More precisely, the mission of the EPA guidance is defined as 'to improve quality of mental health care in Europe by disseminating written information based on best evidence and psychiatric practice, to facilitate countries learning from each other'.
In consonance with this need of a wider multinational perspective of European psychiatry, EPA adopted in 2012 through a deep change of its statutes a new membership structure that allows National Psychiatric Societies/Associations (NPAs) in Europe the possibility to become full members of EPA. Up to 40 NPAs corresponding to 37 countries and representing over 80.000 psychiatrists have responded positively to the offer and are now part of the Council of National Psychiatric Societies, the body within EPA that integrates them.
The Council of NPAs has become, in this way, a forum for its members to meet, discuss and work on issues concerning European psychiatry. One of the major issues is about the implementation of European guidance in mental health policy, teaching and learning psychiatry, best clinical practice in different areas, and quality indicators. This presentation provides further details on how participating societies could put these policies and recommendations into practice.
Disclosure of interest The author has not supplied his declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.090

Symposium: The natural history of bipolar disorders: from the age of onset to the long-term course

S017

How long is the interval between the onset and the initial management of bipolar disorder? A meta-analysis

G. De Girolamo[1,*], G. Signorini[2], J. Dagani[2], F. Faustini[2]
[1] *Saint John of God Clinical Research Center, Psychiatric Epidemiology and Evaluation Unit, Brescia, Italy*
[2] *IRCCS St John of God Clinical Research Centre, UOPEV, Brescia, Italy*

Objective To evaluate the length of the interval between the onset and the initial management of bipolar disorder (BD).
Method We conducted a meta-analysis using the preferred reporting items for systematic reviews and meta-analyses guidelines. Systematic searches located studies reporting estimates of the age of onset (AOO) and indicators of the age at initial management of BD. We calculated a pooled estimate of the interval between AOO and age at management. Factors influencing between-study heterogeneity were investigated using sensitivity analyses, meta-regression, and multiple meta–regression.
Results Twenty-seven studies, reporting 51 samples and a total of 9415 patients, met the inclusion criteria. The pooled estimate for the interval between the onset of BD and its management was 5–8 years (standardized difference, .53; 95% confidence interval, .45 to .62). There was very high between-sample heterogeneity (I2 ¼ 92.6; Q ¼ 672). A longer interval was found in studies that defined the onset according to the first episode (compared to onset of symptoms or illness) and defined management as age at diagnosis (rather than first treatment or first hospitalization). A longer interval was reported among more recently published studies, among studies that used a systematic method to establish the chronology of illness, among studies with a smaller proportion of bipolar I patients, and among studies with an earlier mean AOO.
Conclusions There is currently little consistency in the way researchers report the AOO and initial management of BD. However, the large interval between onset and management of BD presents an opportunity for earlier intervention.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.091

S018

Cognitive impairment in bipolar: Neurodevelopmental or neuroprogressive?

A. Young
Institute of Psychiatry, Psychology and Ne, London, United Kingdom

Background Bipolar Disorders (BD) are common and complex diseases. Recent findings have provided evidence that impairments in cognition are evident in the various sub-groups of Bipolar Disorder and persist after resolution of acute episodes.
Method An opinion paper based on a narrative review of the field.
Results Quantifiable cognitive deficits are clearly found in Bipolar 1 and Bipolar 2 Disorders. These persist after recovery from acute episodes. The aetiopathogenesis of these phenomena is likely to be multifactorial. It seems clear that these cognitive impairments are not in general neurodevelopmental and for most are related to repeated episodes of illness [1]. However, the issues of subgroups with differential profiles of impairment and the trajectory of cognitive change remain to be fully established. The effects of putative treatments (e.g., pharmacological, neurostimulation, cognitive remediation) are at an early stage of evaluation.
Conclusions Future efforts should focus on further integrating the current and emerging research findings into a coherent model, which generates testable hypotheses and allows treatment effects to be tested.
Disclosure of interest Employed by King's College London Honorary Consultant SLaM (NHS UK)
Paid lectures and advisory boards for all major pharmaceutical companies with drugs used in affective and related disorders
No share holdings in pharmaceutical companies
Lead Investigator for Embolden Study (AZ), BCI Neuroplasticity study and Aripiprazole Mania Study
Investigator initiated studies from AZ, Eli Lilly, Lundbeck, Wyeth
Grant funding (past and present): NIMH (USA) CIHR (Canada) NARSAD (USA) Stanley Medical Research Institute (USA) MRC (UK) Wellcome Trust (UK) Royal College of Physicians (Edin) BMA (UK) UBC-VGH Foundation (Canada) WEDC (Canada) CCS Depression Research Fund (Canada) MSFHR (Canada) NIHR (UK).
Reference
[1] Lewandowski KE, Cohen BM, Ongur D. Evolution of neuropsychological dysfunction during the course of schizophrenia and bipolar disorder. Psychol Med 2011;41(2):225–41.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.092

S019

Impact of age at onset on the long-term course of bipolar disorder

R. Kupka
VU University Medical Center, psychiatry, Amsterdam, The Netherlands

Introduction Bipolar disorder (BD) typically starts in adolescence or young adulthood (early-onset; EO-BD), which may have different backgrounds and consequences than late-onset (LO) BD. There are controversies over pre-pubertal age of onset (AoO).
Objectives To give an overview of the various concepts of AoO in BD, the impact of AoO on subsequent illness course, and findings of the Stanley Foundation Bipolar Network (SFBN) with relationship to AoO.

https://doi.org/10.1016/j.eurpsy.2017.01.093 Published online by Cambridge University Press

Methods literature review and additional analyses of SFBN database.
Results BD usually begins with a depressive episode. SFBN-data reveal that an earlier AoO is associated with a less favourable prospective illness course (more depression, mood instability and rapid cycling), longer delay to first treatment, past history of suicide attempts, being abused in childhood abuse, more psychiatric and medical comorbidities. Comparison of the US sample with the European sample of SFBN showed an earlier onset in US patients.
Conclusion and early AoF of BD is associated with a poorer long-term outcome, despite adequate current treatment.
Disclosure of interest The author has not supplied his declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.093

S020

Age at the onset of a first episode of psychotic mania: Does it have an impact on outcome?

