ABSTRACT BOOK

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on Integrated Care and Assertive Outreach

SHAPING THE FUTURE OF COMMUNITY MENTAL HEALTH CARE

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Index

Oral Presentations

Workshop

Poster

Symposia

Oral Presentations

FRIDAY, SEPTEMBER 6

PARALLEL SESSION 1 - DEINSTITUTIONALIZATION TRAJECTORIES

O21 • IMPACT OF CTO ON BEDS USAGE IN ASSERTIVE OUTREACH

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Aims: Examine the impact of using Community Treatment Orders in Assertive Outreach team

Methods: Comparing use of inpatient care before and after CTO in mirror image design study. All patient that are under the care of Assertive Outreach team in Leicester and subject to CTO since its introduction in 2008 were assessed for their use of inpatient care. The days that spent in inpatient were. compared with their use of inpatient care when they were not under CTO.

Results: There was significant reduction in number of admissions and inpatient days when under CTO compared to when not under CTO in same patients group

Conclusions: CTO may present an effective intervention in reducing inpatient usage for patients under care of Assertive Outreach.

O3 • SHAPING DEINSTITUTIONALIZATION: ONE FOR ALL VS. ALL AGAINTS ONE

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Aims: The purpose of this study is to reveal the peculiarities of the implementation of deinstitutionalization with the contribution of different groups of society in post-Soviet region. The study will include the following inter-groups: the public sector, which can be divided into two groups: policy-makers and policy-implementators. Other important part of groups include the non-governmental sector and the academic community. These groups will allow us to reveal the discourse of existing deinstitutionalisation shapes.

Methods: Triangulation of methods will be used at checking the coherence between the scientific disability discourse and disability practice thus contributing to the understanding of the process of incorporating the perspective of human and disability rights in science and civil society.

Results: The results will show which groups are most shaping the deinstitutionalisation process and at the same time distorting its proper implementation, as the implementation of this process requires sustainable interaction and feedback from all stakeholders.will analyze scientific articles related to deinstitutionalisation, as well as interviews with scientists who are in charge of the relevant field. Management documents will provide information on the involvement of various stakeholders in the closure of institutions and the development of community services.

Conclusions: It is very important to investigate what is the main factor influencing the emergence of community services in creating a new, innovative, human rights-based social service system. The essential problems with this research will be to show the places that need improvement.

O18 • IDENTIFYING PATTERNS OF PSYCHIATRIC HOSPITALIZATIONS: TOWARDS A TYPOLOGY OF POST-DEINSTITUTIONALIZATION TRAJECTORIES

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Aims: Over the past fifty years, deinstitutionalization changed the face of psychiatry. However, outpatient treatment does not always fit the needs of those who left institutions and sometimes leads to frequent re-hospitalizations, a mechanism known as the "revolving door" phenomenon or the inability to find a rightful place in the community. The study aim was to identify different typologies of hospitalization trajectories.

Methods: Records of 892 inpatients from the Department of Psychiatry of Lausanne University Hospital, Switzerland, were analysed over a three-year period with discrete sequential-state analysis.

Results: Trajectories could be split into atypical users (4.9% of patients totalling 30.6% of hospital days) and regular users. Within the atypical users group, three categories were identified: "Permanent stays" (3 patients totalling 6.3% of hospital days), "long stays" (1.7% patients / 8.6% hospital days) and "revolving door" stays (2.9% patients / 15.8% hospital days). The remaining 95.1% of the patients were classified as "unique episodes" (70.0% patients / 24.5% hospital days) and "repeated episodes" (25.0% patients / 44.9% hospital days). Diagnosis of schizophrenia was overrepresented among heavy users.

Conclusions: While the shift of previously institutionalized individuals towards high users of psychiatric hospital seemed limited, this phenomenon should not be neglected since 4.9% of patients used about a third of hospital beds. The development of programs such as ACT or housing first, which remain scarce in Switzerland, should be considered.

O24 • IS HOME TREATMENT SUITABLE FOR PATIENTS WITH INVOLUNTARY ADMISSIONS TO A PSYCHIATRIC HOSPITAL?

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Aims: Home Treatment (HT) is an effective alternative to inpatient treatment for individuals with severe, acute mental illness, although not applicable in every situation (e.g., risk of self-harm). Here we examined whether HT is also suitable in case of involuntary admission before transferring to HT.

Methods: We analyzed data of 377 treatment cases in HT between 2016 and 2018 of a large University Hospital with an urban and peri-urban catchment area. We compared the frequency of documented treatment complications such as serious incidents, patient-initiated treatment termination, and need of hospital days during or directly after HT between involuntary and voluntary admissions.

Results: In total, 15.1% of all cases were involuntarily admitted to hospital before transferring to HT. These cases did not differ from voluntary admissions regarding gender, age and severity of symptoms, however, they had more often an F2-diagnosis as main psychiatric problem. Overall, serious incidents were rare (< 2%) and 45 cases (12%) were in need of hospital days during or directly after HT with no differences regarding the voluntariness of admissions. Involuntary admissions, however, significantly more often terminated HT prematurely (8 of 21 cases).

Conclusions: We conclude that treatment complications are not more frequently in involuntarily admitted patients with the exception of premature treatment termination. These results emphasize the need of an initial assessment including the risk of harm to self/others as well as the ability to cooperate and the patients' preference for HT.

O100 • THE AVILÉS ASSERTIVE OUTREACH TEAM (199-2019). TWENTY YEARS OF EXPERIENCE

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In last decades, mental health services have improved with the development of balanced healthcare systems focused on the development of community services and the integration of hospital beds in general health facilities.

Assertive community treatment (ACT) teams were firstly adopted in the USA in the late 1970s. Their main objectives are to maintain patients in contact with the health services, avoid treatment dropouts, improve community integration and avoid hospital admissions. ACT teams have become a standard model of very intensive community healthcare for people with severe mental. In Spain, ACT teams have been progressively implemented in several autonomous regions, led by the Asturias Mental Health Services more than 15 years ago. The so-called "Aviles model", named after a town which has been a pioneer in the implementation of this type of service, has been recognised as an example of good practice in the Strategy for Mental Health of the Spanish National Health System (2007). The Avilés Assertive Outreach movement started to be deployed in 1999.
Methods: The main objective of this study was to assess the impact of the establishment of a new healthcare service for patients with severe mental illness, in this case an AO team, on the use of hospital facilities. Our hypothesis, endorsed by previous studies, is that patients receiving care by AO teams or similar have lower levels of admissions than similar patients under standard treatment. A secondary objective was to assess the impact of the ACT team on hospitalisation costs. The activity of an ACT team was assessed from when it started in June 1999.
We analysed the progression of the 285 patients involved in the programme over a period of 20 years, and compared psychiatric admissions prior to and during the operation of the AO programme. We considered the number of hospital stays in inpatient units before and after the programme, as well as the costs of hospitalisation and of ACT through the Rehabilitation Service.
We also analyse: clinical outcome, psychosocial functioning or social integration, quality of life involuntary admissions, suicides, voluntary drop-outs, returns to standard treatment, satisfaction with the programme (Both patients and families), needings satisfaction…

Results: After enrolling on the programme, hospital bed days decreased. Also did hospitalization costs. Most of parameters evaluated improved after patients were discharged from CMHC to AO team

Discussion: The present study endorses numerous previous stud-ies carried out in different contexts, confirming that ACT- AO is effective in reducing the need for psychiatric hospitalisation in patients with severe mental disorders with ow levels of adherence, complex healthcare needs and multiple admissions.
Most participants gained access to the AO team, often with a history of prolonged hospitalisations in previous years, and this may contribute to the spectacular results achieved.

Conclusion: Together with other alternatives to hospitalisation and residential social and healthcare facilities, our experience confirms that ACT programmes are an effective tool, for the development of a community model. In particular, these programmes (with their associated costs) are an efficient use of resources, leading to a significant decrease in the need for inpatient facilities. Further research should investigate the impact of this type of service on other factors beyond hospitalisation, including patient clinical status, psychosocial functionng, quality of life and the satisfaction of patients and caregivers. It is also necessary to properly identify the type of patient who may benefit most from this type of service compared to standard care, in order to reduce redundancy and duplicity of services, while maintaining continuity of care.
It is very important for us to make a difference between AO teams and Case Management.

PARALLEL SESSION 2 - FACT AND ACT INTERVENTIONS – 1

O1 • FACT TEAMS: DEVELOPMENT IN SLOVENIA AND IMPLEMENTATION WITH THE NATIONAL RESOLUTION FOR MENTAL HEALTH

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Aims: To present implementation of FACT in the National Mental Health Plan in Slovenia.

Methods: Describing the community care implementation in the national document as well as protocol, evaluation

and educational materials used in the process including FACT Manual adaptation. First evaluation of FACT Teams developed in rural and high risk areas regarding suicide in Slovenia used Camberwell Assessment of Need, demographics and clinical characteristics of the population involved.

Results: Reduction of overall needs were proved in population of 250 patients using new services. The characteristics are high prevalence of schizophrenia and related disorders, involving service users with high needs regarding financial income, personal safety, loneliness and unemployment. A large proportion of the sample was transferred to other services in the prolonged period of assessment and collaboration with other community services.

Conclusions: Implementation of FACT in Slovenia needs continuous consultation among all stakeholders and international partners.

O8 • THE EFFECTIVENESS OF FLEXIBLE ASSERTIVE COMMUNITY TREATMENT - A QUASI-EXPERIMENTAL CONTROLLED STUDY

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Aims: F-ACT has expanded widely in Denmark despite scarce evidence for the effectiveness of F-ACT compared with Assertive Community Treatment (ACT). Current studies are limited due to lack of a control group and call for research to establish whether F-ACT will dilute care and result in worse outcomes for patients with the highest treatment needs. The aim of this quasi-experimental controlled study was to explore the differences in mental health care use between F-ACT compared with ACT and Community Mental Health Treatment (CMHT).

Methods: We combined cross-sectional socio-demographic data from index date and register-based hospitalization data in the two years before and two years after the index date. The study also includes data from the F-ACT board to study transitions between the levels of care.

Results: Results of the follow-up study are expected soon and will be presented at the EAOF conference. Results of the F-ACT board show that the mean duration of upgraded intensive care was 22,5 days. There was no difference in the mean number of days in intensive care between patients from previous ACT and CMHT.

Conclusions: Preliminary findings indicate that the need for intensive care within F-ACT is equally important for patients from ACT and CMHT. How these findings are associated with changes in health care use will be demonstrated with register-based follow-up data to understand how F-ACT impacts health care delivery.

O15 • ASSERTIVE OUTREACH, COMMUNITY TREATMENT ORDERS AND QUALITY OF LIFE ASSESSMENT

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Aims: Assess quality of life (QOL) of Assertive Outreach Program (AOP) Clients and CTO clients enrolled in the AOP (Red Deer Area, Central Zone, Alberta). Describe QOL prevalence in terms of four domains (Physical, Psychological, Social Relationships and Environment). Depict characteristics of subgroups and portray satisfaction with the AOP.

Methods: Applied a qualitative cross-sectional evaluation design and conducted a survey during September - October 2018. The World Health Organization Quality of Life (WHOQOL-BREF) questionnaire was administered to collect data.

Results: In context of equity in service provision the evaluation yielded the following: 17 CTO clients perceived their overall QOL ($\bar{x}$=4.1, SD=0.5) and Health ($\bar{x}$=3.6, SD=0.9) slightly better than 97 AOP clients (QOL: $\bar{x}$=3.8, SD=0.8; Health: $\bar{x}$=3.4, SD=1.1). CTO clients were more satisfied with the Psychological ($\bar{x}$=65, SD=16.0) and Physical ($\bar{x}$=61, SD=17.8) domains than the AOP clients ($\bar{x}$=59, SD=20.4 & $\bar{x}$=58, SD=18.6). AOP clients were more contend with the Environment ($\bar{x}$=67, SD=17.7) and Social Relationships ($\bar{x}$=56, SD=24.9) domains than CTO clients ($\bar{x}$=65, SD=14.7 & $\bar{x}$=55, SD=23.7). AOP clients were somewhat more satisfied with the AOP than CTO clients. Highest rankings related

to services received (AOP: $\bar{x}$=4.3, SD=0.7; CTO: $\bar{x}$=4.3, SD=0.7), the caring/involvement of staff (AOP: $\bar{x}$=4.4, SD=0.7; CTO: $\bar{x}$=4.3, SD=0.7) and how the service helped (AOP: $\bar{x}$=4.1, SD=0.7; CTO: $\bar{x}$=3.9, SD=1.0).

Conclusions: Uncertainty about the effectiveness of CTOs remains. Nevertheless, results suggest that a combination of a CTO issuance and enrollment in the AOP positively affects QOL. The challenge is to strike a fair balance of service provision and care among competing needs of AOP and CTO clients.

O19 • IMPLEMENTATION OF NATIONAL MENTAL HEALTH PLAN 2018-2028 IN SLOVENIA THROUGH PREVENTION, PROMOTION AND FACT

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Aims: The aim is to present opportunities and obstacles to implementation of mental health reform in first Community Mental Health Centres in Slovenia. The outline of the reform will be presented and first steps in pilot regions with evaluation of first FACT teams. Training of mental health workers in line with European Community based Mental health Service Providers guidelines and FACT manual will be presented, as well as planned evaluation of new services. The process evaluation of the reform is to be discussed regarding service users and families participation. Major remarks and criticism are to be presented.

Methods: Pilot FACT teams were evaluated with demographic and process variables, as well as with needs assessment, using CANSAS questionnaire.

Results: First FACT teams were and are currently working with more than 1000 service users. These are predominantly people with severe mental illness, with low income and socially excluded and with many needs. One third of the this group are in risk of suicide or self harm. In people who were discharged from FACT unmet needs were much lower than at the beginning of treatment.

Conclusions: The development of assertive outreach in Slovenia is important for people with severe mental illness, and probably for all groups of service users. Slovenia needs international support in the implementation of mental health reform.

O20 • FACT 3.0, WORKING IN A NEIGHBORHOOD WITHOUT "SEGREGATION" OF CAREGIVERS

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Aims: We believe that working in a small catchment area of only two boroughs and providing al services in one team in close cooperation with the local general practitioners and other local services we can make a difference in the patients journey. In the Netherlands, the health care is segregated resulting, especially in mental health care, in very ineffective care and treatment provision. Most consumers are dissatisfied because waiting lists are long, care is not effectively coordinated and in complex cases the given care is not meeting standards of cooperation that is needed nor wished for.

Methods: In this oral presentation, we will start with an explanation on the changes on mental health care in the Netherlands and the necessity for FACT 3.0. Then we will give an insight in our first findings and tell you about our experiences with our patients and local caregivers.

Results: In our project we have bridged this segregation and are working in one team in a small catchment area with an integrated team of colleagues from a mental health organization, addiction service provider, sheltered housing provider and social services. All four organizations have committed in working together with the local government. Aim is to be responsible for all psychiatric (including addiction) needs of all civilians living in our catchment area and working in close cooperation local General Practioners. In our presentatieon we hope to have a discussion with the audients about working in the neighborhood with an integrated care team.

Conclusions: Working closely to the community in small teams providing integrated mental health care including psychiatric and addiction treatment besides providing sheltered living and home care to all people living in the neighborhood is the best way of organizing mental health care in the community in densely populated area's.

PARALLEL SESSION 3 - RECOVERY-ORIENTED COMMUNITY INTERVENTIONS

O22 • COLLABORATING BETWEEN MENTAL HEALTH AND WELFARE: NEIGHBORHOOD CARE IN DE DUTCH NEW MENTAL HEALTH MOVEMENT

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Aims: Positive Health is defined as the the ability to fulfil goals despite illness and handicap. This shifts focus from ill-health (symptom/failure) to well-being (challenges/resilience). Relevant domains are symptomatic (somatic and psychological), participatory (self-care and (social) engagement) and personal recovery (goal realisation and quality of life). The concepts matches the ideas that have been propagated for years in the patient movement in psychiatry. They are always relevant but even more so in patients suffering from severe mental illness, for which psychopathology is both cause and consequence of social marginalisation.

Methods: Starting from epidemiological research we assessed the feasibility of the current care. In focus groups and stakeholder exchanges, alternatives were formulated. Developments are open ended and discussed within communities to progressively change care. Proof of concept is piloted in neighbourhood communities.

Results: Recovery and Positive Health add the importance of daily life adaptational strategies, to the traditional overemphasis on symptom relief. This is facilitated by ambulatory care, where patients live in their own environment, there were they want to succeed. Their living environment is the place in which they are challenged and encounter stress, but also the natural training situation. Optimised treatment helps building resilience. The shift towards Positive Health requires resources, beyond what is traditionally provided in a silo-ed mental health system. It requires better collaboration with the somatic care field (primary care) and the welfare system (social participation). Over the years self-profiling and specialisation has aleniated psychiatry from its natural partners. Sector broad collaborations through contracts between institutions, are no solution.The Dutch New Mental Health movement shifts most mental health resources to the neighbourhood, to develop a face-to-face collaboration with general practitioners and local community resources. It also allows to activate the personal resources of individuals in their own living environments.

Conclusions: The change in approach, that is piloted in different local communities, often allows for more creative solutions for the different challenges of the positive health domains. It allows a comprehensive and more flexible care, that does not neglect crucial domains, but empowers clients, relatives and even professionals from other domains.

O23 • DELIVERING PERSON-CENTERED CARE IN THE COMMUNITY

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Aims: Although most providers report they deliver person-centered care, a key component of quality mental health care, there is a lack of objective measures in routine mental health settings. This NIMH funded study utilized an objective measure to examine competency in person-centered care across service programs within community mental health clinics.

Methods: The study setting was 8 community mental health clinics participating in a RCT of person-centered care planning (PCCP), a recovery oriented practice. At baseline, 155 consumer service plans were reviewed using the Person-Centered Care Planning Assessment tool measuring PCCP competency (0-13) with subscales measuring

person-centeredness of the service plan (0-8), person-centeredness of the care process (0-2) and technical proficiency of the service plan (0-3).

Descriptive statistics calculated PCCP competency by program and analysis of variance compared differences across program types.

Results: Overall, clinics demonstrated a medium level of PCCP competency (M=6.35, SD=2.30). Subscale scores indicated low levels of person-centeredness of the service plan (M=2.71, SD=1.73), high levels of person-centered care process (M=1.79, SD=0.42) and medium levels of technical proficiency (M=1.84, SD=0.90). There were significant differences across programs (F (7,147)=6.40, p<.001) with Assertive Community Treatment demonstrating the highest level of PCCP competency (M=8.35, SD=1.60) and outpatient therapy (M=4.95, SD=1.70) and partial hospitalization (M=5.38, SD=1.19) demonstrating the lowest levels.

Conclusions: This study indicates that despite provider perceptions, person-centered care may not be consistently delivered in mental health settings. More research is needed to operationalize, measure and promote person-centered care across community mental health programs.

O53 • THROUGH DEPENDENCY TO RECOVERY: USERS' AND PROFESSIONALS' OPINIONS IN THE MENTAL HEALTH DEPARTMENT OF TRIESTE

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Aims: Institutional dependency was historically defined as inmates' passive adaptation to the deprived environment of asylums, yet some authors suggested that also community care systems may unintentionally limit patients' autonomy and generate dependence. A recent review found out five different concepts of dependency on community mental health services, and suggested that dependence may not be considered as an entirely negative condition of deprivation nor simply the contrary of recovery and autonomy. The current emphasis on whole system, recovery-oriented approach to community mental health care requires a deeper understanding of the complex relationship between dependency and recovery.

Methods: In this qualitative research we explore how users and professional of the Mental Health Department of Trieste perceive, define and live features of dependency on the community services. We conducted eight focus group with 29 users and 39 professionals of the four Community Mental Health Centers. Each focus group was audiotaped, the interviews were transcribed and a thematic analysis was conducted with the support of the RQDA software.

Results: We found out nine themes and 42 subthemes which describe the dimensions of users' dependency in the CMHCs. The nine themes are named: 'What is dependency', 'How the social context foster or hinder dependency', 'Dependency and service organization', 'Interpersonal dependency', 'Types of support and help that foster dependency', 'Dependency as a protection both for the users and the service', 'The identikit of the dependent person', 'Ruling dependency', 'Time of dependency'.
'Time of dependency' theme collects users' and professionals' opinions about the the ranges of roles dependency may have in relation to two variables: duration and awareness.
Transitional and meaningful forms of dependency on the CMHCs are recognized by the two groups as an useful condition during the process of recovery and personal growth. Six subthemes are linked with 'Time of dependency' theme: 'Transitory dependency', 'Dependency during a meaningful project', 'Dependency and recovery process', 'Dependency and inactivity', 'Dependency and unproductivity', 'Dependency as the repetition of the same'.

Conclusions: Our results enlarge the conceptual map of users' dependency in the recovery-oriented community-based services. Dependency may represents a positive element in the recovery process, as long as the person need to rely temporarily on the service for the rehabilitation aimed at re-integration in the community.

O29 • RECOVERE: IMPLEMENTATION OF COMMUNITY MENTAL HEALTH TEAMS IN 5 EUROPEAN COUNTRIES

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Aims: The aim of the presentation is to inform participants about the RecoverE research project (LaRge-scalE implementation of COmmunity based mental health care for people with seVere and Enduring mental ill health in EuRopE) Croatia, Montenegro, Romania, Bulgaria en Macedonia.

Methods: This is an example of a European collaboration involving 16 consortium partners under the project management of the Trimbos Institute, The Netherlands.

Results: The aims, methods and organisation of the project will be discussed. We will illustrate the challenges and successes of the project implementation. Partners on the project will be approached using video connection to inform participants of the latest news in their implementation process.

Conclusions: Participants understand the aims and methods of RecoverE and the ethos of supporting other cultures in sustainable practical change.

O4 • REORIENTATION OF MENTAL HEALTHCARE IN CROATIA AND THE MINDSET

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Aims: In Croatia mental disorders rank third in the burden of diseases. Mental disorders are the main cause of hospital morbidity in active population, while morbidity at the level of primary care is 4% - 5% of all causes of morbidity. Although there was a continues decline in hospital days from the year 2000 to 2016, the total number of hospitalizations increased. A reorientation of the way Mental Healthcare is organized was necessary. In 2017 Croatia started the first teams for Community based Mental Healthcare. To make a change possible, training the mindset of all stakeholders was part of a program.

Methods: In a one year European Twinning project, Croatia and the Netherlands worked together to prepare and start a change from Hospital based Mental Health Care to Community based Mental Healthcare. A change in mindset about Mental disorders among all stakeholders, clients, family, professionals and policymakers was an important part of the project. Guidelines and policy documents were prepared. Mindset tips were introduced.

Results: In Croatia now are five Community based teams operational. In three cities they do homevisits, they work as a team together with people with lived experience. The goal is recovery by using care connected to the needs of the people based in community. 15 mindset tips are formulated and used as a compass. The emancipation of people with lived experience is increased. Clients have more influence on the policy on different levels.

Conclusions: There is a start working with Community based mental Healthcare teams. Continuation and support is needed. A good policy by the government is necessary. The needs of the clients should be the primary reason to invest in good community based mental Healthcare. Community will benefit from a change in mindset.

PARALLEL SESSION 4 - FACT AND ACT INTERVENTIONS – 2

O50 • STAKEHOLDER PERCEPTIONS OF IMPLEMENTING FLEXIBLE ACT IN GENERAL MENTAL HEALTH SERVICES IN SWEDEN

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Aims: The aim of this study was to explore different stakeholder perceptions of implementing the Flexible ACT model in Swedish general mental health services for users with fluctuating complex needs. Integrated services such

as Assertive Community Treatment (ACT) and Flexible ACT has been implemented in Swedish mental health services to meet the needs of persons with psychosis. No integrated care model, however, exist for persons with mood, anxiety, personality and post-traumatic stress disorders who suffer from low functioning with fluctuating complex needs in risk of suicide. To enable the implementation of a new model, it is important to explore stockholder views.

Methods: In this case-study, eight focus groups with stakeholder groups of staff, managers, and service users' in mental health and social services were performed. Data was analyzed using thematic analysis and within and across group comparisons.

Results: Flexible ACT had high legitimacy among stakeholder groups. It was perceived to have the potential to increase availability and continuity of care and support for the user group. Providing flexible individually adapted seamless transition of care and support was highlighted as well as the need to keep the user-professional relationship throughout the chain of events. Furthermore, Flexible ACT was perceived to increase quality of care and client safety by providing a structure when handling client crises, increasing service user satisfaction, and the flow between mental health services and primary care. Working with a shared caseload was perceived by the staff in mental health and social services to have the potential to decrease stress and increase control over the work situation. Organizational barriers regarded lack of personnel.
Furthermore, lack of experiences of integrating mental health and social services including difficulties of confidentiality between services was considered a barrier. Care and support values and perspectives also differed between stakeholder groups. Services users perceived the new model to be very different from the current care model and reflected on whether staff were prepared to leave the more distanced clinical role in favor of getting to know the user and his or her needs.

Conclusions: The implementation of Flexible ACT has high legitimacy in all stakeholder groups as a potential care and support model in general mental health services. However, several implementation barriers needs to be considered when implementing the model.

O58 • F-ACT+; INTEGRATED CARE FOR FLEXIBEL ASSERTIVE COMMUNITY TREATMENT IN DUTCH PSYCHIATRIC AND ADDICTION HEALTHCARE

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Aims: In the Dutch province of Friesland, the two organisations that delivere their aid are GGZ-Friesland for psychiatric help and VNN for addiction-treatment. Both organisations had their own teams for outreaching care according to the principles of Flexibel Assertive Community Treatment (F-ACT). Both teams provided care sequentially or parallel; But never together. Until the year 2014 when both organisations, more specifically both F-ACT teams started to work as one. From that point on these teams would be named F-ACT+ (plus).

Methods: The NEMESIS study (2010) states that 20-60% of all psychiatric patients have some form of addiction. The 2010 Dutch survey (Graaf,et.al.) states that in addiction 60-80% also deal with some form of psychiatric illness. Giving these patients integrated treatment ends with better results. Psychiatric symptoms and substance abuse can lessen. Also the total number of admissions in clinics will lower.

That's why F-ACT+ was founded; An integrated team recognises the psychiatric symptoms in patients suffering from addiction and vice versa.

Results: Since 2014 F-ACT+ has 3 teams. First as a pilot, now as a new standard, with an active total caseload of 600 patients. Even in the pilot-fase all three teams got certified by the CCAF; And last year all teams got the highest possible rating for patient-satisfaction.

Conclusions: Being the first team(s) offering this type of integrated care we want to share with you our experiences: What we've learned along the way and from one another. We want to share with you our vision and our future goals.

O62 • FACT TEAM FOR PEOPLE WITH SUBSTANCE USE DISORDERS (SUD): PRACTICAL CONSIDERATIONS AND PRELIMINARY RESULTS

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Aims: To investigate if the FACT model is feasible and effective for patients with severe SUD.

Methods: A FACT team for people with SUD was established in cooperation between the municipality of Sagene in Oslo, the Agency for Addiction and Social Services in Oslo and Oslo University hospital. The team has 10 employees, and started recruiting patients June 2018. The inclusion criteria were: Persons above age 18 with a main diagnosis of SUD, poor social functioning, in need of integrated treatment services and with several previous unsuccessful attempts of ordinary treatment. A research team will conduct a longitudinal observational study, and evaluate the team according to fidelity and effect in accordance with standard FACT team evaluation procedures.

Results: To date, 32 patients are included in the team. Their mean age is 48 years. All patients use substances on a daily basis. The majority of patients use opioids, and half of these are included in opioid substitution treatment. The first 26 included patients had a total number of 64 somatic diagnoses, including infectious diseases, renal diseases, hepatic failure, hypertension, COPD, and cancer. Even so, at inclusion, most patients had not seen a physician for years. In addition to poor somatic health, the patients are characterized by poor dental health, nutrition status and cognitive functioning. Also, mental disorders are common, including affective disorders, anxiety disorders, ADHD, personality disorders and psychotic disorders. Common challenges are chaotic lives, poor cognitive functioning and negative experiences with health care services.

Conclusions: Working with hard-to-reach substance users according to the FACT model is feasible and useful. In addition to use harm reduction strategies targeting substance use, the team succeeds in examining and treating somatic health and mental disorders.

O63 • IS DOUBLE DIAGNOSIS “TRIPLE TROUBLE”? OUTCOMES OF SOCIAL RECOVERY FOCUSED TREATMENT OF AN ACT TEAM

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Aims: The last ten years early intervention psychosis teams have been set up in the Netherlands to make the treatment of first episode psychosis more effective. Our team started in 2006 as second in the country and stands out because of its ACT model fidelity and the strong focus on social recovery. The focus is to start treatment as early as possible and offer treatment in multiple areas of social functioning. We hypothesized that comorbid addiction problems/disorders lead to longer duration of treatment, more treatment in the specialized mental health care and lower level of social functioning in different terrains.

Methods: Since 2006 the ACT team collected prospective data on different outcome measures. We used the 10 years follow up data from 2006 until 2009. One important outcome measure is ‘treatment after discharge’. In the Netherlands there are a few options: ‘General Practitioner with or without the combination with basic mental health care’ or ‘specialized mental health care’. The other outcome measure is the total score on the Functional Remission Instrument (FRI). We analyzed the FRI and “treatment at discharge” outcomes, the different patient characteristics, the psychiatric and addiction diagnosis at discharge from the ACT and after 10 years.

Results: 62% is male, mean age is 29 yrs. 30% has the diagnosis schizophrenia, 25% the diagnosis psychotic disorder NOS, the other 45% had diagnosis like schizoaffective disorder, delusional disorder or a personality disorder. 32% has a comorbid addiction disorder or problem, defined as an high score on the HONOS measure of addiction and/or an official diagnosis at the time of the intake. The drop out was 7,8%. At discharge 51% has follow up in the specialized mental health care (SMHC) and 43% at the GP, 6% was unknown. After 10 years 62% had treatment in specialized mental health care and 38% with the GP. Addiction or an addiction disorder had no influence on the level of social recovery (Pearson X2 =2,457; p=0,28), treatment duration (Pearson X2= 4,8430, p= 0,304) or discharge to SMHC

(Pearson X2 =0,833; p=0,661). Age at start of the treatment with the ACT had a significant influence on the chance of follow up in SMHC at discharge (Pearson X2 =7,48; p= 0.017) and at 10 years (Pearson X2 =13,847; p=0.016) . On the FRI there is no significant influence of the different variables on remission (y/n).

Conclusions: In contradiction to our hypothesis addiction does not have a significant influence on the outcome in terms of social recovery, treatment duration and follow-up treatment. A younger age at start of the treatment associated with a bigger change on (long term) follow up treatment in the SMHC.

O44 • AFTER FACT: HOW WELL DO CLIENTS MANAGE AFTER DISCHARGE FROM A FACT TEAM?

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Aims: Originally, an important aim of de model of Flexible Assertive Community Treatment (FACT) was to support all patients with a severe mental illness within a catchment area of 50.000 inhabitants and to keep these patients in care as much as possible. Time has changed, however. In the mental health care Organisation, GGZ Noord-Holland-Noord, where FACT was originally developed, nowadays clients are stimulated to end the support of a FACT team when possible. In this study, we aimed to follow-up patients who were discharged from a FACT and referred to their general practitioners.

Methods: One year after their discharge from a FACT team, clients who weren't re-enrolled in a FACT team, were asked to participate in an assessment of their functioning and quality of life. When they were willing, a telephone appointment was made. In this appointment assessments were done using the Health of the Nation Outcome Scales (HoNOS), and the Manchester Short Assessment of Quality of Life (MANSA) and a short assessment that measures Personal Recovery. Also, questions were asked about their living and working situation and the extent to which they received care from the GP or the social psychiatric nurse.

Results: In all N=72 clients participated and the final analyses of their data are still underway. Preliminary findings show that more than 40% of the patient didn't receive support from a GP or SPV. The HoNOS total score was relatively low and the MANSA score relatively high, with better outcomes among patients who didn't receive support from either the GP or the community psychiatric nurse.

Conclusions: The first preliminary findings show that, with exceptions, the group of patients who weren't re-enrolled in mental health care, seem to functioning reasonably well, which justifies their discharge of mental health care.

PARALLEL SESSION 5 - PREVENTION AND EARLY INTERVENTIONS IN CHILDHOOD AND ADOLESCENCE

O41 • A PILOT STUDY OF THE COST-EFFECTIVENESS OF YOUTH F-ACT IN THE NETHERLANDS

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Aims: Cost-effectiveness evaluations of treatments with children and adolescents are not sexy, but highly necessary in times council and national budgets face deepening cuts. F-ACT youth care is a community-based intervention for children and adolescents with complex problems in multiple areas of life and their families. Due to its outreaching and multidisciplinary character, costs of this intervention are high, but it avoids more costly inpatient care. Little is known about the cost-effectiveness of this intervention, especially for youth populations.

