



## 26th European Congress of Psychiatry

### Workshop

#### Workshop: Asylum Seeker and Refugee Mental Health: Training Needs of Psychiatrists

W0001

##### Introduction

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In the introduction of this workshop, it will be underlined, that according to the United Nations High Commissioners for Refugees (UNHCR), the worldwide numbers of asylum seekers and refugees show an upward trend, reaching 65 million and above. It is well known that migration is one of the risk factors for developing mental disorders, and that traumatized migrants in particular may face psychological distress and even serious psychiatric illness as they have been exposed to adverse conditions before, during and after migration. Prior to migration, migrants may have been exposed to deprivation, persecution, violence, imprisonment, human rights violation, including sexual harassment, even torture. Many studies report on the multiple and highly complex stressors with which refugees are often faced and which are at risk of having a lasting impact on their mental health. In line with growing globalisation and an increasing number of people on the move across national and international boundaries, it has become vast important that psychiatry and psychotherapy are aware of the different needs of the patients they are responsible for. Therefore, during times of global migration and an increasing number of ethnic minority migrants including refugees and asylum seekers, psychiatrists and psychotherapists may have a different cultural background than their patients. Thus, cultural psychiatry and psychotherapy is a matter of primary relevance and training of psychiatrists is needed. *Disclosure of interest.* – The authors have not supplied their declaration of competing interest.

W0002

#### Developing training for psychiatrists treating refugees: Some reflections

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Taking care of refugees as a psychiatrist is a challenging experience for many reasons. A refugee faces an episode in life confronting with many different transitions on all kind of levels. These include not only questions of language, but include also societal, cultural and religious aspects, among them concepts about psychic suffering.

The Section of psychiatry of the Union Européenne de Médecins Spécialistes (UEMS; [www.uems.eu](http://www.uems.eu)) developed in the past the *European Framework for Competencies in Psychiatry*. This document is based upon the CanMEDS criteria and describes these as metacompetencies, further developing into competencies and sub-competencies including ways these can be assessed. Very recently the Section also reviewed the *European Training Requirements for the Speciality of Psychiatry*.

It is evident that a professional treating refugees as patients must dispose of a large set of transcultural competencies while trying to address their needs. But also their own psychic health is exposed to some risks by listening to the traumatic stories of these patients. By the particularities of being a refugee scientific research seems to be rather difficult. This presentation will address some questions about ways scientific and professional associations, training institutes and universities might come to programs for training professionals involved in this kind of work.

European Framework for Competencies in Psychiatry <http://uemspychiatry.org/wp-content/uploads/2012/01/2009-Oct-EFCP.pdf>.

Charter on Training of Medical Specialists in the EU. Training Requirements for the Speciality of Psychiatry. <http://uemspychiatry.org/wp-content/uploads/2012/01/ETR-Psychiatry-201703.pdf>.

UEMS training requirements for the speciality of psychiatry: Annex on knowledge, skills and professionalism required for the care of refugees and asylum seekers. <http://uemspychiatry.org/wp-content/uploads/2013/09/2009-Oct-EFCP.pdf>.

Union Européenne de Médecins Spécialistes – UEMS [www.uems.eu](http://www.uems.eu).

Section of Psychiatry [www.uemspychiatry.org](http://www.uemspychiatry.org).

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W0003

### Forced displacement: A challenge for psychiatry residency programs

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Forced displacement of millions of people especially increasing in the last decade sets a major mental health challenge demanding the attention of psychiatrists and mental health workers. Its consequences on the mental health of refugees and asylum seekers also invite psychiatry to review current psychiatric training besides developing adequate mental health services and research.

People forcibly displaced to leave their homes and thus their psycho-social support systems are under threat in all areas of attachment, mastery, and survival. Refugees fleeing with few possessions leading to neighboring or more developed countries face many life threatening risks before, during and after displacement, and they have nowhere to return. Although, there is a marked variability in the content and quality of psychiatric training across Europe and the world, the current psychiatric residency and training programs could be improved to incorporate the unique mental health aspects of this humanitarian disaster.

Psychiatric residency and training programs should cover basic knowledge on the nosology/terminology and on the current dimensions of problems related to the forcibly displaced people (i.e., refugees, asylum seekers, IDPs, and etc.). Besides, mental health consequences of the physical and psychological traumas, including sexual abuses and human trafficking, related to the displacement process need to be emphasized. Considerable time should be spared to understand the mental health situation and prerequisites of specific risk groups (e.g., elderly, unaccompanied children, single mothering, people with disabilities) and resilient factors. Psychiatry training programs should also aim to develop the skills of the trainees on culturally sensitive clinical interview and assessment techniques for the forcibly displaced people and related human rights issues. Learning outcomes should be revised accordingly.

This presentation aims to highlight the importance of developing current psychiatry training programs to cover the necessary knowledge and skills that the future psychiatrists need in dealing with the mental health situation of forcibly displaced people (refugees and asylum seekers) living in Europe.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0004

### Psychiatry across borders: Insights from EFPT's survey on training needs

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*Introduction.*– According to the United Nations High Commission for Refugee's (UNHCR) report, 65.5 million people were uprooted worldwide by conflicts in 2016. Forcibly displaced persons (FDPs) are more at risk for developing depression, anxiety, PTSD, psychosis, somatic disorders (Priebe et al., 2016). EPA called the European refugee crisis as one of the 21st century's biggest challenges, the WHO recommends specific training for mental health care professionals.

*Objectives.*– To survey European psychiatric trainees about their experience, knowledge of the FDPs mental health issues.

*Methods.*– An online questionnaire was designed collaboratively by the European Federation of Psychiatric Trainees (EFPT) Psychiatry Across Borders (PAB) Working Group, distributed via local networks among European trainees in 2017.

*Results.*– 407 respondents from 28 European countries answered the survey (64% female, 36% male, mean age 30 years old, SD: 4.6). 71% trainees had contact with FDPs in the last 12 months; 80% had encountered refugees as part of clinical work. The majority (75%) expressed a strong interest in the issue of FDPs' mental health, only 34.5% felt confident assessing and treating them. Specific training was provided to 16% of trainees, but only 25% felt it was adequate. Trainees rated transcultural competencies, PTSD and trauma management training, as the most necessary skills to confidently manage traumatised refugees.

*Conclusions.*– This survey shows a clear unmet need for specific training regarding refugee mental health for psychiatry trainees. Existing training may need improvement, for example, practical skills (interview with a translator). Trainees from almost all European countries are highly motivated to improve their knowledge.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0005

### Mental health needs in immigration removal centres

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Each year up to 30,000 asylum seekers and migrants are detained in the UK in immigration removal centres (IRCs) or, post sentence, in prison while the Home Office makes decisions on their immigration status and/or arrangements for their removal or deportation. Whilst the UK is the only country in Europe who detains individuals indefinitely the phenomena of immigration detention in European wide and growing.

Such evidence that exists indicates that immigration detention can be harmful to mental health, especially for people with pre-existing mental health problems such as post-traumatic stress disorder. A systematic review of ten studies investigating the effect of immigration detention identified high levels of mental health problems among detainees. Time spent in detention was shown to be positively associated with the severity of mental health problems. In addition official inspectorates, international organisations, non-governmental organisations, and the law courts have repeatedly criticised both the immigration detention of mentally ill people and the conditions in which detainees are held. The needs of detainees are often not identified, and those in treatment often experience interruptions in care. No effective safeguards exist to prevent vulnerable people – for example, those who have been tortured-from being detained. In addition there is currently no process for identifying detainees who lack the mental capacity to participate in decision making relating to their immigration situation. Mental illness and distress are common among detainees.

This presentation will consist of three parts – an introduction to immigration detention worldwide (with a specific emphasis on the UK), followed by a brief review of the evidence relating to the impact of immigration detention on individuals with pre-existing mental health conditions and those without. The final part of the talk will cover the training and educational needs of psychiatrists who encounter individuals who have been detained and those who are seen in detention centres

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0006

### Reflections from the UK'S global health curriculum group

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The Global Health Curriculum Group was commissioned by the Academy of Medical Royal Colleges to develop an educational framework for global health capabilities. This conceptualises the necessary skills in five categories: Diversity, human rights and ethics; environmental, social and economic determinants of health; global epidemiology; global health governance; and health systems and health professionals. In this workshop, these principles will be briefly presented and discussed in the context of the training psychiatrists need to respond to the needs of refugees and asylum seekers.

*Disclosure of interest.* – The authors have not supplied their declaration of competing interest.

W0007

### Introduction to the field of e-mental health and the eMEN Interreg project

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Mental illnesses present a huge and growing economic and social burden for society, accounting for 20% of the disease burden. Innovative and high-quality e-mental health plays an important role in tackling this societal challenge. However, the average use of e-mental health is still very low, with large differences between EU Member States. The reasons for this are complex but must be addressed in order to keep mental health care accessible and affordable.

The objective of this workshop is to give a brief overview of e-mental health implementation in the Netherlands, France, Germany, the UK, Ireland and Belgium, and to get a better understanding of the many implementation challenges: product quality (clinical effectiveness, costs effective evaluation, privacy, CE compliance, 'look & feel'); product development process (co-creation SMEs); awareness and acceptance; organisational priority; digital skills; confidence; high start-up costs; reimbursement; legal and policy framework; training and curricula; ICT infrastructure; 'blended care' implementation protocols; integration with integrated healthcare systems; definitions (transparency, reliability, validity, etc.).

eMEN is co-funded by the Interreg North West Europe programme, and has a total budget of €5.36 million (2016–2019). eMEN is led by Arq Foundation in the Netherlands and implemented with partners in Belgium, France, Germany, Ireland and the UK. It will undertake a unique combination of digital mental health activity in research, product development, policy and communications. The eMEN cooperation platform will further grow after the project phase.

