consequently,even male suicidality decreased on Gotland for the first time. Since than, the "Gotland Study" of educating GPs as a suicide preventive effort in suitable endemic suicide regions has been widely spread and replicated in many countries, regions, and populations of societal transition,, often with positive results. Educating GPs according to the Gotland Model is today considered to be one of the essential measures that should be offered in comprehensive,multimodal and multisectorial national programs of suicide prevention.

S01.05

Substance abuse and suicide risk in schizophrenia

P. Girardi, M. Pompili. *Department of Psychiatry, Sant'Andrea Hospital, Rome, Italy*

The literature suggests that nearly 50% of patients with schizophrenia have a co-occurring substance use disorder (SUD), most frequently alcohol and/or cannabis (at a rate about three times as high as that of the general population). Outcomes associated with Comorbid SUD and Schizophrenia are earlier onset of schizophrenia, increased relapses, treatment noncompliance/more side effects, poorer response to antipsychotic medication, more hospitalizations, increased risk for violence, increased medical costs, more affective disturbance. These conditions are also associated with increased suicide risk. The increased suicide risk of substance abusing schizophrenic patients could be the result of a cumulative effect of many factors or events, such as the loss of remaining social control through the consumption of psychotropic substances, noncompliance with antipsychotic medication, presence of paranoia and depression.

Abuse substances worsen both symptoms and prognosis of the illness and are related to higherrelapse rates.

Studies suggest that some of the second-generation (atypical) agents may be helpful for these patients. Some researchers have suggested that the lower incidence of neurologic side effects produced by the atypical antipsychotics, along with the possibility that these agents may be more likely to decrease negative symptoms, make them a logical choice for patients with co-occurring substance use disorder (even though parameters of the metabolic syndrome must be monitored while using these agents).

Joint AEP/ECNP: Psychopharmacological intervention in major psychiatric disorders

JW01.01

Strengths and weaknesses of evidence-based medicine (EBM)

M. Davidson. *Department of Psychiatry, Tel-Aviv University, Tel Aviv, Israel*

As medicine and magic began to slowly part ways in the Enlightment era, scientific evidence became the driving force and currency of medicine. As scientific evidence was being defined, the newly established medical schools imparted this knowledge to their students. Those who mastered the evidence, and committed to adhere to it, became physicians who enjoyed public trust and the statutory position that came with it. With some exceptions, the idea that scientific evidence should constitute the only foundation for medical practice has withstood the test of time and the occasional attacks, by well-meaning but naïve individuals as well as charismatic charlatans.

The principal stakeholders of clinical practice - consumers, practitioners, and providers of services and products - are all trying to influence the stream of evidence. The current debate on EBM focuses on what constitutes true scientific evidence, and how best to translate this evidence into clinical practice. The evidence available to the practitioner varies widely in terms of source, quality, and potential for bias, while the relevance of evidence, derived from statistical analyses of data from mega-trials, to the treatment of individual patients is sometimes difficult to grasp.

This presentation will discuss the gap between EBM and clinical practice and ways to bridge the two.

JW01.02

Lessons from the long term bipolar study, balance

G. Goodwin. *WA Handley Professor of Psychiatry, Warneford Hospital, Oxford, UK*

Objectives: To explore the times of onset of response and remission associated with combination therapy in patients with bipolar I disorder.

Methods: Patients who are suitable for long term treatment are initially recruited and treated with the combination of lithium and valproate (as ®Depakote). For a four to eight week run-in period these drugs are given together to assess the tolerability of this combination. At the end of that time patients are randomised to either continue on the combination itself, or lithium alone, or depakote alone

Results: The central problems are patient recruitment and clinician capacity. An update on trial procedures and progress will be presented. The results will be analysed after trial completion later this year

Conclusions: The long term treatment of bipolar disorder is frequently based on polypharmacy. While this approach seems logical, it is not supported by much empirical evidence since industry has hitherto had little interest in studying other than monotherapy. BALANCE has the virtue of being enriched for adherence and tolerability. Whether outcomes are better in combination treatment is a finding that will be eagerly awaited.

Reference

[1]. Geddes, J.G. & Goodwin, G.M. (2001) Bipolar disorder: clinical uncertainty, evidence-based medicine and large-scale randomised trials. British Journal of Psychiatry 178 (suppl. 41), s191-s194

JW01.03

Lessons from schizophrenia study: Eufest

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The EUFEST Steering Committee. *Rudolf Magnus Institute of Neuroscience, Department of Psychiatry, University Medical Center Utrecht, Utrecht, The Netherlands*

Background: Most studies comparing second generation antipsychotics with classical neuroleptics have been conducted in more or less chronic schizophrenia patients.

Aims: The aim of the European First Episode Schizophrenia Trial (EUFEST) is to compare treatment with amisulpride, quetiapine, olanzapine and ziprasidone to a low dose of haloperidol in an unselected sample of first episode schizophrenia patients with minimal prior exposure to antipsychotics.