Methods: Between 2017 and 2019, F-ACT youth care was implemented in three teams in a Dutch region in which a routine outcome measurement system was implemented. Patients receiving F-ACT were compared with patients receiving TAU in a Dutch mental health clinic with similar population during a 6 month intervention period. In all, 30 adolescents aged 12–18 years and their parents, participated; (15 F-ACT; 15 TAU). Outcome measures were the percentage of adolescents with a clinically significant improvement on the Kidscreen and QALYs. Costs were measured using a retrospective cost-questionnaire. Outcomes and costs were assessed at pre- and post- treatment.

Results: Results will be presented during the conference after analyses have been performed.

Conclusions: Conclusions will be presented during the conference after analyses have been performed.

O83 • THE EFFECT OF CHILDHOOD ADVERSITIES ON BIOMARKERS RELATED TO GLUCOSE METABOLISM IN FIRST-EPISODE PSYCHOSIS PATIENTS

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Introduction: We have no reliable predictors of treatment response in first-episode psychosis (FEP), which makes difficult to develop treatment strategies tailored to the individual needs. Biomarkers of metabolism hold great potential to assume this role. Childhood trauma (CT) increases the vulnerability to develop both mental and metabolic disorders. One of the possible biological mechanism underlying the association between CT and the development of metabolic dysfunctions is represented by glucose metabolism. We explored the effect of CT on plasma levels of biomarkers related to glucose metabolism in a large cohort of first-episode psychosis (FEP) patients, recruited within the GET UP Research Project.

Methods: Clinical data were collected by SCAN for diagnosis, PANSS, HAM-D and BRMRS for psychopathology, CEQ for cannabis use, and CECA-Q for CT. Stressful life events (SLEs) were recorded using a semi-structured interview. The concentrations of C-peptide, Ghrelin, GIP, GLP-1, Glucagon, Insulin, Leptin, PAI-1, Resistin and Visfatin were analysed. Multivariate linear regression models were estimated to test the associations.

Results: Out of the 148 patients assessed, 49% (55% males, mean age 29) reported CT. Multivariate models showed that CT influenced only the levels of C-peptide and Insulin after adjusting for age, sex, BMI and SLEs. Specifically, patients who had experienced CT showed higher C-peptide and Insulin concentrations when compared with those who had not.

Conclusions: Our results suggest that CT increases the plasma levels of some biomarkers related to glucose metabolism in FEP subjects, thus suggesting that abused children could benefit from target interventions aiming at improving both mental and physical health.

O72 • THE INTEGRATION OF INNOVATIVE FIRST EPISODE PSYCHOSIS MODELS OF TREATMENT IN A STANDARD PSYCHIATRIC SERVICE

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1 Aulss 6 Euganea - Psychiatry Department

Aims: The present work refers to the development of a specific multidisciplinary intervention program based on the GET-UP model in one outpatient unit of the Psychiatric Department of Padova.

Methods: The program includes, after the first specialized diagnostic phase, the admission of First Episode Psychosis patients to the program, which is based on the Case Management model, including specific interventions such as CBT, family psycho-education, and the case manager role.

Results: This innovative treatment model has been assimilated in a psychiatric service with a psychodynamic and phenomenological clinical and cultural tradition, with specific attention to individual and group therapy. We want to reflect on and bring our considerations to the past years' changes, during which the program was included in a pre-existent service with a standard care model. Along with these changes, further training was needed for the involved operators. At the beginning of our experience, obstacles in the development of the model (such as operators' resistance to change) have cropped up. As a result, in this phase the involvement and treatment of patients with psychosis onset were sporadic. In the past year and currently, however, the program has been applied to almost all

the new referred cases, in coordination and synergy with other involved structures, such as the DHT, an outpatient service dedicated to the youths and families group psychotherapy.

Conclusions: Clinical cases and adjustments in the service organization aimed at this innovative model implementation will be discussed. Also, further qualitative data and feedback from workers involved in the experiences will be presented.

O84 • THE ROLE OF CANNABIS USE IN PROVOKING PSYCHOSIS ONSET AND PRECIPITATING RELAPSE AND HOSPITAL READMISSION

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Aims: Cannabis use is common among patients with psychosis and has been identified as a risk factor for poor remission, relapse and hospital readmission, having substantial economic implications. The aim of this work was to clarify the contribution of cannabis consumption to poor outcome of psychosis.

Methods: Two independent samples of 205 first episode psychosis patients (FEP cohort) and 161 early psychosis inpatients (EP cohort) were evaluated for use of most common substances (tobacco, alcohol, cannabis and stimulants) at psychosis onset and hospital admission, respectively. In the FEP cohort, data on medication adherence and symptom remission were collected in a 1-year follow-up. In the EP cohort, data on number of hospital readmissions and length of stay (LOS, number of inpatient days) were extracted from clinical notes in a 6-year follow-up.

Results: FEP patients had high rates of cannabis use before (65.4%) and after psychosis onset (66.3%). 43.9% showed poor medication adherence and 54.6% did not reach remission from psychosis. Cannabis use and nicotine dependence after psychosis onset significantly predicted both poor medication adherence and non-remission, and poor medication adherence mediated the effects of these substances on non-remission. EP patients had similar rates of lifetime cannabis use (62.4%). Their admission lasted on average 54.3 ± 75 days and over the following 6 years they had 2.2 ± 2.8 hospital readmissions, for a total of 197.4 ± 331.5 days. Cannabis use predicted a higher number of hospital readmissions and a longer LOS in the following 6 years, the latter remaining significant after adjusting for use of other substance.

Conclusions: Cannabis use affects medication adherence after a first episode of psychosis, impacting negatively on remission rates. Moreover, in the early years of the disorder, patients with a history of cannabis use are more likely to be readmitted to hospital and for longer periods.

O76 • AUTISTIC STUDENTS AND HOW THEY LIVE THEIR LIVES AT THE THE CASA CONFETTI PROJECT

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Aims: We will show that students with autism and a higher intellec at the Casa Confetti project are capable, with limeted guidance and peer2peer , to combine their study, social activities, their relations network, and their life operations to continue their lives and try to achieve a life without guidance with neurotipycals (people without autism).

Working Format: Interactive, theory, at the end there will be a moment to ask questions.

Content workshop / Learning objectives: information about Autism in general (we will explain the tree types of Autism witch are the most used to explain how Autism works.) -specific fot students with a normal of higher IQ -information about what the Casa Confett project is and what the students can aspect like: - guidance offer - Apply course to get a room (In Holland you have to apply with other studentens to get a room, therefore social skills etcetera are verry important. You can compare it to a employment interview. We have created our own course which we like to explain).

PARALLEL SESSION 6 - COMMUNITY MANAGEMENT OF VIOLENT BEHAVIOURS

O11 • REFLECTIONS ON EPISTEMIC VIOLENCE AND DIALOGUE IN MENTAL HEALTH CARE RESEARCH

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Aims: Despite the importance of the lived experiences of service-users in mental health care research and policy, their perspectives often remain overshadowed by academic and professional voices. To counteract this, we – an academic researcher (Clara) and an expert by experience (Pete) – aimed to gain insight into the concept of recovery by exploring Pete's recovery process.

Methods: To do justice to the complexity of recovery processes and the diversity of experiential knowledge, we applied a collaborative research design, starting from a bricolage approach.

Results: During our research, we experienced the necessity of a far-going co-creation between us in every step of the process, as it was the ethical imperative to keep an open-ended dialogue between us alive that brought rigor to our research.

Conclusions: The aim of this presentation is to unravel the research process that we have traveled together and to reflect on our search for a more dialogical researcher-participant relationship.

O2 • COMMUNITY TREATMENT ORDERS- VARYING EFFECTIVENESS IN DIFFERENT JURISDICTIONS

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Aims: Community treatment orders [CTOs] remain a subject of controversy. Depending upon where and how they are employed, their assessed effectiveness varies from ineffective to highly effective. This presentation describes how much of this variation may be due to inter-regional differences in the mental health laws that govern the administration of medication.

Methods: A review was performed of the consequences in different jurisdictions of acting upon a CTO. This required gaining familiarity with the respective mental health laws, particularly those governing the administration of medication to a patient who refuses medication while subject to a CTO. In addition, a file and history review was performed of patients of an ACT team in Ontario, Canada ,who have been subject to a CTO for minimally three years, with the purpose of comparing time in hospital pre and post CTO initiation.

Results: Marked inter-regional differences exist in those laws that deal with administration of medication to a patient who is subject to a CTO and refusing medication. Patients of an ACT team and subject to CTOs in Ontario, Canada, demonstrated markedly less time in hospital post-initiation of a CTO.

Conclusions: Differences in the opportunity to maintain medication without delay in patients subject to a CTO who are refusing medication,likely plays a major role in explaining the markedly differing views about the effectiveness of CTOs.

O14 • INVOLUNTARY HOSPITALISATIONS FOR PSYCHIATRIC PATIENTS IN SWITZERLAND: EPIDEMIOLOGY AND ASSOCIATED FACTORS

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Aims: During the last decades, both mental health services and legal frameworks of involuntary treatments were adapted in order to enhance patients' rights and autonomy and to reduce the use of coercion. Despite that, compulsion is still commonly used around Europe, especially in Switzerland where the rate of involuntary admissions has been reported as one of the highest in the world. This presentation aims to provide a thorough understanding of

the use of coercion in Western Switzerland. Epidemiological data and the results of a retrospective study on factors associated with the use of compulsion will be discussed.

Methods: Involuntary hospitalisations rates and incidence between 2013 and 2016 were estimated. For the retrospective study, all admissions occurred in 2015 in four psychiatric hospitals were analysed (n = 5027). Differences between voluntary and involuntary patients were examined. In order to identify the factors associated with coercion, a multivariate logistic regression model was performed.

Results: Between 2013 and 2016, the incidence of involuntary hospitalisations increased from 2.8 to 3.3 per 1'000 inhabitants, with significant variations among hospitals. People affected by organic mental disorders (F00-F09), with higher levels of psychotic symptoms, aggression and problems with medication adherence, were more likely involuntarily admitted. Moreover, living in a specific area, being referred by a general practitioner, a general hospital or a psychiatric hospital and being involuntarily admitted during the previous year, was associated with a higher risk of coercion.

Conclusions: These results confirmed that compulsion is still widely used in Switzerland. The retrospective study allowed us to trace a clearer profile of high-risk patients and to provide inputs that could help local authorities, professionals and researchers to develop better-targeted alternative interventions reducing the use of coercion.

O78 • NON-VIOLENT RESISTANCE FOR FACT FAMILIES

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Aims: The goal of this presentation is to gain knowledge about how NVR changes the social climate in families and their surroundings. This presentation will demonstrate how our FACT-team is able to give extra direction to clients who show unacceptable behaviour (agression, school resistance). It demonstrates that a team is able to work together in difficult situations and is able to continue and not to give in by using constraint measures (hospitalisation, forced medication). NVR promotes the approach by standing next to the young patients and to help parents with practical techniques to restore realtionship and help them feel less powerless.

Working Format: During this power point presentation we want to illustrate in an interactive way how the NVR methodology was introduced in our FACT team. We want to share some our team experiences, but also those of the clients and their families, and the positive effect NVR has on all of us.

Content workshop / Learning objectives: This is 'how we do NVR' in the Netherlands and we are proud to see that NVR inspires so many of us; not only we see the effects in ambulant care but also in our residential settings.

O68 • MANAGING VULNERABILITY AND HARM IN COMMUNITIES USING A MULTI AGENCY TEAM

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Aims: To manage vulnerable and risky patients who have mental health , substance misuse, and police contacts in a collaborative supportive manner.

Methods: The pro- active vulnerability engagement team was set up at Leicester, England in November 2016 . It is a team comprised of staff from the mental health services, police services and substance misuse services which is a charity organisation. The team support individuals who are high users and/or callers of emergency services. Collectively the team visit patients in the community, support them on all aspects as needed including health, substance misuse, courts, social, housing by contacting other agencies. Many of the patients who present have personality disorder as a primary or comorbid diagnosis.

Results: Since November 2016 the team have supported a number of patients . There has been a significant reduction in admissions and use of emergency services due to the proactive support. Patients are provided treatment for all their needs. Several of the case studies have shown significant individual benefits and also savings in terms of

resources and reduction in use of emergency services. Relationships between teams have significantly improved. Having the police support helped to implement boundaries through the criminal justice system to help patients on the track to treatment and recovery. It was felt that many aspects of the presentations included social and housing issues and in future a team with staff from these agencies can be considered.

Conclusions: Multiagency single team working can have significant benefits in patient care, prevention of use of emergency services and prevent admissions to hospitals. The benefits of staff with different skill sets and expertise working together in one team enables quicker engagement from patients who are difficult to engage.

PARALLEL SESSION 7 - PSYCHOTROPIC DRUG USE AND TRIALS METHODOLOGY

O91 • NICE GUIDELINES: ARE PSYCHOSOCIAL INTERVENTION TRIALS FOR PSYCHOSES REALLY PRAGMATIC?

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Background: In the UK, the National Institute for Clinical Excellence (NICE) provides national clinical guidance based on the appraisal of randomised controlled trials (RCTs). However, questions about generalizability of findings from RCTs to real-world patients have been raised. In particular, when studying situations of high treatment complexity.

Aims: To study the level of pragmatism of psychosocial intervention trials included in the NICE guideline for treatment and management of psychoses and schizophrenia, aiming to understand the evidence-practice gap on psychosocial intervention.

Methods We critically appraised 143RCTs included in the psychosocial section of NICE guideline for psychoses and schizophrenia. Pragmatism was assessed using the PRECIS-2 tool, which covers 9 domains, each scored using a 5-point Likert-scale. We calculated the number of pragmatic/intermediate/explanatory trials and the mean value of pragmatism for each intervention.

Results: Overall 16.8%studies were explanatory, 49.7%intermediate and 33.6%pragmatic. Art therapy, adherence therapy, psychoeducation, CBT and family intervention were on average more pragmatic than psychodynamic and psychoanalytic therapies, social skills training, cognitive remediation, counselling and supportive therapy ($p<0.001$).

Conclusions: This review found that psychosocial intervention trials have different levels of pragmatism depending on the intervention being studied. This finding may have relevant implications for further research and clinical guideline implementation in clinical practice, as evidence for some interventions, such as CBT and family therapy, may be easier to apply to real-world circumstances as compared with evidence for other psychosocial interventions for schizophrenia and other psychoses.

O86 • ISSUES IN THE IMPLEMENTATION OF PRAGMATIC RANDOMIZED TRIALS IN HIGHLY COMPLEX POPULATIONS

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Aims: Pragmatic randomized clinical trials (RCTs) aim to assess interventions under real-life circumstances. In order to do that, novel interventions should be compared with current standards of care rather than inactive treatments, and characteristics of patients and settings should resemble as much as possible those of ordinary care. However, there are practical limitations in implementing pragmatic principles when conducting RCTs. In psychiatry, this is particularly true for fragile populations (e.g. elderly), which are generally excluded from RCTs because of difficulties

in recruitment, adherence to medications, tolerability issues, and follow-up assessments.

Methods: According to the PRECIS-2 tool, nine domains concur in defining the trial's level of pragmatism, namely: eligibility criteria; recruitment; setting; organisation; flexibility delivery; flexibility adherence; follow-up; primary outcome; primary analysis. Possible obstacles in implementing highly pragmatic principles are examined, using examples from an ongoing RCT on antidepressants in the elderly conducted in Italy (VESPA study).

Results: For some of the PRECIS-2 domains, a high level of pragmatism carries feasibility issues. Regulatory issues might have a relevant role. For example, in the VESPA study a major limitation is represented by a poor implementation of current EU Clinical Trial Regulation in Italy. This implies complex procedures to label and deliver medications directly to participants, with substantial deviations from routine clinical practice, and possible consequences on patients' adherence, staff and resources employed and costs.

Conclusions: Currently, many factors, including regulatory and policy issues, may hamper the possibility to achieve high levels of pragmatism. European and international regulations should facilitate the conduct of pragmatic RCTs, which are an essential step to help close the gap between research and practice, by providing evidence for highly complex populations.

O93 • HOW MUCH CAN WE TRUST META-ANALYSES FINDINGS? THE CASE OF ANTIPSYCHOTICS AND LIFE-THREATENING ADVERSE EVENTS

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Objectives: To grade the credibility of evidence supporting the risk of life-threatening medical events associated with exposure to antipsychotic (AP) drugs.

Background: In clinical practice, the beneficial effects associated with AP drug use are often limited by the occurrence of side-effects. Aside from the most common ones, APs were found to be associated with an increased risk of some life-threatening medical events.

Materials and Methods: We conducted an umbrella review of systematic reviews of observational studies investigating the association between AP drug exposure and risk of hip fracture, venous thromboembolism, stroke, myocardial infarction, pneumonia, and sudden cardiac death. AMSTAR- 2 was used to assess the quality of eligible systematic reviews, while the credibility of evidence was assessed using the GRADE approach. Moreover, we re-extracted and re-analysed data from all observational studies to quantitatively determine the strength of significant associations on the basis of established umbrella review criteria.

Results and Conclusions. Sixty-eight observational studies from six systematic reviews were included. There is convincing evidence that antipsychotic use increases the risk of pneumonia and highly suggestive evidence for an increased risk of hip fracture and thromboembolism; however, the credibility of evidence supporting such associations is low according to GRADE criteria. Associations between antipsychotic drug use and stroke, sudden cardiac death and myocardial infarction were all supported by low-quality evidence according to GRADE as well as umbrella review criteria. The evidence herein synthesized may inform clinical practice and the development of guidelines on the rational use of AP drugs.

O5 • MOTIVATIONAL INTERVIEWING FOR MEDICATION ADHERENCE: ACTIVE INGREDIENTS AND PATIENT-THERAPIST INTERACTION IN PATIENTS WITH SCHIZOPHRENIA

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Aims: To explore active ingredients and assess whether these ingredients activate mechanisms of change in motivational interviewing (MI) for medication adherence in patients with schizophrenia.

Methods: A Mixed methods study. We analysed the cases of 14 patients, comprising 66 MI-sessions. For the qualitative analysis, we used the methodology of Multiple case study analysis, to explore the active ingredients and the mechanisms of change in the MI-sessions. For the quantitative analysis, we used sequential analysis to calculate the transitional probabilities between therapist use of MI-techniques and subsequent patient reactions.

Results: We observed a range of factors which seemed to contribute to the active ingredients. Most prevalent were (eliciting) 'change talk', and factors such as 'experiencing competence' and 'changing sense making'. Since mechanisms of change are psychological processes within the patient's mind, it is impossible to observe these. However, we recognised clues for mechanisms of change, the most prevalent being 'arguing oneself into change'. The most important conversational techniques are reflections and questions addressing medication adherence behaviour or intentions, which was followed by change talk in 74% and 69% of the time respectively.

Conclusions: Active ingredients of MI seem to consist of a sufficient combination of factors. This combination may act as an active ingredient and can trigger mechanisms of change. In particular the patient factors seem a pool of factors from which, after activation by therapist factors, different combinations can form active ingredients.

O60 • FROM INSTITUTION-BASED TREATMENT, TO COMMUNITY-BASED RECOVERY: ACTION RESEARCH IN THE UK

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Aims: 1. To collaboratively transform the design of a psychiatric service, employing the expertise of each person in the network of relationships which constitute the service 2. To shift the emphasis from a narrow institutional range of interventions, often relying on admission to a hospital, to a broader recovery-based service 3. To construct a dispersed network of supportive relationships in community living 4. To improve the use of assessment and outcome measures in the formation of therapeutic alliances 5. To monitor change in a 'post-Assertive Outreach' healthcare system

Methods: Rather than using experts to design and impose a structure, techniques were employed from Action Research (Parkin, 2009) and Quality Improvement methodologies (Ham, Berwick & Dixon, 2016). All the people involved in, and effected by, the existing inpatient and community services were asked to contribute. This was informed by Recovery Philosophy (Leamy, et al., 2011) and all participants were encouraged to adopt practical research skills and critical evaluation. They were viewed as a part of a dynamic system or network, which would have inherent properties, expressed in processes which could be harnessed to drive changes, with outcomes monitored by surveys.

Results: Factors which were found to be driving change were identified in several areas. Commissioning: A competitive market was created in which voluntary sector charities held contracts to provide vocational services, drug and alcohol services, housing and benefit advice. These services involved service users and their families in the design and delivery of their interventions. Providers: The main NHS provider had inherited offices and hospitals which were old, with high maintenance costs. A ward was closed and workers employed to linked patients with recovery services in the community. People using services and their families: Conflicts often arose where expectations were not met and these were used to drive change. Geography: Outpatients and hospitals were not evenly spread across the locality. Link workers were employed to support recovery work where patients live. Building relationships between competing providers was facilitated in some instances by Peer Workers, commissioned in a part of consultative process. They were supported in re-designing and transforming service provision. Family carers were involved through a model called; 'Triangle of Care.' A 'Housing First' model was facilitated with partner organizations. An unhelpful use of the HoNOS measure was augmented with the use of the ReQol measure.

Conclusions: Services can be transformed when a process of change is collaboratively designed to engage as many people in all roles in that service; when research skills and critical evaluation are fostered in that network of people; when a process of feedback and adaption is mutually built into the change process.

PARALLEL SESSION 8 - CROSS CULTURAL MENTAL HEALTH CARE

O16 • THE EFFECTIVENESS OF ŪLOA MODEL, A TONGAN MODEL OF CARE

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Aims: Overall aim: To investigate the effectiveness of a culturally appropriate model, ūloa model to improve mental health care provided for Tongan people in New Zealand.

Methods: The design is Qualitative, however the cultural approach of talanoa informed the research as a whole. This research project will investigated the effectiveness of a culturally appropriate model, the ūloa model when working with Tongan people experiencing mental distress in South Auckland. The model was presented to health provider and community groups and amended according to the outcomes of these discussions. The model is now being trialled in the mental health services and the Tongan community to test its effectiveness.

Results: Ūloa captures Tongan interpretations and constructions of mental distress and also emphasises Tongan worldviews through these concepts: collectiveness, connectedness, collaboration, communication and culture. Ūloa was an effective fishing tool in terms of looking after people in our Tongan communities through food provisions, checking on peoples well-being, team work, effective communication and allocating tasks to their strengths. These components of ūloa can be transferred and applied to improve mental and substance use disorders in Tonga, Pacific islands and other migrant population.

Conclusions: This presentation will discuss a Tongan model which is based on a communal fishing technique called ūloa.

O94 • LOW INTENSITY PSYCHOSOCIAL INTERVENTIONS FOR PREVENTING MENTAL DISORDERS IN REFUGEE POPULATIONS IN EUROPE

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Aims and objectives: RE-DEFINE (Refugee Emergency: DEFining and Implementing Novel Evidence-based psychosocial interventions) is an EU funded project, which aims to implement effective psychosocial interventions for preventing the onset of common mental disorders in refugees and asylum seekers with psychological distress resettled in middle-income and high-income countries. RE-DEFINE is particularly relevant for the refugee crisis in Europe and in bordering countries (i.e., Turkey), as the progressive increase in refugees seeking asylum poses a significant challenge to the health systems' capacity to adequately respond to the health needs of this population.

Methods: The project consists on adaptation, testing, and implementation of Self Help Plus, a novel trans-diagnostic self-help preventive psychosocial intervention specifically developed by the World Health Organization to respond to humanitarian crises. The intervention will be delivered by non-specialists to groups of up to 30 participants at a time. The cost-effectiveness of SH+ will be tested in two large, multicentre, pragmatic randomised studies, one conducted in Italy, Germany, Finland, Austria, and the UK (high-income countries), and a second one in Turkey (middle-income country).

Results: In Europe so far one hundred seventy-five asylum seekers and refugees were randomized so far and eleven SH+ groups were carried out, with a 75% attendance rate. RE-DEFINE is expected to generate a strong evidence-base for the low-intensity indicated preventive psychosocial intervention SH+, and to create a scientific framework to adapt and equip health care systems in countries inside and outside Europe with such low intensity intervention to provide sustainable and cost-effective preventive interventions to refugees and asylum seekers.

Conclusions: The implementation of effective preventive strategies will represent a crucial step towards optimising the responsiveness of health systems to humanitarian emergencies, and in the long run for promoting accessibility

of evidence-based psychosocial interventions for vulnerable population groups. RE-DEFINE will additionally be of paramount relevance to human rights, health and gender equity, and accessibility to high quality mental health services.

O87 • "HOW" AND "FOR WHOM" PSYCHOSOCIAL INTERVENTIONS WORK IN HUMANITARIAN SETTINGS? INDIVIDUAL-PARTICIPANT-DATA META-ANALYSIS FROM 3143 CHILDREN

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Aims: Research on psychosocial interventions has been focused on the effectiveness of psychosocial interventions on mental health outcomes, without exploring how interventions achieve beneficial effects, and which subgroups of children benefit most. Identifying the mechanisms of action of psychosocial interventions would potentially allow further strengthening of interventions by emphasizing specific components connected with such pathways.

Methods: We conducted an individual participant data meta-analysis from a dataset of 11 randomized controlled trials (RCTs) which compared focused psychosocial support interventions versus waiting list conditions in children living in low-resource humanitarian settings. We identified a priori mediators (resilience outcomes, functioning) and moderators (age, gender, household size, displacement) of interventions' effect based on an ecological resilience framework. A systematic search on the Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, Pubmed, PyscArticles, Web of Science, and the main local LMICs databases was conducted up to August 2018.

Results: We included 3143 children from 11 studies (100% of data from included studies). We found benefits of psychosocial interventions on PTSD symptoms (Standardised Mean Difference [SMD] -0.33 95% Confidence Interval [CI] -0.52 to -0.14), that was maintained at follow-up (SMD -0.21 95% CI -0.42 to -0.01). We also identified a beneficial effect on protective factors: coping (SMD -0.22 95% CI -0.43 to -0.02), hope (SMD -0.29 95% CI -0.48 to -0.09), social support (SMD -0.27 95% CI -0.52 to -0.02), and functional impairment (SMD -0.29 95% CI -0.43 to -0.15). In IPD meta-analyses according to age, gender, and displacement status, we found a stronger improvement in PTSD symptoms in children aged 15 to 18 years (SMD -0.43, 95% CI -0.63 to -0.23), and in non-displaced children (SMD -0.40, 95% CI -0.52 to -0.27). Finally, interventions work through the mediation of functional impairment.

Conclusions: Future studies should focus on better understanding the intervention mechanisms and the contextual processes involved, aiming to match interventions with smaller groups of children presenting specific socio-demographic and clinical characteristics, towards a "personalized intervention" approach.

O90 • PSYCHOLOGICAL DISTRESS AND PSYCHIATRIC DISORDERS IN ASYLUM SEEKERS AND REFUGEES: AN ITALIAN EPIDEMIOLOGICAL STUDY

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Aims: In recent years there has been a progressive rise in the number of asylum seekers and refugees displaced from their country of origin, with significant social, economic, humanitarian and public health implications. The aim of this study is to describe the frequency of traumatic events and correlates of psychological distress and psychiatric disorders in asylum seekers and refugees resettled in two different Italian catchment area.

Methods: In the catchment area of Verona and in part of the catchment area of Rome, male asylum seekers and refugees aged 18 or above were screened for traumatic events, psychological distress and psychiatric disorders using validated questionnaires.

Results: During the study period, 211 asylum seekers or refugees were recruited. The frequency of traumatic events experienced was very high (mean 4.9). More than one-third of the participants (35.5%) showed clinically relevant psychological distress, and one-fourth (24.6%), met the criteria for a psychiatric diagnosis, mainly PTSD and depressive disorders. In multivariate analyses, a significant association was found between psychological distress and depressive symptoms and number of traumatic events, social support and country of origin.

Conclusions: In an unselected sample of male asylum seekers and refugees, the frequency of traumatic events is very high; psychological distress and psychiatric disorders were substantial and clinically relevant. Health care systems should include a mental health component to recognize and effectively treat mental health conditions.

O64 • NEUROLOGICAL FUNCTIONING OF ELDERLY POPULATION IN GILGIT-BALTISTAN A COMPARATIVE STUDY OF GILGIT & SKARDU

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Aims: The aim of this study was to assess neurological functioning of elderly residents in mountainous areas of Gilgit and Skardu, districts of Gilgit-Baltistan. Data were collected duration 2015 and 2016 from a cross-sectional study.

Methods: Neurological functioning was assessed using Mini Mental State Examination (MMSE), STROOP Neuropsychological Screening Test (SNST), and Dementia Rating Scale-2 (DRS-2). After excluding the incomplete protocols of the participants with missing data, 91 participants of age range 60-83 years were analyzed

Results: The finding suggests that participants performed poorly on sensitive tests of neuropsychology on DRS-2 and SCWT. Finding also suggests cognitive deficits in Gilgiti elderly and poor frontal lobe functioning in Balti elderly participants. Increased odds of dementia were present in the female elderly of Skardu and both male and female elderly from Gilgit. Balti male elderly reported satisfactory mental state. However, elderly associated certain cultural features with different stimulus of neuropsychological instruments that confirmed the conceptualization and orientation these elderly.

Conclusions: Findings indicate need for intervention and support for the elderly designed after due assessment is carried out

PARALLEL SESSION 9 - FORENSIC PSYCHIATRY

O45 • ITALIAN REFORM OF FORENSIC PSYCHIATRY: A HAZARDOUS MODEL OR A NEW PARADIGM FOR FORENSIC CARE?

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Aims: to identify the dual treatment goals of mental illness recovery and reducing risk of recidivism, within the organizational framework of the new REMS. To verify the capacity of the service to provide adequate specialist forensic treatment and ensure public safety in the context of recent legislative and service organization reforms.

Methods: in the first part of this study, we will describe the functioning of the REMS, from admission to the therapeutic processes leading to discharge. We will also present preliminary data on the outcomes of a cohort of subjects discharged from the REMS and followed up for 12 months.

Results: the results from our study will provide insights on the functioning of the new regional based forensic services, in terms of service delivery, development of effective treatment programs and prevention of recidivism in those discharged from forensic inpatient units.

Conclusions: Modernization of the Italian forensic services must also include reform of the prison health services,

establishment of prison mental health in-reach services and psychiatric units, improved collaboration with the Judicial Services and their psychiatric experts, who still make autonomous decisions about admissions to the forensic units.

O36 • OUTREACH CARE AND MOTIVATION

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Aims: Quality of outreach care for forensic adolescents can be evaluated through outcome measurements (questionnaires, treatment goals, risk recidivism or clinical impression by the professional). An alternative method is by interviewing the involveld adolescents, their parents and their schoolteachers. One of te main problems in forensic youth psychiatry is the motivation for treatment. By an outreach way of working we try to increase the motivation of the youngsters and their families. In this presentation we present some issues put forward by them. The aim is to discuss how to use these comments to improve the quality of our care.

Methods: We will present two vignets followed by short video interviews. We want to discuss the comments brought forward by adolescents and parents.

Results: Several strengths and pitfalls of our forensic outreach care wille be listed. A set of recommendations to improve the quality of care will be conducted.

Conclusions: The use of video recordings of adolescents, their parents and their teachers is a very valuable method to evaluate the quality of outreach care, in relation tot motivation.

O99 • THE PERSON PROJECT (PROCESS, REHABILITATION, SERVICE USE, OUTCOME AND NEEDS IN COMMUNITY FORENSIC PATIENTS): RESULTS FROM A THREE-YEAR OBSERVATIONAL STUDY

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In Italy, the date of March 31th 2015 marked an historic moment in the process of deinstitutionalization in mental health care, ending up in the final closure of the six forensic psychiatric hospitals (FPH).
FPH were obsolete facilities, with a massive presence of prison guards. Treatment was almost totally custodial and pharmacological. The current forensic psychiatric facilities laid down by the law 81/2014, known as REMS (Residenze per l'Esecuzione di Misure di Sicurezza), may host a maximum of 20 residents (the previous six FPHs as whole hosted up to 1200 residents) and serve a defined catchment area and operate in the framework of the Community Mental Health Departments (MHDs).
Concerns have been expressed on the new law that the reform has been promoted without clear evidence of its safety and cost-effectiveness. It has been argued that at the moment of the reform, MHDs (Mental Health

Departments) were unprepared to manage the risk of violent behavior among forensic patients. The PERSON (ProcEss, Rehabilitation, Service use, Outcome and Needs in community forensic patients) Research Project aims to provide epide sed information on the process of Forensic Hospital deinstitutionalization.

Methods: The PERSON Project is an observational-naturalistic study with an epidemiological approach. Data collection is performed by means of a standardized chart shared among 8 Mental Health Departments (MHDs). After the collection of anamnestic data, we recorded information about pathways and outcomes of care referring to the conventional date of 31th October for 3 years (2014, 2015, 2016).

Results: The results refer to a total sample of respectively 129 mentally ill offenders assessed at the reporting day 31th October 2014, 109 at 31th October 2015, 109 at 31th October 2016.
After FPH discharge, hospital admissions and compulsory treatments occurred in a small percentage of the sample. Most of patients were under psychotropic medications and the sample showed a compliance ranging from complete to satisfying for the most part. Rehabilitations programs were provided to the majority of the patients. On the contrary, only less than half received any kind of psychotherapy. Notably, almost all the patients did not have a job.