Participants in this workshop are encouraged to give their opinion about the use and implementation of e-mental health.

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W0008

### eMen – Focus on transnational policy solutions

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The implementation of e-mental health is hindered by several challenges which must mainly be addressed on the policy level: lack of training curricula and acceptance, lack of funding and high start-up costs for eHealth developers, lack of interoperability, quality and safety (standards), as well as lack of legal clarity with regards to accountability and data use and overall, lack of e-mental health implementation strategies. Moreover, there is a great variance in development of e-mental health between North West European (NWE) countries with respect to access, speed or reliability of internet services. The eMEN work package "Transnational policy solution for e-mental health implementation" aims to develop and actively promote effective and workable policy solutions for the NWE countries in order to enhance the uptake of e-mental health and hence, reduce unmet need and close the treatment gap. In order to develop applicable policy solutions, a collaboration between the European Psychiatric Association (EPA) and the LVR – Institute for Healthcare Research (LVR-IVF) has been agreed on and determined by an Agreement to Partnership.

The development of transnational policy recommendations can be seen as a series of interrelated actions. First, all relevant national and European policy documents that are dealing with e-mental health implementation as well as e-mental health projects and initiatives will be gathered, and the respective level of e-mental health development in the NWE countries will be analyzed. Subsequently, each participating country selects and interviews national and European experts in technology, policy, organization and legal issues.

On European level, relevant EU e(-mental)health policies and initiatives, such as the eHealth network, the Green paper on mHealth, the Joint Action on Mental health and wellbeing, have been taken into account. On the national level, several initiatives and projects on e-mental health have been identified, whereas policy documents addressing e-mental health are quite rare. Based on the literature review and the stakeholder interviews, differences in NWE countries in terms of driving factors, barriers and facilitators as well as implementation approaches (e.g. top-down vs. bottom-up) will be presented.

The gathered information builds the basis for the recommendations in the transnational policy solution which will address challenges, differences and similarities on the national and transnational level and will be actively promoted through meetings, seminars and conferences.

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W0009

### Environmental risk factors of attenuated psychosis in migrants and general population

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(W03). – Attenuated psychosis in migrants and general population in a trans-national study.

*Scientific background/objectives.* – There is growing evidence that attenuated psychosis (schizotypy, psychotic experiences) and schizophrenia share common risk factors, such as childhood trauma, cannabis use, obstetric complications, and maternal viral infections (Barrantes-Vital and Kwapiil, 2015).

The association between psychosis and migration and/or ethnic minority status is well established and a variation of this risk across countries and ethnic groups has been observed (Bourque, van der Ven, & Malla, 2011; Cantor-Graae & Selten, 2005). However, only a few studies have explored migrant/ethnic status as a risk of schizotypy so far. We would like to explore this association in the light of these possible confounding factors. Moreover, these studies were conducted mainly among college students, which limit the generalizability of the results and using different methods/instruments, which make comparison between studies difficult (Zhang and Brenner, 2016).

**Objectives.**– To conduct a cross cultural study on attenuated psychosis dimensions in subjects from the general population using a homogeneous methodology.

To compare the impact of demographic and psycho-social risk factors on these dimensions across the different ethnic groups and different national contexts.

**Methods.**– We will analyse data from all non-psychotic subjects (i.e. controls and sibs) included in the EUGEI study, for which measures of attenuated psychosis (derived from CAPE and/or SIS) and birth place and ethnicity are available; and potential confounding data such as demographic data (gender, age, education, marital status), cannabis, socio-economic status.

**Results.**– Findings will be discussed in the light of the context of the psychosis continuum and associated risk factors.

**Conclusion.**– The context of EU-GEI allows for conducting a cross-cultural research and investigating the factors that influence attenuated psychosis dimensions in migrant and minority ethnic groups.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0010

### **Migration history and risk of psychosis in the EUGEI first episode psychosis study**

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**Introduction.**– The European Network of national schizophrenia networks studying Gene-Environment Interactions (EU-GEI) study – the largest international incidence study of psychotic disorders in 30 years – confirmed marked heterogeneity in risk of psychosis by person and place, including markers of area-level socioeconomic stability. Rates were elevated in minority groups (IRR: 1.6; 95%CI: 1.5–1.7).

**Aims.**– To present preliminary findings from the EUGEI European Network of National Schizophrenia Networks Studying Gene Environment Interactions study on the interaction between migration history and risk of psychosis.

**Methods.**– The EU-GEI study is an international multi-site incidence study. Setting: England (N=2 catchment areas), France (N=3), Italy (N=3), the Netherlands (N=2), Spain (N=6) and Brazil (N=1). The Bologna Migration History and Social Integration interview was administered to all first generation migrants (FGM).

**Results.**– 535 FGM with first episode psychosis (FEP) and 225 FGM controls were evaluated. FGM with FEP were more often unemployed and unsatisfied for family and friends' relationships in the pre-migration phase and moved from their country of origin more often for work reason compared to controls; in the post migration phase they received less social support from social services, acquired families and friends compared to healthy migrants. Cases are less satisfied in post migration phase for work, families and social relationships.

**Conclusion.**– The EUGEI study allows a deeper understanding on the relationship between the characteristics of the history of migration and the excess of FEP found among FGM in Europe. These preliminary results shape the scene for preventive interventions of the psychosis among migrants in Europe.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0011

### **Minority status and psychosis: A comparison of group density effects**

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**Introduction.**– It has been frequently observed that mental disorders, such as psychosis, are more common for people in some ethnic groups living in areas where their ethnic group is less well represented.

**Objectives.**– We set out to test the hypothesis that this 'ethnic density' effect reflects minority status generally by looking at three situations where individual characteristics differ from what is usual in a locality.

**Methods.**– Using data collected from the South East London Community Health study (N=1698) from 2008 to 2010 we looked at minority status (defined by: ethnicity, household status and occupational social class) and rates of psychotic experiences as well as common mental disorders and attempted suicide.

**Results.**– Being black in an area where this was (10%) less common was associated with higher rates of sub-clinical psychosis, odds ratio (OR) 1.34 (95% CI 1.07 to 1.67). Being single in an area where this was less common (10% less) was also associated with an increased risk of psychotic experiences (OR 2.18 95% CI 0.91 to 5.26). Minority status due to social class was associated with an increased risk of attempted suicide only (OR 1.33 95% CI 1.03 to 1.71). No association was observed between minority status and common mental disorders.

**Conclusions.**– The relation between social marginalisation and mental distress is most apparent when minority status is defined in terms of ethnicity. Similar although less consistent effects are also seen where individual household status and social class are incongruent with local norms.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0012

### **“Life is pleasant. Death is peaceful. It's the transition that's troublesome” (Isaac Asimov): The elderly and suicide**

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The reflection about old age, suicide, and assisted suicide should start with a reflection about the meaning of aging. As Carl Gustav

Jung wrote: “. . .the life of an older person is characterized by a contraction of forces, by the affirmation of what has been achieved, and by the curtailment of further growth”. Existing as an old person compels to individual to reflect: “. . .The fantasy of omnipotence is shattered by the arrival of youth: childhood dreams are broken and this requires that one adjusts to reality. . .in the second half of life. . .one’s man time is no longer rise and growth: here comes the unavoidable encounter with ‘the birth of death’” (Eugenio Torre, 2013).

Have opinions changed since Terentius’s statement that old age was a disease itself? Or is it consistent with the current research and interest about healthy ageing? The meaning of healthy ageing is another topic for discussion: healthy ageing and good ageing are not the same, just as the ‘solitary elderly’ is not the same of the ‘lonely elderly’, as described by Guido Ceronetti. Good ageing does not mean that one lives well in all the dimensions at once. The founder and master of the Psychiatry School in Novara, Eugenio Torre, in a recent conference about healthy ageing suggested that “To live well and to live healthy are not necessarily synonyms. Actually, sometimes they are opposite. And I am not thinking about an unrestrained hedonism, but rather to Norbert Bensaid’s words in his wonderful “La Lumière médicale. Les illusions de la prevention” . . .to remove our fear of death, they make us die of fear. . .”.

While it is widely acknowledged that old age has a greater risk of suicidal behaviour compared to other age classes, and several studies about this topic are available, there are a lot of questions which still have no answer in the field of euthanasia and assisted suicide in the elderly. Why is there the need for “assisted” suicide? Are there differences between those who ask for assisted suicide and those who commit suicide without assistance? How to conciliate, in the same country, assisted suicide and suicide prevention? What is the impact of legal euthanasia and physician assisted suicide on suicide rates? Does it represent an actual alternative to non assisted-suicide, or has the opportunity of assisted-suicide a different target population from the one of those who consider self-inflicted death?