Methods: 500 patients between the ages of 18-40 meeting DSM-IV criteria for schizophrenia, schizoaffective disorder or schizophreniform disorder will be randomly allocated to one year of treatment

https://doi.org/10.1016/j.eurpsy.2008.01.025 Published online by Cambridge University Press

with one of the drugs under study. Maximum prior antipsychotic treatment is limited to two weeks. The primary outcome measure is retention in treatment, defined as time to discontinuation of study drug. Secondary measures include changes in different dimensions of psychopathology, side effects, compliance, social needs, quality of life, substance abuse and cognitive functions

Conclusions: At present, recruitment has been concluded and more than 490 patients have been recruited and randomized. The data have been analyzed and outcome data of this sample will be presented.

Symposium: The consequences of insomnia

S05.01

A comparison of insomnia and depression in disability pension award

S. Overland. *University of Bergen, Bergen, Norway*

Background and Aim: Depression and insomnia are common and frequently co-morbid. Both are associated with impaired occupational functioning. The objective of this historical cohort study was to compare their relative impact upon medically certified disability pension award.

Method: Data from a population-based health survey in Nord-Trøndelag County in Norway (HUNT-2) was linked with a comprehensive national social security database. Participants within working age (20-66) not already claiming disability pension were included in the study (N=37 308).

Results: We compared insomnia and depression as predictors of disability pension award between 18-48 months after the health survey. Both insomnia and depression approximately doubled the risk of disability pension award after adjustment for multiple health and sociodemographic factors. Co-occurrence was less prevalent (2.1%) than expected and produced an additive risk for pension award. 25% of the 3800 participants with insomnia had no other health condition. Due to higher prevalence, insomnia predicted more work-related disability than depression in terms of population attributable fractions.

Conclusions: Depression is consistently recognized as a major contributor to work disability and is frequently the eliciting diagnosis in disability pension award. Our results suggest that insomnia has an equally important and independent role, particularly amongst the younger group, but rarely found in official registries of disability pension causes. This suggests that this potentially treatable factor has considerable economic impact, and should receive more attention in clinical and public health management.

S05.02

Sleep disturbances and duration of sleep as risk-factors for mortality

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Objective: Study prospectively the effect of sleep-related complaints and sleep duration on all cause mortality in a general population sample.

Method: The data were gathered from the adult population from the County of Nord-Trøndelag as part of a general health survey whichhad a participation rate of 71.2%. Data included self-reported somatic disorders, somatic symptoms,health related behaviour, impairment, public benefits, medication use, anxiety and depression as well as anthropometric measures, blood pressure and cholesterol level.

Main outcome measure: Mortality during a 4-year period following the general health survey as recorded in the Norwegian Death register.

Results: An ordinal five point scale of sleep disturbance predicted mortality in the observation period, even in the probable over-adjusted model including all available confounders. The variables that most strongly accounted for the effects of the sleep disturbance were (in order of magnitude) somatic diagnoses, health related behaviour, anxiety and depression, subjectively reported physical impairment, educational and social differences, blood-pressure, cholesterol level, and BMI. Time in bed was strongly associated with mortality, and the association was U-shaped. Compared to the median value of 7 hours, spending either less or more time in bed predicted death.

Conclusions: Sleep disturbances as well as spending either short or long time in bed are predictors of mortality. Both predictors are robust for adjustment for multiple confounding factors.

S05.03

The effect of short sleep duration on ongoing psychiatric morbidity

N. Glozier, R. Ivers, A. Martiniuk, M. Stevenson. *The George Institute, Sydney, Australia*

Introduction: Psychiatric morbidity in young adults can lead to a host of poor sequelae including later psychiatric disorder, welfare dependence and psychosocial disability, all worse if the disorder becomes chronic.Early intervention strategies could be enhanced by targeting those likely to have a more chronic or repetitive course.

Material and Methods: Twenty thousand young Australians, aged 17-24, were recruited into a prospective cohort study at the time of obtaining their driving license. A random sample of 5000 were recontacted a year later and 2994 completed re-survey questionnaires. Psychiatric morbidity was assessed using the Kessler 10 (cut point 21/22) and DSH was assessed by slef report. Two trained research assistants and a psychiatrist then coded the open responses.

Results: Psychiatric morbidity was present in 954 of the sample at baseline. 45& of these were still cases one year later. Older age, female gender, previous deliberate self harm and symptom scores, but not substance or alcohol misuse were the baseline independent association with chronicity vs. remission. Short sleep duration was the only other independent factor, with a 10% decrease in the likelihood of having morbidity at follow up for every extra hour slept on average per night.

Discussion and Conclusions: This study suggests yet another poor outcome of short sleep duration in young adults which may aid targeting of early intervention for psychiatric morbidity.

S05.04

The effect of insomnia and sleep duration on work disability

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https://doi.org/10.1016/j.eurpsy.2008.01.025 Published online by Cambridge University Press