The most common legal prescription was the admission to a therapeutic facility. A large majority has been considered social dangerous. Crime committed after OPG discharge was reported in a few percentage.
The most common unmet needs perceived by the patients concern work, economic stability and a fulfilling personal life. Percentages are similar also according with clinicians' and relatives' point of view.
Relatives are not supportive in a few cases. However, the support has been often considered intermittent. Only a small part received a psychoeducational treatment or made complaints. The most common concerns are about patients' compliance, recidivism and future care.

Conclusions: This study is the first to evaluate pathways and outcomes of care in a sample of mentally ill offenders, in the framework of the community mental health system in Italy and one of the few giving epidemiological information about this specific population. Further studies are needed to increase awareness in this field of psychiatry, long enough neglect.

O33 • SUCCESFUL TOWARDS A DIPLOMA: WHERE MENTAL HEALTH CARE AND REGULAR EDUCATION JOIN FORCES

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Aims: For a lot of users in treatment by a Forensic Assertive Community Treatment (ForACT) team in a mental health care organization, it is very difficult to get a paid job or follow regular education. Having a criminal background and suffering from a mental health condition makes this problematic. In collaboration with a local college, we organised the possibility of attending regular school (1 day/week) in combination with internship (24 hours/week) in different companies.

Methods: Every Tuesday the students come to school. When they have difficulties getting there, we make a wake-up call or even pick them up at their homes. During the day at school we are working in the room next-door, so whenever they have a difficult moment, or there is trouble, we are literally just a footstep away. We started with a rather small group which makes it possible for us to give every individual the coaching they need. This personal approach make this project different from other initiatives.

Results: We started this class in September 2018 and their goal is a diploma. With this diploma they can either apply for a paid job or continue their studies at a higher level.

Conclusions: During the presentation we would like to share our experiences, the do's and don'ts and all our lessons learned.

PARALLEL SESSION 10 - APPLICATIONS OF E-HEALTH INTERVENTIONS/DIGITAL HEALTH – 1

O12 • EFFECTIVENESS OF EHEALTH INTERVENTIONS TO REDUCE PERINATAL ANXIETY: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Aims: eHealth interventions have been shown to be effective in improving anxiety among the general population. Despite the effectiveness of eHealth interventions for perinatal depression, a recent review reported mixed results for perinatal anxiety. The review, however, was not focused on anxiety, and studies with various designs were included. The aim of this systematic review is to summarize the evidence specific to anxiety and to conduct a meta-analysis to examine the effectiveness of eHealth interventions in reducing perinatal anxiety.

Methods: We searched MEDLINE, CINAHL, EMBASE, and PsycINFO beginning with the date that the databases were available through March 2018. We included randomized controlled trials that were conducted during the perinatal period, examined the effectiveness of an eHealth mental health intervention, measured anxiety symptoms or disorders as a primary or secondary outcome, provided data on anxiety levels both pre- and postintervention, had a comparison group, and were published in English. We used the Cochrane Collaboration's Review Manager software to conduct the meta-analysis.

Results: We retrieved 770 articles and reviewed the full texts of 64 articles. Five studies met the inclusion criteria, four of which fulfilled the quality criteria and were included in the meta-analysis. Data were extracted using a data extraction form developed for this study. The test for heterogeneity (I2=0%; p-value=0.80) suggested a homogeneous sample. The meta-analysis for the total effect size showed that at postintervention, the eHealth group had significantly lower anxiety scores than the control group, with a standardized mean difference (SMD) of -0.41[95% CI=-0.71 to -0.11;P=0.007].

Conclusions: eHealth interventions are promising in improving perinatal anxiety. The content of these interventions should account for common comorbid mental health conditions during the perinatal period and provide opportunities to tailor further treatment if necessary.

O25 • COULD PHYSIOLOGICAL BIOFEEDBACK AND VIRTUAL REALITY SUPPORT PATIENTS WITH A GENERALIZED ANXIETY DISORDER TO RELAX?

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Aims: Patients with a Generalized Anxiety Disorder (GAD) are often unaware of their current relaxation status, due to experiencing long-term stress. By measuring the heart rate variability of patients, the level of stress can be indicated. The research aim is to determine how people with a GAD experience physiological biofeedback like heart rate variability while relaxing with the Virtual Reality (VR) Relax Tour app.

Methods: This qualitative study included ten patients diagnosed with a GAD. To measure the biofeedback experience each participant used the VR Relax Tour app for one week at home. Only the first and last relaxation session took place with a biofeedback session of 20 minutes in presence of a healthcare professional. In addition, after the last relaxation session an in-depth interview was conducted.

Results: Preliminary results of this study show that most participants experience the benefit of biofeedback in terms of increased insights and awareness of their current status. The participants noticed that these new insights helped them with better self-regulation and increased relaxation. Several participants suggested to integrate biofeedback into the virtual environment for enhancing autonomy of the patient. However, some participants do think the presence of a professional can create a sustainable effect by using this tool on a more structural basis.

Conclusions: Based on this research, most participants experience benefits by gaining biofeedback in relation to the VR Relax Tour app. More research has to be conducted to investigate the long-term effects of relaxation-training and how biofeedback could be successfully integrated in relaxing virtual environments, without disturbing the actual experience of relaxation.

O26 • E-MENTAL-HEALTH AS PART OF SEVERITY GRADED AND CROSS-SECTOR COORDINATED CARE

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Aims: The RECOVER model is a severity-graded and cross-sector coordinated care model (see www.recover-hamburg.de), which is funded by the Innovation Fund of the Joint Federal Committee (G-BA) from 2017 to 2020. eRECOVER consists of a portal and a so-called therapy room.

Methods: The portal informs patients about all contents and functions of eRECOVER on a public website, the therapy room is the protected area and contains three so-called dashboards for administrators, therapists and patients. Within the Administrators Dashboard there are two content management systems for the creation of digital diagnostic and therapy programs. In Therapists Dashboard, therapists have access to the patient file of the patients assigned to them, in the patient file different areas arrange the treatment of a patient. The patient dashboard is the patient area.

Results: The patients can find eight areas for digital diagnosis and therapy, for communication with their therapist, for appointment coordination and for the promotion of E-Mental-Health literacy. eRECOVER is a new E-Mental-Health platform developed within the RECOVER project. Practical strategies for application and implementation will be reported.

Conclusions: eRECOVER will support the treatment of people with mental health problems and diseases through internet-based counseling, diagnostics and therapy in the future.

O49 • VIRTUAL REALITY EXPOSURE TREATMENT FOR PEOPLE WITH ANXIETY IN THE SOCIAL WORLD

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Aims: Many people with mental health problems experience anxiety in social situations. Often, people prefer to avoid these social situations which can cause isolation, loneliness en a seriously decline in the quality of life. One of the main strategies, that is evidence based in the treatment of anxiety, is exposure. When the anxiety is so high that it becomes a therapy interfering factor, making a regular protocol difficult to implement, VRET can be the solution. Virtual reality exposure treatment (VRET) can then help bridge this gap between the therapist's room and the outside world.

Methods: During the VRET sessions people practice in the virtual world with exactly what they want to learn in the real world. Research shows that this virtual world is real enough in order to have an effect in the real world.

Results: For the past years, we have implemented VRET in our mental health organisation (GGZ Noord Holland Noord, the Netherlands). We would like to share with you our experiences, the opportunities we see and the challenges that we have faced in the use of VRET. But most of all, we would like to share and show our enthusiasm for the wonderful opportunities that this application holds for the field of mental health care.

Conclusions: Particpants are informed on the use of virtual reality in the treatment of anxiety

O43 • INCREASE AUTONOMY OF PATIENTS BY USE OF E-HEALTH '24/7 ACCESSIBILITY THROUGH TELECARE'

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Aims: Share results so far - Show the relations between people, process and technology - Show best practices and lessons learned - Share experiences from a nurse and patient's point of view.

Methods: Presentation - Live demonstration with the central post and a patient.

Results: People know - That GGZ-nhn is leading in using e-health - What kind of e-health we are providing - How the use of telecare and other e-health helps to increase the autonomy of patients, prevents crisis and helps during recovery.

Conclusions: E-health is used as an enrichment of care.

SATURDAY, SEPTEMBER 7

PARALLEL SESSION 11 - HUMANISED CARE

O85 • COMMUNITY HUMANIZED HEALTHCARE: CHALLENGES AND OPPORTUNITIES IDENTIFIED BY DIFFERENT STAKEHOLDERS

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Aims: Given the automatization of care and time and staff rationing due to economic imperatives, often resulting in dehumanized care, the concept of "humanization of care" (HoC) has been increasingly discussed in the scientific literature. However, it is still a vague concept, lacking clearly defined dimensions and no literature review has tried so far to capture it. Thus, we aimed to clarify the concept of HoC and identify the key elements by exploring its main features, barriers to and strategies for its implementation according to different stakeholders' (patients, patients' caregivers, healthcare providers) perspectives.

Methods: We conducted a systematic search of five electronic databases up to December 2017 and screened additional sources (e.g., gray literature). Search terms included "humanization/dehumanization of care". We conducted a thematic synthesis of the extracted study findings to identify descriptive themes and to generate key elements.

Results: Of 1,327 records retrieved, 54 potentially relevant studies were identified. Full-text evaluation led to a selection of 14 studies. Three main areas (relational, organizational, structural) and 30 key elements (e.g., Respect for patient's dignity, uniqueness, individuality, and humanity, Adequate working conditions, Human and material resources) emerged. Several barriers to implementation of HoC were found in all areas.

Conclusions: Our systematic review contributes to a better understanding of the concept of HoC. The proposed key elements are expected to serve as practice guidance for healthcare institutions aiming to overcome challenges and to achieve efficient and integrated care in different medical settings (e.g., psychiatry; oncology).

O47 • IMPACT IN THE FIRST YEAR EXPERIENCE OF HOME CARE UNIT ON EMERGENCY SERVICE

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Aims: The following study aims to analyze the impact of the implementation of our psychiatric homecare unit (PHCU) on the pressure over the care load at the psychiatric emergency unit (PEU).

Methods: We conducted a descriptive and retrospective study. For the analyze of the impact on the PEU, we studied

average stay, number of transfers to other hospitals and total number of visits at the PEU between 31/10/2017 and 31/10/2018 and compared with previous years. Comparison of means was carried out with the Student's t test.

Results: Regarding the impact on the PEU, we observed an increase of 29% of the number of total visits per month at the PEU in relation to previous years ($p<0.05$). The waiting time for hospitalization was decreased from 26.7h to 20.6h ($p<0.05$), as well as the number of necessary transfers to other hospitals, due to lack of beds, from 8.9 per month in the previous years to 5.7 per month after the implementation of the PHCU ($p<0.05$).

Conclusions: In our study we observed a clear reduction of the care burden over the PEU, coinciding with the implementation of the PHCU. High care load in the PEUs is very common in general hospitals all over the country.

O38 • NATIONAL PARTNERSHIP FOR MENTAL HEALTH IN THE WORKPLACE

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Aims: 1 in 5 Danes in the working age have mental health problems such as stress, anxiety and depression. A range of initiatives are being undertaken in this area. However, workplaces lacked an overview, and stakeholders experienced trouble finding materials that matched their needs. Thus, a transverse, cross-sectoral effort was initiated, bridging the health and employment sectors in a national partnership commenced in order to pool knowledge and experience, to create an overview of the existing knowledge and tools within the field of mental health in the workplace, and to prepare and disseminate clear and common advice to Danish workplaces.

Methods: Led by the Danish Ministry of Health (MoH), a partnership has been established between 35 partners, ranging both employee and employer organizations from the private and public sector and participants from patient organizations and the private sector. The partnership – called 'Sammen om mental Sundhed' ('Together on mental health') has launched a shared toolbox at www.mentalsundhed.dk, bridging partners' professional knowledge in a science-based Q&A, lending support to the various roles at the individual workplace. Additionally, more than 400 relevant tools, provided by partners, were tagged, sorted, and linked to the science-based Q&A, providing inspiration for possible actions to undertake.

Results: A representative survey conducted on behalf of the partnership has shown that one year after the digital toolbox was launched 5 percent of people in Denmark already knew about the effort (equivalent to 136,500 employees). 92 percent of these state that they have found helpful information at www.mentalsundhed.dk. Material from the partnership's joint national campaign, especially aimed at colleagues, was shown more than 7 million times, and seen by more than one in four Danes. Following the initial MoH-led project, 21 of the partners stated that they would like to contribute – among other things financially – to the continuation of the partnership. From 2018 and forth the partnership has achieved permanent government funding has been allocated to meet the partners' and governmental wishes for the continual operation of the partnership.

Conclusions: The partnership constitutes a professional cooperation on mental health, bridging the health and employment sector, mobilizing a larger part of the Danish workforce. The toolbox on www.mentalsundhed.dk represents a professionally rooted joint action to possibly change the future trajectory within the field of mental health in Danish workplaces.

PARALLEL SESSION 12 - MENTAL AND PHYSICAL HEALTH

O27 • SHAPING NEW APPROACHES IN MENTAL HEALTH SERVICES: THE "MENS SANA"

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Aims: The high comorbidity between mental disorders and organic disorders requires a deep reflection on health care and treatments inside territorial services, from the very first contact between the person and the psychiatric

services. The first contact must face not only the emerging health issue, but should offer also a broader approach, which is not solely restricted to the crisis treatment but comprehensive of people global wellness; the loss of this approach would influence the treatment experience and whole course.

Methods: During 2017 and 2018, operators codify the activities "Mens Sana" and the names of patients in the electronic register of the Mental Health Department

Results: The project's outcomes presented relate to the years 2017 and 2018 with the elaboration of the statistic system of Mental Health Department

Conclusions: The "Mens Sana in Corpore Sano" project, focusing on physical comorbidities and lifestyles, suggests the concept of people global welness which goes beyond mere psychiatry, being therefore less stigmatising.

O59 • LIFE PARTICIPATION, SOCIAL SUPPORT AND QUALITY OF LIFE IN PARENTS HAVING CHILDREN WITH CEREBRAL PALSY

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Aims: Prevalence of Cerebral Palsy is increasing in Pakistan. A growing concern is for the parents caring for children with this condition who, upon diagnosis, experience loneliness, anxiety and helplessness. Given the gap in literature addressing needs and challenges for families dealing with changing circumstances, this research is carried out to compare life participation issues of mothers and fathers of children with cerebral palsy. It also looks into differences in terms of social support and quality of life.

Methods: A sample of 33 parents was approached using convenient sampling. Three self-reported scales, Life Participation for Parents (2005), WHOBref QOL (2003) and Social Support Scale (2001), were administered along with demographic sheet assessing information in terms of age, education, occupation, income, family status and clinical variables related to child's CP.

Results: The findings of the study revealed significant differences between mothers and fathers in terms of participation in life, social support and quality of life. Qualitative assessment of life participation scale responses indicated concerns in areas such as participation in social activities, health, dissatisfaction with treatment and access to resources.

Conclusions: Clinicians need to explore further, the issues experienced by families involved in the care. Qualitative interpretation of Life Participation Scale is useful in assisting therapists with identifying specific concerns in order to tailor family oriented interventions.

O67 • TYPE D PERSONALITY AND QUALITY OF LIFE IN PATIENTS FOLLOWING MYOCARDIAL INFARCTION

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Aims: The current study examined Type D personality in patients following MI. It further assessed the impact Type D personality on quality of life of MI patients after controlling for sociodemographic and clinical variables.

Methods: In this prospective cohort study, 300 patients with definite myocardial infarction were recruited and assessed at baseline (2 -8 weeks) post MI (time 1). Out of 300 participants 191 completed assessments at 9 months follow up (time 2). Type D personality was evaluated with Distress scale 14(DS-14), while quality of Life was assessed with WHO quality of life scale (WHOQOL-BREF) at time 1 and time 2. Results

Results: Analysis revealed that a significantly high percentage (52%) of MI patients were identified with Type D personality characteristics. Type D personality emerged as most significant predictor of quality of life after controlling for sociodemographic and clinical variables at time 1 and time 2 assessments.

Conclusions: This research emphasized the importance of Type D personality in risk stratification for adverse

outcomes such as impaired quality of life in MI patients. This research highlighted the need for a more personalised approach to therapeutic interventions along with medical treatment for the management and rehabilitation of MI patients.

O77 • IDENTIFYING THE NEUROPSYCHOLOGICAL SYMPTOMS OF DEMENTIA

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Aims: Approximately 47 million people live with dementia worldwide and this is projected to increase to 75 million by 2030. The number of cases of dementia are estimated to triple by 2050. It is critical to obtain the proper diagnosis of dementia, including type, as several health conditions can mimic dementia. This workshop will explore the various parts of the brain, and how damage to each affects the body. The most prevalent neuropsychological symptoms of dementia will be discussed. Treatment options will be reviewed. A case study will be presented to further enhance participants' interaction and learning.

Working Format: Powerpoint presentation and case study

Content workshop / Learning objectives: 1. Identify areas of the brain and the corresponding deficits if impaired due to stroke, brain injury and other brain disease; 2. Recognize neuropsychological symptoms of dementia; 3. Explore treatment options, as well as key healthcare referral sources for individuals living with dementia

PARALLEL SESSION 13 - STRATEGIES IN SEVERE MENTAL ILLNESS

O7 • NARRATIVE EXPOSURE THERAPY FOR POSTTRAUMATIC STRESS DISORDER IN SEVERE MENTAL ILLNESS: "GETTING A DIFFERENT LIFE"

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Aims: Despite the high prevalence of interpersonal trauma and comorbid Posttraumatic Stress Disorder (PTSD) in Severe Mentally Ill (SMI) patients, trauma focused treatment is scarcely offered. Narrative Exposure Therapy (NET) is effective for vulnerable patient groups with repeated trauma. However NET has not been studied specifically in SMI patients receiving FACT. The primary aim is to evaluate NET in SMI patients with comorbid PTSD associated with repeated interpersonal trauma. Outcome measures are: PTSD, dissociation, SMI symptoms, care needs, quality of life, and global functioning. The second aim is to gain insight into patients' experiences with NET and to identify influencing factors.

Methods: This mixed methods design used quantitative repeated measures and qualitative semi-structured in depth interviews based on Grounded Theory. NET was provided to 23 eligible adult SMI outpatients with comorbid PTSD. At baseline (T0), one month after NET (T1) and six month later (T2) the outcomes were assessed by CAPS-5 and DES. Mixed models were used to analyse the changes at T2, taking in account T0 en T1. The qualitative interview focused on the meaning of NET and perceived changes.

Results: Of 23 eligible patients, two quitted NET prematurely and dropped out. 21 patients finished NET and had complete data. Preliminary analyses suggest that clinical relevant changes in PTSD and dissociation occur. The interview results suggest that NET makes substantial differences to their daily lives. Respondents emphasize that during the NET intensified supporting interventions by psychiatric nurses are crucial.

Conclusions: These preliminary results show that SMI patients with co-morbid PTSD can benefit from NET, provided that concurrent adequate support by community psychiatric nurses is offered.

O48 • INCORPORATING SEXUALITY AND INTIMACY IN THE CARE FOR PEOPLE WITH SEVERE MENTAL ILLNESS

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Aims: Sexuality and intimacy are fundamental contributory elements of general well-being and quality of life. However, sexuality and intimacy are not self-evident for everyone. Research shows that a large proportion of the people with SMI struggle to fulfil their need for intimacy and sexuality. Both health care providers and users often avoid talking about sexuality and intimacy within the context of mental health care and as a consequence the door towards help usually remains closed. Therefore, we also aim on finding tools that help create more openness on the topic within the field of mental health care.

Methods: We have conducted several studies on the topic including two reviews and three qualitative data studies using in-depth interviews and focus groups. Currently, we are working on a feasibility study on an intervention that aims to improve openness about sexuality and intimacy within mental health care.

Results: So far, we have identified several possible barriers in the expression of sexuality and intimacy among people with SMI, principally: psychotropic side effects, self-stigmatization, sexual trauma, symptomatic distress, interpersonal skills and functioning. We have also learned that for users, the issue might not be their willingness to discuss their sexual concerns but their caregivers not creating opportunities or providing permission to discuss the topic.

Conclusions: It is important to address sexuality and intimacy in order to promote recovery. Caregivers should provide the opportunity, permission and space to do so.

O80 • AUTONOMY IN PHYSICAL HEALTH AMONG PEOPLE LIVING WITH SEVERE MENTAL ILLNESS

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Aims: Inequality in physical health has been raised as a concern among people with severe mental illness compared with the general population. Treatment actions are required to address suboptimal lifestyle choices and to monitor and treat crucial physical parameters. Autonomy can play a key role in the continuation of physical activity programs and healthy lifestyle behaviours. This study aimed to clarify the critical mechanism underlying autonomy in physical health promotion based on the perspectives of people with severe mental illness.

Methods: We employed a conventional content analysis of narrative data from the Healthy Active Lives in Japan (HeAL Japan) workshop meetings. HeAL Japan began in 2014 with support from the international HeAL group. During 2015–16, we held annual workshops for networking individuals who are committed to physical health promotion in people with mental illness. A total of 40–60 participants attended each workshop and they were divided into 5–8 groups.

Results: The participants' narratives mainly comprised barriers to the encouragement of autonomy in physical health promotion among people with severe mental illness. 'Inhibited autonomy' was extracted as a central component of the barriers to physical health promotion. This component emerged based on the lack of an empowerment mechanism in psychiatric services. The inhibited autonomy component was shaped by the service users' experiences both in the healthcare setting and in real life.

Conclusions: Our study first elucidated the impact of the decision-making process in psychiatric and mental health services on autonomy regarding physical health among persons with severe mental illness. An effective strategy to improve the care provided to persons with mental illness should be explored.

O54 • THE PROFILE AND MENTAL HEALTH OF THE DUTCH HOMELESS SERVICE USERS: RESULTS OF CROSS-SECTIONAL RESEARCH

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Aims: From 2015 to 2018, homeless service (HS) users of 8 centers in 7 Dutch cities were assessed. We focused on the background, problems and needs of the participants.

Methods: The data was collected in semi-structured interviews by the same researcher (CvE, a medical doctor). In addition to collecting personal biographies, the InterRAI Community Mental Health questionnaire and a homelessness supplement was evaluated. It yields a broad assessment of the mental and physical health, and the social situation, of service users.

Results: All of the 436 participants had experienced homelessness. 98% were homeless at the interview: 8% slept rough, 67% in a night shelter, and 23% were houseless. The majority was male (81%), single (89%), had a migration background (52%), and a low education (82%). 14% were never employed and 60% were persistently unemployed. Comorbid conditions were high: mental illness in 93%, substance related disorders in 58% and intellectual disability in 39% of the participants. 61% had to cope with one or more chronic physical conditions. Life histories showed 78% previous homelessness.
Traumas were also common: in 32% past life events still invoked a sense of horror. HS users were socially isolated: 21% had only one, and 32% had no informal helper at all. Considering this complex pattern of severe needs, most (72%) were best served in comprehensive long-term integrated care for serious mental illness.

Conclusions: Serious mental illness is a common problem in the mainly chronic or episodic HS users in the Netherlands.

O92 • ARE WE OFFERING ALL OPTIONS TO PATIENTS? AN INVESTIGATION ON ITALIAN PRESCRIBING ATTITUDES ON LONG-ACTING ANTIPSYCHOTICS

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Aim: In recent years, scientific literature supported a paradigm shift for the use of long-acting antipsychotics (LAIs), from being a last option in the treatment of chronic psychosis to their prescribing in the early phases of psychotic conditions, with endorsement by national and international guidelines. LAIs are generally prescribed in highly complex clinical situations where patients', clinicians' and context's characteristics play a relevant role. On these grounds, we aimed to describe, within the context of ordinary clinical practice in Italy, the usage patterns of LAIs, assessing drivers of clinicians' choices and whether the above-mentioned "new paradigm" has been up-taken in practice.

Methods: We present data from the cross-sectional phase of the STAR Network "Depot" Study, an observational, longitudinal, multicentre study. Thirty-five centres enrolled patients starting a LAI on a 12-months timeframe. Clinical and sociodemographic features, and reasons underlying prescriptions, were collected using a pre-established questionnaire which included potential clinical reasons underpinning LAI choice.

Results: 451 patients were enrolled. In the overall sample, heterogeneous reasons for LAI prescribing were found. When comparing the usage of second versus first generation LAIs, we found that the latter were more frequently prescribed as a last resource in patients with "several therapeutic failures" (OR 0.51, 95% CI 0.29 to 0.90) or requiring "a better management of aggressive/impulsive behaviour" (OR 0.37, 95% CI 0.23 to 0.61). These views are in line with an "old paradigm" that apparently does not apply to second generation LAIs.

Conclusion: Findings from the STAR Network "Depot" Study suggest that the advocated paradigm shift has been occurring, especially for the prescription of second generation LAIs.

PARALLEL SESSION 14 - PEER SUPPORT AND RECOVERY

O30 • THE RECOVERY ORIENTATED INTAKE: INCLUDING TREATMENT AND RECOVERY IN MENTAL HEALTH CARE FROM THE START

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Aims: Aims of the recovery orientated intake are: - Improve client satisfaction - More involvement of clients, participants and caregivers from the start (supported decision making?) - Diversity in therapy supply, between highly professionalized, e-health and peer run programs - Shorten waiting lists - Make use of three sources of knowledge: scientific, professional and knowledge by experience. - Focus on resilience instead of symptoms

Methods: This presentation introduces the recovery orientated intake used at GGZNHN. Participants will be introduced to the aims and process of the intake procedure which uses video-calling, peer workers as part of the intake team and supported decision making.

Results: Patients are more satisfied, waiting-lists are shorter, workers have more pleasure in their work. About 30% of patients look further for treatment in primary mental health care GGZ or recovery workshops. People who choose treatment in our teams are more motivated to work on their problems. Exchange between professionals and peer workers. Normalization of mental health problems Research results are expected june 2019

Conclusions: Patients are capable of choosing their support or treatment when we provide appropriate information. They request less professional care or choose for less extended care. They use more e-health and peer run programs

O81 • A SIMULATION-BASED SOFT SKILLS TRAINING PROGRAM FOR PEER SUPPORT SPECIALISTS WORKING ON ASSERTIVE OUTREACH TEAMS

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Aims: Peer support training programs have proliferated in recent years in response to the need to equip the growing workforce of peer support workers with tangible and technical skills. Despite the increase in training programs, many peer support workers continue to experience difficulties successfully integrating into the workplace. Research is needed to determine appropriate training for peers in the more intangible and non-technical skills that are required for success at work. The purpose of this study was to evaluate the outcomes of a simulation-based training program designed to teach peer support workers essential soft skills required on assertive outreach teams.

Methods: Twelve simulated scenarios were developed to approximate the realities and complexities of working on assertive outreach teams. Actors were trained to portray the scenarios in a standardized manner. Groups of peer support specialists worked through the simulated scenarios together with a trained facilitator on a weekly basis over twelve weeks. Group debriefs were held following each simulation to allow participants to reflect on their learning experience. Learning about communication, interpersonal, problem solving, decision making, organizational, customer service and adaptability skills required in each scenario was reinforced by the facilitator post-simulation.

Results: Fifteen peer support workers employed on assertive outreach teams participated in the first cohort of the simulation-based training program. The training program was evaluated positively by 93% of the participants. Eighty seven percent of participants reported increased self-efficacy ratings on the General Self-Efficacy scale upon completion of the training program. Semi-structured interviews conducted with participants reinforced the importance of learning more intangible and non-technical soft skills to integrate successfully in the workplace.

Conclusions: The 24 hour simulation-based soft training program enabled peer support workers to hone their communication and interpersonal skills in an active way. The availability of immediate corrective feedback was positively evaluated by all participants. For most peer support specialists, simulation provided a safe, low anxiety learning environment.

O79 • HOW NON-VIOLENT RESISTANCE ASSISTS IN REDUCING FORCED INTERVENTIONS ON AN ACUTE PSYCHIATRIC UNIT FOR ADOLESCENTS

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Aims: This presentation will demonstrate how we are able to give extra direction to these clients who show severe forms of unacceptable behaviour without using constraint interventions like fixation, forced medication or separation. Recent data will be shown on how NVR reduces the number of forced interventions. It demonstrates that a team is able to work together in difficult situations and is able to continue and not to give in by using constraint measures. NVR promotes the approach by standing next to (aggressive) young patients demonstrating unacceptable behavior and collaborate with them and their parents.

Working Format: During this power point presentation we want to illustrate in an interactive way how the NVR methodology was introduced on this unit. We want to share some our team experiences, but also those of the clients and their families, and the positive effect NVR has on all of us.

Content workshop / Learning objectives: The goal of this presentation is to gain knowledge about how NVR changes the social climate on an acute psychiatric ward. This is 'how we do NVR' in the Netherlands and we are proud to see that NVR inspires so many of us. We strongly believe that the NVR method will not only work for residential settings for children and adolescents but also on adult units where teams are confronted with aggressive and unacceptable behavior. We have made the first steps to inspire them. And we our proud to see so many effects of the NVR in the ambulant care for child and adolescent psychiatry.

PARALLEL SESSION 15 - DECISION-MAKING AND SOCIAL RECOVERY

O74 • CLINICAL, SOCIAL AND PERSONAL RECOVERY IN PSYCHOSIS IN ONE MODEL! A LATENT MIXTURE MARKOV MODEL

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Aims: Recovery of people with severe mental illness takes place in three domains: clinical, social and personal recovery. Most studies analyze these recovery processes separately. To get more insight in the recovery process and how these processes might interact and overlap, we will analyze all three domains jointly.
This study aims to develop an integral recovery model including clini-cal, social and personal recovery. We will examine different states of recovery in patients with psychotic disorders and the transi-tion rates between the detected states.

Methods: Data of the yearly ROM Phamous screenings in the Netherlands were used (2006-2017). Clinical recovery (PANSS-R (8 items)), social recovery (Functional Remission Tool (3 items)) and personal recovery (Happiness Index (1 item)) were assessed. In total, we included 12 recovery outcomes in the latent mixture Markov model (LMMM) (total n=2327).

Results: The LMMM demonstrated four different recovery states. People in state 1 were mostly recovered on all three domains (40%); people in state 2 had significant needs on social recovery and experienced mostly positive symptoms (22%); in state 3 comparable needs on social recovery, but they suffered more from negative symptoms (25%); in state 4 people had significant care needs on all three domains (13%). The recovery state at a particular moment was strongly associated with the state a year later (77-89% chance to stay in the original state).

Conclusions: Four different recovery states were detected. Transition between states is possible, although the odds of staying in the original state are very high.

O89 • AN ITALIAN RECOVERY-ORIENTED PILOT STUDY TO ACHIEVE SHARED DECISION-MAKING REHABILITATION PROJECTS

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Aims: Literature reports recovery-oriented practices, particularly shared decision-making (SDM), improve users' quality of life, autonomy, and health outcomes. However, frequently lack in co-production of rehabilitative interventions causes difficulties in defining personalized rehabilitation paths.

The South Verona Community Mental Health Service (SVCMHS) conducted a pilot study to explore feasibility and acceptability of integrating recovery with evidence-based clinical practice to increase user's active participation in personalized rehabilitation projects.

Methods: 25 users and 19 professionals experimented the Mental Health Recovery Star (MHRS), integrating other socio-rehabilitative scales, in an observational study to measure and motivate the change. Two focus groups with an average of 15 voluntarily participators, users and staff, were run to experiment SDM.

Results: Crossing MHRS areas, staff and users' characteristics, and other scales domains, most suggestive data for the highest capability to measure and motivate the change were described for areas 1, 3, 6, and 7 of MHRS. Moreover, MHRS improved trust relationship between user and key-worker. Focus groups were appreciated by participants and a co-produced group was formed.

Conclusions: The pilot study reported the feasibility and acceptability of recovery-oriented practices in the SVCMHS. However, future efforts are needed to implement adequately recovery-oriented practices in the SVCMHS.

O34 • IPS AND HOW TO GET PARTNERS INVOLVED AND COMMITTED

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Aims: Individual Placement and Support (IPS) is the dominant model for vocational rehabilitation for people with a severe mental illness and effective in finding and maintaining competitive work. IPS is widely implemented in mental health services in the Netherlands; IPS however can only exist in fruitful cooperation with partners like the organization for social security. We aim to offer the opportunity to learn from our experiences.

Methods: We will first give a short introduction about IPS itself. Next we'll explain and illustrate how our strong and lasting relationship with our main partner started and developed over the years and how this partnership became model for the cooperation with other partners. Finally we will explain our difficulties in organizing partnerships in cases where financial benefits are not directly present for the partners (like education).

Results: Partnership resulted in a solid (financial) basis for IPS and helped to develop new directions and implicit challenges.

Conclusions: IPS is a powerful tool in rehabilitation if well embedded in cooperation with partners.

O69 • THE ECONOMIC SAVINGS AND THE NON-VOCATIONAL IMPACT WITH INDIVIDUAL PLACEMENT AND SUPPORT MODEL

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Aims: One type of programs that has more experiences evaluated systematically and with rigorous experimental designs are the Supported Employment Programs, and the best known and studied of all of them is the so-called Individual Placement and Support (IPS).

