with more prominent negative symptoms and greater general cognitive impairment, but not with greater executive/frontal dysfunction; such executive/frontal deficits appear to be 'locked in' considerably earlier in the evolution of the illness, especially among males.

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NR11. Clinical services and community care — II

Chairmen: D Olajde, T Brugha

OUTCOME OF REHABILITATION PROGRAMME: IS THERE A DIFFERENTIAL RESPONSE?

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Outcome measures of various Rehabilitation Programmes of Psychiatric patients have often lacked specifity. Various criteria have been taken into consideration and the outcome measured, some of these being number of subsequent hospital admissions, employment status or change in the social and mental status of the individual. However very few studies have looked into the differential response of patients with different psychiatric diagnosis to the given Rehabilitation programme. This was tried to be evaluated in our study. The study is based on a retrospective design, where notes of patients admitted to the rehabilitation unit of the hospital during the years 1992–94, were evaluated semiquanti-tatively. The Demographic data, symptom profile at admission and discharge, the Psychiatric diagnosis and the overall outcome of these 27 patients were noted. Each of these patients underwent the standard Rehabilitation Programme. The outcome in these patients was compared with the symptom profile, psychiatric diagnosis and the duration of illness prior to their admission to the programme using the Chi square test and t-test. It was noted that the outcome was not influenced by any particular symptom or the duration of illness before admission to the Rehabilitation programme in a statistically significant manner. However the only statistically significant finding was that, the patients with personality disorder showed poor outcome to the programme when compared with other patients who had similar disabilities but differed only in the diagnosis. This differential response seen, points to us that probably patients with personality disorder have different set of needs, and a successful programme might be devised for them taking into account these needs.

SERVICE PROVISION — A DIFFERENT APPROACH TO MOTHER AND BABY SERVICES IN NEW SOUTH WALES, AUSTRALIA. THE WENTWORTH TRESILLIAN

I. Bialas, G. Boyle.

Some of the Mother and Baby Services are provided in New South Wales (10 million population) by 4 Tresillian Family Care Centres. This is a Government funded organisation which offers a broad range of support services to parents with children aged 0–5 years. The 4 Tresillian Centres have 42 residential units. I will concentrate on a description of one of them, the Wentworth Tresillian.

The Residential Programme: The Wentworth Tresillian has 14 residential units for mother and baby diads. The units can accommodate other family members. Each unit includes en-suite nursery, bathroom and bedroom. There are common areas such as dining, group rooms and play areas. A programme of 6 days is offered. Clients are seen by the nursing staff, psychologist, social worker and other staff as required. A paediatric specialist medically examines all babies on admission. Groups are conducted during the programme including relaxation and discussion, education, parenting and relationships.

Reasons for admission include feeding and sleep problems, low weight gain, behavioural problems, post-natal depression, parent craft and parenting education, Department of Community Services referrals etc.

Referrals are made by telephoning the intake officer and received from General Practitioners, Paediatricians and Community Nurses.

The Day Stay Programme: Families attend 9.00am–2.00pm Monday to Friday. There are 5 nurses running this programme. Time is given to discuss problems, devise a management plan, assist, educate and support.

Referral is made by clients or health professionals.

Total Cost: Salaries are the bulk of the $1.9m (£0.9m) annual expenditure of the unit. 67% of these are for nursing staff and 1% for Paediatric and Psychiatry cover.

Staff Profile: 3 Counsellors (1 social worker and 1 psychologist), 21.8 Registered Nurses, 4.7 Enrolled Nurses, 2 Nursing Managers, 3.8 Cleaning/Hotel Staff, 3 Clerical Staff, 1 Educator and 1 Unit Manager.

Clients Assisted: In 1994, 843 babies and 797 mothers were assisted at the Wentworth Tresillian. 675 new registrations were made at the Day Stay Unit.

Access is currently improving with opening of the 24 hr free 'phone Parents Help Line which offers advice, support and referral. It is staffed by 4 workers on 5 hr shifts and takes 60,000 calls per year. This is in addition to the usual referral channels.

SERVICE PROVISION — A DIFFERENT APPROACH TO COMMUNITY MENTAL HEALTH TEAM SERVICE ORGANISIATION IN NEW SOUTH WALES, AUSTRALIA. THE WENTWORTH AREA MENTAL HEALTH SERVICE

I. Bialas, M. Wheeler.

The Wentworth area has a population of 326,000 and is located at the far western edge of Sidney encompassing the Blue Mountains, Penrith and Hawksbury Local Geographical areas. Service to the area is provided by a 30 bed inpatient unit with 2.5 consultants and 4 registrars in psychiatry. The area also has 2 main community bases and 3 smaller satellite community centres operating 9.00 am to 5.00 pm Monday to Friday.

After business hours the 2 Extended Hours Teams (EHT) operate from the 2 main community bases. The EHTs have 3 shifts per day. They take written and telephone referrals from families, clients, GPs, social workers and police. This way, round-the-clock care and crisis intervention in provided 7 days per week. After an assessment by a team worker who often goes out for the visit, the client is either managed by the team or referred to the on-call psychiatric registrar. The EHT carry a stock of medication and can take verbal orders for dispensing. The Team Base files records on existing clients which are readily available after hours. Team members on call carry mobile phones and pagers and use cars provided by the Health Authority ("community cars"). They generally visit in pairs after hours and sometimes may request police escort. Occasionally the on-call registrar is required to go out with the team and schedule a client under the Mental Health Act. This can also be done by a GP or Accident and Emergency doctor.

Following discharge of clients from hospital the team are often