the suicidal thoughts and the timeframe planned before the occurrence of the suicidal behavioural. Risk level depends on age, gender, substance use, etc. Evaluation of these items and intervention programs concerning these issues will be discussed in a real life emergency department environment.

S07.04

Quality of care in emergency psychiatry: Developing an international network

C. Lazignac [1], C. Damsa [1], E. Adam [1], A. Mihai [1,2], L. Caihol [1], D. Stamatoiu [3], M.H. Allen [3]. [1] *Emergency Crisis Intervention Unit Department of Psychiatry, University of Geneva, Geneva, Switzerland* [2] *University of Medicine and Pharmacy, Tg Mures, Romania* [3] *University of Denver, Denver, CO, USA*

In a period of growing interest in expert's guidelines on the management of psychiatric emergencies, there are few empirically validated data in the emergency settings. Based on this observation, we developed an International Research Network in Emergency Psychiatry, by connecting several European Centers (Switzerland, France, Belgium, Romania) and United States. The aims of our collaboration are to evaluate and ameliorate the quality of care, to develop European clinical guidelines, to provide a structured educational program for trainees and students and to conduct international studies focused on Emergency Psychiatry. Clinical research and the use of some standardized tools appear to be successful in improving the quality of care as an 'effective medication' administered to the emergency staff [Damsa et al., 2006]. Moreover, introducing new psychotherapeutic models in emergency psychiatry, could avoid unnecessary hospitalizations, by increasing the compliance of the patients to ambulatory follow-up care, and might have a positive economic impact on the health systems. In conclusion, we hope to develop new links with other emergency psychiatric teams, through the Emergency Psychiatry Section from the AEP.

Damsa C, Ikelheimer D, Adam E, Maris S, Andreoli A, Lazignac C, Allen MH. Heisenberg in the ER: observation appears to reduce involuntary intramuscular injections in a psychiatric emergency service. Gen Hosp Psychiatry. 2006; 28: 431-433.

Symposium: Pathways to care and the immigrant patient: Ethical perspectives from cultural psychiatry

S02.01

Access to mental health care: How can barriers for migrants be reduced?

C. Haasen, A. Agorastos, C. Demiralay, J. Reimer. *Department of Psychiatry, University Medical Center Eppendorf, Hamburg, Germany*

Background: There is sufficient evidence in different countries, that migrants from different cultural backgrounds do not use mental health services to the same extent as natives. Reasons are different barriers in the access to care for migrants with mental health problems. These barriers can be found both on the institutional level as well as on the subjective level of the patients and caregivers themselves.

Methods: Qualitative analysis of barriers in the access to care.

Results: The institutional barriers are mainly a lack of information about and for migrants, as well as a lack of more specific treatment modalities. The subjective barriers are associated with issues of discrimination as well as preconceptions about mental health services and disorders.

Conclusions: Several measures are being undertaken in different countries to reduce these barriers in the access of care for mentally ill migrants in Europe.

S02.02

Ethical dilemmas in assessment and treatment of asylum seekers in Denmark

D. Mucic. *Psychiatric Centre Little Prince, Copenhagen, denmark*

The challenges of providing mental health care to a culturally diverse patient population include having sufficient knowledge about cross-cultural issues in generally and especially knowledge about cultural background of the specified ethnic groups. Asylum seekers are certainly individuals with specific needs that are combination of potential traumatic experiences, current political situation in home country and asylum policy in third country where they seek the asylum. Language barriers, a mistrust of authority, and fears about confidentiality are well documented obstacles to the effective care of asylum seekers. Therefore, the language abilities and cross-cultural background of the therapist are not negligible. Current assessment and/treatment of asylum seekers in Denmark raises several controversial but important ethical dilemmas:

Sufficiency and satisfaction by the assessment and/or treatment provided via interpreters seen by the patient and the therapist

The impact of psychiatric statement on the process of asylum determination (used and/or abused by authorities and asylum seekers)

This paper describes clinical cases related to mentioned issues and give potential useful hints for future development within assessment and/or treatment of asylum seekers.

S02.03

Racism is an ethical issue

A. Qureshi, F. Collazos, H.W. Revollo, M. Ramos. *Servei de Psiquiatria, Hospital Universitari Vall D'Hebron, Barcelona, Spain*

A growing body of research links the experience of racism to a variety of health and mental problems, with stress as the most direct link. The understanding of racism has become more complex in recent years, wherein investigators have shifted the focus away from overt forms of racism such as that associated with white supremacy to unintentional or "aversive" racism. Racism in mental health care is an ethical issue for psychiatrists and psychologists because it represents a very damaging force that is associated with mental health problems, and as such requires effective response. Racism and race related issues may enter the consulting room indirectly through the experiences of patients in the outside world, or, indeed, directly through the clinician's implicit and unintentional behavior. Both cases clinicians demand the awareness and responsiveness necessary to ensure that patients are not harmed. Conventional therapeutic approaches situate the locus of change in the individual yet racism is not a psychological problem as such. Recent work on racial microaggressions indicates that mental health professionals are prone to low level acts of racism that are of relevance only to the racially different patient; the clinician is unaware of such an act and as such not inclined to take corrective action. The Racial

https://doi.org/10.1016/j.eurpsy.2008.01.017 Published online by Cambridge University Press

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,

https://doi.org/10.1016/j.eurpsy.2008.01.017 Published online by Cambridge University Press