This Individualized Employment Support Model was born in the USA. starting from the concepts of integration and normalization. Most of the studies focus on the vocational results but lack of depth in the non-vocational results and their impact on the lives of people and their families. Our study tries to reveal this type of additional benefits.

Methods: Non-randomized case-control study for 1 year with measurements at six months and a year of non-vocational variables. The IPS strategy was compared with the vocational rehabilitation strategy. We have analyzed the relationships between employment and clinical status in patients with schizophrenia receiving either IPS or a conventional vocational rehabilitation program and the saving that can produce people with serious mental disorder working at full time.

Results: People with mental disorders who worked full time and did not receive a pension were analyzed in a year. The saving in pensions was higher than the total cost of the IPS team In people who obtained employment, significant differences were observed in GAF, quality of life and total GSDS.

Conclusions: Clinical status and public savings are greater using the IPS strategy There is still to investigate or deepen the non-vocational results

PARALLEL SESSION 16 • HOME CARE AND ACT

O82 • FAMILIES IN RESOURCE GROUP ASSERTIVE COMMUNITY TREATMENT (RACT): RELATIVES' EXPERIENCES

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Aims: Relatives often provide extensive support to their next of kin suffering from psychotic disorders. However, they often experience lack of support from psychiatric services. Cooperation with relatives is a central component in Resource Groups Assertive Community Treatment (RACT). Little is known about relatives' experiences of RACT. The aim was to investigate relatives' experiences of encountering psychiatric care, with and without RACT, in relation to quality of life, family burden and family stigma.

Methods: A total of 137 relatives of individuals suffering from psychotic disorders in the Region Västra Götaland, Sweden filled out the self-report instruments Family Involvement and Alienation Questionnaire – Revised (FIAQ-R), the Burden Inventory for Relatives of Persons with Psychotic Disturbances, the Inventory of Stigmatizing Experiences (family version), and RAND-36.

Results: Seventy-seven of 137 relatives participated in RACT, whereof 70% were females. Mean age was 63 years (SD 12.5). A majority came from Sweden (91%), had >12 years of education (63%) and did not live together with the patient (76%). A majority were parents, (71%). There was no difference between the two groups regarding demographic characteristics. We found that family members who participated in RACT experienced a more positive approach from the healthcare professionals than did other family members ($\chi 2=5.96$, $p=.015$). Furthermore, family members who participated in RACT felt to a lower extent, that they were alienated from the provision of care than did other family members ($\chi 2=5.93$, $p=.015$). No difference was found between the two groups regarding family burden, mental Quality of Life or family stigmatization.

Conclusions: The results suggest that participating in RACT will contribute to a higher level of satisfaction for family members in their encounter with healthcare professionals.

O17 • ETHICAL DISCOMFORTS LIVED WITHIN TREATMENT AND CARE IN THE COMMUNITY: ACT AND HOMELESSNESS TEAM

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Aims: To develop a grounded theory that would explain how ethical reflection and deliberation evolve in a context

of treatment and care in the community (ACT and homelessness team).

Methods: The present study uses the methodology of grounded theory to better understand the process underlying the phenomenon of adressing ethical discomfort. We conducted focus group interviews with 7 mental health care teams in the community representing a total of 51 participants. The analysis of the data, carried out by five researchers, was carried out with the techniques of the grounded theory of Corbin and Strauss (2015).

Results: Preliminary results show that participation in this research project has been an opportunity to develop skills that will enable care providers and users to better deal with certain ethical problematic situations.
It has also helped to understand the benefits of creating discussion groups inside the work team to facilitate problem solving and to create a feeling of personal efficiency, self-esteem and better relationships between care providers and users. Another result is a contribution to scientific knowledge because few ethical knowledge is related to this issue. Finally, this research open up new avenues to create an ethics adapted to treatment and care in the community.

Conclusions: Care providers use dialogue to cope with ethical discomforts. But there is a need to have an outsider to lead the ethical reflection and deliberation.

O57 • HOME CARE FOR HÖLDERLIN AND LENZ

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Aims: Home care, when possible, are the treatment for people with severe mental illness. We present two examples taken from literature and history in order to support the need of developing specialized home care interventions for people with mental illness better than taking them to institutions or hospitals.

Methods: Friedrich Hölderlin (1770-1843), the great German poet, suffered a psychotic illness during most of his life. He lost a lot of abilities, mainly related with social isolation. But he lived for many years with a man called Ernst Zimmer, a carpenter, since 1807. Zimmer, who was a Hölderlin´s poetry follower, cared for him and Hölderlin´s crisis decreased a lot. He lived there for 43 years even after Zimmer´s death. But he lived in a quiet way, writing until he dead.

Results: LENZ, the great book written in 1839 by George Buchner, describes the suffering of the writer Jakob Reinhald Lenz because of schizophrenia. Lenz was supported by a priest called Oberlin who wrote about his illness and was caring for the writer many years. Important ideas arise from Oberlin´s writings in order to improve our model of home interventions with psychotic population living at home.

Conclusions: Both Lenz and mainly Hölderlin improved their mental state by living far from hospitals. Breaking social isolation and working in activities related with art and creativity may delay cognitive damages and maintain social abilities.

O70 • CARE FOR A VULNERABLE GROUP OF PEOPLE IN THE SHADES OF THE DUTCH SOCIETY

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Aims: Keeping track on this group Efficiency through avoiding double work Setting up a personal approach Collaboration in a network nationwide (set ACT nationwide or even abroad)

Methods: Case management nationwide and abroad Making the connection in the network both formal and informal ACT Long-term commitment Use of unconventional solutions Collaboration with involved parties (both formal and informal)

Results: If we look at parameters of inclusion (homeless, psychiatric/addiction problems/mildly mentally handicapped, but not diagnosed as such and longer existing, causing public nuisance, no help or healthcare known and no connection with any region) in the region Schiphol airport we know a group of 10 - 15 people. We focused

on this group and set up a personal approach. For 7 people we have arranged care: daycare for the homeless, temporarily institutionalized, or brought back to the land of origin. Nationwide we think this group of vulnerable people who doesn't get the help they need, is bigger.
In the progress we made agreements with the formal network in case of registration. Nationwide institutions recognize and acknowledge these situations and problems.
They are open for a collaboration. For now there is an agreement till 2020 to continue the corporation with Schiphol Airport, the townships Haarlemmermeer and Haarlem for this personal approach.

Conclusions: A personal approach without any limitation of borders and a long-term commitment using several methods as ACT nationwide, can provide in a successful method for this vulnerable group.

O32 • SPECIALIZED TREATMENT IN COMMUNITY-BASED TEAMS: THE EXPERT NETWORK FOR ANXIETY DISORDERS

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Aims: To demonstrate a way of promoting and ensuring quality of specialized treatment of anxiety disorders in teams providing community-based and general mental health care.

Methods: A reorganization of care within GGZ NHN lead to combining the exisiting FACT teams with the teams for specialised treatment. Expert networks were set up around certain areas of interest. Expert networks disseminate knowledge, provide consultation, and (temporarily) assist in treatments. The main focus of the expert network for anxiety disorders is to promote exposure treatment.

Results: Although guidelines recommend exposure therapy as a treatment of first choice, research demonstrates that most people with anxiety disorders do not receive exposure treatment. To overcome these problems, the expert network of anxiety disorders spends most of its time on assisting therapists (a psychologist or a psychiatric nurse) during exposure treatment. It further offers an intensive outpatient program for patients with highly persistent anxiety problems

Conclusions: A number of case reports supported with outcome monitoring data will be presented to demonstrate our approach. The formation of expert networks enables specialized mental health care within community-based general settings.

PARALLEL SESSION 17 - STIGMA AND USERS' PERCEPTION

O97 • ANTI-STIGMA CERTIFICATION. DEVELOPMENT OF USER-GENERATED QUESTIONNAIRE TO EVALUATE PROVIDER-BASED STIGMA IN MENTAL HEALTH SETTINGS

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[1] *Section of Psychiatry; Department of Neuroscience, Biomedicine and Movement Sciences; University of Verona*

Aims: The present study aimed to investigate, by employing a specific user-generated assessment measure, perceived levels of stigma endorsed by mental health staff (i.e. "provider-based stigma") within the South Verona community mental health service.

Methods: A group of 14 mental health service users attending the South-Verona Community Mental Health Centre (Verona, Italy) participated to a series "focus groups" on the theme of stigma and discrimination with the aim to develop a self-rated questionnaire designed: (1) to assess perceived and received stigma in mental health settings, and (2) to evaluate propensity to anti-stigma actions by service staff. The questionnaire was subsequently administered to a sample of mental health service users and tested for its psychometric properties (ie, internal consistency and test-retest reliability).

Results: Seventy service users completed the questionnaire; 28% reported having experienced some degree of

stigmatization by mental health staff; 44% reported to have been treated in an impersonal and distant way and 34% in a paternalistic way by service staff; 36% reported that they were not allowed to negotiate their pharmacological therapies with treating clinicians; 37% perceived that mental health staff had a pessimistic view their prognosis (ie, endorsed the stereotype of 'incurability') and 31% reported that staff advised them to lower life expectations due to their mental health problems. Moreover, 23% reported to be perceived as a burden for the society and 30% felt identified with a psychiatric label rather than considered as a person

Conclusions: This study provided, for the first time in the literature, quantitative evidence that within in mental health services "provider-based stigma" is a relevant phenomenon, which represents a major barrier to users' empowerment and personal recovery.

O95 • DO CLINICIANS PREDICT PATIENTS' READMISSION BETTER THAN A STATISTICAL MODEL? AN EXPLORATORY STUDY ON CLINICAL RISK ASSESSMENT IN MENTAL HEALTH

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Introduction: In recent years, clinical prediction models that should guide healthcare professionals in their decision making during daily practice have been developed. However, to the best of our knowledge, there is a dearth of literature on the performance of clinicians' predictions of readmission in the mental health setting. We explored whether clinicians or a statistical model can better identify patients at risk of early readmission, and investigated variables potentially associated with clinicians' risk judgment.

Methods: The dataset comprised patients discharged from acute psychiatric wards in the Verona Mental Health Department (Italy). Psychiatrists assessed patients' risk of readmission at 30 and 90 days post-discharge on a scale between 0 and 100, predicted their post-discharge compliance, and assessed their GAF score at admission and discharge. Their prediction performance was compared to the one of a statistical model, and its association with prediction of post-discharge compliance and GAF scores was analyzed through regression analyses.

Results: Clinicians' readmission risk judgment outperformed the statistical model, with the difference reaching statistical significance for 30-day readmission. Predicted compliance with community treatment and GAF score at discharge were found to be associated with clinicians' prediction of readmission both at 30 and at 90 days.

Discussion: Clinicians' superior performance might be explained by their risk judgment depending on non-measurable factors, such as experience and intuition. Patients with a poorer GAF score at discharge and poor assumed compliance were predicted to have a higher risk of readmission.

O73 • YEKE YO (IT'S NOT DIFFICULT), AN ALTERNATIVE APPROACH TO A COMPLEX ISSUE OF COLLABORATION BETWEEN ORGANIZATIONS IN THE DOMAIN OF (EMERGENCY) MENTAL HEALTHCARE IN THE NETHERLANDS

B. van de Velde[1], Bouke Bijnsdorp[2]

[1] GGD Kennemerland, public Healthcare - [2] GGZ inGeest, menthal healthcare

Aims: Inspiring audience with our experience in connecting organizations and professionals and improve mutual understanding resulting in imrovement in quality of care for people with confused or misunderstood behaviour. A strong connection on all levels between organizations is very important but not self-evident. Those who are involved often work from their own point of view, organizational interest or guidelines, legislative framework or personal opinion. The result can be that the person who needs help gets stuck in the middle. And organizations and involved parties muddle lovingly at the edge of the ditch

Methods: GGZinGeest (menthal healthcare) and GGD Kennemerland (public healthcare) have taken the initiative to develop a joint learning path for organizations in the region involved in this issue. Organizations and parties like the police, ambulance transport, addiction care, protected living, housing cooperatives, local government, clients and

other involved agencies will participate on this path alongside the GGD and GGZ. Not to 'solve' the problem, but to sustainably strengthen the learning and problem-solving capacity within the network of organizations in the region.

Results: Central questions during the learningexperience are: what do we actually mean by confused behavior and how much confusion can society handle? How inclusive is an inclusive society when things become inconvenient or people behave less adjustable? Who is responsible for a person who does not want to receive care? And how do we deal our and others shortcomings and impossibilities if there is no immediate or actual solution? It is precisely this problem that makes it important that all actors involved hold on to each other, understand each other better and find each other blindly. This makes a flexible, reflecive and helping approach possible. Not only for de problems we have to cope with now, but also for problems we do not know yet.

Conclusions: Yeke Yo! (African song. Symbol voor joyfull cooperation between professionals of all the organisations that are involved)

O98 • RENAMING SCHIZOPHRENIA? A SURVEY AMONG PSYCHIATRISTS, MENTAL HEALTH SERVICE USERS AND FAMILY MEMBERS IN ITALY

A. Lasalvia[1], A. Vita, A. Bellomo[1], M. Tusconi[1], C. Bonetto[1], G. Favaretto[1], E. Zanalda[1], C. Mencacci[1], B. Carpiniello[1]

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Aims: Over the last decade the term "schizophrenia" has been increasingly contested by patients and their family members, together with professionals and researchers alike, since it holds a negative stigmatizing connotation. This study reports on a survey conducted in Italy exploring how general psychiatrists, service users and family members perceive the term "schizophrenia" and if they consider a name change a useful and viable option.

Methods: Survey promoted by the Executive Board of the Italian Psychiatry Society (SIP). Opinions on the term "schizophrenia" were collected by a self-rated questionnaire used in previous WPA surveys and adapted for Italian respondents. The survey on psychiatrists was performed between June 2017 and November 2018; questionnaires were sent to all SIP members by e-mail at two time point and during three regional congresses promoted by the SIP. Survey of family members and mental health users was performed between April and July 2018 thanks to the help of the AITsaM, an association of family members based in the Veneto region

Results: Completed questionnaires were returned, respectively, by 350 psychiatrists, 71 mental health users and 110 family members. Regarding psychiatrists, 57% expressed the opinion that the term "schizophrenia" was not appropriate to name the disorder which refers to; in addition, 70% considered the term as stigmatising; among them, 71% agreed on the need for a new name to reduce stigma. Similarly, 56% of service users and 71% of family members found the term stigmatising and, among them, 75% and 77% respectively thought that the term should be changed to reduce stigma. More complex and conflicting results were found as regard possible alterative names to replace "schizophrenia". Overall, 62% of psychiatrists in favor of a name change proposed to replace it with "psychosis", 22% with a name referring to an integration failure (eg, integration/aberrant salience/disorganization/ association disorders), 10% with a more descriptive term (eg, perception/though/reality testing disorders).

Conclusions: Professionals, services users and family members agree that it is time to consider a name change for schizophrenia to reduce the stigma attached to it. The main challenge is the lack of consensus among psychiatrists and between psychiatrists and users' on the best alternative term to use

PARALLEL SESSION 18 - APPLICATIONS OF E-HEALTH INTERVENTIONS/DIGITAL HEALTH – 2

O52 • USER EXPERIENCE OF BIPOLAR PATIENTS; MEASURING LITHIUM WITH A MOBILE DEVICE

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[1] *GgzE Karel Ensinckstraat, The Netherlands*

Aims: The aim of the study is to get an insight into user experiences of bipolar patients who used a mobile device in their home to measure lithium. The device was automatically diverted by using a QR code to an online medication module. In this module the measurements were put in a graphic. It offers the option to register a personal life-chart and mood journal for monitoring self-management and life style. We wanted to find out whether it was convenient to use and in which context it contributes to the self-management of patients.

Methods: The qualitative study included 13 patients with a bipolar disorder using lithium. By using the mobile device Medimate Minilab© during six to seven weeks, the patients measured the lithium blood level with capillary electrophoresis twice a week. This was combined with an online blended care module. To describe the patients' experiences, we conducted a semi-structured interview by using a topic list compiled after a literature review. The study is imbedded in a large ongoing study: The "LiZe Cross-care project".

Results: Because of the ongoing research the results are preliminary. One of the focal points was the high usability; home use instead of going to the lab, a faster results outcome and a painless blood sample. Patients found the device easy to use and their self-management increased. That said, patients didn't visit their medical practitioner any less. On the other hand there was the risk of experimenting with lithium-dosage and daily intake moments. A few patients experienced a varying lithium blood level outcome after using alcohol the day before measuring.

Conclusions: In order to create a satisfactory level of self-management and low risk using a mobile point-of-care device, it is highly desirable to develop a lithium self-test protocol.

O65 • OUTREACHING PSYCHOLOGICAL TRAINING USING INFORMATION COMMUNICATION TECHNOLOGY

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[1] *Virtual University of Pakistan Lahore Punjab - Pakistan*

Aims: To evaluate and identify the effectiveness of online training, the present study analyzed the outreach and success of the ICT based psychological training in the Psychology program at Virtual University of Pakistan

Methods: The outreach was based on 318 internship cases submitted by students registered from all over the country. In addition the internship reports provided data for incidence of reported psychological disorders.

Results: This showed that the highest reported disorder was Major Depressive Disorders at 38.7% followed by Obsessive Compulsive Disorder at 13.5% and Generalized Anxiety Disorder was 11.9% prevalent. Chi square analysis showed that age and gender are significantly associated with disorders whereas the marital status is not

Conclusions: This study demonstrates the effectiveness of internship training using on line and digital technology

O71 • VIRTUAL PSYCHIATRY WARD – VIDEO CONFERENING IN THE TREATMENT OF PSYCHOSIS

A. Wegelius[1], T. Töhönen[1], V. Eerola[1], B. Karpov[1], M. Chiramberro[1], M. Holi[1], T. Kieseppä[1]

[1] *Helsinki University Hospital Finland*

Aims: We examined the use of video conferencing technology in the treatment of patients with a schizophrenia spectrum diagnosis presenting with acute psychotic symptoms. Patients with schizophrenia spectrum disorders, including those living in supportive housing units, are frequently hospitalized due to the exaberation of psychotic symptoms. The primary aim was to provide, via video conferencing, the assistance and expertise of a university hospital ward specialized in the treatment of acute psychosis, to supportive housing units, in order to reduce the need for hospitalization.

Methods: The target group were patients with a schizophrenia spectrum diagnosis (n>20) living in supported housing units within the Peijas hospital area, with a catchment area of 250 000 inhabitants. During the first video appointment a treatment plan was evaluated together with the patient, staff at the housing unit, and ward staff (a psychiatrist & a psychiatric nurse). The Brief Psychiatric Rating Scale was used to evaluate symptom severity during the initial and final video appointments. An online questionnaire was used to assess the subjective experience regarding the use of video conference technology, among patients and hospital staff.

Results: None of the patients included in the trial were admitted to hospital. BPRS scores decreased in all patients (figure to be presented later). The majority of patients found the use of video conferencing to be a subjectively positive experience, hospitalization was not required. The majority of staff members found the use of the technology positive. Although there were many technical difficulties.

Conclusions: Video conferencing may be effective to reduce the hospitalization of patients presenting with acute psychotic symptoms residing in supportive housing units. It provides a method to promote the management of psychotic patients by facilitating the direct delivery of psychiatric expertise to the patient and staff of supportive housing units.

O75 • SUPPORTING COMMUNITY MENTAL HEALTH CARE BY DIGITAL COMMUNICATION STRATEGY – CONTENT, CHANNELS AND EVALUATION

R. Krogvig Karlsen[1], R. Lund Fleiner[1], A. Kristiansen Rønning[1]

[1] *NAPHA (Norwegian Resource Center of Community Mental Health) Trondheim Norway*

Aims: Community mental health services in need continually development. Clinical practice should be based upon updated knowledge, userneeds and competence. ACT-/FACT-teams are part of this. Norwegian Resource Center for Community Mental Health (NAPHA) aims to contribute by distributing knowledge, tools and connecting the field by building networks for learning. A challenge is to reach out and be relevant to a target group of 13 000 health workers and leaders in services in 420 Norwegian municipalities, busy clinical professionals with little time to study. NAPHA gives priority to communication strategy, digital channels and digital content in particular, and has employed communication advisers.

Methods: 1. Strategy of communication. 2. Publishing of relevant digital content, as the digital handbook for ACT/FACT. 3. Presenting contents easily accessible. 4. Daily news, feature stories on scientific papers, guidelines, local initiatives, innovative projects. 5. Digital library for in-depth learning and critical analysis. 6. Development and use of multiple digital channels: Website napha.no, newsletter, social media channels as Facebook, Twitter and Instagram, and media. 7. Enabling professionals to share opinions, experience and knowledge. 8. Adding value by video and video-on-demand. 9. Regularly investigating of preferences and needs of target groups. 10. Evaluation of outreach and quality of our communication.

Results: 600 000 visits to napha.no, 14 000 Facebook-followers, 5000 subscribers to the weekly newsletter. In 2018 315 municipalities responded to a Quantitative Research Questionnaire to measure NAPHAs reputation and usability. NAPHA measure user experience of napha.no every year by a websurvey. Several thousand respondents give us demografic data, opinions on relevance, design and usability. Two full-day high quality videostream-conferences were produced winter 2018-19, with positive response. Direct dialogue and qualitative investigation give us advice for adjustments.

Conclusions: Digital communication strategy to build competence, is cost-efficient. It highlights Community Mental Health Care topics and makes them understandable. NAPHA connect professionals. The implementation of best practice may benefit from these methods of communication.

O96 • UNDERSTANDING MENTAL WELLBEING IN THE OLDEST OLD: A EUROPEAN STUDY USING AN EXPLORATORY STRUCTURAL EQUATION MODEL APPROACH

V. Donisi[1], F. Tedeschi[1*], J.L. Gonzalez-Caballero[2], J. Cresswell-Smith[3], E. Lara[4,5,6], M. Miret[4,5,6], A.K. Forsman[7], K. Wahlbeck[3], F. Amaddeo[1], J. Kalseth[8]

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Sciences, Åbo Akademi University, Finland; 8 Department of Health Research, SINTEF Digital, Norway

Introduction: In line with the growing of oldest old population in Europe, increased focus has been placed on promoting mental wellbeing (MWB). In the context of the European Welfare Models and Mental Wellbeing in Final Years of Life (EMMY) project, the present study aims to provide empirical evidence about the structure of MWB in oldest old (the 80+ age group), and to compare it with the structure of MWB in old (65-79) and adults (18-64).

Methods: Twenty-eight items were selected from the European Social Survey (ESS) survey data. An exploratory approach using an Explorative Structural Equation Model (ESEM) was adopted. Measurement invariance across the three age-groups was assessed. In case of support of measurement invariance, analysis of means of latent factors scores was performed.

Results: Our inclusion criteria resulted in a dataset comprising of 2,058 oldest old, 4,931 old and 36,578 adults. Both the 5-factor and the 6-factor- model solutions were found to be statistically appropriate as well as lining up with the most widely studied theoretical dimensions of MWB. Despite differences in factor models and in item loadings emerged, the evaluation of formal invariance highlighted that dimensions built in the same way are comparable across groups. Differences in average levels of MWB dimensions emerged across age-groups.

Discussion: Results support the multidimensional construct of MWB also in the oldest old age. Albeit explorative, results contribute with insights into the structure of MWB for oldest old and can be used as a starting point in further research on promoting positive MWB at later stage of life.

Workshops

THURSDAY, SEPTEMBER 5

W18 • CAN STRUCTURED INTERVENTIONS AT THE COMMUNITY SERVICE-LEVEL REDUCE INVOLUNTARY ADMISSIONS TO SPECIALIST MENTAL HEALTH SERVICES?

T. Hatling[1], I. Wormdahl[1], T. L. Husum[2], S. Kjus[3], J. Rugkåsa[4]

[1]Norwegian Resource Centre for Community Mental Health, Trondheim, Norway - [2] Centre for Medical Ethics, Institute of Health and Society, University of Oslo, Norway - [3]Norwegian Resource Centre for Community Mental Health - [4]Health Services Research Unit, Akershus University Hospital, Norway

Aims: Being exposed to coercion is dramatic for service users and their families, as well as challenging and expensive for services and for the wider society. There is a lack of research aimed at community service level to reduce the use of involuntary admissions in specialist services of people with severe mental health problems. An ongoing study in Norway aims to co-develop, implement and test the effectiveness of a community-based intervention aimed to reduce involuntary admissions. The study will incorporate qualitative interviews and action research within an RCT-design.

Working Format: The workshop will include a mix of presentation and discussion. To set a framework for the discussion we will start by presenting background, research design and preliminary ideas for the intervention. The following discussion will be in plenary.

Content workshop / Learning objectives: Despite significant differences in legislation and structure of mental health services between countries development and results of this intervention are of international interest, also due to consequences of CRPD. This workshop will particularly discuss content and direction of the intervention. The learning objective is to explore how this work is done in different countries, learn across borders and through discussions get ideas and inspiration to take back home.

W16 • SELF DISCLOSURE: OPENNESS ABOUT MENTAL VULNERABILITY AND STRENGTH

S. Vanner[1], S. Bakker[1], J. Bakker[1], E. Struik[1], C. Koek[1], J. van Honk[1]

1GGZ Noord Holland Noord The Netherlands

Aims: The view that personal experiences should be kept out the professional atmosphere is changing. Hands-on expertise is now seen as added value and fitting within the view on recovery, provided that it is deployed professionally. In this workshop, we will explore the use of self-disclosure by professionals

Working Format: The workshop leaders share their own recovery stories with the participants and their practical experiences with deploying self-disclosure. Theoretical backgrounds and an explanation of professional distance/ proximity within the vision on recovery are given. There will be time for practice and discussion

Content workshop / Learning objectives: Participants are introduced to the use and value of self disclosure within mental health treatment. Participants are able to make an informed choice as to whether or not to use lived experience with mental ill health to benefit the treatment of users

W5 • THE BRAIN BECOMES WHAT THE BRAIN DOES

V. Callahan[1]

[1] Centurion of Florida - Florida United States

Aims: This presentation provides information regarding mental illness and the re-establishment of neural pathways through targeted relational therapeutic measures. At the center of learning objectives, the question is asked: “At what point does the brain become rigid versus remaining neurally plastic due to mental illness?”

Working Format: Group discussion

Content workshop / Learning objectives: "The Brain Becomes What the Brain Does. " This presentation provides information regarding mental illness and the re-establishment of neural pathways through targeted relational therapeutic measures. At the center of learning objectives, the question is asked: "At what point does the brain become rigid versus remaining neurally plastic due to mental illness?"

W2 • THE LIVING MUSEUM, CREATING OUTSIDER ART UTOPIA'S ON A GLOBAL SCALE

R. Loopik[1], R. Haen[1]

[1] *The Living Museum Netherlands*

Aims: How to create Outsider Art Museums, World Wide, and make Artists run their Living Museum, with Zero Euro, in 10 Steps.

Working Format: Interactive workshop, larded with digital presentations from New York, Seoul, Wiel, Barcelona, Stavanger, Tysvær, Eindhoven, Tilburg, Haarlem, as well as a group (open) dialogue, movie's, and a true art workshop: all unfolded in 10 Steps, in the most vibrant fashion.

Content workshop / Learning objectives: What if somebody offers you a building, to start a Living Museum? What does it take to clean up the space, open the door and turn your Living Museum into the most successful Recovery Tool in ample 2 years? How can you start your own Living Museum in your city of residence? All this will be revealed in this very sensitive workshop. Participants are asked to open their senses, we take care of the rest. Leave your diagnosis and professionalisms at the door when you register for this workshop.

MASTER CLASS • TRAINING AND TECHNICAL ASSISTANCE TO PROMOTE EVIDENCE-BASED PRACTICES

L.B. Dixon[1]

[1] *MD, MPH, Edna L. Edison Professor of Psychiatry, New York State Psychiatric Institute, Columbia University Vagelos College of Physicians and Surgeons and NewYork-Presbyterian; Director, Division of Behavioral Health Services and Policy Research & Center for Practice Innovations; New York, USA*

This workshop will provide detailed case studies in how the Center for Practice Innovations, an intermediary organization devoted to supporting the delivery of evidence based practices across New York State, structures its activities within an implementation science framework. Considerations will include so called "inner" and "outer" setting targets, and preimplementation, implementation, and post-implementation activities. Methods include inperson and online synchronous and asynchronous activities. The workshop will discuss strengths and weaknesses of different methods and how to build an approach given system limitations.

W12 • CASE DISCUSSION MAKING USE OF THE AGRESSION SIGNAL GUIDE AND THE SAFEWARDS MODEL

S. van Duin[1], S. Vanner[1]

[1]*GGZ Noord Holland Noord The Netherlands*

Aims: With a movement towards community mental health care and less beds, there is also attention for improvement of inpatient care. One of the guiding principles in the Netherlands is reduction of use of seclusion. Safety for users and staff is of great importance

Working Format: This workshop teaches participants how to use the Agression signal guide and the Safewards model Participants know the aims of a Case discussion making use of the Agression signal guide and the Safewards model Partcipants are able to initiate and carry out a case discussion

Content workshop / Learning objectives: Recognition of: - Factors that can give rise to specific flashpoints which can then trigger a conflict incident - Dynamic reciprocal relationship with conflict, and that sometimes the use of containment can itself give rise to conflict rather than successfully prevent it - Ways for staff to intervene in order to promote greater safety and decreased seclusion

W23 • POSITIVE HEALTH, TREATMENT AND RECOVERY: REDEFINING THE ROLE OF TREATMENT IN RECOVERY ORIENTED MENTAL HEALTH

B. Jacobsen[1], M. Elfrink[2]

[1] Psychiatrist ACT team Early Psychosis Pro Persona Nijmegen, The Netherlands - [2] Clinical psychologist FACT team SMI, GGZ Oost Brabant Cuijk, The Netherlands

Aims: In this workshop we will redefine the role of treatment from a recovery oriented mental health perspective and discuss the way in which treatment needs to be organised in order to best serve the individuals recovery and positive health. We identify ingredients that contribute to recovery. But will also have a close look at what threaths and dilemma's lay ahead both in theory and organistion

Working Format: Presentation of dilemma's and good practices combined and group discussion

Content workshop / Learning objectives: This workshop will start with an introduction of the traditional way in which the role of treatment in mental health has been percieved and the way this role has to be adjusted in light of the change towards a more recovery oriented mental health. We will then focus on the concepts of positive health and recovery. And how these three concepts, treatment, positive health and recovery , relate to each other in the modern practise of recovery oriented mental health. A number of dilemma's related to his changing position of treatment will be presented and discussed. We will then illustrate a Dutch solution to these dilemma's from the perspective of working in an ACT team and F_ACT team and present the dilemma's and threats related to these models. A number of practise-based interventions that can be used in the new context of recovery oriented mental health settings will be presented. Their will be plenty of room during the workshop for discussion and sharing with the audience their experiences and practises regarding this dilemma in their country of origin.

W6 • REHABILITATION FOR PATIENTS WITH INTELLECTUAL DISABILITIES, MENTAL HEALTH PROBLEMS AND OFFENDING BEHAVIOUR

O. Has[1]

[1] Psychologist Fivoor Ambulant Centrum Utrecht - Utrecht , The Netherlands

Aims: There is an increasing awareness that patients with mild or borderline intellectual disabilities (MBID) and mental health problems and offending behaviour are a particularly complex patient group whose needs are difficult to meet. To give those patients the care and treatment that they need Fivoor started a Forensic FACT team for individuals with intellectual disabilities in 2012. (F)ACT is a Dutch version of Assertive Community Treatment and is strongly rehabilitation oriented. The main goal of this team is to connect with those complex patients in order to decrease the risk of recidivism and to improve psychiatric and social functioning.

Working Format: Presentation/ discussion

Content workshop / Learning objectives: In this presentation we will discuss the difficulties of rehabilitation for patients with MBID and offending behaviour. Is rehabilitation possible for these complex patients, and if so: what are the difficulties and differences to achieve those goals ?

W28 • AN INTEGRATED CBT TREATMENT FOR PSYCHOSIS: STRATEGIES TO OPTIMIZE THE TREATMENT AND MISTAKES TO AVOID

A. Pinto[1]

[1] Psychiatrist and CBT Supervisor Adjunct Professor at University of Bologna - EMDR Practitioner and Supervisor Coordinator of the Early Intervention Program and Neurocognitive Rehabilitation Program at UOSM of Pollena, (NA), DMH ASL NA 3 Sud

The psychosis therapy, has undergone several changes in recent years. From an initial work on skills, to the strengthening of problem solving skills and information processing until a new way of managing the symptoms.
Third-generation therapies and the identification of metacognitive deficits also enabled us to enhance and improve

the standard CBT approach to the treatment of this disease.
However, in clinical practice, the presence of therapeutic errors that often represent one of the causes of failure of therapies and drop-out by patients ,is still rather frequent.
In fact, there are several elements that can influence the course of therapy, such as:
The overcoming of prejudices about the nature of the pathology, the greater or lesser timeliness of the intervention, the appropriate use of pharmacological therapies, the assumptions on which to base the therapeutic alliance, the greater or smaller sharing of the objectives to be achieved, the target of therapeutic intervention, the possibility or not to include patients in structured and integrated protocols, the choice of the individual or group setting, etc.
In this workshop these issues will be discussed in order to provide indications that can be of help in the clinical practice of the therapist. Furthermore will be showed an example of CBT integrated protocol for psychosis.

