Identity Interaction model will be presented as a basis from which to understand the ethical impact of racism in the clinical context.

# Symposium: Suicide, an unexpected event for health professionals: Focus on prevention

## S01.01

Suicide, an unexpected event for health professionals

R. Tatarelli. *Department of Psychiatry, Sant'Andrea Hospital, Sapienza University of Rome, Rome, Italy*

Suicide has a profound effect on the family, friends, and associates of the victim that transcends the immediate loss. Health professionals as well family members are usually unaware of immediate suicide risk and often present disbelief. The event is totally unexpected. This is a key issue in suicide prevention as underestimation of suicide risk and

As those close to the victim suffer through bereavement, a variety of reactions and coping mechanisms are engaged as each individual sorts through individual reactions to the difficult loss. Literature suggest that health professional in general and mental health professionals in particular are often unprepared and uneasy when it comes to deal with suicide risk. Communication of suicide intent has been reported as a common feature among suicide victims, yet some patients barely let other people know their intention to commit suicide or clinicians are not trained to notice warning signs. So it is of paramount important to integrate such communications with tactics to better identify suicidal patients. Managment of these patients is therefore a great issue and a difficult task which can be accomplish with the help of GPs, family members, psychiatrists and community members. Substance abuse disorder comorbid with other psychiatric disorders impairs positve outcome and dramatically increase suicide risk. Combined treatment is not always provided for such patients and proper management of suicidality is generally reduced. This symposium addresses some of the key issues in suicide prevention related to the role of health professionals in the assessment of suicide risk.

## S01.02

Communication of suicide intent, fact or myth?

M. Pompili [1,2]. [1] *Department of Psychiatry, Sant'Andrea Hospital, Sapienza University of Rome, Rome, Italy* [2] *McLean Hospital, Harvard Medical School, Boston, MA, USA*

From psychological autopsy studies emerged that suicide victims do communicate their intent to end their life; nevertheless health professionals are often stricken by surprise when a suicide occurs. On average, 45% of suicide victims had contact with primary care providers within 1 month of suicide. Two third of the suicide victims communicated their suicidal intent over a period of weeks prior to their death, usually several different persons, 40% communicated their suicidal intent in very clear and specific terms. About 90% of suicide victims had received some kind of health care attention in the year prior to death, but this care was not provided by a mental health professional. Half of the persons dying by suicide had never been in contact with a mental health professional in their lifetime, not even once.

There are various elements that impair recognition of suicide risk by treatment professional and that are associated with stigmatization such as: Lack of knowledge and skills in relation to treatment of self-destructiveness; Professional's loss or absence of concern; Acceptance of patient's suicide as a solution to problems; Wishes that patient would commit suicide as a solution to his or problems; Degree of familiarity with patients; Unfounded optimism in relation to treatment; Fear of patient; Defects or problems associated with treatment system. This presentation explores possible educational interventions for health professional in general and mental health professionals in particular. Reactions after patient's suicide are also discussed.

## S01.03

Dealing with suicidal patients

Z. Rihmer. *National Institute for Psychiatry and Neurology, and Semmelweis Medical University, Budapest, Hungary*

Suicide attempt and particularly committed suicide are relatively rare events in the community, but they are quite common among psychiatric (mostly depressive and schizophrenic) patients who contact different levels of healthcare some weeks or months before the suicide. The most common current psychiatric illness among consecutive suicide victims is major depressive episode (56-87%), which, in the majority of cases, is unrecognized or untreated. The current prevalence of patients with major depressive episode in the primary care practice is around 8-12%, and earlier studies, performed 15-20 years ago, found that less than 20% of them were recognized by their GPs, and the rate of adequate antidepressant pharmacotherapy was under 10%. More recent papers reported much higher rates (62-85%) of recognition and treatment of depression in primary care indicating that the situation shows improving tendency. Since succesfull acute and long-term pharmacotherapy of depression significantly reduces the risk of both attempted and committed suicides, and 34-66% of suicide victims (two-thirds of them should have current depression) contact their GPs 4 weeks before their death, GPs play a priority role in suicide prevention. Although prior suicide attempt (particularly in the presence of major depression or schizophrenia) is the best single predictor of future suicidal behaviour, two-thirds of suicide victims die by their first attempt. Therefore the prediction of the first suicidal act is particularly important for the prevention. Followed the pioneering Swedish Gotland Study, several large-scale community studies demonstrated that education of the GPs on the diagnosis and treatment of depression.

## S01.04

Is education enough for preventing suicide? the Gotland study and beyond

W. Rutz. *Faculty of Social Sciences, University of Coburg, Coburg, Germany*

During the eigthies an educational project on the recognition and treatment of depressive disorders was carried out in the swedish island of gotland, an island and Swedish count of dramatic societal transition and afflicted by the highest suicidality in sweden at that time. The educational intervention resulted in a decrease of suicides to the lowest figures in sweden, however mainly in females.

After a psychological authopsy of all persisting male suicides, that could not be reached due to their not -helpseeking behaviour and their lack of contact with the health care system, new educational efforts on gotland were completed with a focus on males suicidality, using the ad hoc constructed "Gotland male depression scale" as a main tool in an approach directed even to other societal structures on gotland than the health care system. During the nineties,

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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

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