P. Conus[1,*], S.M. Cotton[2], P.D. McGorry[2]
[1] *Lausanne University, Department of Psychiatry, Prilly, Switzerland*
[2] *Orygen Youth Health, Psychiatry, Melbourne, Australia*
[*] *Corresponding author.*

Purpose Studies conducted in child psychiatry suggest that patients with earlier onset of psychosis have poorer outcome. Similar findings have been published regarding onset of bipolar disorder. However, few studies have been conducted in youth mental health program where these patients may actually receive treatment. Identification of subgroups with distinct need and outcome among first episode mania patients would facilitate the development of specific treatment strategies better suited to the actual needs of patients.
Methods Sixty-seven patients with a first episode of psychotic mania were followed up over 12 months after recovery from this initial episode. Syndromic and symptomatic outcome were determined with the brief psychiatric rating scale, functional outcome with the quality of life scale and premorbid adjustment scale sub items.
Results While 90% of patients achieved syndromic recovery (disappearance of manic syndrome) at 6 and 12 months, 40% had not recovered symptomatically, still presenting with depression and anxiety. Return to previous level of functioning was achieved only by 34% of patients at 6 months and 39% at 12 months. Age at the time of first manic episode with psychotic features was a significant predictor of recovery of functional level.
Conclusions While manic symptoms reduce quickly in most patients after a first episode of psychotic mania, an important number of patients still display symptoms of depression and anxiety after 12 months and 2/3 do not reach functional recovery. Younger age at first episode predicts risk of poorer functional outcome.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.094

Symposium: Negative symptoms: phenomenology, clinical aspects and neuroimaging

S021

Clinical psychopathology of negative symptoms: A phenomenological perspective

A. Raballo
University of Oslo, Norwegian Centre for Mental Disorder Research NORMENT, Oslo, Norway

Negative symptoms encompass a broad constellation of psychobehavioral phenomena, including affective flattening, poverty of speech, alogia, avolition, social withdrawal, apathy and anhedonia. These phenomena obviously exert a substantial impact on personal autonomy, quality of life and broad functional outcomes, ultimately being an important challenge for clinical decision-making and therapeutic support. In recent years, the attention to negative symptoms in schizophrenia has revamped, boosting the development of new rating tools as well as a broader conceptualization of derivative constructs (e.g. apathy, amotivation, anhedonia). However, despite its behavioral expressivity, the in-depth phenotypic characterization of negative symptoms remains partly unaddressed. Similarly, their clinical intertwining with other non-productive clinical features (e.g. anomalous subjective experiences, cognitive-perceptual basic symptoms and schizotypal features) is generally overlooked. Therefore, the current presentation specifically offers a stratified overview of the phenomenology of negative symptoms filtered through lens of clinical psychopathology.
Disclosure of interest The author has not supplied his declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.095

S022

The Evolution of negative symptom constructs

A. Mucci[*], S. Galderisi
University of Campania "Luigi Vanvitelli", Department of Psychiatry, Naples, Italy
[*] *Corresponding author.*

Introduction Negative symptoms represent a separate dimension of schizophrenia psychopathology, distinct from positive symptoms, disorganization and cognitive impairment. It is increasingly acknowledged that negative symptoms are associated with poor functional outcome and represent an unmet need in schizophrenia treatment. Improvement in definition of their phenomenology, assessment instruments and experimental models are needed in order to improve schizophrenia prognosis.
Aims The presentation will review key aspects of the evolution of negative symptom constructs. In particular, findings concerning phenomenology, clinical assessment, association with functional outcome and brain imaging correlates will be presented.
Methods We searched PubMed for English full-text publications with the keywords
Schizophrenia AND "negative symptoms"/"primary negative symptoms"/"deficit schizophrenia"/"persistent negative symptoms"/"affective flattening"/alogia/"expressive deficit"/apathy/asociality/"social withdrawal"/anhedonia/"anticipatory anhedonia"/avolition/neuroimaging.
Results The distinction between secondary negative symptoms (i.e., those due to identifiable factors, such as drug effects, psychotic symptoms or depression), and primary or persistent negative symptoms (i.e., those etiologically related to the core pathophysiology of schizophrenia) is grounded on solid research evidence and might have major implications for both treatment development and clinical care. The evidence that negative symptoms cluster in motivation- and expressive-related domains is founded on large consensus and empirical evidence and will foster pathophysiological modeling. The motivation-related domain is a stronger predictor of functional outcome than the expressive one.
Conclusions An improved definition and assessment of negative symptoms needs to translate in large-scale studies to advance knowledge. In the short-term, the improved identification of treatable causes of secondary negative symptoms can translate into better care for people with schizophrenia.