W21 • BATTLING STIGMA

M. Noort[1], D. Jacksteit[1]

[1]*GGZ-NHN Stationsplein heerhugowaard Noord Holland The Netherlands*

Aims: Experience and discussion of stigma within mental health care

Working Format: Use of a method allowing participants to experience stigma in a group recovery story position statements

Content workshop / Learning objectives: participants have an understanding of how we all stigmatise and how it feels to be on the receiving end of this discrimination participants are aware of how to reduce stigma in their daily practice participants realise the negative impact of stigma on service users and the importance of addressing this issue

W3 • THE FARM IS THE 'THE CHAMPIONS LEAGUE'

H. Gras[1]

[1] *Social psychiatrie Nurse, System therapist, Mental health specialist Lister Utrecht, The Netherlands*

Aims: Taking a Risk; -Searching for a dignified form of living for people with complex problems. - What if the system does not fit... and society tends to cal the other the misfits - Who deserves it? and what are the real costs?

Working Format: Powerpoint, smal movie. Discussion. Interactive workshop. Maybe I take a homeless person from the street to join me.

Content workshop / Learning objectives: Which attitude aspects are important in working with extraordinary people with a manual and who have done anything god has forbidden ? -How do you keep track of the course? -Where do the dangers lie?

W17 • LEARY'S ROSE A MODEL TO MANAGE INTERACTIONS TOGETHER WITHIN A COMPLEX SOCIETY

B. Jacobsen[1], M. Elfrink

[1] *Pro Persona, department of psychosis and serious mental illness, Nijmegen - The Netherlands*

Aims: Feeling more powerfull in interaction with a wide range of people and institutions in working together.

Working Format: Short presentation, with afterwards practical exercises tot learn more about this technique.

Content workshop / Learning objectives: People with serious mental problems can get into troubles with a large impact on family, work, school, housing, financial support and more. We need to work alle together, client, family, professional network to turn this in a good direction. But there may be discomfort and disagreement how to do this. In 1957 Leary, an English Psychologist, developed his famous model of interaction, called Leary's Rose. He defined peoples behavior as a result of interaction with one another. In this theory people interact by two dimensions: People want to have power and people want to be accepted, to feel connected. People differ in the way of focusing

on one of these two aspects But also ones position defines the position of the other and vices versa. Leary's Rose, first described for therapeutic purposes is nowadays adopted by different fields like education and human resource management and is forgotten a bit in psychotherapy. But you can use the model as a family intervention or in cooperation with other people in society or hospital as wel. In this workshop you will get insight and exercise how the model can be used. The main goal means recovery and growth by working all together (everybody feels powerfull and satisfied, in connection).

W7 • PSYCHOTHERAPY FOR SMI: JUST DO IT!

E.M.A. Horsselenberg[1], H. Festen[2]

[1] *Clinical psychologist BIG GGZ Drenthe The Netherlands* - [2] *Healthcare Psychologist BIG GGZ Drenthe The Netherlands*

Aims: To transfer the idea that psychotherapy is an important part of the recovery of people with SMI and that they are capable of it. Offering enough holding & containment with the team is important. Psychotherapy can be done safe with this population. Don't deprive people with SMI good psychotherapy!

Working Format: Oral presentation, case presentation, practicing and role-play.

Content workshop / Learning objectives: Evidence based assessment, conceptualization and psychotherapeutic treatment of people with SMI. Including: CBT & EMDR in psychosis, Short Term Group Schema Cognitive Behavioral Therapy (SCBT-g) and recovery oriented Acceptance & Commitment Group Therapy (ACT) for people with SMI

W13 • DESIGNING A POSTGRADUATE TRAINING COURSE IN COMMUNITY MENTAL HEALTH CARE FOR GRADUATE NURSES

C.H.M. Latour[1], I. Schaap[1]

[1] *University of Applied Sciences Amsterdam, The Netherlands*

Aims: The participants of the workshop will learn the implications of the implementation of community based mental health for designing a training course for Graduate Nurses

Working Format: Group discussion

Content workshop / Learning objectives: After this workshop, particpants will be able to: - outline the implications of the implementation of community based mental health for designing a traing course for Graduate Nurses - identify essential elements for a curriculum for communitya based mental health

W15 • FROM 'TREATING' TO 'HEALING' THE POWER OF REAL CONNECTIVITY! AND HOW TO CREATE THIS…

S. Kraaij[1], E. Otto[1]

[1] *GGZ Noord-Holland-Noord The Netherlands*

Aims: Optimizing recovery from a peer experts perspective: creating awareness and self-reflection with caregivers on real connectivity. Suppose YOU are in a deep crisis, how would you like to be approached, what do you need? Do you have ideas? Do we have to do it differently? Think along! A workshop for out-of-the-box thinkers who like to explore new roads in connecting with service users

Working Format: Introduction, short presentation Brainstorm in small groups Plenary discussion Wrap up and next steps

Content workshop / Learning objectives: Participants are able to examen the concept of 'connectivity' and how to use this principle in their daily practice in order to support a user's recovery journey

FRIDAY, SEPTEMBER 6

W4 • DOING IS THE BEST WAY OF THINKING FLEXIBLE INTEGRAL APPROACH. ONE ON ONE PERSONAL COACHING

H. Gras[1]

[1] *Lister Utrecht, The Netherlands*

Aims: The primary objective of the approach is to provide a sustainable positive change in living conditions of a group, where nobody wants to burn his fingers. - a new model besides the institutionalized way of working as fact and act? - being free as necessity -Prevention detention and admission -

Working Format: Showing a the new model. The first results. Maybe I do battle between the old school (F) act and new school Fit.

Content workshop / Learning objectives: Personal Coaching is that the way that really contributes to the well- being of the client? - Do we have the courage to follow the client and what he needs? and really look for other possibilities and not be led by all the systems of the mental health?

W14 • 'NOTHING ABOUT ME, WITHOUT ME, HOW DO YOU DO THIS IN PRACTICE

M. Kole[1]

[1] *Founders of Enik Recovery college in Utrecht Lister and Enik RC Hogelanden Wz Utrecht, Netherlands*

Aims: Our aim is to letting others experience what the principle 'nothing about me without' means and how you can handle it during conversations with family's.
One of the principles of POD is 'Nothing about me, without me'. How do you share your thoughts, feelings, inner polyphony in the presence of the network.

Working Format: Beginning with a group discussion, after this doing a exercise in reflecting.

Content workshop / Learning objectives: We would like to challenge each other in this workshop by exploring the question, what means 'nothing about me, without me' for yourself, your team, clients and how do you see this in practice. We also want to challenge each other with an exercise in reflecting.
Reflection is the way to share our thoughts, feelings and inner polyphony in the presence of the network.

W22 • NEIGHBOURHOOD-ORIENTED OFFERING OF TREATMENT AND SUPPORT

M. van Raalte[1], S. Wullems[1]

[1] *Lister Utrecht, The Netherlands*

Aims: To provide integrated care in collaboration for people with severe mental illness and their support system.

Working Format: group discussion

Content workshop / Learning objectives: Recovery and participation at home and in society, an outline of how we develop in Utrecht towards an inclusive society and full citizenship.
Health care services work together in neighborhoods to build a diverse range of 'recovery support', to promote self-care and self-management and to increase the chances of recovery and social participation for psychologically vulnerable people.
A network organization has been set up in which the social domain and the care domain (treatment and support) find each other and work together. In which employees do what is necessary over organization and system boundaries. And in which the use of peer support expertise and close relatives get a significant role.

W25 • MIND SOMEONE ELSE'S BUSINESS

A. Schäfer[1], S. van Houten[1], E. Beld[1]

[1] *GGZ Noord-Holland-Noord*

Aims: In our workshop we will present the model and the resources needed to implement this model. We will illustrate how different types of professionals contribute to it and discuss the success factors and pitfalls of the model.

Methods: The Forensic Assertive Community Treatment (For-ACT) teams treat patients with a severe mental illness. Most of these patients have committed a serious offence and receive involuntary outpatient forensic care. Motivation and compliance for the treatment are rare. Treatment aims to reduce the recidivism risk and to reduce the psychiatric symptoms. In addition there needs to be focus on recovery. The For-ACT teams have developed a way to offer assertive outreach care to all their patients. This results in increased compliance and positive results of the forensic treatment which provides a reduction in recidivism risk.

Results: The method Risk-Needs-Responsivity (RNR) is our leading principle. Risk assessment and management are a consistent part of the treatment and determine a large part of the forensic interventions that we apply. The second principle is recovery orientated care. Recovery in forensic care is almost identical to recovery in regular mental health care. Except for one crucial aspect; patients in forensic care have a history of crime and have to face these offences and their history of severe mental illness. This means addressing guilt, shame, confusion, turmoil and sometimes denial – with sensitivity and respect.

Conclusions: Recovery and RNR are 2 principles of forensic treatment that can be effectively used together

MASTER CLASS • HONEST, OPEN, PROUD

P.W. Corrigan[1], L. Pingani[2]

[1]*Distinguished Professor of Psychology, Principal Investigator and Director, Chicago Health Disparities Center, National Consortium on Stigma and Empowerment, Illinois Institute of Technology, Chicago, USA - [2] Department of Mental Health, UNIMO University of Modena e Reggio Emilia, Italy*

Self-stigma is one of the egregious impacts of mental illness stigma, a diminished sense of selfesteem and self-efficacy leading to a "why try" effect in many people: "why try to get a regular job, someone like me doesn't deserve it." Recently, innovative programs have emerged to challenge self-stigma, programs based in part on psychoeducation and cognitive reframing skills meant to challenge stigmatizing self-statements. An interesting result has emerged out of research by our group that informs an alternative program for dealing with self-stigma: the Honest Open Proud program (HOP). Research shows those who have disclosed aspects of their mental illness frequently report a sense of personal empowerment that enhances selfesteem and promotes confidence to seek and achieve individual goals. In this light, a group of people with lived experience and stigma researchers developed the Honest, Open, Proud program now being used in beta research in the United States, Europe, Australia, and China. We propose an interactive workshop for the conference: a chance for participants to learn about and experience the HOP and a chance for presenters to gain further perspective on strengths and limitations of the beta version. The workshop will begin with a very brief summary of the research on self-stigma and disclosure. The main of the workshop will be a review of the three lessons of the HOP:

1. Considering the pros and cons of disclosing;
2. There are different ways to disclose; and
3. Telling your story.

HOP currently includes a 100 page manual and 35 page workbook with exercises and worksheets meant to engage participants. E-copies of the manual and workbook will be, available to workshop participants. In addition, evaluation instruments to assess outcomes of participating in the HOP will be reviewed and provided to workshop participants.

W20 • GOOD NEIGHBOURS: INCLUSION AND COMMUNITY BUILDING IN MIXED HOUSING PROJECT PLACE2BU (NL)

S. Popovic[1], M. Davelaar[2]

[1] Mental health care professional and project manager on behalf of Lister for mixed housing projects - [2] Project manager Community of Practice on Mixed Housing, Research Centre for Social Innovation, HU University of Applied Sciences Utrecht

Aims: To share lessons from research on innovative mixed housing projects home to people with mental health disabilities, in general, and the mixed housing practice Place2BU (Utrecht NL) in particular. We focus on the role of the community in the recovery and social inclusion of people with severe mental illnesses. We pay attention to the possibilities and limitations of reciprocity and mutuality in daily interactions between the residents of Place2BU.

Working Format: After a 3mins movie on Place2BU we will present key lessons from research on mixed housing projects. Additionally, we give an overview of characteristics of Place2BU. There is time for questions and participants can share knowledge on similar developments. To end with, we will discuss a statement.

Content workshop / Learning objectives: After attending the workshop, the participants have obtained information on the main characteristic of 'mixed housing' projects that are home to people from different backgrounds, including 'regular' tenants and (former) users of mental health services (such as protected housing facilities). Through the example of Place2BU (490 inhabitants), they are informed how these innovative practices contribute to the inclusion of citizens with mental health disabilities. Furthermore, they have acquired knowledge on how residents, community builders and professionals providing individualised support cooperate together to create an active, welcoming and safe living environment for all. In addition, possible obstacles that prevent people from being 'good neighbours' will be discussed.

W24 • THE EXPERIENCE OF PEOPLE WITH SEVERE MENTAL ILLNESS WITH CREATIVE THERAPIES

F. Rodriguez Pulido[1], N. Caballero Estebaranz[1], P.M. Martín Cuadrado[1], P. Guillén Barroso[1]

1 ASCATEC C/Suarez Guerra, 19 Santa Cruz de Tenerife, Spain

Aims: To present our experience developing with different creative therapies for the benefit of people with severe mental disorder

Working Format: In a movie we will explain the different groups open to all people with severe mental illness in collaboration with the different rehabilitation resources

Content workshop / Learning objectives: Association Canary Creative therapies (ASCATEC) has ten years of experiencia with creative therapies in Tenerife for people with severe mental illness. With this kind of therapies, supported by scientific foundations, we find a large number of patients who affirm that when they develop their artistic part they are able to feel and express something that they could not do otherwise.Continuous and innovative work regarding the methods and modalities of intervention in patients with severe and chronic mental illness.Normalization of the situation of people with TMS. Restructuring of thought.Attenuation of negative symptomatology.Activation of new channels of expression-communication.

W1 • COORDINATION OF CARE DIALOGUE

K. Westen[1], P. Peeters[1]

[1] Avans University of Applied Sciences, Breda, The Netherlands

Aims: A Coordination of Care Dialogue (CCD) promotes interprofessional collaboration, shared decision making and advanced care and discharge planning for outpatient and inpatient teams collaborating closely with other outpatient or inpatient teams in treatment of people with severe mental illness. The workshop will introduce

the newly developed CCD, its practical implications and the results of multiple action-research implementation processes in mental health care.

Working Format: Plenary session

Content workshop / Learning objectives: The participant will learn about the content of a Coordination of Care Dialogue. The participant will learn about the theoretical background of a CCD. The participant will learn about CCD-research and its pros and cons. The participant will be able to introduce a CCD in his/her own practice. The participant will be able to use the basics of action-research whilst implementing a CCD.

W26 • AN OUTCOME EVALUATION OF ASSERTIVE COMMUNITY TREATMENT TEAM'S (ACTT) STEPPED CARE MODEL

S. Pepin[1], F. Islam[1]

[1] *Ontario Shores Centre for Mental Health Sciences – Ontario Canada*

Aims: The goals of this workshop: • To present a researched model that has proven to show dramatic reduction in psychiatric bed utilization • The use of Stepped Care measures can be transferable across medicine disciplines • Discuss the viability of expansion of the model • Brief presentation on the level of care tools that facilitated this project This initiative translates over multiple LEADS dimensions as it: • Achieved Results both in the existing ACTT teams and Stepped Care • Developed Coalitions between 6 different organizations • System Transformation by challenging the status quo of Assertive Community Treatment Teams

Methods: A mixed-method approach of an observational cohort design was used for the evaluation. Four outcome variables: change in the use of hospital days; change in quality of life measures; change in OCAN unmet needs and change in Assertive Transition Readiness (ATR) score were used to compare the outcomes of Stepped Care clients mainly with ACT clients.

Results: The first 204 clients that entered regular ACTT since the implementation of Stepped Care had 36,064 combined beds days the previous two years before entering ACTT. Two years into ACTT treatment, those same 204 clients saw a reduction in bed days by 90% to a total of 3,497 bed days for a total bed savings of 32,567 days. The Stepped Care model was successful in keeping its clients away from hospital with 9 times greater odds of spending 0 days in hospital in 2016-17 compared to the ACT clients. In addition to keeping a very low use of hospital, the Stepped Care clients were also able to maintain the gains in reduced heavy system use, psycho-social treatment resistance, functional impairment and addictions and improved employment without a relapse or decompensation.

Conclusions: Stepped Care clients demonstrated statistically significant improvement in ATR score, common functioning and some quality of life indicators that include employment, heavy system use, treatment resistance, functional impairment and addictions.

W27 • "EX-IN RELATIVES ACCOMPANIMENT - TRAINING AND EXPERIENCES IN THE WORK"

K. Nagel[1]

[1] *University of Hamburg, EX-IN Hamburg Germany*

Aims: to inform about the existence of EX-IN relatives companions in Germany, the professional training and basic goals. Rreport about our work in different institutions, hospitals etc. The inclusion of experts through experience and experts through witness can change the whole understanding and proceeding in psychiatric interventions

Working Format: ppt, film clips, discussion

Content workshop / Learning objectives: brief historical expiration of the EX-IN training, the training for relatives, work in hospitals, social facilities, psychosocial services, one to one talks with relatives (family members, partners, friends, neighbors etc.), questions and discussion

Poster Presentations

TOPIC 1_DEINSTITUTIONALIZATION

1.4 INNOVATIVE PRACTICES IN HOUSING SERVICES

P11 • FIRST YEAR EXPERIENCE OF THE IMPLEMENTATION OF THE HOME CARE SERVICE FOR ACUTE MENTAL ILLNESS

A. Guàrdia Delgado[1], J.D. Barbero, M. Betriu, E. Izquierdo, E. De la Cruz, V. Agasi, S. Mulero, I. Merodio

[1] *Hospital Universitari Parc Taulí, Universitat Autònoma de Barcelona, Sabadell Barcelona*

Aims: The following study aims to obtain a quantitative and qualitative overlook on the 1rst year experience of our unit.

Methods: It consists of a descriptive and retrospective study. Our unit is composed by 3 psychiatrists, Pand 3 mental health nurses to attend a maximum of 15 patients in our reference area of 430,788 inhabitants. We included all 140 patients admitted in our PHCS between 31/10/2017 and 31/10/2018. We studied socio-demographic variables, diagnosis with the DSM-V, average stay and care trajectory of all patients.

Results: The average stay of our sample of the 140 patients was 25.3 days. The most prevalent diagnostic group was psychotic disorders (62.9%), followed by affective disorders (35%). Anxiety and personality disorders constituted the smallest part of the sample. The patients came largely from the Adult Acute Inpatient Unit (AIU) (50%), followed by the Psychiatric Emergency Service (PES) (23,6%), and thirdly from the Outpatient Psychiatry Consultation Service (16,4%). The destination of the patients when they were discharged was the Outpatient Psychiatry Consultation to continue with the follow-up (76,4%), followed by AIU (14,3%).

Conclusions: Our finding allows us to better understand the profile of psychiatric acute patients that can obtain best profit of this new type of care unit. It is a pioneer unit in our country and all these data can be useful for the implementation of new units in other areas.

TOPIC 2_OUTPATIENT CARE

2.1 TREATMENT AND CARE IN THE COMMUNITY: FACT, ACT, CMHT, OTHER MODELS

P4 • SELF-REPORTED QUALITY OF LIFE OF PATIENTS WITHIN ASSERTIVE COMMUNITY TREATMENT (ACT) FORENSIC CARE

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[1] *GGzE, instituut for Mental Health Care Eindhoven Noord-Brabant, the Netherlands*

Aims: Patients with ACT forensic care have complex problems and rehabilitation is frustrated by subjective and objective factors. In the present study is investigated whether quality of life depends on personality disorder and the living conditions of patients.

Methods: The explorative cross-sectional study includes 43 patients within ACT forensic care of a mental health care institute in the Netherlands. Personality disorder, demographic characteristics and quality of life are operationalized using information from the electronic patient file and the Manchester Short Assessment of Quality of Life (MANSA).

Results: Preliminary results indicate that there are no significant differences in quality of life, between the patients with and without cluster B personality disorder. Homeless patients experience significantly lower levels of satisfaction with their living conditions than patients with a permanent address. In comparison with a population of patients with severe psychiatric disorders, patients within ACT forensic care report significantly lower levels of quality of life.

Conclusions: Patients within ACT forensic care in general have a low quality of life, especially related to living conditions and finances. Therefore, it's desirable that treatment goals focus on housing and finance.

P10 • STAFF SELF-PERCEPTION ON MANAGING USERS' REFERRALS IN THE CMHC IN TRIESTE: AN INTERVIEWS-BASED RESEARCH

T. Bonavigo[1], S. Bertoni[1], D. Papanti[1], F. Sandri[1]

[1] *Dipartimento di Salute Mentale di Trieste – Trieste Italy*

Aims: User's referral to a mental health service is the first step of the care process. Accurate management of the referral is a crucial function of the Community Mental Health Centers (CMHCs) in Trieste: it aims to understand and address the request in relation to the complex needs of the person. Though a high level of flexibility and a low threshold accessibility is guaranteed, over the years a set of procedures and tools have been developed in our Department to help professionals in dealing with referral management. We recently evaluated the professionals' self-perceived confidence with these practices in a CMHCs.

Methods: An anonymously self-administered structured interview measuring self-perception in addressing users' referrals was proposed to 38 staff members of a CMHC in Trieste.

Results: The professionals' confidence is generally higher in the management of the self-referrals (80%) than of referrals from other services or family members (71%). Controlling for type of profession, different levels of confidence are observed in relation to autonomy, collaboration with colleagues and use of different communication tools (i.e. telephone, fax, email). The "first contact questionnaire" tool is valued by half of the professionals, and the majority consider it more useful for the service functioning than for the users.

Conclusions: We found out good level of confidence among the professionals in referrals management, with constant training recommended to strengthen the perceived ability. Though some ask for clear protocols, the common perception of evaluation tools as a form of bureaucracy should require deep reflection and shared review of the current procedure.

P15 • A COMMUNITY MENTAL HEALTH TEAM IN A HEALTH CENTER, - WORKING TOGETHER

A.V. Araujo[1], M.L. Ribeiro[1], A. Correia[1], J. Machadeiro[1], L. Lourenço[1]

[1] *Community Mental Health Team, leiria Norte, C.H.U.C. Coimbra, Portugal*

Aims: better care in mental health in a region of Portugal

Methods: proximity of health mental care, with outcomes of eitgh years of community care.

Results: outcomes of eitgh years of community care: decrease of hospitalization, and lack of appointment, decrease of presence in emergency services, and increase of home intervention.

Conclusions: it is possible to reply this way of work in community care, in model of chain/network with the concept of balanced care.

2.3 DEALING WITH COMPLEXITY: CO-MORBIDITY, INTELLECTUAL DISABILITY, SOMATIC DISEASES, ADDICTION

P6 • MULTIPLE SCLEROSIS AND PSYCHOSIS. UNCOMMON BUT COMPLEX CO-MORBIDITY FOR COMMUNITY MEDICINE

A. Riolo[1], G. Lo Nigro[1]

[1] *Mental Health Center "Domio", Department of Mental Health, Trieste, Italy*

Aims: We present an unresolved case of neuropsychiatric co-morbidity with complex needs, according to the perspective of community medicine. Many operators (community nurses, social workers, psychologists, psychiatrists,

neurologists, specialists in physical rehabilitation, general practitioners, support administrator) have tried, without success, to improve physical and mental health and quality of life of this male adult suffering from multiple sclerosis and psychiatric problems (paranoid personality, cognitive distortions, psychotic behaviors). This person with reduced motor capacity only accepts a private home psychotherapist, few friends or some family members. He has never wanted to cure himself for multiple sclerosis and does not recognize psychiatric problems.

Methods: This is a case study, known many year before from the mental health center and neurologists.

Results: Facing the difficulties of approach, through multidisciplinary meetings, we have acted de-medicalization of the case, proposing a relational offer according to assertive outreach model.

Conclusions: The assertive outreach model, most likely, is not specific for neuropsychiatric co-morbidity but this approach reduces social deprivation of fragile individuals with complex needs who reject any proposed help.

P2 • SHORT-TERM GROUP SCHEMA THERAPY (SCBT-G) FOR PEOPLE WITH PSYCHOTIC DISORDERS AND CO-MORBID PERSONALITY PROBLEMS

E.M.A. Horsselenberg[1], H. Wolters[1], J.M. Brink[1], E. Sportel[1]

[1] *GGZ Drenthe, Assen, Drenthe, The Netherlands*

Methods: Paired t-tests and intention-to-treat analysis have been done

Results: Dysfunctional schemes measured by the YSQ decrease significantly with mean (r> .30) to large (r> .50) effects. In addition, significant improvements were found in the maladaptive parent modes and functional modes by the SMI. The SIPP scores show a significant improvement in personality problems in three of the six domains. In addition, SCL-90 scores of the scales anxiety, distrust, interpersonal sensitivity and sleep problems decreased significantly. The greatest treatment effect is achieved in the first eleven weeks of treatment.

Conclusions: The results support the hypothesis that schema-based group therapy (SCBT-g) can also be effective for patients with a psychotic vulnerability and an extent of personality disorder comborbidities. Don't deprive patients with a psychotic vulnerability this type of psychotherapy!

P12 • FACILITATING AND OBSTRUCTING FACTORS OF PSYCHO-EDUCATION FOR IMPROVING COPING BEHAVIOR BY PATIENTS WITH A DUAL-DISORDER

C. van den Broek[1], K. de Haan[1]

[1] *De Rooyse Wissel Asten Brabant, The Netherlands*

Aims: The study is tock place in the forensic FACT de Horst Maastricht, Nederland. More than half of the patients who are being treated, besides their psychiatric and forensic problems, also have addiction problems. The objective of the study is to gain insight into which aspects of psycho-education, aimed at developing coping behavior with regard to addiction, are perceived by patient as facilitating and obstructing. These insights can help in developing an innovative approach to psycho-education intervention for patients with DD, so that the quality of care can be improved.

Methods: A phenomenological study based on seven in-depth interviews with patients with DD who are in treatment by the forensic FACT. Data was collected and analyzed using Colizzi's method

Results: The study is in progress. Preliminary results have identified four core theme's: 1. Therapeutic relation; giving hope, believing in the patient and availability are mentioned by all respondent. 2. Psycho-education tailored to the patient's individual needs, level and motivation. Five of the patients experienced it as obstructive when the information and goals of the psycho-education did not match their needs or wishes. "I didn't want to stop with drugs at that moment, and they only talked about abstention" 3. Developing new skills: all of the patient experienced it as facilitating to identify high risk situates and practice new behavior with their therapist. "what would my therapist do/say now" 4. Empowerment: patient experienced that he can take responsibility for his own actions and can make is own goals.

Conclusions: Preliminary results show that by patients of Forensic FACT aligning with the personal needs and level of motivation in the contents of the interventions is essential in the facilitating and improving coping behaviour by patients with DD.

P28 • SHAPING NEW APPROACHES IN MENTAL HEALTH SERVICES: THE "MENS SANA"

P. Zolli[1], R. Bracco[1], L. Frattini[1], C. Canova[1], M. Impagnatiello[1], G. Lonigro[1], L. Marrazzo[1], S. Reuther[1]

[1] *Mental Health Department of Trieste*

Aims: The high comorbidity between mental disorders and organic disorders requires a deep reflection on health care and treatments inside territorial services, from the very first contact between the person and the psychiatric services. The first contact must face not only the emerging health issue, but should offer also a broader approach, which is not solely restricted to the crisis treatment but comprehensive of people global wellness; the loss of this approach would influence the treatment experience and whole course.

Methods: During 2017 and 2018, operators codify the activities "Mens Sana" and the names of patients in the electronic register of the Mental Health Department

Results: The project's outcomes presented relate to the years 2017 and 2018 with the elaboration of the statistic system of Mental Health Department

Conclusions: The "Mens Sana in Corpore Sano" project, focusing on physical comorbidities and lifestyles, suggests the concept of people global welness which goes beyond mere psychiatry, being therefore less stigmatising.

2.4 SPECIALTY SERVICES VERSUS GENERAL SERVICES

P8 • A RANDOMIZED CONTROLLED TRIAL OF COMPREHENSIVE EARLY INTERVENTION CARE IN PATIENTS WITH FIRST-EPISODE PSYCHOSIS

S. Yamasaki[1], A. Nishida[1], S. Ando[1], S. Koike[1], J. Smith[1], P. French[1], K. Kasai[1], Y. Okazaki[1]

[1] *Tokyo Metropolitan Institute of Medical Science Setagaya – Tokyo, Japan*

Aims: The first episode of psychosis represents a critical period wherein comprehensive early intervention in psychosis (EIP) may alter the course of illness. However, evidence from randomized controlled trials that have examined the impact of comprehensive EIP care on clinical and functional recovery assessed by independent blinded raters is limited. The objective of this study was to conduct a single-blinded multicenter trial comparing comprehensive EIP care and standard care in young patients with first-episode psychosis (FEP) in Japan (J-CAP Study).

Methods: A total of 77 participants with FEP (aged 15–35 years) were randomized to receive standard care or specialized comprehensive EIP care and were followed up for 1.5 years (trial no.: UMIN000005092). Function (measured with the Global Assessment of Functioning) and clinical remission (defined by internationally standardized criteria proposed by the Remission in Schizophrenia Working Group) were evaluated by independent raters who were blinded to group assignment. Dropout rate and other secondary outcomes were also examined.

Results: The specialized EIP care group had a higher clinical remission rate (odds ratio, 6.3; 95% confidence interval, 1.0–37.9) and lower treatment dropout rate (odds ratio, 0.038; 95% confidence interval, 0.002–0.923) than the standard care group, even after adjusting for baseline characteristics. Functional improvement in the specialized EIP care group was slightly higher than that in the standard care group, but this difference was not statistically significant (p=0.195).

Conclusions: From the results, we conclude that comprehensive EIP care may provide advantages over standard care in patients with FEP.

2.7 INNOVATIVE PSYCHOLOGICAL AND BIOLOGICAL TREATMENTS

P22 • DEVELOPMENT OF AN INDIGENOUS HEADACHE PAIN ASSESSMENT AND PROTOCOLS

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[1] *Tanwir Ahmed Medical Center, MM Alam Road Lahore Punjab - Pakistan*

Aims: In the present study a Pain Questionnaire was developed for Headaches in Urdu, based on McGill Pain Questionnaire (MPQ), (Melzack & Wall, 1975). The MPQ is a leading pain measurement protocol which assesses 3 component areas of Pain namely, Sensory. Affective and Evaluative components of headache.

Methods: For Sensory. Affective and Evaluative components of Headache, standard translation/adaptation protocols used to translate MPQ checklist of 78 words into Urdu, two choices closest in meaning were selected. Then 5 headache patients and 5 experts were asked to select one of the two Urdu words closest to MPQ. A list of 78 Urdu words generated from words most frequently chosen by patients and experts. Back translation into English by 3 Experts and 3 patients .

Results: Also pain diary was required to be maintained to document unique pain descriptions. These descriptions were also documented as part of the protocol. The Reliability scores indicate that the Urdu adaptation of MPQ is a valid tool to assess headaches and pain.

Conclusions: It is well suited for use on the Pakistani population and particularly in the clinical setting and is ready for use in research; it requires further investigation on a wide range of patient population.

P26 • IMPACT OF MINDFULNESS MEDITATION ON PSYCHIATRIC SERVICES UTILIZATION IN A MENTAL HEALTH SERVICE

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Aims and objectives: Mindfulness is an attitude that is cultivated through a practice of meditation aimed at bringing attention in a non-judgmental way towards the present moment. In the last two decades, Mindfulness-based interventions (MBI) have generated enormous interest both on a scientific and popular level. Despite the ever-increasing evidence of clinical efficacy, no published studies has examined the effect of mindfulness meditation on psychiatric services utilization.
The aim of this study was to evaluate the effect of attending MBI sessions on the utilization of mental health services.

Methods: Using data from South-Verona Psychiatric Case Register, contacts with mental health services were recorded for 24 months (in the year before and after the first MBI session) for patients attending at least two MBI sessions from May 2012 to January 2018. A binary variable for whether at least one psychiatric contact took place in each month was created. Patients with contacts in the same service from May 2001 to May 2011 were considered to identify a control group through propensity score matching.
Results: Eighty-eight patients were identified. Patients were more likely to have psychiatric contacts the more they approached their first MBI session, with 85% (n=75) of them having at least one contact in the month before. After starting MBI, the percentage of patients having contacts decreased, up to 50% after 6 months. Eighty-five matches were identified by matching on propensity score: frequency of contacts will be compared between the groups of patients attending MBI sessions and the control group.

Discussion: A steady decrease in service utilization was observed among patients attending MBI sessions. If, as the literature suggests, uncertainty, worry and fear are among the main drivers of high service utilization, it is reasonable to assume that MBI would reduce service utilization by raising the subjective threshold for this type of mental states.

P27 • THE IMPACT OF COGNITIVE REMEDIATION IN MAJOR PSYCHOSES: PRELIMINARY FINDINGS

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Aims and objectives: To compare cognitive functions and brain Grey Matter volumes between patients with Major Psychoses (MP) and Healthy Controls (HC) and to explore the effect of cognitive remediation (CR) on cognition and neuroplasticity.