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0013

### **Suicide prevention and prevention of assisted suicide in Switzerland**

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In most countries of the world, suicide rates are highest in the elderly population. The debate on preserving autonomy and dignity throughout the life span has also led to the demand to allow assisted suicide, which is possible in some countries. In Switzerland the numbers of people committing assisted suicide have increased dramatically in recent years. The average age of these people is 77 y. In order to prevent suicide a national plan for suicide prevention has been started with the focus on awareness, reduction of risk factors and promotion of models of good practice. During the last years there was some progress with regard to the prevention of falls and access to weapons. The prevention of suicide in the elderly focuses on access to diagnosis and therapy of depression, providing social integration and more. However, what should be done to prevent assisted suicide? Should it be prevented? The Swiss physicians and society are torn. It seems that the “risk factors” for assisted suicide differ from those for suicide. By use of a pragmatic approach to initiatives shall be presented. One is to contact people who have sought contact to private organisations for assisted suicide (EXIT) and have not yet plans to commit it in the very near future. The

second is a proposal to regulate the “process quality”, especially by law.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

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W0014

### **Assisted suicide and second opinion requests for euthanasia in elderly patients with concomitant psychiatric and somatic disorders. A case series**

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In the Netherlands, euthanasia is an accepted practice if the guideline is strictly followed. Also patients with mental disorders can file a request for euthanasia, and a guideline for this practice also exists, which recommends that euthanasia can only be possible if the patients suffers greatly, no relief of suffering is suspected, and a mental disorder exists that has been treated according to the relevant guideline for that disorder to the full extent without solace. However, recent research has shown that patients may receive such euthanasia without these requirements being met. Special clinics have been opened in the Netherlands that help patients with such a request and they ask second opinions to psychiatrists with the question if the condition could be treated or not. Current practice shows that even patients who could receive treatment, but who refuse that, may get euthanasia by such clinics, which has led to a lot of criticism. The advent of the new guideline for assisted suicide in the Netherlands has elicited a societal debate as well as a debate amongst psychiatrists who are divided between feeling that assisted suicide should be possible in desperate cases in order to avoid suicides; and psychiatrists who feel that patients should be able to count on their psychiatrist to provide them optimal treatment and being inclined to keep them alive. An overview will be provided and an illustrative case of a patient with combined somatic and mental disorder will be discussed.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0015

### **Big data to track and treat? Proposing online therapy to problem gamblers: A randomized clinical trial**

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*Background.*– Collaboration between academics and gambling service providers allows working on account-based gambling data. These massive data can help understanding the gambling disorder course, and developing new tracking tools to help gamblers before the impact of gambling grows out of control. We present two examples of the potential of such data, through an interventional study, and through the observation of the impact of a spontaneous responsible gambling measure. We present the results of an online randomized control trial and an exploration of self-exclusions motives and course of gambling after a self-exclusion. *Methods.*– In the first study, all active poker gamblers from a website were systematically offered screening and proposed to be included if Problem Gambling Severity Index (PGSI) score was  $\geq 5$ .

Problem gamblers were randomized into four groups: (1) waiting list (control group), (2) personalized normalized feedback on their gambling status by email, (3) an email containing a self-help book to be downloaded with a Cognitive Behavioral Therapy (CBT) program without guidance, and (4) the same CBT program emailed weekly by a trained psychologist with personalized guidance. Efficacy was assessed based on the change in PGSI between baseline and 6 weeks or 12 weeks and supported by player account-based gambling data automatically collected at the three time points. In the second study we included all poker gamblers who first self-excluded since the launch of a poker gambling website and reported a motive for self-exclusion ( $N = 1996$ ). We explored two groups: self-excluders who declared a motive linked to addiction and those who declared a commercial motive. We described and compared account-based gambling summary and session-data ( $N = 38206$  and  $14020$  respectively) in the previous month of both groups. We explored return to gambling and following self-exclusions.

**Results.**– In the first study, all groups met high attrition rates (83%), but the group with guidance had a significantly higher dropout rate than the other three groups, including the control group. Although all groups showed some improvement, no significant difference in efficacy between the groups was observed on the PGSI.

In the second study, we found that both groups of self-excluders were heavy gamblers. No between groups adjusted difference was found on summary gambling data, and sessions from both groups were poorly discriminated one from another with multiple machine learning models. 68.5% of gamblers were back on gambling after a first self-exclusion ( $N = 1368$ ), half within the first month. Gambling in the month of return was less heavy than before first self-exclusion, but rapidly increased and 60.1% self-excluded again ( $N = 822$ ).

**Conclusions.**– If very intrusive designs seem to be aversive, a currently available spontaneous responsible gambling tool, self-exclusion, seems to have a non persistent positive effect on gambling course for most gamblers. New intermediate responsible gambling tools, including tracking and proposal of guidance, could be developed to better protect problem gamblers.

**Disclosure of interest.**– Non funded collaboration with Winamax.

W0016

### Development of a text-message brief contact intervention following a suicide attempt

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Suicide is a leading cause of death, particularly among young people. Continuity of care following discharge from hospital is critical, yet this is a time when individuals often lose contact with health-care services. A meta-analysis has shown that postcard-based brief contact interventions following a suicide attempt can reduce the number of repeat attempts, and text message interventions are currently being evaluated.

We sought to extend post-attempt caring contacts by designing a brief online intervention targeting proximal risk factors and the needs of this population during the post-attempt period. This

presentation details the development process and describes the realised RAFT (Reconnecting AFTER a suicide attempt) system.

To inform the design of the intervention, a lived experience design group was established. Participants were asked about their experiences of support following their suicide attempt, their needs during this time, and how these could be addressed in a brief contact ehealth intervention. The intervention design was also informed by consultation with lived experience panels external to the project, and a clinical design group.

Prompt outreach following discharge, initial distraction activities with low cognitive demands, and ongoing support over an extended period were identified as structural requirements of the intervention. Key content areas identified included coping with distressing feelings, safety planning, emotional regulation and acceptance, coping with suicidal thoughts, connecting with others/interpersonal relationships, and managing alcohol consumption.

The RAFT text message brief contact intervention combines SMS contacts with additional online brief therapeutic content targeting key risk factors. It has the potential to reduce the number of repeat suicidal episode and to provide accessible, acceptable, cost-effective support for individuals who may not otherwise seek face-to-face treatment. A pilot study to test the feasibility and acceptability of the RAFT intervention is underway.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0017

### Sleep inducers in elderly patients. What to prescribe?

J. Bobes

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Insomnia is a heterogeneous disorder characterized by difficulties in initiating or maintaining sleep, early awakening or non-restorative sleep accompanied by daytime consequences and interference with everyday functioning. In elderly, the estimated prevalence varies between 20 and 50%, and it is more frequent in women.

Benzodiazepine and nonbenzodiazepine receptor agonists are among the most commonly prescribed drugs along with sedative antidepressants (i.e., doxepin, mirtazapine, and trazodone) and antipsychotics (i.e., quetiapine) used as “off-label” medication. In the last years, one dual orexin receptor antagonist (suvorexant) and three melatonin agonists (prolonged-released melatonin, ramelteon, and tasimelteon) have demonstrated efficacy in managing insomnia and received approval by the EMA and/or FDA as hypnotic agents.

In this talk, I will address the reported efficacy and the potential adverse effects of the different medications employed for the treatment of chronic insomnia in the elderly, as well as, the recommendations made by the new updated Clinical Guidelines.

**Disclosure of interest.**– Julio Bobes has received research grants and served as consultant, advisor or speaker for the companies: AB-Biotics, Adamed, Almirall, AstraZeneca, Bristol-Myers Squibb, Ferrer, Glaxo-Smith-Kline, Hoffman La Roche, Janssen-Cilag, Lilly, Lundbeck, Merck, Novartis, Organon, Otsuka, Pfizer, Pierre-Fabre, Sanofi-Aventis, Servier, Shering-Plough and Shire, research funding from the Spanish Ministry of Economy and Competitiveness – Centro de Investigación Biomedica en Red area de Salud Mental (CIBERSAM) and Instituto de Salud Carlos III-, Spanish Ministry of Health, Social Services and Equality – Plan Nacional sobre Drogas – and the 7th Framework Program of the European Union.

W0018

## How to avoid irrational polypharmacy in elderly patients?

### Psychopharmacologist's view

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**Background.**– Our population is getting older and therefore more and more medications have been used in elderly patients. Almost 50% of elderly patients are treated with at least 5 different medications concomitantly, which can lead to serious drug-related problems and irrational polypharmacy. Nearly 50% of elderly patients take one or more medications that are not medically necessary. Research has clearly established a strong relationship between irrational polypharmacy and negative clinical consequences. These patients are often excluded from the treatment guidelines, although they represent a huge patient population. The best intervention for irrational polypharmacy reducing involves an inter-professional approach (a collaborative care approach) that often includes a clinical pharmacist.

**Aims.**– The main aim of this talk is to present impact of different interventions in irrational polypharmacy reducing including older ambulatory primary care, hospital, and nursing home patients. Firstly, different approved methods will be presented to avoid irrational polypharmacy in association with inappropriate prescribing in elderly (e.g. STOP/START, Beers and PRISCUS). Secondly, different possible mechanisms of rational psychopharmaceuticals and other medications prescribing will be presented to reduce irrational polypharmacy. In addition, antihypertensive drugs, proton pump inhibitors, antibiotics and some another groups will be discussed in term of irrational polypharmacy reducing. Lastly, a collaborative care approach including clinical pharmacist with clinical cases will be discussed. The participants will learn how to reduce irrational polypharmacy in elderly patients who need psychopharmacological treatment by using medication reviews and well planned drug prescriptions and collaborative care.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0019

## Drug discontinuation in elderly patients. When it is possible and rational in patients with mood disorders?

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Depression is a frequent disorder in the elderly. Treatment with antidepressants is useful and common even though studies providing sufficient relevant evidence for the elderly patient population are rare. Most therapy recommendations are based on studies with younger samples. However, elderly depressed patients might be more difficult to treat as a result of physical and mental co-morbidities. In addition, elderly patients often receive multiple medications for various diseases. Drug-drug interactions are therefore most likely. Consequently, it has been recommended to describe lower doses of medications and to reduce these, if possible, and stop, as soon as possible. Sadly, scientific evidence for such clinical recommendations on how to and when to reduce or stop is very limited. More research to address these most urgent clinical gaps in scientific knowledge to help this population is required.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0020

## Psychopharmacological approach to mood disorders in the elderly. Realities and perspectives

M. Martín Carrasco

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Mood disorders in the elderly are a significant, common, and growing problem that requires treatment. It has serious implications for the patient, family, and community. Identification followed by a thorough assessment can help guide the selection of an appropriate medication.

