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

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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?

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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

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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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