Methods: Twenty patients with MP were recruited and matched with 20 HC. All participants underwent clinical and cognitve evaluations and an MRI exam at baseline (T0) and after three months (T1). MP patients were randomized to three groups of intervention i.e., CR + Social Skills Training (SST); CR + mindfulness (MF) and TAU, and treated for three months. Due to the small sample size, patients undergoing CR+SST and CR+MF were merged in one group (CR). Patients vs HC and patients treated with CR vs TAU were compared on demographic, clinical, cognitive and neurostructural variables at T0 and T1.

Results: Compared to HC, MP patients showed (i) lower scores in the List Learning, Verbal Fluency, Digit Sequencing, and Symbol Coding tests; (ii) clusters of smaller volumes in anterior cingulum and insula and (iii) larger volumes in the thalamus ($p < .05$, FWE corrected; cluster size $k \geq 200$). No differences were found between patients at baseline. After the intervention, patients undergoing CR improved in the Reading the Mind in the Eyes and Digit Sequencing Tests showing trends of greater GM volumes in fronto-occipital gyri, cuneus and thalamus ($p < .001$, uncorrected; $k \geq 100$). No pre-post training differences were observed in patients undergoing TAU.

Conclusions: Preliminary findings suggest that CR might improve cognitive dysfunctions and determine structural neuroplasticity in MP patients. Further analyses will be carried out to replicate the findings on a larger sample and test the long-term effect of CR. Moreover, the specific effects of CR+ SST and CR + MF compared to CR alone will be also explored.

TOPIC 3_RECOVERY

3.5 PATIENTS IN THE LEAD: SHARED DECISION MAKING

P25 • THE NEWBORN USERS' ASSOCIATION "IL CERCHIO APERTO" (THE OPEN CIRCLE): A CO-PRODUCTION EXPERIENCE

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Aims: Creating a service users' association aims to overcome social exclusion, the lack of users' representation inside the Mental Health Department (MHD) board, to sensitize population about mental health, to co-produce mental health services, to form peer experts, and, overall to implement recovery-oriented practices.

Methods: Since 2017 a self-help group has been formed. Initially, it counted only three users of the 4 Mental Health Services (MHSs) of Verona and some mental health professionals, who supported it. The meetings are held on a quarterly basis and at the DC of South Verona Community MHS. Some members participated as listeners in MHD boards, deepening in the perspective of co-production and empowerment. Some others participated in seminars

about stigma, recovery and peer support teachings.

Results: The group achieved an average attendance at the meetings of 6-7 participants. The small number has, however, favored greater cohesion and confidence among the members, with the consequent development of a spirit of belonging. Moreover, education and shared perspectives with mental health professionals improve users self-efficacy as a future social association.

Conclusions: To intervene actively and officially, the users' group must be legally constituted as a registered social association. Thus, more focus meetings were carried on, the name of the association was chosen: "Il Cerchio Aperto", and the articles of the association, needed for the official registration, were drafted

3.6 INVOLVING SIGNIFICANT OTHERS IN TREATMENT

P24 • EXPLORING ADDICTION RECOVERY: FOCUS GROUPS WITH INDIVIDUALS IN RECOVERY AND FAMILY MEMBERS

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Aims: Addiction recovery has been an emerging focus in both practice and research. However, the concept remains vague and due to its professionalization, recovery tends to be a concept that is 'designed' without the involvement of the individuals concerned. Furthermore, the voices of social networks, that have their role in and provide support during the recovery process, should be recognized and heard. Starting from lived experiences, this study aims to provide insight in perspectives on addiction recovery. Emphasis is put on tensions and discrepancies that arise from the perspectives of those directly and indirectly involved in addiction recovery.

Methods: To gain insight in perspectives on recovery, focus groups (n=6 with individuals in recovery, and n=3 with family members of individuals in recovery) were conducted in both in- and out-patient treatment and support settings. These all started with the question 'what does recovery mean to you?'. All focus group were audio-taped and transcribed verbatim. Themes and subthemes were analyzed by using mind maps.

Results: Preliminary findings show several tensions and discrepancies between perspectives of individuals in recovery and family members. Individuals in recovery state the importance of support from family members, while family members often feel powerless and experience to have little impact, mainly with regard to initiating recovery. Furthermore, the recovery process seems to have two speeds: (1) the reality of slow identity change and regaining life for individuals in recovery and (2) expectations that something has to change drastically and rapidly in the strive for a 'normal' life as perceived by family members.

Conclusions: Different perspectives on addiction recovery should be brought under attention to provide sufficient and appropriate support and treatment for all parties involved, in order for recovery to be a personal yet shared process.

TOPIC 4_DIGITAL PSYCHIATRY

4.1 INTERNET BASED INTERVENTIONS

P3 • COMPLEXITY-MAPPING IN DIGITALIZATION PROJECTS: REVEALING THE CHALLENGES OF DEVELOPING A SCHIZOPHRENIA POINT-OF-CARE DASHBOARD

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Aims: Use of new technologies is critical to achieving evidence-based healthcare, but failure is common regarding

adoption, scale-up and spread due to a high level of complexity. Treatment failure in schizophrenia is common, and evidence suggests that decision aids can enable increased patient participation. A point of care dashboard (PoC dashboard) is under development. How can complexity-mapping inform the ongoing development?

Methods: The Nonadoption, Abandonment, and challenges to Scale-up, Spread, and Sustainability (NASSS) framework served as a backdrop when studying the case of the PoC dashboard at Sahlgrenska University Hospital in Sweden. Data was collected through observations, field notes and the use of a prototype complexity assessment tool (NASSS-CAT) in a workshop with managers and developers from five collaborating departments. This was done to assess the complexity profile of the project and to identify areas where complexity can be reduced or handled.

Results: Complexity is especially found in domains like the condition or illness (schizophrenia is a complex condition to treat), the technology (being dependent on few individuals and the IT-department), the value-proposition (not established to what extent use increases cost-effectiveness), the organization (multiple organizations coordinating the project without a clear mission). Complexity related to the potential adopters of the technology was low due to the perception of a good technology-organization-fit.

Conclusions: Complexity-mapping increases awareness of challenges. Complexity could be reduced or handled, e.g., by the making of a value proposition, a plan for strategic governing of the project and by finding a sponsor in the greater organization who recognizes the importance of the project and helps negotiate its progress.

P13 • 'USER EXPERIENCE OF BIPOLAR PATIENTS; MEASURING LITHIUM WITH A MOBILE DEVICE'

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Aims: The aim of the study is to get an insight into user experiences of bipolar patients who used a mobile device in their home to measure lithium. The device was automatically diverted by using a QR code to an online medication module. In this module the measurements were put in a graphic. It offers the option to register a personal life-chart and mood journal for monitoring self-management and life style. We wanted to find out whether it was convenient to use and in which context it contributes to the self-management of patients.

Methods: The qualitative study included 13 patients with a bipolar disorder using lithium. By using the mobile device Medimate Minilab© during six to seven weeks, the patients measured the lithium blood level with capillary electrophoresis twice a week. This was combined with an online blended care module. To describe the patients' experiences, we conducted a semi-structured interview by using a topic list compiled after a literature review. The study is imbedded in a large ongoing study: The "LiZe Cross-care project".

Results: Because of the ongoing research the results are preliminary. One of the focal points was the high usability; home use instead of going to the lab, a faster results outcome and a painless blood sample. Patients found the device easy to use and their self-management increased. That said, patients didn't visit their medical practitioner any less. On the other hand there was the risk of experimenting with lithium-dosage and daily intake moments. A few patients experienced a varying lithium blood level outcome after using alcohol the day before measuring.

Conclusions: In order to create a satisfactory level of self-management and low risk using a mobile point-of-care device, it is highly desirable to develop a lithium self-test protocol.

4.2 TELEMENTAL HEALTH

P20 • VIRTUAL PSYCHIATRY WARD VIDEO CONFERENING IN THE TREATMENT OF PSYCHOSIS

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Aims: We examined the use of video conferencing technology in the treatment of patients with a schizophrenia

spectrum diagnosis presenting with acute psychotic symptoms.

Patients with schizophrenia spectrum disorders, including those living in supportive housing units, are frequently hospitalized due to the exaberation of psychotic symptoms. The primary aim was to provide, via video conferencing, the assistance and expertise of a university hospital ward specialized in the treatment of acute psychosis, to supportive housing units, in order to reduce the need for hospitalization.

Methods: The target group were patients with a schizophrenia spectrum diagnosis (n>20) living in supported housing units within the Peijas hospital area, with a catchment area of 250 000 inhabitants. During the first video appointment a treatment plan was evaluated together with the patient, staff at the housing unit, and ward staff (a psychiatrist & a psychiatric nurse).
The Brief Psychiatric Rating Scale was used to evaluate symptom severity during the initial and final video appointments. An online questionnaire was used to assess the subjective experience regarding the use of video conference technology, among patients and hospital staff.

Results: None of the patients included in the trial were admitted to hospital. BPRS scores decreased in all patients (figure to be presented later). The majority of patients found the use of video conferencing to be a subjectively positive experience, hospitalization was not required. The majority of staff members found the use of the technology positive. Although there were many technical difficulties.

Conclusions: Video conferencing may be effective to reduce the hospitalization of patients presenting with acute psychotic symptoms residing in supportive housing units. It provides a method to promote the management of psychotic patients by facilitating the direct delivery of psychiatric expertise to the patient and staff of supportive housing units.

4.4 VIRTUAL REALITY

P5 • COULD PHYSIOLOGICAL BIOFEEDBACK AND VIRTUAL REALITY SUPPORT PATIENTS WITH A GENERALIZED ANXIETY DISORDER TO RELAX?

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Aims: Patients with a Generalized Anxiety Disorder (GAD) are often unaware of their current relaxation status, due to experiencing long-term stress. By measuring the heart rate variability of patients, the level of stress can be indicated. The research aim is to determine how people with a GAD experience physiological biofeedback like heart rate variability while relaxing with the Virtual Reality (VR) Relax Tour app.

Methods: This qualitative study included ten patients diagnosed with a GAD. To measure the biofeedback experience each participant used the VR Relax Tour app for one week at home. Only the first and last relaxation session took place with a biofeedback session of 20 minutes in presence of a healthcare professional. In addition, after the last relaxation session an in-depth interview was conducted.

Results: Preliminary results of this study show that most participants experience the benefit of biofeedback in terms of increased insights and awareness of their current status. The participants noticed that these new insights helped them with better self-regulation and increased relaxation.
Several participants suggested to integrate biofeedback into the virtual environment for enhancing autonomy of the patient. However, some participants do think the presence of a professional can create a sustainable effect by using this tool on a more structural basis.

Conclusions: Based on this research, most participants experience benefits by gaining biofeedback in relation to the VR Relax Tour app. More research has to be conducted to investigate the long-term effects of relaxation-training and how biofeedback could be successfully integrated in relaxing virtual environments, without disturbing the actual experience of relaxation.

TOPIC 5_CHILD & ADOLESCENT PSYCHIATRY IN COMMUNITY CARE

5.2 C&A SERVICES IN THE COMMUNITY, OUTREACH, WORKING WITH SCHOOLS

P18 • A STUDY OF RESILIENCE AMONG UNIVERSITY STUDENTS AT THE CAMPUS IN THE SOUTH THAILAND INSURGENCY

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Aims: This survey aims to compare levels, clinical representations and associated factors of resilience among university students at Pattani campus, and a nearby province (Hatyai campus).

Methods: This cross-sectional survey studied university students, who were studying at the Prince of Songkla university, Pattani campus, which is located in the restive area of Southern Thailand's insurgency. The study was conducted between: 1 June 2018 and 1 August 2018, at both the Prince of Sonkla university, Pattani and Hatyai campus, which is classified to have 3 categories of faculties; health science, social science and pure/applied science. All of the participants completed the personal information, and Thai resilience questionnaires (Thai-RQ) by themselves. The data were analyzed using the R program for both descriptive statistics, and logistic regression.

Results: Most of the 443 students who studied at Prince of Songkla university, Pattani campus were female (80.3%) and Muslim (76.3%). Most of them at were at a normal level (55.7%), however, 35.1% of the participants were below the normal range. The domain of resilience with the highest prevalence in the normal range along with higher than average was coping strategy (75.9%), with the lowest one being emotional stability (67.2%). No statistical difference of levels and characteristics of resilience were found between the two campuses. Satisfaction towards: university teaching, age, religion and birth order were also significantly associated to resilience among students at the Pattani campus. However, only gender and satisfaction towards university teaching were found at the Hatyai campus.

Conclusions: Most university students, who were studying within the campus in the restive areas of south Thailand insurgency, had a normal level of resilience. There was no significant difference of resilience between two campuses. Satisfaction towards: university teaching, age, religion and birth order was associated to resilience among them.

P29 • CHILDHOOD ABUSE AND NEGLECT PREDICT DIFFERENT SYMPTOM PROFILES IN FIRST-EPISODE PSYCHOSIS

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Background: Childhood adversity (CA) has been linked to an increased risk of mental disorders including those within the psychosis continuum. However, pathways from early adversity to negative outcomes in psychosis are yet to be revealed. We explored these associations in a large, representative and well-characterized sample of first-episode psychosis (FEP) patients enrolled in the GET UP PIANO Trial.

Methods: Detailed information on history of sexual and physical abuse, antipathy and neglect was obtained from

296 patients, using the Childhood Experience of Care and Abuse Questionnaire. Logistic regression analyses were performed to test the associations between types of CA and psychotic symptoms, using the Positive and Negative Syndrome Scale.

Results: Prevalence of any adversity was 61.0% in FEP. Patients with any CA presented with more severe positive symptoms, depression and functional impairment. Physical abuse predicted grandiosity (OR 2.80, 95%CI 1.19-6.48), unusual thought content (OR 1.78, 95%CI 1.01-3.14), emotional withdrawal (OR 1.80, 95%CI 1.07-3.03) and active social avoidance (OR 1.72, 95%CI 1.03-2.87). Antipathy was associated with grandiosity (OR 2.70, 95%CI 1.16-6.30). Neglect predicted emotional withdrawal (OR 1.81, 95%CI 1.04-3.14), passive-apathetic social withdrawal (OR 2.03, 95%CI 1.18-3.50) and active social avoidance (OR 2.09, 95%CI 1.21-3.60). Sexual abuse was associated with passive-apathetic social withdrawal (OR 2.57, 95%CI 1.25-5.29).

Conclusions: FEP patients exposed to CA present with a more severe clinical profile. Specific symptom-level relationships have been revealed, including neglect predicting more severe negative symptoms. Different forms of CA may foster specific psychopathological presentations in FEP. Targeted interventions should thus be provided to these patients.

P30 • AN EARLY INTERVENTION FOR HIGH SCHOOL STUDENTS FROM VERONA, AIMED TO PREVENT MENTAL HEALTH STIGMA, STIMULATE PROBLEM-SOLVING SKILLS, AND HELP IDENTIFYING AND MANAGING EMOTIONS

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The presented intervention is part of the larger project "Prevention 0-25", conceived and conducted by the Verona Hospital Trust of Verona, with the support of Rotary club, and under the patronage of the Education Office of the Province of Verona.
The goal of this intervention is to improve the psychological well-being of young people and their families, by the identification of their potential mental health needs at an early stage of life. Up to date, the intervention has involved 208 students from three high schools from the Verona area. A psychologist from the Psychiatry unit has delivered two awareness and prevention interactive sessions per class (3 hours each), tailored to anonymous questions left by students in a box. These activities included peer-to-peer discussions and role-plays based on real-life experiences, TV series, music, and movies. The topics that ranked the most popular among the students were: relationships problems (both with peers and with families), self-esteem issues, assertiveness, identification and management of emotions. Furthermore, based on the results of the questionnaires as well as the active involvement of the teachers, it has been possible to identify a number of high-risk situations, for which we proposed targeted interventions.
The next steps of the project would be to extend these interventions to other schools and to offer additional tailored activities for the most difficult and sensitive situations.

TOPIC 6_COMMUNITY CARE EVALUATION

6.1 • QUALITY ASSESSMENT

P19 • DOES THE DEINSTITUTIONALIZATION MODEL OF TRIESTE APPLIED TO SECURITY MEASURES IMPROVE SOCIAL RE-INCLUSION OUTCOMES?

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Aims: The aim of the study is to establish whether the Deinstitutionalization model applied in Trieste, starting from

L.180/78, improves the outcomes in terms of social re-inclusion for people admitted to REMS (Residential facilities for of Security Measures) compared to the provisions of the Court System.

Methods: L.81/2014 abolished the Forensic Hospitals and established REMS. The Department of Mental Health of Trieste applied to the REMS, an operative model, based on high integration, networking with community servicies and no restrain. The activities data, based on a small sample size, but representative of complex needs, allow to highlight some quality index: cases in which the security measure was transformed before it expires; activities within the Widespread Day Center located in the REMS facility; days not spent inside the facility compared to days spent inside the REMS; nights not spent inside the REMS compared to nights spent inside.

Results: Data show that REMS stays are reduced by median of 48% (mean 42%, min 15%, max 74%) with a theoretical saving of 38% (€270000 compared to €706000 expected). Social reinclusion is precocious, with participation in the activities of the Widespread Day Center and the direct collaboration with the Judges for the approval of personal care plans that imply the possibility of leaving the structure (% days spent outside the REMS during the Security **Measure:** median 69%, mean 60%, min 22%, max 92%).

Conclusions: The operative model, strictly in contact with places of life, favours a recovery of social function and the improvement of psychopathological conditions and reduces healthcare costs.

TOPIC 7_PREVENTION

7.2 • PREVENTION OF SEVERE MENTAL ILLNESS / CHRONICITY

P14 • ASSESSMENT OF THE EFFECTS OF GROUP TREATMENT IN AGGRESSIVE OUTPATIENTS.

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Aims: As part of the RECOVER care model, which has been established in January 2018 at the University Hospital Hamburg-Eppendorf (UKE), we provide cross-sectoral, highly-graded, evidence-based and needs-based care for people with mental illnesses. Both the dysfunctional handling of emotions and aggressive behavior are associated with various mental illnesses such as mood disorders, personality disorders and psychotic disorders. These problems are common in clinical practice, but are often not addressed adequately in therapy. Part of RECOVER is the implementation and invesigation of an outpatient group therapy: Anger and Aggression - Group (AAG).

Methods: The AAG teaches strategies for healthy emotion regulation aiming to reduce aggressive behavior and long-lasting unpleasant feelings. Therapeutic techniques are instructions for self-observation and reflection, body and mindfulness exercises, role-playing games, expressive writing and problem-solving training in individual, partner or group work.

Results: The aim is to present the concept of the AAG and its evaluation in a pre-post comparison and to present first-person accounts of patients. We want to present the concept of the AAG With DBT and RnR exists an effective method of treatment for patients with centre of which seems to be a disturbed affect regulation.

Conclusions: We think that it is possible to implement violence prevention in an outpatient setting and we would like to discuss clinical implications and future perspectives of our results.

TOPIC 8_INTEGRATED CARE AND COLLABORATION BETWEEN MENTAL HEALTH AND OTHER SERVICES

8.4 • COLLABORATION WITH THE INFORMAL NETWORK

P16 • A COMMUNITY MENTAL HEALTH TEAM AND THE DISASTER OF PEDROGÃO GRANDE

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Aims: a coordenation and clinical work in the catastrophe in june 2017

Methods: Care in the Health center and in the institutions of the community

Results: an increase of care in the community integrated with GP and others

Conclusions: a good perception of the population of the care and the organization of the methods in the different stages of crise of catastrophe.

8.6 • WORKING WITH MIGRANT POPULATIONS

P17 • "A SYSTEMATIC REVIEW OF SUBSTANCE USE RECOVERY RESEARCH AMONG MIGRANTS AND ETHNIC MINORITIES"

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Aims: Recovery is a widely used concept within substance use (SU) research, treatment and policy. However, recovery literature is mostly based on the study of 'white', Western populations and rarely includes voices of persons with a migration background and ethnic minorities (MEM). As a first step towards including these voices in recovery oriented treatment and policy, this review aims to bring together research concerning SU recovery among MEM, to discover possible lacuna, to identify recovery components and to discuss this in relation to the different interpretations of recovery.

Methods: The databases CINAHL, Cochrane Library, Embase, ERIC, MEDLINE, PsycARTICLES, Scopus & Web of Science were systematically screened for studies (with English title and abstract, published until February 2018) that focus on recovery among adult MEM and its components (identified needs, facilitating and hindering elements, subsequent recovery components).

Results: The identified recovery components are systematically discussed. Additionally, we critically look into how the recovery components and interpretations are situated in well accepted recovery frameworks (i.e. clinical, social and personal recovery, recovery capital) and which blind spots remain in research concerning substance use recovery among MEM. The majority of the identified studies originates from the USA and most studies depart from a clinical recovery perspective. Most research focusses on the efficacy of specific treatment, rather than researching how recovery takes place in the personal environment of MEM. Personal and structural barriers in treatment and general society are discussed to a lesser extent.

Conclusions: Given the limited research concerning social and personal recovery processes, facilitating and hindering elements at both the individual, communal and societal level in the European context, more research is needed.

Symposia

S19 • EVIDENCE-ORIENTED SERVICES AND NEW ORGANIZATIONAL MODELS: EFFICACY VS EFFECTIVENESS, "ORGAN PIPES" SERVICES VS USER-CENTERED PROGRAMS

Short general introduction symposium: *In the last decade, Mental Health Services are facing two main challenges. The first concerns is the extent to which we can offer effective psychosocial treatments; the second refers to the increase in the number of people with complex treatment needs, that requires different professionals and different services in order to guarantee a continuum of care. The symposium will be focused on implementation of EBPS in services and related issues, on the obligatory shift from an "organ pipes" organizational model to user-centered interdisciplinary programs and on example of implementation of a Psychosocial Ebp (IMR) in MHD of Ferrara, highlighting the outcomes obtained on treated patients. The aim is increasing awareness about new methods of developing expertise and new organizational models to try both filling the gap between the research outcomes and "dirty" service settings outcomes and to integrate the different professionals and services, involved in the complex patients care.*

1 • CRITICAL ISSUES IN THE IMPLEMENTATION OF EBPS IN "DIRTY" SERVICE SETTINGS: FROM EFFICACY TO EFFECTIVENESS

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Aims: The aims are: 1. to analyze the extent to which we can offer effective psychosocial treatments, considering their complexity, the time needed to learn and deliver them, the resources available, the harmony of the different professional backgrounds with the psychosocial approach and other variables (staff turnover, motivation of leadership, priority of psychiatric urgency on medium-long term interventions, resistance to evaluation of outcomes, etc.). 2. to evaluate the gap between the research outcomes and "dirty" service settings outcomes

Methods: The presentation will draw from research and our experience of training all personnel of two Italian Mental Health Departments in main psychosocial treatments.

Results: Participants will understand the factors that impede or foster the implementation of evidence in mental health service systems as well as the major issues in dealing with the gap from line-guide fidelity and her application in the real service settings.

Conclusions: New methods of developing expertise and new technology will be necessary to evaluate the gap between the research outcomes and "dirty" service settings outcomes and to adapt the evidence-based recommendations to the reality of daily practice.

2 • MULTIDIMENSIONALITY OF MENTAL ILLNESS: FROM AN "ORGAN PIPES" ORGANIZATIONAL MODEL TO USER-CENTERED INTERDISCIPLINARY PROGRAMS

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Aims: 1. To explain why it is necessary shifting from an "organ pipes" organizational model to user-centered interdisciplinary program 2. To describe the structure, the target population and the results of user-centered interdisciplinary program

Methods: The presentation will draw from research and our experience. This model have implied to build an interprofessional team (practioners come from different services of Department) and to plan perodical meetings

between all practioners involved with the aim to rewiev the treatment plan of patients with comorbidity (mental illness and substance addiction, for example)

Results: 1. Participants will understand the structure and the results of user-centered interdisciplinary program, besides the features of target population, characterized by people with complex treatment needs, that requires different professionals and different services (health, social and welfare services) in order to guarantee a continuum of care. 2. Participants will be aware of some barriers that prevent from implementing user –centered program and team work

Conclusions: 1. Participants will understand the structure and the results of user-centered interdisciplinary program, besides the features of target population, characterized by people with complex treatment needs, that requires different professionals and different services (health, social and welfare services) in order to guarantee a continuum of care. 2. Participants will be aware of some barriers that prevent from implementing user –centered program and team work

3 • ILLNESS MANAGEMENT AND RECOVERY, EFFECTIVE EBP IN THE VULNERABILITY / STRESS / COPING MODEL

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Aims: 1. To increase understanding the psychosocial EBP "Illness Management and Recovery", highly effective EBP in the vulnerability / stress / coping model. 2. To increase awareness of needs to integrate pharmacological treatment with psychosocial treatments

Methods: The presentation will draw from research and our experience to present an example of how to transfer an EBP in mental health services and how to increase personal, functional and clinical recovery, training patients to learn and practice skills and strategies to manage illness and to achieve personal recovery goals.

Results: Participants will understand how people with mental illness can learn strategies and skill to manage illness and medication, to cope with stressors, to prevent from relapses and to achieve their recovery goals.

Conclusions: The need to integrate psychosocial EBPs with psychopharmacology is based on the following contributions: Mental illness impacts psychological, biological and social dimensions The improvements of mental health is not only related to the symptoms but also to the ability to cope with stressors and to manage feelings and emotions.

S13 • EUROPEAN COMMUNITY MENTAL HEALTH SERVICES NETWORK (EUCOMS): LEARNING FROM EACH OTHER BY EXCHANGE

Short general introduction symposium: *European community mental health services can learn from each other, by exchange. Visiting another service can open doors to new practices that can be adapted to the regional situation of your service. Being visited is also a learning process: visitors can ask you questions that help you evaluate your own service and improve your practice. In this symposium we report on the results of two exchanges: between Norway and Spain and between Germany and The Netherlands.*

1 • COMMUNITY MENTAL HEALTH SERVICES IN EUROPE: LEARNING FROM EACH OTHER WITH AN EXCHANGE TOOL

N. Mulder[1], M. Ruggeri[2]

[1] *Department of Psychiatry Erasmus MC: University Medical Center Rotterdam, The Netherlands -* [2] *Professor of Psychiatry; Director, Institute of Psychiatry, University of Verona and Verona Hospital Trust; Director, Specialization*

School in Psychiatry, University of Verona, Italy

Aims: Mental health care organizations have expressed their wish to learn from each other while implementing good community mental health care.

Methods: In the context of the European Community Based Mental Health Services Providers Network (EUCOMS) an international exchange program - including an exchange-tool - was developed. The aim of this ''Exchange-tool on good community mental health care'' (ETCMHC) is to facilitate mutual learning about the way the six principles of good community mental health care are implemented.

Results: Mutual learning in this case means that a multidisciplinary team (peer experts, clinicians, managers) of one organization visits an organization in another country and vice versa, while using the ETCMHC. The six principles of good community mental health care (as described in the ''Consensus Paper on Fundamental Principles and Key Elements of Community Based Mental Health Care'', and discussed earlier in this symposium) include ethics, public health, recovery, effectiveness of interventions, community network of care, and peer expertise.

Conclusions: During this presentation I will describe the structure of the ETCMHC, some preliminary experiences working with this instrument which yields qualitative results, and how it can be used during international multidisciplinary site-visits.

2 • LESSONS LEARNED IN AN EXCHANGE BETWEEN COMMUNITY MENTAL HEALTH SERVICES IN NORWAY AND ANDALUCIA (SPAIN)

T. H. Tjelta[1], E. Huizing[1]

[1] *Local Centre for Mental Health Care and Addiction Development/FACT Gamle Oslo*

Aims: Study the mental health (MH) services in Andalucia and see if we can learn something which we can bring home to our services in Norway. We want to learn from each other.

Methods: We were the first group that tried the new manual for site visits developed by professor Mirella Ruggeri (IT) and professor Niels Mulder (NL) for EUCOMS. The manual looks at the six principles in the consensus document for EUCOMS: 1. Ethics 2. Public health 3. Recovery 4. Effectiveness of interventions 5. Community network of care 6. Peer expertise We established a knowledge based working group of people with lived experience, research and development experience from specialized services and primary mental health care and a senior adviser from the County Governor. We looked at Hospital Universitario Virgen de la Victoria.

Results: In the symposium we will present the overall opportunities for improvement, overall points to take home and overall lessons learned on all the six principles. The learning process of being visited will be provided by the andalusian colleagues, in line with the perspective of mutual learning.

Conclusions: In the symposium we will present the overall opportunities for improvement, overall points to take home and overall lessons learned on all the six principles. The learning process of being visited will be provided by the andalusian colleagues, in line with the perspective of mutual learning.

3 • LEARNING FROM EACH OTHER BETWEEN GERMANY AND THE NETHERLANDS: THE DACHVERBAND GEMIENDEPSYCHIATRIE AND LISTER

N. Greve[1], J. Berndsen[2]

[1] *Psychosozialer Trägerverein Solingen e.V - Germany -* [2] *CEO Lister Utrecht*

Aims: The Netherlands: Lister has served mental wellbeing for over 30 years in the Utrecht area. In the first 20 years the primary focus was on providing sheltered living. In 2008 we made a transition to recovery supporting care and started a recovery college, retreat and inspiration centres and a close collaboration with the regional mental health care provider Altrecht in forming regional integrated community mental health teams. Germany: The Dachverband Gemeindepsychiatrie is a network of mental health services across Germany that supports the interest of persons with mental ill health. They envisage an inclusive and preferably ambulatory care that places the needs and goals of

persons with mental health in the heart of the care and supports full participation.

Methods: Lister and The Dachverband Geimeindepsychiatrie learn from each other in 2019 using the exchange tool of EUCOMS.

Results: The results of the exchange will be presented.

Conclusions: Differences and similarities between two neighboring countries will be presented.

S1 • MENTALIZATION AND RF IMPAIRMENT IN A LARGE SPECTRUM OF PSYCHOPATOLOGY: EVALUATION AND TREATMENT

Short general introduction symposium: *The aim of this symposium is to present clinical and research experiences focused on the construct of mentalization as proposed by Fonagy and collaborators. Authors will discuss the role of RF impairment in clinical assessment (both in adult BPD patients and adolescents at High-Risk for psychosis) as well as outcome measure in clinical interventions focused on mentalization (MBT).*

1 • BPD PATIENTS: PRELIMINARY OUTCOME EVALUATION AND PROCESS ANALISYS IN MBT TREATMENT AT CAMPOSAMPIERO MHC

J.Y. Cappelletti[1], W. Padoani[1], A. Frasson[1], G. Pandolfi[1], S. Carrera[1], S. Salcuni[1]

[1] *Ulss 6 Padova, Italy*

Aims: This contribution aims to show the possibility of implementing a treatment based on Mentalization in patients with severe personality disorders evaluating outcomes and analyzing treatment processes, within a Mental Health Service

Methods: On a 12 patients group that had completed the oriented MBT protocol, symptoms (SCL-90-R), psychodiagnostic scale and global health functioning (Honos, SCID-II, GAF), data on service impact and service costs (PES, folder data) were compared at the beginning of the treatment (T0), at the end of the treatment (T2) and 1 year (FU1) after the end of the MBT project. Due to the fact the MBT is an open-group, we started to analyze the micro-analytical mentalization changes using the Mentalization Imbalance Scale (MIS) and Reflective Functioning (RFQ) at T0, T1 T2 on a 6 patients group

Results: Preliminary results confirmed the improvement in the overall functioning of patients (GAF), the reduction in BPD-related symptoms and in diagnostic criteria for BPD (SCID-II), the improvement of patients' mentalization skills, and a significant reduction in workload for staff.

Conclusions: The MBT bring to an improvement of the overall functioning of the patients, a reduction of the symptoms, a decrease of the diagnostic criteria for the BPD disorders, a reduction of the costs of the assistance. And this correlates with an improvement in reflexive functioning and mentalization capacity

2 • EVALUATION OF MENTALIZATION IMPAIRMENT IN ASAMPLE OF BPD PATIENTS TREATED IN AN OUTPATIENT ITALIAN UNIT

E. Caverzasi[1], P. Ambrosi[1]

[1] *Università degli studi di Pavia*

Aims: MBT approach to BPD patients implies that an impaired reflective functioning (RF) could mediate symptoms – mainly affect dysregulation, interpersonal instability and impulsive behaviour. Our study aims at evaluating impairments of mentalization in a sample of BPD patients, their relation to the severity of pathology and to other relevant social, psychopathological and clinical variables.

Methods: 62 patients fulfilling criteria for BPD based on DSM-IV have been recruited between 2011 and 2015 from the Centre for Research on Personality Disorders of the University of Pavia, Italy, an outpatient unit dedicated to the study and treatment of personality disorders in patients referred by community mental health services. They have

been assessed with a battery of clinical and rating scales: SWAP-200, SCL-90, H Anxiety Scale, H Depression Rating Scale, GAF. Impairments in mentalizing have been evaluated with The Italian version of the Reflective Functioning Questionnaire, a self-report measure of RF developed by Fonagy and colleagues.

