which promises improvement of symptoms and social functioning. Given that mental health services provision in post-conflict countries differs from that in countries that accepted refugees, the presentation aims to find reasons for this by searching for differences in war traumatized non-treatment seekers in former Yugoslavia and refugees from former Yugoslavia having been accepted in two EU member states.

Methods: Within the STOP-study (Priebe et al., 2003), about 600 participants suffering from posttraumatic stress following conflicts in the former Yugoslavia were recruited in four sites in Croatia, England, Germany, and Serbia. They were assessed using several standardised instruments on socio-demographic features, posttraumatic stress (e.g. CAPS), general psychopathology (BSI), and quality of life (MANSA). Structured questions on coping strategies and barriers to treatment complemented the interview. Status of mental health treatment was rated on a 4-point scale differentiating "no treatment at all", "primary care incl. medication and talks with a GP", "secondary care incl. psychiatrists and clinical psychologists" and "tertiary services and specialised treatment for symptoms of posttraumatic stress."

Results: We will compare non-treatment seekers to treatment seekers and focus on findings on the differences between non-treatment seekers in the two post-conflict countries and the two countries that accepted refugees.

Conclusion: Findings will be discussed with respect to mental health services planning.

Monday, April 4, 2005

S-24. Symposium: Adjusting to cultural differences for interventions in mental health care

Chairperson(s): Christian Haasen (Hamburg, Germany), Marianne Kastrup (Copenhagen, Denmark)
08.30 - 10.00, Gasteig - Lecture Hall Library

S-24-01

Cultural sensitivity for institutions of mental health

C. Haasen. *University Hospital Eppendorf, Hamburg, Germany*

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

S-24-02

Cultural aspects of psychosocial interventions

M. Kastrup. *Rigshospitalet Psychiatry Clinic, Copenhagen, Denmark*

A comprehensive assessment of the patient is a necessary prerequisite for adequate psychosocial interventions. It comprises e.g. an evaluation of the level of social functioning, habitually as well as presently; the psychosocial and circumstantial factors contributing to the present situation; a psychological understanding of the self and its abilities, and an overview of the total life situation. Assessing patients from other ethnic backgrounds comprises similar elements, but certain aspects require particular attention. The cultural formulation in DSM-IV (1994) underlines the need for the clinician to assess e.g. any cultural explanation of the illness, cultural factors related to psychosocial functioning, cultural elements in the physician-patient relationship, as well as the cultural identity of the individual. Furthermore, special emphasis should be paid to the cultural competence of the professionals responsible for the intervention. According to Tseng (2003) clinicians need to sharpen their cultural sensitivity, be perceptive to cultural differences and willing to learn from patients and families, their value systems and ways of handling the problems. Family involvement in all decision-makings should be taken into account. In the light hereof the paper will discuss strategies to optimise psychosocial interventions.

S-24-03

Ethnic factors in pharmacology and pharmacogenetics

A.-M. Pezous. *ECIMUD Service de Psychiatrie, Paris, France*

S-24-04

Cultural mediators for mental health services

W. Machleidt, R. Salman. *Med. Hochschule Hannover Sozialpsychiatrie, Hannover, Germany*

Objective: Within the in- and out-patient psychological and (social-)psychiatric services migrants are underrepresented. So far they could not be reached via the usual informational and motivational pathways.

Methods: In order to enable an access to these services a concept to train "key persons" as cultural mediators has been developed. Cultural mediators are key persons having on one hand the specific linguistic and cultural access to the different migrant groups and on the other the knowledge about the language and structures of the host country. They are trustworthy "authorities" as well as for the migrants' groups and the institutions of the majority population. Coming from different cultures these key persons are trained to pass on medical and social information through multilingual and cultural sensible campaigns during which they inform their countrymen about addiction, mental health etc. as well as about the available health services.

Results: The Ethno-Medical Center Hannover trained more than 400 mediators in the fields health system, addiction, AIDS, dental hygiene, mother-child health etc. Since 1995 more than 600 preventive organisations which reached more than 10.000 migrants. As a consequence the migrants' use of psychosocial services in this region increased.