There are several factors to consider when selecting, adjusting, and changing drugs in the elderly. Treatment of mood disorders in the elderly is particularly challenging due to the relative scarcity of well-designed trials, atypical clinical presentations, presence of multiple comorbidities (i.e., cognitive impairment) and adverse effects (i.e. falls). While meta-analyses involving antidepressants, antipsychotics and mood stabilizers have generally shown modest treatment benefits in this population, clinicians treating geriatric patients must be especially mindful of issues regarding polypharmacy, drug metabolism, and adverse event profiles. Issues related to pharmacodynamics, safety, tolerability, and the unique features associated with the use of drugs in this population are further discussed.

Together, these strategies can help promote the safe use of psychoactive drugs in the elderly. Besides medications, other therapies might be considered include various forms of psychotherapy and neurostimulation, with electroconvulsive therapy still being the gold standard for severe or psychotic depression.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0021

## Building national collaborations with senior psychiatrists: The Spanish experience

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National Trainees Associations (NTAs) represent the interests of psychiatric residents in their home countries. The European Federation of Psychiatric Trainees (EFPT) aims to unite their efforts at an international level. These organizations may help trainees to work more closely with senior psychiatrists, which in turn may be beneficial for both parts, and lead to a better psychiatric practice. The Spanish Society of Psychiatric Trainees (SERP), established in 2015, is one of the newest NTAs in Europe. In these two years, SERP has collected a valuable experience of cooperative work with senior psychiatric associations in Spain, which can serve as a model for trainees in other countries from Europe and beyond.

First of all, we started signing formal collaboration agreements, allowing trainees to obtain rights such as double affiliation to senior associations, scholarships and access to their newsletters and journals. Other relevant results have been the opening specific spaces and tracks for trainees in national scientific conferences, as well as co-authorship in academic publications.

More recently, SERP has been involved in national research projects on delirium and agitation management, in collaboration with senior associations.

These collaborations seek also to allow trainees to participate in the establishment of national policies regarding Mental Health and training in psychiatry.

How did we create these partnerships? Have been these collaborations beneficial for the trainees? What else can be done? These questions will be discussed during this talk.

*Disclosure of interest.* – The authors have not supplied their declaration of competing interest.

W0022

### Challenges of Psychiatric Trainees in Eastern Europe

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Psychiatric Trainees in Eastern Europe often face different problems to those experienced by their colleagues from the other parts of the continent.

The low expenditure on health care systems and particularly on mental health care results in difficult working conditions and low salaries of psychiatric trainees in these countries. In some of the countries, the shift of the model of mental health care from an institution-based to a community-based care has not yet been completed and the trainees have often to perform their whole postgraduate training in large psychiatric hospitals, equipped with old facilities. The training curricula also often limit the possibilities of a more diversified development and force the trainees to organize themselves additional internships abroad to supplement their growth. The difficulties surrounding the training in Eastern Europe force them to also seek temporary or permanent migration to Western European countries to continue their work in significantly better conditions, which results in the brain drain effect and cause further problems in their respective countries.

Maintaining and Establishing a National Trainee Association (MENTA) Working Group, a part of the European Federation of Psychiatric Trainees (EFPT), has always been in support of the psychiatric trainees in European countries, with a particular focus on Eastern Europe. During the last years, the Working Group helped establish trainee associations in Poland and Rep. of Macedonia, as well as supported the associations in Czech Republic and Slovakia. Currently MENTA is trying build a trainee network in Bulgaria to create a similar organization in this country.

*Disclosure of interest.* – The authors have not supplied their declaration of competing interest.

W0023

### Coordinating the efforts from trainees around Europe

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EFPT (the European Federation of Psychiatric Trainees) is a non-profit organization for European national psychiatric trainees. It is a federation of the National Trainees Associations from almost all European countries. In our era it is important that doctors from different countries share their experiences and develop common

research projects. This goes for motivated trainees too. EFPT pleads in favour of reducing the differences between training programs in the European countries and actively helps trainees by encouraging them to exchange opinions, information and compare their training programs. It enables many trainees to participate in exchange programs in other countries.

In 2016 EFPT has established the CET (Connecting European Trainees) program, designed to bring psychiatric trainees in Europe even closer. Thus we have created the EFPT NTA page, where one can find data such as the name of the NTA, of its president and of a delegate within the association, whom trainees will be able to contact when they have questions regarding, for example, training, research and exchange programs in this country. These contact persons will then be able to refer them to the most suitable doctor in their country. Thus communication between psychiatry trainees across Europe has become much easier.

Exchanging information between trainees mainly takes place through email, although social media platforms such as Facebook are also often used. Other social media platforms are also important for the communication between EFPT members and trainees.

The NTA Coordinator is a newer position in the EFPT organigram. The holder thereof is in charge of gathering the above-mentioned data and updating the page. He works closely with the IT Manager, the Chairman of the working group called MENTA (Maintaining and establishing a National Trainee Association) as well as the national delegates.

Our current objective is to create a page for each association. At this moment, more than half of the EFPT members have a page. The CET Program is an important part in bringing trainees of different background, nationality, culture, and training together.

*Disclosure of interest.* – The authors have not supplied their declaration of competing interest.

W0024

### Crossing the bridge: Achievements of psychiatric trainees in Turkey

E. Sönmez

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Trainees have played a major role since the first organisational attempts among psychiatric professionals were made during 1990s. Trainee Committee of Psychiatric Association of Turkey (TCPAT) has been formally established in 2013, which has been the culmination of long-term efforts of trainees in previous generations.

It now functions as a platform where hundreds of trainees are linked, can immediately react to each other's inquiries and provide peer support. Under the umbrella of TCPAT, local and international surveys regarding psychotherapy training, working and training conditions have been conducted and published, aiming to improve the existing status in each aspect. Several members of the committee participate as representatives in international early career psychiatrist associations. Moreover, for the last two years, national psychiatric trainee meetings are organized and this initiative was crowned by the EFPT Excellence Award in 2017.

In 2017, the European Forum of Psychiatric Trainees was hosted by TCPAT, for a second time after 2005. More than hundred delegates and observers from over 35 countries have been able to observe the local training scheme and examples of practice. These activities have enhanced trainees' feelings of autonomy, improved their leadership skills and capacity of working in teams and strengthened their professional identity.

*Disclosure of interest.* – The authors have not supplied their declaration of competing interest.



W0025

### Exploring training and working opportunities of substance abuse and dual disorders for early-career psychiatrists

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**Introduction.**– Substance abuse and dual disorders (substance abuse+another psychiatric disorder) represent a challenge for early-career psychiatrists. An overview of training schemes around the world is important in order to encourage policies of improvement, and to strengthen international collaborations.

**Objective.**– To conduct a pilot survey comparing training schemes for psychiatric residents in substance abuse and dual disorders across countries from all over the world.

**Methods.**– National delegates from the countries included in the European Federation of Psychiatric Trainees (EFPT) and Young Psychiatrists' Network (YPN) were e-mailed with a 6-question survey about training and working opportunities for early-career psychiatrists in their countries regarding substance abuse and dual disorders. Questions asked for: length of psychiatric residency, specific training in substance abuse/dual disorders, specific training on adolescent populations, and facilities used for those disorders.

**Results.**– 60 countries were contacted, providing 13 responses: Nigeria, Iran, India, Azerbaijan, Turkey, Spain, Poland, Denmark, Czech Republic, Argentina, Mexico, Canada and USA. Great heterogeneity was found among training schemes. Only North American countries reported specific training on dual disorders and specific training in adolescent populations. Duration of training in substance abuse disorders is 1–4 years in North American countries and 1–7 months in the others. The most common kind of facilities are community-based centres, frequently coexisting with other public and private resources.

**Conclusion.**– Training in substance abuse and dual disorders seems heterogeneous around the world. North America counts with longer and more specific training programmes. A further survey, including more quantifiable data and countries, would provide policy-making results.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0026

### Developing and improving training in child and adolescent psychiatry in Europe

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Efforts have been made, in Europe, in order to clarify the different training programs in the psychiatric field in terms of examinations, clinical rotations, psychotherapy and research, as well as whether if there is a specific program for Child and Adolescent Psychiatry as a speciality itself. Furthermore, some European associations have gone one step forward and have taken different actions seeking the unification of the training system throughout Europe.

In this workshop, detailed information is going to be presented regarding the differences in the Child and Adolescent Psychiatry residency throughout Europe according to the data pro-

vided by the European Federation of Psychiatric Trainees Annual Survey.

In addition, information about different free courses, international fellowships, grants and awards offered by worldwide psychiatric associations are going to be exposed, disclosing specific information about the application procedure and providing some tips and suggestions directed to trainees in order to be selected.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0027

### Implementing early detection and intervention services for psychosis in Europe: Obstacles and how to overcome them

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**Introduction.**– There is now enough evidence for establishing early detection and intervention services for psychosis and for the assessment of the at-risk mental state, including “staging” and staged interventions. However, such services are not available yet for all patients in the European countries.