Results: The impairments in RF measured with the RFQ are related to the severity of borderline pathology in BPD patients. Uncertainty about mental states was found to have a unique contribution to the severity of BPD as independently assessed by trained observers using the SWAP. These findings are discussed in relation to the other relevant social, psychopathological and clinical variables.

Conclusions: The impairments in RF measured with the RFQ are related to the severity of borderline pathology in BPD patients. Uncertainty about mental states was found to have a unique contribution to the severity of BPD as independently assessed by trained observers using the SWAP. These findings are discussed in relation to the other relevant social, psychopathological and clinical variables.

3 • EXPLORING THE ROLE OF ATTACHMENT PATTERNS, MENTALIZATION, INFANT TRAUMA IN THE PRODROMAL PHASE OF SCHIZOPHRENIA

T. Boldrini[1], S. Salcuni[1], V. Lingiardi[1]

[1] *Università degli Studi di Padova*

Aims: The aim of this study was to explore attachment patterns, mentalization capacity and childhood traumatic experiences among HR adolescences.

Methods: 40 UHR outpatients were compared with 40 other outpatients who did not meet the high-risk criteria. A multi-method diagnostic assessment was implemented, including the Structured Interview for Prodromal Syndromes (SIPS). Adult Attachment Interview was also administered, and the transcripts were further assessed using both the Reflective Functioning (RF) Scale and the Complex Trauma Questionnaire.

Results: Although no differences between groups with respect to childhood traumatic experiences have been found, HR patients showed a higher degree of insecure ($\chi2=7.91$; $p=.006$) and disorganized ($\chi2=8.46$; $p=.004$) attachment patterns. Moreover, the RF scores were significantly lower in the UHR sample ($t=3.27$; $p<.001$) and significant correlations between RF and SIPS subscales were found.

Conclusions: Our results suggest that attachment-informed and mentalization-based psychotherapies may be effective preventive treatments for UHR patients.

S6 • CROSS-SECTORAL FORMS OF CARE AT THE UNIVERSITY MEDICAL CENTER HAMBURG-EPPENDORF

Short general introduction symposium: *At the University Medical Center Hamburg-Eppendorf a competence center for integrated care of mental illnesses is founded. All cross-sectoral forms of care have been unified there. These include the RECOVER care model as the organizational logic of trans- and intersectoral care processes and include the outreach team-based treatment models Crisis Resolution Team and Therapeutic Assertive Community Treatment. In the symposium, the RECOVER care model and all outreach team-based treatment models will be presented, with regard to the integrated care of people with severe mental illnesses also differentiated into psychoses and borderline personality disorders.*

1 • RECOVER - MODEL OF A SEVERITY GRADED, CROSS-SECTOR COORDINATED AND EVIDENCE-BASED CARE FOR PSYCHIATRIC DISORDERS

M. Lambert[1], A. Karow[1], V. Kraft[1]

[1] *Univerity Medical Center Hamburg - Eppendorf*

Aims: RECOVER aims to identify, diagnose and treat people with a mental disorder of every degrees of severity in a catchment area and coordinates service providers from all sectors (inpatient, outpatient, rehabilitative), exclusively

integrates evidence-based treatment models and therapies, and integrates efficient cost reduction approaches, including outpatient pre-inpatient (partial) and outpatient severity-degree. As part of the RECOVER model, a new E-Mental-Health platform called eRECOVER was developed (see www.erecover.de). Accordingly, E-Mental-Health including digital diagnostics and therapy is now an integrated part of the staged and coordinated care.

Methods: To reach this aim, the RECOVER model was developed, established and evaluated with the following innovations: Access to care, diagnostics and acute treatment in the home environment are improved by a 24/7/365 active, specialist, multi-professional and interdisciplinary crisis resolution team. After precise diagnosis, the patients are assigned to one of four severity levels. Each stage comprises a combination of evidence-based interventions, always starting with the most effective and resource-saving interventions. A treatment plan as well as outpatient psychotherapy is then created and organized for and with the patient in the network.

Results: Currently the waiting time is 2 weeks. Depending on their vocational status, patients immediately receive access to a Supported Employment team, which clarifies the work situation and initially supports them when they return to work. At higher levels of severity, patients receive additional support: case management for stage 3 patients and for patients with severe mental illnesses (stage 4) access to so-called assertive community treatment teams, which intensively treat and rehabilitate patients in their home environment over the long term, replacing them in the ward.

Conclusions: The RECOVER model is a severity graded and cross-sector coordinated care model (www.recover-hamburg.de) which has been successful established in the local care system. The model is currently under evaluation and first steps towards a transfer to a rural catchment have been taken.

2 • CRISIS RESOLUTION TEAM - ACUTE TREATMENT IN THE HOME ENVIRONMENT

D. Lüdecke[1], A. Karow[1], J. Gallinat[1], M. Lambert[1]

[1] *Univerity Medical Center Hamburg - Eppendorf*

Aims: Crisis resolution teams (CRTs) are multidisciplinary, specialist mental health services that offer brief intensive treatment in their living environments to people, who are experiencing a mental crisis. One of the goals is to avert hospital admission whenever possible.

Methods: According to a new law in Germany in 2018, CRTs have only been structured and implemented since then, improving the development of care and compensation for psychiatric and psychosomatic. These CRTs are being established in psychiatric departments with a regional care obligation to provide inpatient-equivalent psychiatric treatment ("STäB") at home. While the legislations have been passed, only few hospitals provide CRTs for their communities yet.

Results: We describe the process of establishing a CRT within the RECOVER model at the University Medical Center Hamburg-Eppendorf for patients suffering from any mental crisis. Furthermore, we would like to present obstacles, advantages and disadvantages of inpatient-equivalent psychiatric treatment within the German mental health system by means of exemplary case studies.

Conclusions: We describe the process of establishing a CRT within the RECOVER model at the University Medical Center Hamburg-Eppendorf for patients suffering from any mental crisis. Furthermore, we would like to present obstacles, advantages and disadvantages of inpatient-equivalent psychiatric treatment within the German mental health system by means of exemplary case studies.

3 • INTEGRATED CARE INCLUDING ASSERTIVE COMMUNITY TREATMENT FOR PSYCHOSES

A.C. Rohenkohl[1], F. Ruppelt[1], M. Lambert[1], A. Bussopulos - Orpin[1] & IV Team[1]

[1] *Univerity Medical Center Hamburg - Eppendorf*

Aims: At the University Medical Center Hamburg - Eppendorf an integrated care treatment model including therapeutic assertive community treatment (ACCESS model) for patients with psychoses was implemented. Results

of ACCESS proved more effective compared to standard care (ACCESS-I study) and was successfully applied into clinical routine (ACCESS-II study).

Methods: The evaluation of the ACCESS study was designed as a pragmatic cohort study to continuously evaluate the effectiveness of the ACCESS model under real-life conditions in severe mental illness. Assessments were carried out at baseline, week 6, and months 3, 6, 12, and every 6 months by trained raters independent of the treatment team to avoid bias. At baseline and follow-up time points, the following structured assessments were applied: psychopathology (BPRS), severity of illness (CGI – S), level of functioning (GAF), quality of life (Q-LES-Q-18) and patients' satisfaction with care (CSQ-8).

Results: To date more than 400 patients with a psychotic disorder were included in the ACCESS model since 2007. First results of a 5-year follow-up will be shown with a focus on quality of life (LQ) which plays a central role as a patient-reported outcome (PRO) criterion in the evaluation of the model, beside the burden of symptoms (BPRS) and severity of the illness (CGI/ GAF).

Conclusions: This long-term study confirms the effectiveness of continuous treatment with a therapeutic ACT embedded in an integrated care system in a clinical routine setting for patients with severe and mostly multiple-episode schizophrenia spectrum disorders and bipolar I disorder with psychotic features.

4 • INTEGRATED CARE – BORDERLINE – A TREATMENT CONCEPT FOR PATIENTS WITH SEVERE BORDERLINE PERSONALITY DISORDER

J. Bierbrodt[1], K. Krog[1], I. Schäfer[1], A. Schindler[1]

[1] *Univerity Medical Center Hamburg - Eppendorf*

Aims: Borderline Personality disorder (BPD) leads to enormous suffering in those affected and causes massive costs for health care systems. Although evidence based treatment options exist, there is a treatment gap especially considering outpatient settings for severely affected patients. Integrated Care – Borderline (IC-B) combines structural aspects of the Hamburg-model of integrated care for patients with psychosis with a BPD-specific psychotherapeutic approach, Dialectic Behavioral Therapy (DBT) at University Medical Center Hamburg-Eppendorf (UKE). The concept offers an outpatient, multimodal long-term treatment aiming at an improved level of functioning and a reduction of BPD symptoms and dysfunctional behaviors like self-harm, substance abuse and suicidal ideation. Furthermore, this multidisciplinary, team-based treatment approach offers flexible crisis management to reduce hospitalizations.

Methods: In an ongoing evaluation study, we compare 50 patients treated with IC-B with 50 patients in a treatment as usual control condition over a period of four years. Primary outcomes are Global Assessment of Functioning (GAF) and Clinical Global Impression (CGI). Secondary outcomes include overall BPD severity and hospitalizations. The talk will portray the structural and therapeutic concept of IC-B as well as first interim results of the ongoing study.

Results: First data suggest promising outcomes considering GAF, BPD symptom severity, suicidal ideation and hospitalizations.

Conclusions: Five Years of clinical experience and first promising data of the ongoing study support the feasibility and effectiveness of IC-B. Benefits and limitations if the treatment approach and the evaluation study will be discussed.

S12 • INTEGRATING YOUTH AND MENTAL HEALTH CARE SERVICES IN AMSTERDAM

Short general introduction symposium: *It is known that part of the children and adolescents that grew up in an adverse environment, also experienced maltreatment. Specifically this group show a wide range of social, psychological and psychiatric problems.*
Unfortunately, general treatment programs or therapeutic interventions proved not successful for these children, with the risk of their psychiatric problems. For these children specialized care in needed. Therefore, it is essential that youth care services and mental health care services thoroughly work together. In Amsterdam, different assertive outreach teams are set up to bring this in practice.

This symposium will present a variety of teams that serve these children and adolescents, and enhance their healthy development with specialized treatment programs. With the presentations in this symposium we aim to illustrate how integration of youth care and mental health care services can increase the quality of care for various subgroups of youth with severe developmental problems.

1 • BUILDING BRIDGES BETWEEN YOUTH CARE AND CHILD AND ADOLESCENT PSYCHIATRY

N. de Koning[1]

[1] *de Bascule Rijksstraatweg 145 Duivendrecht Amsterdam The Netherlands*

Aims: Approximately 70% of the children and adolescents that receive youth care (care at home, foster care, open and closed residential settings) need to be treated for psychiatric disorders. As a result of their unfavourable and traumatic experiences during their development, they are at risk to develop even more severe psychiatric problems. To improve outcome and recovery, an organization for youth care (Spirit) and an academic child and adolescent psychiatry centre (de Bascule) in Amsterdam, decided to join their efforts and integrate their care. Both children and their parents give us feedback and advise on the care and treatment they receive. This presentation aims to show how we make use of the input of the children and their parents in several ways in order to improve and innovate the treatment and care.

Methods: Various teams in our organizations started to provide integrated care. Several difficulties with the integration of care are presented. In different ways, youngsters (some of them trained as a peer support worker), parents and foster parents outlined important issues we have to focus on in our care. With these issues and comments we learn to make new steps to optimize our care for these vulnerable young people in several ways.

Results: The issues brought up by the children and their parents shows different aspects that are important; directly at the level of the children and their parents who are in care, at the level of the teams, and at the level of the organizations. We present quantitative and qualitative information of (foster)parents and their children, and whether they are satisfied with integrated care we offer.

Conclusions: Building bridges between youth care, and child and adolescent psychiatry, gives the opportunity to create integrated care. Young people and their (foster)families have an important role in improving and innovating care together with our professionals.

2 • FORENSIC OUTREACH CARE FOR ADOLESCENTS: INTEGRATING TWO WORKING MODELS

T. Jambroes[1], M. Kloosterman[1], M. van de Velde[1], J. Terpstra[1], M. Melissen[1]

[1] *de Bascule Rijksstraatweg 145 Duivendrecht Amsterdam, The Netherlands*

Aims: Youth and mental health care services in Amsterdam each offered specialized forensic care for adolescents. The youth care service specifically supported adolescents with their social, educational, financial and housing problems to reduce the risk of future delinquency. With the same goal, to diminish recidivism, the mental health services focussed on treating psychological and psychiatric problems of the adolescent. With these approaches next to each other, it occurred that important risk factors were overlooked. To increase the efficacy and improve the quality of forensic care, a new team was created to integrate both working models. This presentation will demonstrate the process that led to a new team with a new working model providing integrated care.

Methods: Both models, of the youth care service and that of the mental health care service are presented. The strengths and weaknesses of both models will be highlighted and, subsequently, the new working model will be demonstrated and discussed.

Results: The new model shows there are several aspects that makes the integration to a success. However, several difficulties in this process also appeared.

Conclusions: The new model shows there are several aspects that makes the integration to a success. However, several difficulties in this process also appeared.

3 • OUTREACH PSYCHIATRIC CARE IN VARIOUS OPEN RESIDENTIAL YOUTH CARE SETTINGS, 7-YEARS OF COLLABORATION

R. Stoffelsen[1], M. Ooms, A. Popma[1]

[1] *de Bascule Rijksstraatweg 145 Duivendrecht Amsterdam, The Netherlands*

Aims: In the past 7 years, our multidisciplinary team of outreach psychiatric care in Amsterdam, named 'the Flying Team', has built up an intensive collaboration with several open residential settings for youth care. The children and adolescents in these settings show a variety of developmental problems in different areas. Most of them have severe psychiatric problems. The social workers and specialized foster parents at these settings give ample support to the youngsters and their families. By the same token they try to motivate them to accept psychological or psychiatric specialized interventions. Most of the children and adolescents have severe attachment problems, which makes them reluctant to get into a therapeutic relation. Therefore, it is extremely important to work very closely with the social workers and specialized foster parents. This makes outreach care a necessity. In this presentation, the success of this special outreach team will be presented and discussed.

Methods: We will demonstrate the working elements of this collaboration between mental health care and open residential youth care settings, and also highlight some pitfalls.

Results: An important success factor is the 'diagnostics on demand'. Further, tailored therapeutic possibilities and team-coaching on the wards showed to be important. Also some other, special requirements for a successful collaboration need to be considered. The team proved to prevent hospitalization and reduces transfers.

Conclusions: There is a fruitful collaboration between specialized psychiatric outreaching team and various open residential youth care settings. The collaboration leads to better care and to a customized treatment on several developmental areas of the children and adolescents.

4 • FAMILY ORIENTED CARE: TREATMENT AT HOME AFTER PLACEMENT IN A CLOSED TREATMENT FACILITY

S. Kleeven[1], M. Dijks, G. Hogema[1]

[1] *de Bascule Rijksstraatweg 145 Duivendrecht Amsterdam, The Netherlands*

Aims: Closed residential youth care is a drastic measure that can be applied when many other interventions proved not to be effective. Most adolescents assigned to these settings show severe behavioural problems. With an new therapeutic intervention, called 'Together Strong at Home', we try to prevent long-term out-of-home placements by changing the inadequate interaction between the adolescents and their parents in an earlier stage. The closed placement should only be a short period.
The adolescents and their families benefit briefly from the secure environment of the closed facility offers, in order to make agreements for a new start after placement. The systemic therapy starts immediately by working on the new start in their home situation. This presentation aims to discuss the ideas and the model of working of this therapeutic intervention and briefly show the results.

Methods: We present how the method 'Together Strong at Home' method works. Feedback from group workers, therapists, adolescents and their parents will be shown. The strengths and pitfalls of this models will be demonstrated.

Results: The model shows the relevance to involve parents in the treatment of adolescents in closed treatment. The adolescent is part of a family. We demonstrate the influence of the family on the behaviour and emotions of the adolescent, and vice versa. Directly after assignment, a treatment plan will be made with the adolescent and the family. The goal is constantly to create a safe situation, with treatment in the home situation.

Conclusions: Treatment shows a better result when parents are involved in the treatment plan. This results in a shorter stay in the institution. Moreover, the adolescents proved to be more stable due to the outreach care by the systemic interventions. In addition, adolescents reported to be satisfied with their received care.

S7 • WHAT ABOUT INTELLIGENCE?

Short general introduction symposium: *The prevalence of mild intellectual disability or borderline intellectual functioning in patients with Severely Mentally Illness has been a blind spot for many years in mental health care. This symposium will bring together current knowledge of prevalence of mild intellectual disability or borderline intellectual functioning in this patient group, first experiences of modifications that has been made in training professionals and recovery-focused treatment. Our aim is to create awareness for this substantial group of patients and to enthuse working with them. So, what about intelligence? It's all about recognizing blind spots, bridging gaps and creating possibilities.*

1 • PREVALENCE OF MILD INTELLECTUAL DISABILITY AND BORDERLINE INTELLECTUAL FUNCTIONING IN DIFFERENT SETTINGS IN MENTAL HEALTHCARE IN THE NETHERLANDS; MID AND BIF A HIGHWAY TO CHRONICITY?

J. Nieuwenhuis[1], E.O. Noorthoorn, H.L.I. Nijman, C.L. Mulder

[1] *GGNet,The Netherlands*

Aims: In this presentation we pay attention to intellectual impairment in General Mental Health Care. As we know from two former studies, the prevalence of Mild Intellectual Disability (MID) or Borderline Intellectual Functioning (BIF) is much higher in (General) Mental Health care than may expected from the prevalence in the general population. People with MID/BIF are more at risk to develop psychiatric problems. When not noticed by clinicians this may lead to missed or improper diagnosis and treatment leading to a long history in psychiatry, less quality of life, poor functioning and high care costs.

Methods: We used the SCIL (SCreener for Intelligence and Learning disability) to detect patients suspect for MID or BIF. We included 371 patients of three outpatient services, 1920 seriously mentally ill over four out and inpatient services and 214 patients on long stay wards. Intellectual disability may be acquired by cognitive decline or be inborn, so we verified school diplomas. To understand whether missed diagnosis of intellectual impairment was associated to history in psychiatry, quality of life, functioning and care costs we first compared SCIL findings to diagnosis set in medical charts. Second, we investigated whether a low score on the SCIL (showing MID/BIF) was associated to lesser outcome on the Health of the Nations Outcome scale (HONOS, the MANchester Short Assessment of quality of life (MANSA) as well as higher care costs over time.

Results: Of the 371 outpatients, 84,1% were included and screened properly. 27.2% showed a SCIl score below 19, implying a MID or a BIF. Of the 1920 SMI patients screened, 72.0% were included, and 45.2% of these showed a MID or a BIF. In the 214 long stay patients, 72.9% were included and as many as 68.6 % showed a MID of BIF. Preliminary analysis in the subsample of the current population shows an association of MID or BIF to lesser functioning as measured with the HoNOS. Patients with a SCIL below 19 had an OR of 2.175 for a HoNOS above cut- off over the last 2 years. In the presentation, we will add the findings of the MANSA and the care costs in these analyses and investigate the influence of acquired cognitive impairment as a possible confounder of worse outcome as measured by the HoNOS, the MANSA and as expressed in the care costs.

Conclusions: Findings show the prevalence of MID or a BIF rises when findings in outpatient admission teams are compared to those in SMI outpatients or SMI long stay inpatients. Preliminary analysis show this may be related to worse outcome of functioning, quality of life and care costs.

2 • HOW TO MAKE A MID FRIENDLY ORGANISATION?

L. Willems[1]

GGNET mental health care Gelderland, The Netherlands

Aims: To share our expiriences how we tried to make our Mental Health Trust organisation MID proof. This means to regognise early in treatment MID, how to use the SCIL as a screenings instrument in all departments who treat different patientgroups, what kind of education and training do the nurses and clinicians need for daily work . Next

to this goal is that we treat MID patients adequetely in the right treatment program.

Methods: The SCIL was implemented in the whole organisation. We made a dissicion tree to support all the practicioners what to do if a patient is supicious for MID. We made an instruction leaflet and we developt a basic training. In this training we teach employies to make chanches in attitude, communication, treatment ,emotion development, psychiatric diagnoses, brain development and adaptations in interventions.

Results: There is more awarenes in our mental Health Trust organoisation on MID. Not only at the start of the treatment, but also during the patient journy. Patients are better treated and if nessesary experts on the MID, department VGGNet, are more often and for better questions asked for proffessional advise.

Conclusions: It is possible to make a Metal Health Organisation more MID friendy with quite a view and simple adustments. MID patients can profit in general from the regular treatment with simple adjustments and to prevent that they are treated to long, unnessasery and wrong.

3 • MODIFICATIONS IN RECOVERY-FOCUSED THERAPY FOR PATIENTS WITH SEVERELY MENTALLY ILLNESS AND INTELLECTUAL DISABILITY

I. Berger[1], M. van Hout

[1]*Nurse practitioner, Parnassia Groep, The Netherlands*

Aims: To give insight to adequate adaptation of interventions by professionals for patients with Severely Mentally Illness (SMI) and intellectual disability (ID) to improve the quality of care and how to use this adaptions in recovery-focused treatment.

Methods: We performed a study using a qualitative design in 15 responders including 8 interviews and one focusgroup of psychiatric practitioners (working in flexible- assertive community treatment teams in Rotterdam, The Netherlands) and ID-experts (diverse institutions in The Netherlands), followed by an implementation in Rotterdam ambulant psychiatric care.

Results: Results Five main themes were identified to alter therapy: treatment, communication, inclusion of network, support need estimation and selfmanagement. Outcomes of this study were collected in a toolkit for daily-practice and resulted in interventions to improve treatment, care and the introduction of a group program focused on recovery. This group program consist of visits twice a week to the group. During these visits illness-management ''Happy Healthy Life'', participative drama, exercise and relax-groups, creative therapy, and individual job coaching are introduced. The program has attention for poorer understanding and mental slowness. Furthermore, it is focused on the strengths and talents of the participating patients. Supportive learning-materials, such as pictures, games and films are widely implemented to increase understanding.

Conclusions: To align therapy with the requirements of patients with SMI and ID a patient oriented approach to care is necessary. Simple but effective modifications, summarized in a toolkit, appear to contribute to this. To offer correct care to SMI and ID patients focus is needed for their needs, vulnerability àand strengths and talents.

S14 • PUBLIC MENTAL HEALTH. THE EUROPEAN COMMUNITY MENTAL HEALTH SERVICES NETWORK (EUCOMS)

Short general introduction symposium: *Public Mental Health is one of the six principles of EUCOMS. The yearly prevalence of diagnosable mental suffering is around 20%, whilst mental health services have the capacity to treat 4-6% of the population in a given year. This indicates the importance of a public mental health approach, serving the mental health at the population level, in which mental health services are network partners with primary care, social stakeholders and promote self-management and peer support e-communities. This implies knowing and collaborating with stakeholders in the region and building a regional network model of mental health care. We describe such a model in 3 different European countries: Italy, Northern Ireland and Romania.*

1 • INTRODUCTION TO PUBLIC MENTAL HEALTH

R. Keet[1]

[1] *Director Community Mental Health Service Noord-Holland-Noord Chair of the European Community Mental Health Service providers network (EuCoMS)*

Aims: Describing the public health approach in metal health. Social life takes place in communities that bind people into relationships with one another. In community mental health the relevant community is the people who live in a defined geographic locality, the catchment area. The mission of a community mental health service is supporting the health of all citizens in that area.

Methods: A literature study on Public Mental health

Results: Addressing mental ill-health in the community means not only treatment and care but also prevention and promotion of good mental health. Taking actions to eliminate discrimination and reduce stigma are essential. Community mental health care works with multidisciplinary teams in well-defined regions. The size of the region depends on the regional demography, prevalence of mental ill health and the resources of mental health care. It is a trade-off between the advantages of a small region (ability to be present, collaboration with a small number of family doctors) and the necessity of sufficient resources to form a multidisciplinary team. Concepts of community mental health care were developed for the treatment of persons with severe and persistent mental ill health, yet apply to all mental health needs (and beyond).

Conclusions: Community mental health services work for the health of all citizens in their catchment area. This includes existing clients, clients who need care but are hard to engage and potential future clients.

2 • PUBLIC MENTAL HEALTH A POST CONFLICT AREA: NORTHERN IRELAND

P. McBride[1]

[1] *GGZ Noord-Holland-Nood, The Netherlands*

Aims: Conflict has a major impact on mental health. Lessons were learned in Northern Ireland how to deal with that.

Methods: Describe how mental care in Northern Ireland deals with the impact of trauma.

Results: Northern Ireland is as an example of how the psychological impact of trauma on communities (as groups) has had a serious impact on their capacity to create a meaningful and lasting peace.

Conclusions: Northern Ireland is as an example of how the psychological impact of trauma on communities (as groups) has had a serious impact on their capacity to create a meaningful and lasting peace.

3 • PUBLIC MENTAL HEALTH IN THE VERONA AREA

M. Ruggeri[1]

[1] *Section of Psychiatry, Department of Neurosciences, Biomedicine and Movement Sciences, University of Verona*

Aims: To describe the public mental health model in the Verona area in Italy

Methods: The Verona Public mental healh sysrem is explored

Results: Treatment of persons wit mental ill and monitoring are described.

Conclusions: Amblatory mental health care and close monitoring strengthen each ohter in the Verona area.

4 • PUBLIC HEALTH VERSUS PUBLIC MENTAL HEALTH IN ROMANIA

T. Rotaru

1 Manager of Siret Psychiatric Hospital, Romania

Aims: 1. Historical Aspects – Communism, or any other kind of totalitarism and Mental Health. Using psychiatry as

a state instrument of control. a. Where are all the crazy/lunatic people gone – before and after 1945 b. Lost years of communism in psychiatry, or lost years of psychiatry in communism c. No need for social assistance, psychology and pedagogy d. Asylums… A good thing? A necessary one? The only solution available before 1989

Methods: 2. From institutionalized psychiatry to institutionalized psychiatry a. Steps to open institutions b. Examples from Romania c. Deinstitutionalization – good practice example in child care d. There is no momentum in mental health

Results: 3. Siret and Suceava County a. Why are we pioneers b. Where are we now c. From public health to community mental health d. Description of the services provided in Siret and Suceava County

Conclusions: 4. ONU – convention a. A step forward or just a political decision b. Where are the users? c. Where are the care givers? d. Where is the community? e. What's next? Looking to the future

S21 • YOUNG EAOF GROUP - WHAT DO YOUNG PROFESSIONALS THINK ABOUT HUMAN RIGHTS? FROM AN OVERVIEW TO A THERAPEUTIC EXPERIENCE

Short general introduction symposium: *Worldwide several countries do not provide proper legislation for people affected by mental health disorders. In Italy legislation promises equality but there are differences between the theory and the reality. In the Netherlands, there are several information campaigns to decrease stigma, and a movement to give experience experts a more important role in the treatment of patients. From an overview of national legislation, this symposium opens the reflection about the roles of young professionals in gaining the correct attitude in order to overcome stigma and inequalities.*

1 • STIGMA AND THE HUMAN RIGHTS OF PEOPLE WITH MENTAL DISORDERS

S. Pillan[1], A. Lasalvia[2]

[1] *Casa di Cura Villa Santa Chiara S.p.A., Verona, Italy* - [2] *Department of Neuroscience, Biomedicine and Movement Sciences, Section of Psychiatry, University of Verona, Italy*

Aims: To compare local and national realities regarding human rights' respect for people with mental disorders.

Methods: An overview of the legislation regarding this topic, focusing on the role of stigma in limiting human rights' respect.

Results: Despite the legislative efforts, people with mental health disorder can receive far fewer opportunities due to discrimination at different levels.

Conclusions: We all must work to reduce the stigma to ensure equal rights for our patients.

2 • PSYCHOTHERAPEUTIC ASPECTS IN ASSERTIVE OUTREACH WITHIN AN INTEGRATED CARE MODEL

F. Ruppelt[1], A. Rohenkohl[1], M. Lambert[1], A. Bussopulos[1], IV Team[1]

[1] *Universitätsklinikum Hamburg-Eppendorf*

Aims: While caring for people with a severe mental illness, we are often confronted with difficult situations that require a therapeutic attitude in order to be able to solve them. As young professionals we are only on our way to build an attitude without stigma by including users (e.g. peer experts), relatives and caregivers in the mental health care system as well as in research – we will give an example of therapeutic attitude within an integrated care model specialized on treating psychosis patients.

Methods: We will outline our way of contact with service users. Despite a psychotherapeutic attitude, we will discuss recovery, inclusion and an anthropological view in understanding the illness.

Results: We will try to connect these aforementioned aspects to the results of our research and practice.

Conclusions: We will try to connect these aforementioned aspects to the results of our research and practice.

3 • VIEWS ON STIGMA IN DUTCH SOCIETY

S. Vorst[1]

[1] *GGZ Noord-Holland-Noord, locatie Heerhugowaard - Heerhugowaard*

Aims: Description of stigma and role of experience experts in mental health community care

Methods: A qualitative overview concerning views on and social treatment people with mental disorders

Results: Nationwide there are many differences, generally speaking, the position of people with mental health issues has improved over time.

Conclusions: There is further room for improvement in reducing stigma.

S3 • IMPLEMENTATION AND ADAPTION OF FACT IN SCANDINAVIA. RESULTS FROM DENMARK, SWEDEN AND NORWAY

Short general introduction symposium: *The purpose of this symposium is to 1)present how the FACT model has been implemented and adapted in Denmark, Sweden and Norway, and 2) experiences with implementing the model in the three countries. 3) results from research on the FACT model in the three countries.*

1 • IMPLEMENTATION AND ADAPTION OF FACT IN NORWAY FROM 2014-2019

A. Landheim[1], S. Odden[1], K. Nysveen, T. Hatling, G. Strand, E. Hoxmark, G. Evensen

[1] *Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust - Norway*

Aims: To describe the process of implementing FACT in different contexts in Norway, a country with many services, many municipalities with low population density and long geographical distances during the period from 2014-2019. Further to present status of FACT in Norway and experiences so far with training and fidelity measures and results from research.

Methods: We have used different methods for implementing FACT in Norway: handbooks/manuals, national training programs, network for leaders, auditoring/fidelity measurement and Research based evaluation. The research based evaluation includes the seven first FACT teams and we have conducted Fidelity measurement one year after the team started up, a longitudinal observational study of patients, interviews with team staff, partners in the municipalities and specialist services, and service users.

Results: From 2014-2019 approximately 30 FACT-teams have been established in Norway, and 20 teams are in the planning process. Different national guidelines for persons with psychosis and other severe mental illness recommend FACT-teams as an appropriate service model. FACT has been implemented for different target groups, and we have several examples that functional level is more important than severity of the mental illness. Experiences with the national training program will be presented, as well as results from FACT fidelity measurement and some parts of the research based evaluation. Challenges with adapting FACT in different Norwegian contexts will be discussed.

Conclusions: Health authorities in Norway will further stimulate the implementation of FACT to meet the need for Integrated and comprehensive services. Knowledge from the research based evaluation will contribute to further development and innovation of the FACT model in Norway. Several barriers of implementation of the model needs to be addressed.

2 • FACT IMPLEMENTATION, ADAPTION AND RESULTS IN SWEDEN 2013-2019

A. Lexén[1], U. Bejerholm[1], U. Markström[1], L. Hansson[1], G. Cruce[1], B. Svensson[1]

[1] *Lund University, Sweden*

Aims: To make a status report of the implementation, adaption and results of FACT in a Swedish psychosis and

general mental health service context during the time-period of 2013-2019, and present implications for further research.

Methods: Several studies has been conducted during the time-period with focus on adaptation and implementation of FACT in Swedish psychosis and general mental health services, staff experiences of working according to FACT, and outcomes of FACT among persons with psychosis. In these studies data has been collected using 1) interviews with project leaders, team leaders, staff and service users, 2) fidelity assessments, 3) instruments assessing users everyday functioning and social outcomes, 4) times and days on the FACT board, and 5) health care usage. Data has been analysed using directed content analysis, grounded theory, thematic analysis, and quantitative parametric statistics.

Results: In Sweden about 30 teams have been established mostly within the mental health care for persons with psychosis. FACT has also been included as a potential service model for this group in the national guidelines. The reason for the seemingly easy and swift implementation in psychosis teams might be explained by a national initiative to implement FACT in combination with a willingness among managers and staff to implement the model. Psychosis teams have shown good program fidelity 6 months after implementation with stable scores over an 18-month period. A longitudinal observational study of service users in six FACT psychosis teams showed positive results in everyday and social functioning at 18-months follow-up. There was also a significant increase in psychiatric outpatient visits. Interviews with managers, staff and service users in the general mental health care service has shown an interest in implementing FACT also for persons with for example mood and anxiety disorders with low functioning and fluctuating needs. Challenges with implementing FACT in different Swedish mental health care contexts will also be presented as well as implications for further research.