Conclusion: It can be concluded that the concept of cultural mediatiors has been proved to be very effective. Especially socially disadvantaged migrants can be reached by the psychosocial services via native speakers and cultural sensible information. It is recommended that each institution of the psychosocial and psychiatric service network sets up a certain group of mediators who are trained and educated well and continously.

https://doi.org/10.1016/S0924-9338(05)80149-X Published online by Cambridge University Press

S-24-05

Cultural competency training in mental health

A. Qureshi, F. Collazos. *Hopital Val d'Hebron, Barcelona, Spain*

Objective: Cultural competence refers to the capacity, be it clinically or institutionally, to respond effectively to the treatment needs of culturally diverse patients. Cultural competence involves the ability or skills to effectively apply a rather complex knowledge base. The complexity of this knowledge base, combined with the sensitivity of contemporary intercultural relations requires that the clinician attend to attitudes, beliefs, and values associated with race and culture. Cultural competency training, thus, extends considerably beyond the impartation of a knowledge base—which, in the intercultural context is itself rather complex—to the development of the skills necessary to apply the abstraction of cultural knowledge to the therapeutic context. The knowledge and skills components of cultural competency, however, cannot be effectively put into action without cultural sensitivity, which means that cultural competency training requires exploration of, and, if necessary, changes to, cultural and racial attitudes and beliefs. The basis of the knowledge domain in cultural competence, contrary to common perception, does not require detailed knowledge of the cultures of the patients one treats, rather, it demands a profound awareness of the different ways in which culture, minority group membership, and the immigration process can affect psychosocial development, symptom presentation, and treatment response. Further, it is essential that cultural competency training provide a foundation in cultural and medical anthropology as a means of contextualizing entry into academic terrain which has not been sufficiently prepared for by medical or psychological training.

Monday, April 4, 2005

S-29. Symposium: AEP presidential symposium on ethical issues: ethics in psychiatry

Chairperson(s): Henning Sass (Aachen, Germany), Norman Sartorius (Genf, Switzerland)
10.30 - 11.15, Gasteig - Philharmonie

S-29-01

Conflicts of interest in the conduct of medication trials

M. Maj. *University of Naples of SUN Dept. of Psychiatry, Naples, Italy*

A conflict of interests occurs when a professional (e.g., a physician) is unduly influenced by a secondary interest (e.g., financial gain, political commitment, or the desire to favour a relative or friend) in his decisions concerning the primary interest to which he is committed (e.g., the health of the patients, the progress of science or the education of students). Since the early 1980s, one specific type of conflicts of interests has been extensively covered in the medical literature, i.e., the financial conflict of interests (conflict between the primary interest represented by the health of the patients or the progress of science and the secondary interest represented by financial gain). This type of conflict of interests has been largely discussed and documented also in the field of psychiatry. The many, sometimes subtle ways by which a psychiatrist can be influenced in his prescribing habits by his relationships with drug companies, or a researcher can be influenced by these relationships in his scientific activity, have been described, with the support of some empirical evidence. Several possible remedies to this problem have been proposed, including disclosure of potential conflicts and the adoption of a code of conduct by both physicians and drug companies. On the other hand, it has been pointed out that the current discussion on this issue is "affectively charged", that the pharmaceutical industry is virtually the only source of development of new therapeutic agents, and that as far as these agents are effective there is an obvious convergence of interests between psychiatrists, companies, patients and patients' families. Other types of conflicts of interests are beginning now to be discussed. There is an emerging evidence concerning how the allegiance to a treatment modality (in particular, a psychotherapy or a psychosocial intervention) may influence the results of empirical studies concerning that treatment, thus colliding with the primary interest of validity of research. There is also a small body of literature concerning political commitment as a source of conflict of interests. The issue of conflicts of interests in psychiatry is probably more complex and multifaceted than commonly believed.

S-29-02

The psychiatric profession and its human rights aspects: Should they vary from culture to culture?

M. Kastrup. *Rigshospitalet Psychiatry Clinic, Copenhagen, Denmark*

In recent years, we have in the Western countries witnessed an upsurge in the attention paid to the ethical and human rights aspects of the psychiatric profession. Several reasons may be given hereto, including the pluralism seen in modern Western societies, and the increasing respect for the autonomy of the patient. Alongside, the rules and declarations guiding the psychiatric profession are in focus. Some are common to all medical professionals, others reflect the specific role of the psychiatric profession, but all claim their universality independent of the cultural context. The existence of ethical guidelines, etc. is however not sufficient. We are living in a world of rapid change, thrilled in what may be the most rapid global transformation anyone has ever seen. Value systems change and ultimately the individual psychiatrist has to decide whether or not to adhere to ethical guidelines and may look for an answer to: Do they give meaning in the given cultural setting? Are they compatible with the cultural value of the doctor and that of the patient and his immediate families? The paper will comprise an overview of the human rights issues pertinent to the profession and their implementation in different cultural settings.

S-29-03

Ethical implications of sponsoring

H. Helmchen. *Free University Berlin Psychiatric Clinic, Berlin, Germany*

In research and medical education as well an upward tendency of sponsoring can be observed. Such co-operation between industry (or even governments) and psychiatrists is needed be-cause psychiatrists have access to and experience with patients and the industry has the finan-cial means for research which are needed both to its enormous costs and the cutting of public financing. However, this increasing interweaving between industry and psychiatrists on the individual and particularly the institutional

https://doi.org/10.1016/S0924-9338(05)80149-X Published online by Cambridge University Press