**Objectives.**– With my talk I want to stimulate discussion on the lack of such services as well as on the potential obstacles to implementation.

**Methods.**– Overview.

**Results.**– Apart from a lack of services, many European countries also have no specific guidelines for early detection and intervention. Obstacles to further promote early detection and intervention might include traditional and faith-based paradigms in psychiatry which do not appreciate the chances of early detection and intervention. Besides a lack of devotion towards prevention, further obstacles might be a lack of clear policies/implementation plans by stakeholders, a lack of clear coordination between services, and a lack of training and supervision for the staff in this area, etc. In order to establish new services, we also need to involve consumers, their families, and carers in planning such services and encourage them to get involved in policy making towards this goal. And we need outreach campaigns directed to the public, at-risk populations, and professionals with the aim of education and fighting stigma.

**Conclusions.**– All patients of the European countries should have easy access to low-threshold early detection and intervention services with specialized staff oriented towards to patients' needs. It is our duty as professionals to fight for overcoming the mentioned obstacles.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0028

### Implementation of early detection services: Current status and perspectives in southeastern Europe

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Unequal development of both early detection (ED) and early intervention (EI) programs/services for psychotic disorders and of related academic activities has been shown across Europe.

The present ongoing research aims to further fill in the knowledge gap regarding the ED/EI implementation in Central and Eastern European countries. The 17-item questionnaire addressing information about ED/EI in the relevant national educational resources, local policy towards the implementation of ED/EI in the national mental health system, diagnostic and therapeutic methods implemented by local ED/EI and obstacles in its implementation, was disseminated to the colleagues from 23 countries (The Eastern European, Central, Baltic and the Southeast European countries) who had been found through the PUBMED search including the terms: name of the country/region, “mental health”, “psychosis”, “early intervention”, “early detection”. For countries with no ED/EI programs, we asked about the most important factors limiting their implementation.

We hypothesized that the status of the specific education, the guidelines and specific instruments implementation, the service distribution and organization will range from availability in most of the EU member countries, to potential to scale up and even absence in several other countries. Lack of adequate education/information of the professionals has been hypothesized as one of the most prominent reasons for non-implementation.

The obtained results could be used as starting point to plan how to improve utility of the ED/EI services in this region, to accelerate its implementation and to facilitate timely detection and intervention of psychosis across Europe.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0029

### **Implementation of early detection services in France: Current status and further perspectives**

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*Objective.*– Schizophrenia and chronic psychosis is one of the most disabling disorders striking adolescent or young adults. Early intervention, by improving the general outcome, has already demonstrated its cost effectiveness. However, while early intervention services are now spread all over the world, until now France has not implemented nation-wide programs and the reasons of this delay need to be addressed.

*Methods.*– We have collected all available information regarding early detection – early intervention in France: publications or reports, participations to specialized education or training, organization of meeting, workshop or conferences on the topic. In addition, we also have conducted a survey in 300 general practitioners and a comparative survey in 300 youth (15–25 y.o.), 300 parents and 130 teachers.

*Results.*– Less than 10 centers have started to organize EI services attempting to follow the international recommendations, and even less ED, but none fully achieves a complete EI/ED service. Only 7 groups have published on the topic. There is however an emerging willingness of French practitioners: approximately 40 teams are actually interested and actively seeking training or education. Discussions with these teams raised several issues and underline the needs for French-adapted models and recommendations. Propositions have been made to resolve these issues. From the surveys, it is clear that young people are aware by mental health and if concerned they would seek help to their parents, friends, or GP but not

their teachers. GP are interested in improving early detection, but are poorly trained or educated in this field.

*Conclusion.*– France is now ready for a National plan for ED/EI and will benefit from international organizations. However, widespread dissemination in first-line services will not happen if French-speaking tool-kits are not accessible. A careful adaptation to the specificities of French organization of mental health services is also needed. The ‘Transition Network’ is currently launching a French taskforce to organize these tool-kits and propose some adaptations of ED/EI to our national MH organization, within the frame of the French-speaking branch of IEPA.

*Disclosure of interest.*– MOK received honoraria from and participated in advisory boards or did educational conference for F. Hoffmann-La Roche, Janssen Cilag and Otsuka Lundbeck.

W0030

### **Implementation of early detection services: Economic perspectives**

D. McDaid

*United Kingdom*

*Introduction.*– There is growing evidence on both the effectiveness and cost effectiveness of early intervention and detection services, yet services in Europe remain limited. A narrow focus on effectiveness ignores broader issues concerned with implementation that are vital to making services more widely available.

*Objectives.*– This presentation looks at the role of economic evidence and why it has only had a limited impact. It emphasises the importance of moving beyond narrow cost effectiveness measures.

*Methods.*– Narrative review of literature and illustrative use of return on investment decision modelling tool.

*Results.*– Economic approaches that can help facilitate implementation include identifying the return on investment from early intervention and detection services to different stakeholders, including impacts beyond the health system, conducting budgetary impact analyses and looking at the economic benefits and costs of achieving better levels of fidelity in implementation. There is a now an increased focus on considering local context, system organisational, financing and other factors that either act as barriers or facilitators to implementation.

*Conclusions.*– Powerful arguments can be made for investment in early intervention and detection services, but there is a need to move beyond narrow use of economic information. Impacts across and beyond all of the health system (and not just the mental health system) are relevant to implementation strategies. More emphasis also needs to be placed on better communication of the economic case in an appropriate way for different policy makers, practitioners and wider society.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0031

### **Declaration of Geneva: Medical oath as an ethical guideline**

R.J. van der Gaag

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Ever since the days of Hippocrates at graduation medical doctors pleaded an oath, promising solemnly to meet the (high) ethical standards of their “guild”. The medical oath has always been aimed at providing excellent care according to the professional standards, along with respect for life, the patient and his privacy. Some elements though are time bound: for example in old days young

medical doctors did not only express their respect to their mentors, but also did they promise to take care of them until the end of their days. A kind of pension provision for medical doctors. Such cultural aspects were not taken on board when the medical oath was formulated back in 1948 when the World Medical Association was founded in Geneva. In October 2017 after several years of discussions a revised “Declaration of Geneva” was adopted with the important subtitle “the physicians pledge” at the WMA general assembly in Chicago. It was published straight away in JAMA and will be read at the opening of all the future meetings of the WMA. In this presentation the different elements of the pledge will be presented with emphasis on what has been newly formulated: in particular the respect for the patient’s opinion, importance of well informing the patient and the willingness to aim at shared decision making. The other new element is that every medical doctor promises to take care of his/her own health for better care and as an example. All psychiatrists are medical doctors. . . but many seem sometimes to have forgotten.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0032

### **Ethical challenges assessed in the clinical ethic committee of psychiatry in the region of Southern Denmark in the period 2010–2015: A qualitative content analysis**

H. Bruun

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Ethical considerations are an important part of the daily decision-making process in mental health care. A Clinical Ethics Committee (CEC) of Psychiatry in the Region of Southern has since 2010 been offering a structured ethical analysis of ethical challenges experienced by health care professionals in mental health. When analyzed the CEC makes a written case-report of 5–8 pages. On the basis of a qualitative content analysis of 55 written case-reports from the CEC an overview of the ethical challenges described is given. Although complexity is a recurring theme, the ethical challenges can be grouped into three overarching themes: (1) Healthcare professionals and mental healthcare in a wider social context. (2) Healthcare professionals and institutional aspects of mental healthcare. (3) Healthcare professionals and their relation to patients and relatives. In respect of the complexity, illustrative case-reports of each overarching theme are presented. The findings indicate that difficult ethical challenges are an inherent part of mental healthcare that requires time, space and competence to be dealt with adequately.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0033

### **Apathy in pre dementia: Prevalence, neurobiology and treatment**

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*Background.*– Apathy, characterized by diminished motivation, is found in cognitively normal elderly, as well as throughout the spectrum of prodromal dementia states including in those with mild behavioural impairment (MBI) and mild cognitive impairment (MCI). Importantly, the presence of apathy predicts increased risk

of conversion to dementia. This talk will review recent research on the prevalence and neurobiology of apathy and discuss possible treatments.

*Findings.*– The prevalence of apathy in MCI has ranged from 3% to 55% depending on the population and detection methods. Neuroimaging studies assessing structure, functional connectivity, blood flow and metabolism as well as amyloid burden and regional tau depositions reveal consistent differences in those with and without apathy. Findings implicate regions commonly associated with apathy (e.g., frontal involvement), as well as regions typically affected in early AD (e.g., parietal and inferior temporal involvement). Interventions being evaluated include neurostimulation and appear to target a variety of mechanisms. Improved understanding of the underlying neurobiology may have treatment implications.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0034

### **How audio, video and actigraphic sensors can be used for the apathy assessment**

A. König

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Automatic speech analysis for the assessment of apathy.

*Introduction.*– Apathy is one of the most frequent neuropsychiatric symptoms found in dementia. It has an important impact on quality of life of both patients and their caregivers and represents a strong predictor of progression of the illness. Current clinical assessment methods risk bias resulting from the assessor’s subjectivity, pointing to a need for additional objective and systematic assessment tools. Therefore, the use of information and communication technologies (ICT) such as automatic speech analysis could be of interest in addition to current assessment methods.

*Objectives.*– To investigate whether automatic analysis of linguistic and paralinguistic features extracted from audio recordings of patients’ answers to an open questions about personal interests could be useful for the assessment of apathy in elderly people.

