improvement could be transferred to open-label olanzapine at weeks 4, 5, or 6 without unblinding their double-blind treatment.

To enter the trial, patients were either symptomatic ($BPRS_{0-6} \geq 18$), with or without current therapy; or were intolerant of current therapy (other than haloperidol), with or without symptoms. 98.1% of patients with baseline and post-randomization BPRS scores began with baseline $BPRS_{0-6} \geq 18$.

A statistically significantly ($p < 0.001$) greater proportion of the 1,336 patients assigned to olanzapine (66.4%) than of the 660 patients assigned to haloperidol (46.8%) completed the acute phase of this trial. The proportions of patients discontinuing for lack of efficacy (LOE) and adverse events (ADE) were also statistically significantly smaller with olanzapine (LOE: 20.7% vs. 32.1%; ADE: 4.5% vs. 7.3%).

On the primary analysis of overall efficacy, the difference in baseline to endpoint (LOCF) mean change on the BPRS, olanzapine was statistically significantly superior to haloperidol (-10.89, -7.93; $p = 0.015$). Mean change on CGI-S and response rate (> 40% improvement on BPRS with 3 or more weeks treatment) also significantly favored olanzapine as did improvement on BPRS-negative and PANSS-negative. Positive symptom improvement was comparable.

There was statistically significantly less treatment emergent dystonia, parkinsonism, and akathisia with olanzapine than with haloperidol. Scores on the Simpson Angus, Barnes, and AIMS decreased for olanzapine treated patients and mean changes on these scales were all statistically significantly different from the changes observed with haloperidol.

The efficacy and safety data from this large multi-center trial will be reviewed in greater detail.

S46. Suicide prevention strategies across Europe

Chairmen: R Jenkins, D de Leo

SWEDEN'S SUICIDE PREVENTION STRATEGY

J. Beskow. *National Centre for Suicide Research and Prevention, National Institute for Psychosocial Factors and Health, Karolinska Institute, Box 230, S-171 77 Stockholm, Sweden*

Goal. A National Programme for Suicide Prevention was published in September 1995. One of the goals should be a persistent decrease of the number of suicides and suicide attempts in Sweden.

Strategies. Interventions must be based on scientific knowledge, with respect to the cultural situation in Sweden concerning suicide. It includes raising consciousness about suicidal problems; supporting social and medical treatment; meeting the needs of different risk groups, especially children and youth; decreasing the availability of suicidal means and increasing the national competence in suicidology.

Implementation is now going on including better registration of suicidal acts, stimulating local projects as well as promoting evaluation.

ENGLAND'S SUICIDE PREVENTION STRATEGY

Rachel Jenkins, David Kingdon.

Goal: England's Health of the Nation Strategy which includes targets for suicide prevention was published in 1992. One of the goals is to reduce suicides in the general population and the other was to reduce suicides in people with Severe Mental Illness.

Strategy: The Strategy to achieve these goals is multifactorial based on scientific evidence. It includes educating health and social care professionals about assessment and management of depression and suicidal risk, supporting high risk groups, educating the media, reducing the availability of suicidal means, improving services to people with Severe Mental Illnesses and auditing previous suicides to learn the lessons for prevention.

Since 1992 England's rate of suicide in the general population has now fallen.

THE NORWEGIAN PROGRAM FOR SUICIDE PREVENTION

N. Retterstøl. *University of Oslo, Gaustad Hospital, Gaustad, 0320 Oslo, Norway*

The Norwegian national program for suicide prevention has been running since 1993, drawn up by the Ministry of Health. A coordinator group in the Ministry of Health is in charge of the program with a project leader and a broad reference group consisting of psychiatrists, psychologists, nurse, sociologist and representatives from other professions. Plans are made, and programs running for the prevention on: 1. Community level. 2. Regional level. 3. National level.

Regional centres are established in the four university regions of the country and a national centre is established in Oslo, attached to the Oslo University Unit at Gaustad Hospital. Three, hopefully six full time academic positions are under establishment. The program has now been running for 3 years, and several educational programs for health professionals have been given in all 18 counties of the country. Further details will be given in the oral presentation.

SUICIDE RATES OF THE ELDERLY IN EASTERN EUROPE

Norman Sartorius. *Department of Psychiatry, University of Geneva, 16–18, Bd de St. Georges, 1205 Geneva, Switzerland*

Suicide rates of the elderly in Eastern Europe have decreased in the recent past. This may be seen as a surprising finding in view of the hardships which citizen from Eastern and Central European countries experience.

The presentation will include a summary of recent findings in this respect and present several possible explanations for these findings.

S47. Post-traumatic stress disorder

Chairmen: I Marks, B Raphael

Abstracts not received

https://doi.org/10.1016/0924-9338(96)88585-3 Published online by Cambridge University Press