*Methods.*– 150 older persons at different apathy severity stages were recorded while answering the question ‘What interests and motivates you?’. Every participant received the Apathy Diagnostic criteria and Apathy Inventory (AI). Speech signal processing techniques were applied to extract features which were compared to the baseline apathy assessment scores.

*Results.*– Preliminary results show that the feature ‘speech rate’ correlates significantly with the AI. More detailed results will be presented at the workshop.

*Conclusions.*– Our results demonstrate the additional value of vocal analytics for the assessment and monitoring of apathy in elderly people. This time saving automated tool can provide clinicians immediately with reliable data based on non-invasive, simple and low-cost methods.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0035

### How information and communication technologies can be used as therapeutic options for patients with apathy

V. Manera

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New Information and Communication Technologies (ICTs) are more and more employed in the domain of neurodegenerative disorders for patients' treatment and stimulation. In particular, Serious Games (SG, i.e., video-games designed to train specific cognitive and/or physical functions) and Virtual Reality (VR) are now considered as promising solutions to build motivating cognitive and physical trainings, as they embed playful and entertaining aspects. In the present talk we will briefly review the literature concerning the use of VR and SG in people with neurodegenerative disorders, and we will then present some studies conducted by the CoBTeK team employing VR and SG in older adults (apathetic vs. non-apathetic) with mild to moderate cognitive impairment due to neurodegenerative disorders. The results of these studies converge in demonstrating that VR and SG can be successfully employed to create motivating trainings, and that these solutions seem mostly adapted to apathetic patients.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0036

### Relationships between apathy and motor activity in actigraphic studies

R. David

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Apathy is a multi-dimensional syndrome (lack of interest, lack of initiative, emotional blunting) that has been described as a decrease in goal-oriented behaviours. It has therefore been hypothesized that apathy could be associated with a decrease in levels of daily locomotor activity associated to goal-oriented behaviours.

The use of actimetry, a wearable device comprising an accelerometer that records variations in individual's movements, has been proposed as an indirect but objective method to assess apathy in daily routine. In Alzheimer's disease, individuals with apathy had reduced actimetric levels of motor activity compared to non apathetic individuals, in different conditions: over a short 1-hour period during a medical consultation, over seven consecutive 24-hour period in ecological conditions with community-dwelling individuals. Additionally, the daytime patterns of motor activity differed between non apathetic individuals, individuals diagnosed with depression and individuals with apathy.

Levels of motor activity were also found to be reduced among individuals with Mild Cognitive Impairment.

The use of actimetry has to be considered as an objective method in addition to the clinical judgement for the diagnosis of apathy, but also to monitor the evolution of apathy and the response the treatments.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0037

### Diagnostic criteria for apathy revisited

P. Robert

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Apathy is an important and distressing behavioral syndrome in various neuropsychiatric disorders including Alzheimer's disease and related disorders. Apathy is defined as a persistent deficit of motivation reported by the subject himself or by his entourage, affecting behavioral (decreased goal-directed behavior), cognitive and emotional dimensions. During the 2008 EPA meeting a task force developed Diagnostic criteria for apathy, which are now used in various disease conditions and in clinical practice. Concerning the quantitative assessment until today, apathy is scored with the help of clinical rating scales such as the NPI (Neuropsychiatric Inventory), the AES (Apathy Evaluation scale), the LARS (Lille apathy rating scale) or the AI (Apathy Inventory). However, these tools allow only a punctual and not continuous assessment and risk biases resulting from the assessor's subjectivity, pointing to a need for additional systematic assessment tools. The aim of this presentation is to present an update of the diagnostic criteria for apathy and results of the validation study of an application using serious game designed to assess quantitatively apathy in an implicit, more objective and dynamic way

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0038

### Diagnosing autism in adults

B. Perera

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Autism is a neurodevelopmental disorder which is manifested as persistent deficits in social communication and social interactions and restricted, repetitive patterns of behaviour, interests, or activities (DSMV). Prevalence rate is reported to be around 1.1%.

Early diagnosis of autism is important to understand and provide necessary support to individuals and family. However it is often delayed due to multiple reasons. A delay in diagnosis is considered as a missed opportunity to provide necessary support during the critical developmental period. Mean age of diagnosis of Autism has decreased over time. Diagnosis of autism includes a detailed neurodevelopmental history with focus on core symptoms of autism. Availability of diagnostic services varies significantly from one area to another. Post diagnostic support is often important for families to understand and support the individual with autism, however parents often report that post-diagnostic support is unsatisfactory. Comorbid mental disorders and other neurodevelopmental disorders (NDD) such as ADHD and Intellectual disability are often seen in among people with autism. Therefore identification of autism along with other NDD and comorbid mental disorders is important to provide the right support and interventions to improve quality of life of individuals with Autism.

*Disclosure of interest.*– I have received speakers fees from Janssen-Cilag and Flynn pharma.

W0039

### Co-morbid mental disorders in autism

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*Introduction.*– Adults with autism are a heterogeneous group in terms of their level of intellectual ability and their mental health

needs. Reported prevalence of mental disorders in autism varies by study methodology but is likely to be higher than for the general population. Adults with autism have particularly increased rates of specific disorders.

**Objectives.**– This workshop considers evidence on prevalence of co-morbid mental disorders in adults with autism, with a particular focus on co-morbid mental disorders in adults with intellectual disabilities (ID) and autism, using the diagnostic classification system for learning disabilities (DC-LD).

**Methods.**– The literature on co-morbid mental disorders in autism was reviewed. Following this, using a representative sample of adults with ID, the association between autism and DC-LD diagnoses, medication treatments and other clinical features were measured using univariate (Chi-squared test) and multivariate (logistic regression) methods as appropriate.

**Results.**– There are significant differences in the rates of specific mental disorders across DC-LD axes between adults with ID and autism vs. those with ID without autism but attending a psychiatrist. For example, in the sample with ID, there were significant differences in the rates of problem behaviours ( $P < 0.001$ ). There were also differences in treatments used, with notably higher rates of atypical antipsychotic use in those with autism ( $P = 0.001$ ).

**Conclusions.**– There important similarities and differences in terms of both diagnostic co-morbidity and treatment for those with autism and ID attending a psychiatrist vs. those with ID without autism attending a psychiatrist.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0040

### **Behavioural problems in people with intellectual disability and autism**

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People with intellectual disability often present with challenging behaviour. Prevalence rate for challenging behaviour varies from 6 to 40% depending on different settings where research was carried out. Challenging behaviour involves aggression towards others, harm to themselves and destruction of property. Causes of challenging behaviour are complex and multifactorial. Complexity of challenging behaviour causes assessment and management difficulties to health care professionals leading to long stay hospital admissions and unlicensed use of pharmacological treatments. Presence of autism further makes the assessment and management more difficult.

This workshop discusses how the presence of autism increased challenging behaviour and suggest various pathways to assess and manage people with ID, challenging behaviour and autism. It will also address various factors that need to be considered when assessing and managing people with ID, autism and challenging behaviour.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0041

### **Autism in adulthood**

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Autism Spectrum Disorders (ASD) are neurodevelopmental disorders biologically conditioned, and they are usually diagnosed in pre-school or early childhood. Untreated autism in adults often

makes it difficult or even impossible for the patients to live independently. Autistic people cannot express emotions adequately, cannot think abstractly, have high levels of tension and low level of interpersonal skills. They can react with panic and aggression. Unawareness of the disease makes adults with autism have many problems in social, family and professional life. They are discriminated, excluded, unclassified, regarded as arrogant, bizarre. To ensure a minimum of safety they avoid social contacts, prefer loneliness, run away. Other psychological problems may develop in the context of autism, such as depression, mood disorders, oversensitivity. The rehabilitation forms, which may improve their functioning, should reduce anxiety, improve physical and mental health, increase concentration, and engage them in social life, which may lead to, e.g., finding a job, starting to live in protected housing or group homes where patients can count on permanent caregivers.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0042

### **Sensory sensitivities in people with autism**

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Sensory difficulties have been understood by people with autism and their carers as important aspects of disorders. They are now recognized in classification systems as features of autism. Diagnosis of autism requires attention to the impact of sensory difficulties on the person.

In general, people with autism can perceive sensory stimuli that differ from people with such sensory deficits as deafness or blindness. The difficulty is in the processing of sensory information manifesting as Sensory Processing Disorder. The modulation of sensation in Autism is abnormal and described in three domains as registration, defensiveness, and gravitational insecurity. Examples include avoiding bright lights or loud sounds (defensiveness). Hypersensitivities are evident too for example, clothing pulled across the skin.

For people with autism, sensitivity in all sense modalities can cause great discomfort that can go unrecognized especially where the person has difficulty in communicating their distress. Excessive stimulation in one sense can lead to behavioural reactions that can be misinterpreted as anxiety or other mental diagnosis. Recognition of sensory sensitivity by a person with Autism can help them alleviate stress.

In the presentation, sensory sensitivities in Autism are described, with an explanation of their aetiology, and an exploration of measures to effectively manage their impact on people's lives.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0043

### **Autism and intellectual disabilities**

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**Aims.**– Some studies report that up to 70% of persons with Intellectual Disability (ID) may present also pervasive autistic traits, as well as up to 70% of those with Autism Spectrum Disorder (ASD) show early cognitive impairment that falls into the area of ID or borderline intellectual functioning. Further complexities arise in the context of co-occurrence Schizophrenia Spectrum Disorders (SSD).

The purpose of this part of the workshop is to systematically define the boundaries and overlapping clinical characteristics of IDD, ASD and SSD; to highlight the most relevant differences in clinical presentation of ASD and SSD in persons with ID; and to improve sensitivity and validity in diagnosing ASD in ID.

*Methods.*– Authors imprint and bring forward an immediate functioning dimension to the participant's eye and hands by implementing and practicing the concepts and techniques identified through a systematic mapping of the last 15 years international literature and results of an original clinical study.

*Results and conclusions.*– The combination of IDD and ASD presents many challenges and deficits across a range of behaviours and skills that are not seen in IDD or ASD alone. Severe IQ has been found related to higher severity of ASD and higher rates of challenging behaviours. Higher rates of stereotypes tend to be related to severity of autism but not to severity of IDD. For the distinction between ASD and SSD, age of onset, interest towards others, hallucinations, flattened mood (and behavioural equivalents), irritability, neuroanatomical anomalies, scores at block design, digit span, and digit symbol were found to be the most useful dimensions.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0044

### Person-centered dialectical models of mental disorders: The case of schizophrenia

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This paper builds on the self-disorder hypothesis of schizophrenia and further develops it by integrating the notion of 'selfhood' with that of 'personhood'. An important advance in the recent history of schizophrenia research has been the re-conceptualization of this illness as associated with disorders affecting the structure and the functioning of the minimal self. The self-disorder hypothesis conceives schizophrenia as a basic disturbance of the sense of self. The notion 'selfhood' serves to investigate the prereflective structures and dynamics of experience.

What may remain out of focus is the person's attitude towards these anomalous experiences. The notion 'personhood' serves to investigate the reflective, self-interpreting, stance to experience. The patient's attitude to his or her illness plays a significant role in mental illness. This approach is conducive to the development of a person-centred dialectical (PCD) model of schizophrenia that is concerned not only with the phenomenological description of troubled selfhood but also with how persons with schizophrenia interact and cope with their abnormal experiences. The principal clinical implication is the development of a two-tier descriptive system including phenomenal assessment of disordered selfhood and appraisal of personal background. The recognition of the patient's resources is necessary for effective treatment, as recovery requires not only the reduction of full-blown symptoms but also a change in the patient's attitude with respect to her basic abnormal phenomena. The latter involves the person's own effort to make sense of and cope with her vulnerability [1,2].

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

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W0045

### What is like to be in an at risk mental state for psychosis

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At risk mental states designate a variable set of clinical presentations carrying a heightened risk for developing more severe psychopathology, particularly within the psychotic spectrum. Such states, formerly considered as prodromes, are currently conceptualised as prospective and probabilistic signatures of imminent risk of psychosis. They are typically accompanied by profound and characteristic modifications of subjective experience which are essential for the understanding the emergence of psychosis.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0046

### Activities and initiatives of EPA

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Mental health problems that forcibly displaced people (refugees and asylum seekers) experience due to wars, armed conflicts, persecution and human rights violations, and related poverty and trauma currently constitute a serious public mental health problem in Europe. There is increasing evidence that a large proportion of refugees and asylum seekers residing in Europe suffer from the consequences of traumatic events and exhibit psychological problems and mental disorders including, but not limited to, Post-Traumatic Stress Disorder.

The European Psychiatric Association (EPA) considers as one of its major tasks to raise awareness on this important problem and outline strategies for how its member societies and the psychiatric profession at large may contribute to managing these challenges. In line with its policy, EPA has set a special task force, namely "EPA Task Force on Needs of Refugee and Asylum Seeker Patients in Europe" to focus more closely on the mental health consequences of forced displacement. This presentation will give a brief summary of its already fulfilled activities and planned actions aiming to increase professional cooperation and international collaboration regarding the issue of mental health of forcibly displaced people on a European level.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0047

### Activities and initiatives of WPA

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In responding to the needs of people living under extreme stress including forced displacement the WPA's Action Plan 2017–2020 calls attention to the needs and strengths of children and young people. It includes attention to mental health promotion as well as prevention and treatment of mental illness. Three types of actions are anticipated. The first is support for sharing of best practice. The second is building capacity for the profession to work effectively in specific settings of disadvantage. The third is encouraging psychiatrists and other health professionals to use their expertise in facilitating the mental health work of non-specialists across a range of community settings.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0048

### **Evidence on mental health care for forcibly displaced migrants: A review in collaboration with WHO Europe**

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*Introduction.*– The number of refugees migrating to Europe because of violation to their human rights, persecution and war is increasing. There is a need to identify mental health needs of these groups and models to provide effective care to them.

*Objectives.*– Summarising evidence on prevalence rates of mental disorders in refugees and good practice models for their care.

*Methods.*– A synthesis of the available evidence in scholarly and grey literature on mental disorders and interventions for refugee groups in European countries.

*Results.*– The prevalence rates of mental disorders amongst refugees are variable across studies, due to the characteristics of the studied groups, the context in the host country and methodological inconsistencies.

In general, the rates of psychotic, mood and substance use disorders in these groups appear similar to those found in host countries, whilst post-traumatic stress disorder is clearly more prevalent in refugees than in host populations.

Good practices include: (a) social integration through education, housing and employment; (b) outreach services to facilitate access to care; (c) appropriate coordination of physical health, mental health and social services; (d) provision of information on care entitlements and services; (e) the training of professionals in cultural competence and working with interpreters.

*Conclusions.*– Implementing good practice for mental health care of refugees may require: (a) resources for outreach services, the provision of information to patients, the training of professionals, interpreting programmes and social integration initiatives; (b) coordination and organisational flexibility to integrate health and social services, and to facilitate appropriate referrals and care pathways.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0049

### **Women’s mental health in the UK: Yesterday, today and tomorrow**

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This paper will plot the progress of women’s mental health in the UK over three generations; looking back one generation, reviewing our current generation and finally considering the next generation of young women. The position of women and the impact on their mental health status will be considered against the backdrops of their changing economic, political and professional standing. I will be presenting the case that ‘time and place’ cannot be ignored when defining women’s mental health issues and hence, must be considered for both treatment and prevention. In conclusion, I shall be considering what may be the challenges ahead in the UK which must be overcome for young women to thrive.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0050

### **Women’s mental health: Insights from WMH section of the Russian Society of Psychiatrists**

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*Purpose.*– To highlight a range of topics – which provide a coherent integrated coverage of the activity of new-born Women’s Mental Health (WMH) Section of Russian Society of Psychiatrists. Key topics include: “Science,” “Clinical activity,” “Education,” and “Social and educational public activities”.

*Results.*– A section on WMH was created in 2015. The section objectives are outlined. Activities in this area started from creation of multidisciplinary national contact network for specialists. The data collection on Russian-held studies started. The respective symposia were arranged in the national and international conferences. The issues of women’s mental health are actively elaborated by Russian specialists in topics overlapping with those stressed by EPA and WPA: women’s mental health and medical issues, women’s mental health and psychiatric treatments in pregnancy, gender and psychosis, post-traumatic stress disorders in women, violence against women, women’s mental health in conflict zones, women’s leadership, etc. The prominent role of female scientists in foundation and development of Russian psychiatry and clinical psychology are emphasized.

*Conclusions.*– The Section seeks to promote and increase knowledge of women’s perspectives in mental health, as well as fosters communication and interaction among the scientific disciplines that comprise its membership. We are all aware that some of the topics to be presented are not new but the data certainly are, and different professionals have different perspective. Much can be expected from the field of awareness of gender consideration in women’s health in Russia, and an example of such an approach is provided. We are very lucky to have great experts interested in participating and we hope this will make our Section more visible and heard.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0051

### **Women’s mental health in Turkey: Challenges and insights from the WMH section of Psychiatric Association of Turkey**

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Ranked 131st out of 142 countries listed in World Economic Forum’s 2017 Report, Turkey is one of the countries with largest global gender gap and has experienced worsening of gender parity especially in political empowerment and health and survival aspects [1]. Inequalities in various aspects of life, including education and employment, high rates of intimate partner violence, women murder cases, forced early marriages, and more recently the impact of war, forced displacement and informality in the region have all been interrelated causes of mental health prob-

lems for women. The transformation into a more conservative society and predominant conceptualization of women as a dependent member of family by the community evokes feelings of guilt, incompetence and poor self-efficacy. The outcome of these in daily practice is higher numbers of cases of depression, anxiety, trauma-related disorders and suicide.

Gender imbalance also exists among psychiatry professionals. Based on a retrospective analysis of publications from Turkey in international psychiatric scientific journals, the rate of female first and last authors is less than 40% [2]. Only one third of psychiatrists in university hospitals and less than half of those in state hospitals are women.

On the other hand, women are more aware of their psychiatric symptoms and applications to psychiatric care are increasing, together with greater availability of services and efforts for establishing a framework under mental health law in the last few years. Also, formation of multidisciplinary task forces on violence against women and promising work of psychiatrists under Women's Mental Health Working Group of Psychiatric Association of Turkey serve as a base for progressive educational activities and research in the field.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

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W0052

### Cognitive, neuroimaging and pharmacological studies of schizotypy: An overview and introduction

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*Background.*– The phenomenology of schizotypy suggests that this constellation of traits represents a subclinical expression of schizophrenia. Experimental neuropsychological and brain imaging studies are crucial to further bolster this claim. In this talk, I will present new results on cognitive, neuroimaging and pharmacological studies of schizotypy that aim to identify both similarities and dissimilarities between schizotypy and schizophrenia. Genetic risk populations are additionally considered to further demarcate the boundaries between these different schizophrenia spectrum populations.

*Method.*– Higher-level as well as basic cognitive and motor functions are studied in the laboratory in relation to schizotypy, using both extreme groups and continuous sampling methods in healthy volunteers. Schizophrenia patients and clinically unaffected first-degree relatives of patients are studied for comparison.

*Results.*– A replicable impairment in response inhibition is observed in high schizotypy. This impairment and its neural correlates overlaps in part with the deficits seen in schizophrenia. The profile of impairment diverges, however, from that seen in relatives, who are mostly characterised by difficulties in complex sensorimotor transformations on oculomotor tasks. Evidence from pharmacological challenge studies points to selective tolerance of antipsychotic compounds in high, but not low, schizotypal individuals.

*Conclusions.*– The results from these recent studies support the conclusion that schizotypal traits in the general population represent a phenotype that bears resemblance with schizophrenia not only at the level of phenomenology, but also at the levels of brain func-

tion, cognition and neurotransmitter system function. On the basis of this evidence, however, schizotypy can be differentiated from genetic risk status.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0053

### Psychosocial risk factors, gene–environment interactions, and the role of schizotypy in the psychosis spectrum

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The construct of schizotypy was developed both within the personality and medical traditions. The former proposes schizotypy as part of normal personality, being a source of both healthy variation and predisposition to psychosis, whereas the latter conceptualizes it as the inherited vulnerability to schizophrenia spectrum disorders. Current research seems to be progressively integrating both traditions, as schizotypy is progressively being understood and employed as an index of individual differences both within health and clinical high-risk status as well as a risk marker for psychopathology. The interaction of this vulnerability substrate with other genetic and environmental factors shapes the risk of presenting spectrum disorders and yields a wide range of phenotypic variance. Assessment of schizotypy provides an entry point for identifying individuals possessing liability to psychosis prior to the appearance of clinical manifestations. This should facilitate the study of developmental pathways to psychosis and the identification of protective factors in individuals not presenting with typical confounding factors associated with schizophrenia spectrum disorders. Novel research will be presented that confirms the usefulness of this trait for studying the role of psychosocial risk factors and gene–environment interactions across the broad spectrum of individual differences to subclinical and clinical psychosis manifestations.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

W0054

### Emotional processing and schizotypy: Multimodal findings in support of the neurobiological continuum hypothesis

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*Background.*– The continuum hypothesis proposes a dimensional continuity in the underlying neurobiology of subclinical psychotic-like experiences in healthy individuals (or *schizotypy*) and psychotic symptoms in patients with psychosis. Preclinical models posit that excitation–inhibition imbalances within a cortico–limbic–striatal circuit may give rise to schizophrenia-like physiological and behavioral aberrations, such as hyperemotionality, limbic–striatal overdrive, and decreased gray matter volume. Based on preclinical as well as on imaging research in patient groups, this workshop will summarize our recent studies investigating whether brain gluta-



mate levels in healthy individuals with high positive schizotypy are related to changes in (1) cortico-limbic-striatal response to emotion and (2) gray matter volume (GMV).

**Methods.**– Forty-eight healthy participants were recruited based on their score on the O-LIFE questionnaire and divided into two groups: high schizotypy and low schizotypy, matched by age, gender and IQ. A structural MRI scan, glutamate proton magnetic resonance spectroscopy in the anterior cingulate cortex (ACC), and functional magnetic resonance imaging (fMRI) during emotional processing were acquired at 3 T in a single session. Standalone imaging results as well as fMRI/sMRI × glutamate interactions in corticolimbic regions of interest were analysed with SPM12 and considered significant after voxel-wise  $P < 0.05$  family-wise error correction.

**Results.**– We found that participants with HS showed greater activation than LS subjects in the striatum and marginally in the ACC, hippocampus, medial prefrontal cortex (MPFC) and putamen. Moreover, subjects with HS showed GMV increases in the precuneus and ACC. Although no between-group differences were observed in glutamate concentrations, within the HS group ACC glutamate was inversely correlated with activation in the striatum and marginally in MPFC and amygdala. Moreover, in HS subjects ACC glutamate levels were negatively correlated with local GMV. Such correlations were absent in LS.

**Discussion.**– These findings are in line with a dimensional view of psychosis by suggesting that interactions between corticolimbic circuit structure, neurochemistry, and emotional response are involved in the expression of psychotic-like experiences at non-clinical and clinical levels. These findings may also serve as evidence of potentially protective mechanisms as they are based on high-functioning individuals with high schizotypy.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0055

### How can we improve adherence to treatment in psychotic disorders?

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Data strongly support the beneficial effects of continuous antipsychotic treatment as part of a complex treatment program already after the first episode of/hospitalization for schizophrenia (e.g. [1]). There are discussions about the benefits of such treatment, especially about how to interpret psychotic symptoms during treatment discontinuation, however the severe consequences of no antipsychotic treatment in schizophrenia and the benefits of treatment with adequately selected low-medium doses of antipsychotics have been well documented (e.g. [2–4]). The rate of adherence to antipsychotic medication reported during the course of “treatment as usual” is ca. 50%. The call of Andressen is based on evidence based data, that it is important to do as much as possible to ensure treatment adherence as a way of preventing relapse since the time of illness onset [5].

A complex treatment program with well-planned and integrated acute treatment, relapse prevention, and rehabilitation is needed for the improvement of treatment efficacy and adherence to treatment. The program should include psychoeducation.

The Section of Psychopharmacology of the European Psychiatric Association highlighted the need for improvement in teaching psychiatric pharmacotherapy to students, residents, psychiatrists and other professionals [6] and its work on some teaching materials is in progress.

Available data show, that the adherence of health care workers to various guidelines is generally low. Psychiatric and psychopharmacology associations should help (e.g. through their journals, congresses, courses) to improve the knowledge of those, who provide treatment for patients with schizophrenia and other psychotic disorders.

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W0056

### How can we improve adherence to treatment in bipolar disorders?

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Adherence to treatment in bipolar patients is linked to the general dimensions of adherence identified by the WHO:

1. Condition related
2. Therapy related
3. Related to social and economic factors
4. Patient related
5. Related to health system

ad 1. Disorders of the bipolar spectrum are frequent, diagnostic conversion from depression to bipolar disorder is high. Diagnosis of bipolar disorder (as compared to unipolar depression) is particularly difficult. Comorbidities with other psychiatric and medical conditions are frequent. Creating adherence is difficult when the diagnostic process is so particularly complex.

ad 2. Polypharmacy is a common phenomenon in psychiatric treatment, most bipolar patients have complex medication regimens when released from hospital. Polypharmacy undoubtedly reduces adherence rates.

ad 3. Decrease of quality of life, as well as social and economic deprivation obviously affect adherence. In a vicious circle, lack of adherence by itself worsens the brain morphological and functional changes associated with bipolar disorder.

ad 4. Particular lack of adherence has been demonstrated in adolescents, in late-life bipolar disorder, in patients with depressive residual symptoms and in bipolar patients with cyclothymic temperament. Bipolar patients exhibit characteristic cognitive deficits that distinctly influence their capacity to adherence.

ad 5. While psychoeducation can improve medication adherence, the availability of such interventions is still limited.

In summary, a holistic approach to adherence in bipolar disorder should be implemented. Local consensus initiatives to increase adherence are as necessary as global projects.

**Disclosure of interest.**– The authors have not supplied their declaration of competing interest.

W0057

### How can we improve adherence to treatment in anxiety disorders?

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Treatment adherence represents a challenge not only for patients but also for the health profession for many decades.

Adherence as defined by WHO [1] is considered as “The extent to which a person’s behavior—taking medication, following a diet, and/or executing lifestyle changes—corresponds with agreed recommendations from a health care provider”.

WHO classifies these factors into 5 categories:

- socioeconomic factors,
- factors associated with the health care team and system in place,
- disease-related factors,
- therapy-related factors,
- patient-related factors.

Anxiety costs correlated has been estimated in European Union [2] and, excluding PTSD and other Stress related Disorders in 2010 the amount were of 1076 euros per subject in the EU, and in Italy about 1013 euros, for a total of 65,995 millions of euros as total costs (in Italy 8244 millions of euros). Of these more than 60% are direct healthcare costs while large amount is due to other costs.

The last 5 years has witnessed significant attention toward adherence to treatment and to medical guidance with cognitive behavioural therapy (CBT) including homework for anxiety and adherence assessment methods have diversified. Other form of Adherence improvement programme involve use of teleducation, educative fictions specifically appointed, anti-fake news educational mass systematic program. While a large component of the adherence process is not assessed in CBT, with patient effort, engagement, and the known role for treatment appraisals and beliefs necessitating the pursuit of improved adherence assessment methods.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.

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W0058

### How can we improve adherence to treatment in depression?

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While antidepressants play an important role in depression treatment, non-adherence to antidepressant is estimated around 40–60% of patients. Treatment adherence presumes patient’s agreement with the recommendations of the therapist and should be defined as a dynamic process, leading to a collaborative relationship.

It is a multifactorial phenomenon, related to type of drugs and dose, relationships with provider, patient and his/her disorders, health system. Some of the most established factors are the attitudes and beliefs of patients and their family about health, depression and antidepressant. In the acute phases, changes in beliefs about antidepressants occur: perceptions become more pro-adherence with treatment experience. In the maintenance phase, the different degrees of adherence are explained by the balance between the perceptions of need and of potential harm.

All these factors are modifiable. Some interventions were implemented in order to improve adherence to antidepressant: shared decision making, educational interventions, behavioural interventions, cognitive and behavioural therapy. The most effective were multifaceted interventions that used all these strategies and increased the intensity and the frequency of visits.

*Disclosure of interest.*– The authors have not supplied their declaration of competing interest.