Conclusions: In Sweden about 30 teams have been established mostly within the mental health care for persons with psychosis. FACT has also been included as a potential service model for this group in the national guidelines. The reason for the seemingly easy and swift implementation in psychosis teams might be explained by a national initiative to implement FACT in combination with a willingness among managers and staff to implement the model. Psychosis teams have shown good program fidelity 6 months after implementation with stable scores over an 18-month period. A longitudinal observational study of service users in six FACT psychosis teams showed positive results in everyday and social functioning at 18-months follow-up. There was also a significant increase in psychiatric outpatient visits. Interviews with managers, staff and service users in the general mental health care service has shown an interest in implementing FACT also for persons with for example mood and anxiety disorders with low functioning and fluctuating needs. Challenges with implementing FACT in different Swedish mental health care contexts will also be presented as well as implications for further research.

3 • IMPLEMENTATION AND ADAPTION OF FACT IN DENMARK

A. Rosenquist, C. Munch Nielsen

[1] *Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust - Norway*

Aims: To describe the process of implementing FACT in Denmark and preliminary findings

Methods: Measurement of fidelity necessitated the development of a Danish FACT scale that was adjusted to the Danish health care setting. Differences between the Danish and Dutch fidelity scales (2017) will be presented along with results from the first audit of five Danish FACT teams. We will also provide a presentation of the Danish FACT coaching concept that was used in the implementation process to support and assist in managing work changes. Finally, FACT board data from five FACT teams during an 18 month study period will be presented to study transitions between high and low levels of care.

Results: The Danish FACT fidelity scale has been adjusted to match the Danish health care system and context. Audits of the first five Danish FACT teams will be conducted in May 2019, supervised by senior auditors from CCAF. Coaching of new FACT teams by experienced FACT employees facilitated successful implementation and acceptance of new working procedures. Results of the F-ACT board show that the mean duration of high support on the FACT

board was 22,5 days. This is significantly lower than seen in other countries such as Sweden and the Netherlands and may be a consequence of a high flow of patients in the Danish health care system.

Conclusions: WIth few adaptations, the Dutch FACT model can be implemented in a Danish context. Yet, implementation research indicate that there are still pitfalls that future implementation should address.

S2 • YOUTH F-ACT IN THE NETHERLANDS: A HISTORICAL AND CONTEMPORARY OVERVIEW WITH ILLUSTRATIONS FROM DAY-TO-DAY PRACTICE

Short general introduction symposium: *The enthusiasm for Youth F-ACT and thereby the number of Youth F-ACT teams has increased over the past couple of years. Approximately 30 teams have adopted the Youth F-ACT model in the Netherlands, with another 30 teams being in the process of adapting the model. The implementation of Youth F-ACT is a response to deinstitutionalization that lately has been the subject of national health policies and comprises the rise of integrated outreach services tailored to the needs of adolescents with severe mental illness. Youth F-ACT consists of a multidisciplinary team of professionals who deliver a complete range of services on a continuum of care adapted to the adolescents' needs. In this symposium we dive into the field of Youth F-ACT.*

1 • MONITORING THE DEINSTITUTIONALIZATION PROCESS OVER TIME. ARE WE HEADING IN THE RIGHT DIRECTION?

H. Kroon[1]

[1] *GGZ Oost Brabant Oss Noord Brabant, The Netherlands*

Aims: The enthusiasm for Youth F-ACT and thereby the number of Youth F-ACT teams has increased over the past couple of years. Approximately 30 teams have adopted the Youth F-ACT model in the Netherlands, with another 30 teams being in the process of adapting the model. The implementation of Youth F-ACT is a response to deinstitutionalization that lately has been the subject of national health policies and comprises the rise of integrated outreach services tailored to the needs of adolescents with severe mental illness.

Methods: Youth F-ACT consists of a multidisciplinary team of professionals who deliver a complete range of services on a continuum of care adapted to the adolescents' needs.

Results: In this symposium we dive into the field of Youth F-ACT and present and discuss the following subjects: 1) overview of deinstitutionalization in the Netherlands related to the youth population, 2) baseline data on socio-demographic and clinical features of Youth F-ACT patients in the context of a multicenter study, 3) strengths and the difficulties including funding and staff for maintaining Youth F-ACT teams 4) daily practice of a youth F-ACT team by means of a case example.

Conclusions: A full abstract will follow after acceptance of the symposium (as described in the symposium guidelines)

2 • CHARACTERISTICS OF ADOLESCENTS IN YOUTH F-ACT CARE: BASELINE ANALYSES OF A PROSPECTIVE OBSERVATIONAL COHORT STUDY

M. Broersen[1]

[1] *GGZ Oost Brabant Gezondheidslaan Oss Noord Brabant, The Netherlands*

Aims: The enthusiasm for Youth F-ACT and thereby the number of Youth F-ACT teams has increased over the past couple of years. Approximately 30 teams have adopted the Youth F-ACT model in the Netherlands, with another 30 teams being in the process of adapting the model. The implementation of Youth F-ACT is a response to deinstitutionalization that lately has been the subject of national health policies and comprises the rise of integrated outreach services tailored to the needs of adolescents with severe mental illness.

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Conclusions: In this symposium we dive into the field of Youth F-ACT and present and discuss the following subjects: 1) overview of deinstitutionalization in the Netherlands related to the youth population, 2) baseline data on socio-demographic and clinical features of Youth F-ACT patients in the context of a multicenter study, 3) strengths and the difficulties including funding and staff for maintaining Youth F-ACT teams 4) daily practice of a youth F-ACT team by means of a case example.

3 • MAINTAINING THE MOMENTUM IN YOUTH F-ACT TEAMS: ITS STRENGTHS AND CHALLENGES

N. Frieswijk[1]

[1] *GGZ Oost Brabant Oss Noord Brabant The Netherlands*

Aims: The enthusiasm for Youth F-ACT and thereby the number of Youth F-ACT teams has increased over the past couple of years. Approximately 30 teams have adopted the Youth F-ACT model in the Netherlands, with another 30 teams being in the process of adapting the model. The implementation of Youth F-ACT is a response to deinstitutionalization that lately has been the subject of national health policies and comprises the rise of integrated outreach services tailored to the needs of adolescents with severe mental illness.
Methods: Youth F-ACT consists of a multidisciplinary team of professionals who deliver a complete range of services on a continuum of care adapted to the adolescents' needs.

Results: In this symposium we dive into the field of Youth F-ACT and present and discuss the following subjects: 1) overview of deinstitutionalization in the Netherlands related to the youth population, 2) baseline data on socio-demographic and clinical features of Youth F-ACT patients in the context of a multicenter study, 3) strengths and the difficulties including funding and staff for maintaining Youth F-ACT teams 4) daily practice of a youth F-ACT team by means of a case example.

Conclusions: A full abstract will follow after acceptance of the symposium (as described in the symposium guidelines)

4 • EXPERIENCES OF YOUTH F-ACT IN DAILY PRACTICE: A CASE EXAMPLE OF TREATING CHILDHOOD TRAUMA

R. Coolen[1]

[1] *GGZ Oost Brabant Oss Noord Brabant, The Netherlands*

Aims: The enthusiasm for Youth F-ACT and thereby the number of Youth F-ACT teams has increased over the past couple of years. Approximately 30 teams have adopted the Youth F-ACT model in the Netherlands, with another 30 teams being in the process of adapting the model.
The implementation of Youth F-ACT is a response to deinstitutionalization that lately has been the subject of national health policies and comprises the rise of integrated outreach services tailored to the needs of adolescents with severe mental illness.

Methods: Youth F-ACT consists of a multidisciplinary team of professionals who deliver a complete range of services on a continuum of care adapted to the adolescents' needs.

Results: In this symposium we dive into the field of Youth F-ACT and present and discuss the following subjects: 1) overview of deinstitutionalization in the Netherlands related to the youth population, 2) baseline data on socio-demographic and clinical features of Youth F-ACT patients in the context of a multicenter study, 3) strengths and the difficulties including funding and staff for maintaining Youth F-ACT teams 4) daily practice of a youth F-ACT team by means of a case example.

Conclusions: A full abstract will follow after acceptance of the symposium (as described in the symposium guidelines)

S36 • THE CHALLENGES OF DIGITAL PSYCHIATRY

Short general introduction symposium: *The opportunities presented by digital technologies including smartphones, apps and wearable devices for delivering new paradigms of care in people with mental illness is of great interest. The portable, connected nature of such devices enables the longitudinal, remote and high-resolution capture of clinical variables—both actively, for example, via self-rated assessments, and passively, using sensors to sample objective markers*
of social, emotional and cognitive states, with low user burden. New technologies offer the opportunity to facilitate self-management, and trigger timely, preventative interventions. Mobile platforms may promote communication between patients and clinicians, and allow the delivery of therapies tailored to each user's clinical status. in this symposium recent experiences with DIgital Psychiatry will be described and discussed.

1• DIGITAL THERAPEUTICS DTX – RESEARCH AND DEVELOPMENT OF A NEW, INNOVATIVE DIGITAL HEALTH TECHNOLOGY.

G. Recchia[1], M. Beccaria[1], M. Vergnano[1], V. Rosso[1]

[1] *Fondazione Smith Kline Ente Morale - Verona*

Aims: To define and clarify critical aspects of DTx (1) clinical development (2) regulatory assessment (3) reimbursement (4) introduction into healthcare

Methods: Digital Medicine comprises different tools for health measurements, diagnostic and therapeutic interventions. Digital Therapy (Digital Therapeutics - DTx) is a new medical prescription intervention for therapeutic purposes, in which the active ingredient is represented by a software. In a similar way to pharmacological therapies, DTx are developed through RCT to evaluate clinical benefits in terms of effectiveness, tolerability and economic sustainability. DTx can be used in combination with drugs or independently, in most cases as cognitive-behavioural therapies in addition to the standard therapy. DTx improves the patient's health outcomes by reorganizing their personal approach to disease and therapy

Results: We have developed a methodology for Research & Development of a DTx for the treatment of mental illness that involves the identification of a candidate intervention, the design of the software on the basis of this intervention, the introduction of value-added services for the reinforcement of behaviors, communication with the doctor or other patients, the collection of clinical data for research purposes, the design of the management software for the doctor and the platform for delivery and management of the therapy. A pilot clinical trial to verify its usability and explore its effectiveness is the first clinical test. If positive, a randomized controlled clinical trial, according to a design of fixed combination with a drug or add-on to the standard therapy, is the critical step to qualify as DTx a digital technology.

Conclusions: Collaboration between the different stakeholders - academia, startups, companies, healthcare professionals, citizens, patients, institutions - is a fundamental condition to allow the development of this new health technology, able to improve the health of patients and to create new jobs.

2 • EXPERIENCE WITH IFIGHTDEPRESSION

E. Zanalda[1], Y. Sacco[1], A. Signorino[1], M.L. Perucchini[1], P. Giaccone[1]

[1] *Asl 3 Torino - Piemonte*

Aims: Implementing the iCBT tool (iFightDepression) for the treatment of mild and moderate depression in the public mental health service.

Methods: The telemedicine tool iFightDepression (iFD) have been using since 2016 in 2 mental health departments: ASLTO3 and AULSS n.2 Marca Trevigiana in Italy for MasterMind and ImpleMentAll european projects. The iFD tool licensed by EAAD (European Alliance Against Depression) has been translated in italian language. The tool was used in version 1 during MasterMind (2014-2017) and in version 2 during ImpleMentAll (2017-2021). Patients have been

evaluated before and after iFD treatment by: PHQ9, BDI, WHOQOL-Short version and MANSA-2 (CSQ8 and SUS (post treatment only).

Results: In the italian sites of MasterMind study 375 patients were recruited; N. 244 (F 63%) out of them completed the iFD treatment. The average age of the completers was 47 + 14 years; 67% of the patients had at least 13 years of education, 60% were employed.
After iFD treatment, there was a significant reduction in the rating scale scores, particularly PHQ9 scores decrease of 41%. In the ongoing ImpleMentAll study, n. 21 ASLTO3 health professionals are involved to answer quarterly to two online questionnaires (NoMAD and ORIC). These questionnaires measure the level of iCBT implementation in the clinical routine.

Conclusions: The iFD has been effective in treating mild and moderate depression. Through a widespread use of the tool, a larger number of patients would be treated and benefited from it at home and at any time.

3 • SMART HEALTH: HOW TO INTEGRATE DTX IN HEALTHCARE AND CLINICAL PRACTICE FOR SUBSTANCE USE DISORDERS

P. Fedeli[1]

[1] *Country Medical Director Sandoz Italy*

Aims: Digital therapeutics represent a new treatment modality in which digital systems such as smartphone apps are used as regulatory approved, prescribed therapeutic interventions to treat medical conditions. Understand DTx potential to cover unmet medical needs in clinical practice, to treat substance use disorders with specific focus on the Italian context.
Recently, the FDA has permitted marketing of the Reset device from Pear Therapeutics, a mobile medical application intended for use with outpatient therapy to treat substance use disorders with the exception of opioid dependence.

Methods: The Reset device includes a patient application and clinician dashboard. It provides cognitive-behavioral therapy to patients to teach user skills intended to increase abstinence from substance abuse and retention in outpatient therapy programs.
The device is indicated as a prescription-only adjunctive treatment for individuals with substance use disorders not currently receiving opioid replacement therapy, who do not abuse solely alcohol or whose primary substance of abuse is not opioids.

Results: Efficacy of the device was indicated in a multi-site, unblinded 12-week clinical trial. The trial included 399 individuals who received standard treatment or standard treatment with a desktop version of Reset, which could be accessed in the clinic or at home. Abstinence adherence significantly increased among participants with alcohol, cocaine, marijuana and stimulant substance abuse disorders who received Reset compared with participants who did not receive the device (40.3% vs. 17.6%).

Conclusions: Adoption of reSet and O-reSet in US has increased access to care of people with several psychological and behavioural disorders, enhanced confidence in treatment pathway and reduced significantly discontinuation of treatment journey.
The US experience may be considered to maximize impacts of such therapies up to the Italian scenario.

S34 • RESEARCH AND DEVELOPMENT ON ILLNESS (SELF-) MANAGEMENT AND RECOVERY (IMR)

Short general introduction symposium: *Research and development on illness (self-) Management and Recovery (IMR)*

1 • EFFECTIVENESS OF ILLNESS MANAGEMENT AND RECOVERY (IMR); SOME RESULTS OF AN RCT IN THE NETHERLANDS

B-J.Roosenschoon[1], J. Van Weeghel[1,4], A.M. Kamperman[2], M.L. Deen[1,3], C.L. Mulder[1,2]

[1] *Parnassia Psychiatric Institute, Rotterdam/ Castricum/The Hague, the Netherlands -* [2] *Erasmus Medical Center,*

Rotterdam, Netherlands - [3] Leiden University, Leiden, Netherlands - [4] Tilburg University, Tilburg, Netherlands

Aims: To investigate whether IMR leads to better illness management, fewer symptoms and fewer relapses, and to better subjective and objective recovery.

Methods: In a randomised multi-centre, single blinded, clinical trial IMR was compared with treatment as usual for 187 outpatient clients with a severe and persistent mental illness. Measurement has taken place before randomisation, and 12 months and 18 months after randomisation. Primary outcome measure was the client version of the Illness Management and Recovery Scale.

Results: Effects of IMR are found on illness management and clinical recovery, as measured with both IMR-scales; on coping; and on personal recovery.

Conclusions: Our results support the empirical base for IMR as an effective comprehensive psychosocial intervention with a recovery oriented approach for people with severe mental illness.

2 • UPDATING OF THE ILLNESS MANAGEMENT AND RECOVERY PROGRAMME, TOWARDS IMR 4.0

M. Brugman[1], A.D. Bergsma[2], T. Beentjes[3]

[1] Saxion University of Applied Science, Deventer/Enschede, the Netherlands - [2] Radboud university medical center, Nijmegen, the Netherlands - [3] Dimence Group Mental Health Care, Deventer, The Netherlands

Aims: We aimed for a new version of IMR, in which domains of illness management and recovery are equally balanced.

Methods: Focus groups were conducted, which provided input for improvements. Improvement issues and other dilemmas were discussed with the IMR-founding fathers, Susan Gingerich and Kim Mueser. A writing group implemented improvements in the eleven textbooks. A second group provided feedback. The new Dutch IMR 4.0 was implemented in daily practice, followed by an evaluation.

Results: Participants mentioned that in IMR 3.0 indeed the focus on symptom reduction and stress-management could reduce the recovery orientation. IMR 4.0 has an increased focus on aspects of living an inclusive, hopeful, and meaningful life having a severe mental illness. All workbooks contain links for participants to make sense of illness experiences, give meaning to their lives and to achieve personal recovery goals. Main issues of change are reported and the outcome of the first evaluations.

Conclusions: Participants mentioned that in IMR 3.0 indeed the focus on symptom reduction and stress-management could reduce the recovery orientation. IMR 4.0 has an increased focus on aspects of living an inclusive, hopeful, and meaningful life having a severe mental illness. All workbooks contain links for participants to make sense of illness experiences, give meaning to their lives and to achieve personal recovery goals. Main issues of change are reported and the outcome of the first evaluations.

3 • SELF-MANAGEMENT SUPPORT NEEDS AS REPORTED BY PEOPLE WITH SEVERE MENTAL ILLNESS, THEMATIC SYNTHESIS OF QUALITATIVE RESEARCH.

T. Beentjes, B. van Gaal[1,3], T. van Achterberg[4], P. Goossens[1,2,5]

[1] Radboud university medical center, Nijmegen, the Netherlands - [2]Dimence Group Mental Health Care, Deventer, the Netherlands - [3] HAN University of Applied Sciences, Nijmegen, the Netherlands - [4] KU Leuven, Academic Centre for Nursing and Midwifery, Leuven, Belgium - [5] University Centre for Nursing and Midwifery, Ghent University, Belgium

Aims: In the development of a self-management intervention for people with SMI we aimed for identifying their self-management support needs

Methods: A thematic review of qualitative studies was conducted. After searching databases and screening papers for eligibility, 47 papers were included and analysed qualitatively

Results: Main findings show that participants in the studies described informational-, emotional-, acknowledgment-,

encouragement-, and guidance- support needs; respectively, in order to: to give meaning on the illness, to alleviate suffering, to be valued and to be involved in decision making, to be able to execute self-management tasks, and to be led through an unfamiliar or unaware territory.

Conclusions: Results show that self-management support must be tailored individually. A self-management intervention for people with SMI should aim to integrate and fulfil all personal self-management support needs.

4 • THE QUALITATIVE EVALUATION OF AN E-SUPPORTED ILLNESS MANAGEMENT AND RECOVERY PROGRAM FOR PEOPLE WITH SMI

T. Beentjes, B.G.I. van Gaal[1]; P.J.J. Goossens[1,2,3,4]; H. Vermeulen[1]; M.W.G. Nijhuis-van der Sanden[1]

[1] Radboud university medical center, Nijmegen, the Netherlands - [2] Dimence Group, Deventer, the Netherlands - [3] GGZ-VS, Utrecht, the Netherlands - [4] Ghent University, Ghent, Belgium

Aims: Against the backdrop of the great promise of e-mental health, we examined the facilitators and barriers of using the e-IMR platform.

Methods: In open interviews participants in the study were asked to tell about their experience of using or not using the e-IMR platform. The data were qualitatively analysed.

Results: Facilitators and barriers were located in the intervention, trainers, participants, social context, and IMR providing institutes

Conclusions: This study provided great insight into the usability and the boundaries of e-health for clients with SMI.

S23 • RECOVERY OF PSYCHOTIC DISORDERS. DIFFERENT WAYS TO GO

Short general introduction symposium: *Recovery has been found to be a multidimensional concept, consisting of personal, symptomatic, functional and social recovery [(1)]. Although patients and scientists have underlined that recovery from a psychotic disorder can occur, even with symptoms being present [(2-4)], the process of recovery is still largely unknown. Therefore, extensive research is now being done into different determinants and treatments that are associated with recovery. Empowerment [(5)], for example, is shown to correlate with Quality of Life measures [(6)]. Furthermore, attachment [(7, 8)] and positive social support are thought to be associated with recovery [(9)]. The current symposium will discuss different systematic reviews on personal recovery and attachment and will present results of the Dutch Trial on Illness Management and Recovery (IMR).*

1. *van der Stel JC. Focus op persoonlijk herstel bij psychische problemen: Boom Lemma uitgevers; 2012.*
2. *Bellack AS. Scientific and consumer models of recovery in schizophrenia: concordance, contrasts, and implications. 2006.*
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1 • PROMOTING PERSONAL RECOVERY IN PSYCHOSIS – A SYSTEMATIC REVIEW

P. Leendertse[1], A.M. Ruissen, D.P.G. van den Berg, S. Castelein, C.L. Mulder

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Introduction: Interest in personal recovery in psychosis is growing rapidly in both research and clinical practice. The concept however lacks conceptual clarity, resulting in a great variability of studies. Most reviews focus on the conceptualisation.

Objectives: This study aims to offer a systematic review of quantitative studies measuring personal recovery with a

validated questionnaire, to inform clinical practice how to improve personal recovery in psychosis.

Methods: A broad array of keywords was selected to discover all studies focussing on personal recovery in psychosis, in addition with the processes of personal recovery according to the conceptual framework of Leamy et al. (2017)[1]. Qualitative studies on the conceptualisation of personal recovery will be used for background, but will be excluded from the review. The review comprises studies assessing personal recovery as an outcome measure using a valid questionnaire. Cross-sectional, longitudinal as well as intervention studies will be included.

Results: The systematic review is now underway. During the conference results will be presented. The study protocol is registered at the PROSPERO database.

Conclusions: Determinants of personal recovery will be described using a systematic review including studies investigating personal recovery as an outcome measure.

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2 • PATHWAYS TO CLINICAL, FUNCTIONAL AND PERSONAL RECOVERY FOR PEOPLE WITH SCHIZOPHRENIA AND OTHER SEVERE MENTAL ILLNESSES

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Introduction: The rationale for this research lay in the interrelations between different concepts suggested in a conceptual framework of Illness Management and Recovery (IMR)1.

Objective: To analyze relationships between five components of IMR —as determinants of clinical, functional and personal recovery in patients with schizophrenia and other severe mental illnesses.

Methods: The cross-sectional design used baseline data of outpatient participants in a randomized clinical trial on IMR (N=187). We used structural equation modelling (SEM) to describe pathways between degree of insight, medication adherence, addiction, coping and social support, and degree of clinical, functional and personal recovery. We also explored whether clinical recovery mediated functional and personal recovery.

Results: Final model showed that coping was associated with clinical, functional and personal recovery. Direct associations between coping and functional and personal recovery were stronger than indirect associations via clinical recovery. Although SEM also showed a significant but weak direct pathway between social support and functional recovery, there were no significant pathways either between social support and clinical or personal recovery, or between insight, medication adherence, addiction and any type of recovery.

Conclusions: Coping may be a determinant of all three types of recovery, and social support a determinant of functional recovery. Clinical recovery appears not to be a prerequisite for functional or personal recovery. While our results also suggest the relevance of improving coping skills and of enhancing social support, they only partially support the conceptual framework of IMR.

[1] Mueser KT, Meyer PS, Penn DL, Clancy R, Clancy DM, Salyers MP. The Illness Management and Recovery program: rationale, development, and preliminary findings. Schizophr Bull. 2006;32 Suppl 1:S32-43.

3 • ADULT ATTACHMENT AND THE CHALLENGE TO RECOVER FOR INDIVIDUALS WHO HAVE TO DEAL WITH PSYCHOSIS: A SYSTEMATIC REVIEW

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GGZ OOST Brabant, The Netherlands

Introduction: For people who had a psychosis, recovery is a real challenge. There is, however, a great diversity how way people manage this process and in the outcome of recovery. Attachment has been identified as one possible mechanism involved in understanding psychosis. Attachment style is also defined as basis for resilience, emotional well-being, mental health, trust in self and others, emotion regulation and hope and optimism (Bolwby 1973). Our hypothesis is that attachment style (secure versus insecure) could be a basic underlying mechanism contributing to

the outcome in personal, social and clinical recovery.

Objectives: Aim of this systematic review is to investigate the relationship between adult-attachment and personal/social and clinical recovery amongst individuals with a psychotic disorder.

Methods: We searched databases Embase, Medline Epub (OVID), Psycinfo (OVID), Cochrane Central (trials), Web of Science and Google Scholar. We used keywords attachment and psychosis and recovery and related terms. Included were studies with a measurement of attachment and a measurement of recovery in a population with a psychotic disorder. Cross-sectional, longitudinal as well as intervention studies are included.

Results: The systematic review is now underway. During the conference results will be presented. The study protocol is registered at the PROSPERO database.

Conclusions: To be able to support the recovery process, more knowledge about the attachment style can be helpful.

4 • ATTACHMENT AS A FRAMEWORK TO FACILITATE EMPOWERMENT FOR PEOPLE WITH SEVERE MENTAL ILLNESS: A CROSS-SECTIONAL STUDY

C. Tjaden[1], A. Arntz, A.E.G. Delespaul, H. Kroon, C.L. Mulder

[1] *Trimbos Institute, The Netherlands*

Introduction: People with a severe mental illness (SMI) often experience difficulty in developing and maintaining social relationships. This highlights the task of mental health services to facilitate connectedness to contribute to a social environment which facilitates recovery and empowerment. Attachment theory might provide a framework to enhance understanding in creating such interactions, yet there is a dearth of attachment research on recovery related outcomes, such as empowerment.

Methods: Using a cross-sectional design we assessed associations between attachment (Revised Adult Attachment Scale), self-reported social functioning and empowerment (Netherlands Empowerment List) in a sample of 158 participants with SMI in outpatient care.

Results: The dimensions attachment anxiety and attachment avoidance were both linked with lower levels of empowerment. A stepwise multiple regression analysis revealed that adding the two attachment dimensions to quality and frequency of social contact improved the regression model of predicting empowerment.
Attachment anxiety and quality of social contact were significant predictors; attachment avoidance and frequency of contact were not.

Conclusions: If empowerment is identified as focus of treatment and care, facilitating secure attachment bonds in relation to significant others in which it is learned that the self is a reliable, capable resource, might be a promising approach to enhance effectiveness.
This calls for social interventions in which working with significant others is not longer optional but the basis of recovery work.

S10 • PROMISING STRATEGIES FOR IMPROVING (MEDICATION) ADHERENCE IN PATIENTS WITH PSYCHOTIC DISORDERS

Short general introduction symposium: *Psychotic disorders are associated with various problems in cognitive, psychosocial and behavioral functioning. While antipsychotic drug therapy has been considered essential for the treatment, (medication) adherence remains a significant problem. Literature shows a wide range of treatment discontinuation rates, indicating that approximately 50% of patients stop using their antipsychotic drug over one year of time. Non-adherence is associated with an increased rate of relapse and hospitalization, reflecting a significant economic burden too. Adherence is considered multidimensional and therefore various reasons for non-adherence have been proposed. Consequently, different adherence improving strategies have been suggested in order to tackle non-adherence. The scope of this symposium will be (medication) adherence improving strategies, focusing on the effect of financial incentives and different drug formulations on adherence. Finally, we will discuss the association*

between executive functioning, several recovery-related determinants and therapy adherence, in order to gain more insight into this subject of significant importance

1 • MONEY FOR MEDICATION: A RANDOMISED CONTROLLED TRIAL FOR IMPROVING ANTIPSYCHOTIC MEDICATION ADHERENCE USING FINANCIAL INCENTIVES

E.L. Noordraven[1], A. Wierdsma, A.F.T. Bloemendaal, A.B.S Staring, C.L. Mulder

[1] *Erasmus MC Rotterdam The Netherland*

Aims: Provision of financial incentives is a promising intervention for improving adherence in patients taking antipsychotic medication. The aim of this study was to assess the effectiveness of this intervention for improving adherence to antipsychotic depot medication in patients with psychotic disorders.

Methods: A multicentre, open-label, randomised controlled trial at three mental health-care institutions in the Netherlands. Eligible patients were aged 18–65 years, diagnosed with schizophrenia, had been prescribed antipsychotic depot medication and were participating in outpatient treatment. Patients received 12 months of either treatment as usual plus a financial reward for each depot of medication received (€30 per month if fully compliant) or treatment as usual alone. The primary outcome was the Medication Possession Ratio (MPR) during the 12 month intervention period. Patients were followed up for 6 months, during which time no monetary rewards were offered for taking antipsychotic medication.

Results: In total, 169 patients were randomly assigned to the intervention group (n=84) or the control group (n=85). Primary outcome data were available for 155 (92%) patients. At baseline, the mean MPR was 76·0% in the intervention group versus 77·9% in the control group. At 12 months, the mean MPR was higher in the intervention group (94·3%) than in the control group (80·3%), with an adjusted difference of 14·9% (95% CI 8·9-20·9%; p)

Conclusions: Financial incentives are an effective way of improving adherence to antipsychotic depot medication among patients with psychotic disorders. Further research is needed to study the long-term effects of this intervention and its implementation within clinical treatment.

2 • TIME TO DISCONTINUATION WITH DIFFERENT ANTIPSYCHOTIC FORMULATIONS IN SCHIZOPHRENIA: A CLAIMS DATA BASED STUDY

I. Önsesveren[1], A. van der Lee, A. Wierdsma, L. de Haan, C.L. Mulder

[1] *Erasmus MC Rotterdam The Netherland*

Aims: Medication discontinuation due to non-adherence in patients with schizophrenia is common and associated with potentially severe adverse outcomes. The aim of this study was to assess the time to medication discontinuation with different antipsychotic medication formulations, including penfluridol (oral-weekly formulation).

Methods: Real world health insurance claims data, 2013-2016, were used in a retrospective longitudinal cohort study. Time to discontinuation in schizophrenia patients, 18-70 years old, with different antipsychotic formulations on 31-12-2015 and stratified based on treatment duration (less or more than 60 days) preceding follow-up was analyzed using survival analyses.

Results: 8257 patients were selected for analyses. Considerable discontinuation during follow-up for all medication formulations was observed. Overall, time to discontinuation for patients with long-term drug treatment preceding follow-up was longer as compared to short-term drug treatment. After adjustment for patient characteristics and history of psychiatric treatment, the long-term oral formulation showed the longest time to discontinuation. Time to discontinuation with oral-weekly and depot formulations showed a similar pattern. Furthermore, number of prior discontinuations was negatively associated with overall time to discontinuation during follow-up.

Conclusions: Time to discontinuation showed a considerable difference between different antipsychotic formulations. Duration of drug treatment preceding follow-up is strongly associated with time to discontinuation. Penfluridol (oral-weekly) and depot formulations showed similar discontinuation trends. Therefore, penfluridol could be considered

an alternative in case of non-adherence, given the beneficial non-invasive administration route.

3 • EXECUTIVE FUNCTIONING: A NEW WAY TO IMPROVE THERAPY ADHERENCE? A LITERATURE REVIEW

B. van Aken[1], A. Wierdsma; A. Bakia; C.L. Mulder

[1] *Erasmus MC Rotterdam The Netherland*

Aims: Executive functioning has a major impact on illness outcomes. Impairment in these functions can have a severe negative impact on daily functioning, a career or education, but also on therapy adherence, since cognitive dysfunction is known to be a predictor of non-adherence. The aim of this study was to assess the role of executive functioning in therapy adherence, and the improvement thereof through e.g. illness insight.

Methods: 150 interviews were conducted with patients who were in care with fast assertive outreach (fACT) teams in the Southwest of the Netherlands at the time of the interview. All were between 18 and 65 years old with psychosis as their primary diagnosis. The associations between executive functioning and therapy adherence will be looked at, along with some mediating/moderating variables. Furthermore, preliminary results of follow-up measurements after one-year will be presented.

Results: The results are currently unknown, but will be discussed at the conference.

Conclusions: Conclusions will be drawn at the conference, following the results.

S16 • NEW APPROACHES TO IMPLEMENTATION OF HOME-TREATMENT IN GERMANY

Short general introduction symposium: *While Home-Treatment (= HT) has been implemented in a wide range of European countries, it has never overcome the state of pilot projects in Germany. In 2017 the government has established a new law to promote nationwide introduction of acute outreach care programs, called "Stationsäquivalente Behandlung" (= StäB). Since 2018 first hospitals have been implementing these new services. Yet, the concept of the underlying law contains several restrictions and is only partly congruent with internationally evaluated models like HT or CRT. Resulting are various practical and conceptual problems that are challenges to everyday practices. In this symposium we want to present this new German approach to HT. Further we want to collate first practical experiences, research findings and discuss principal implications for the ongoing development of HT in Germany.*

1 • "STATIONSÄQUIVALENTE BEHANDLUNG" A NEW CONCEPT: EXPERIENCES AND EVALUATION RESULTS FROM A RURAL CATCHMENT AREA

H. Friederich[1]

[1] *Die Zentren für Psychiatrie in Baden-Württemberg*

Aims: After HT was made possible by law in early 2018, the Centres of Psychiatry Südwürttemberg (ZfP) started to build up new treatment teams in each of their hospitals. The aim was to develop within a few months powerful und functioning treatment units in order to deliver this new form of treatment. During the whole implementation process of the StäB-concept we prepared and conducted a multi-sited interrogation-study to compare the satisfaction-rates and opinions of the patients, their relatives and the treatment team members concerning the StäB-setting towards those of the inpatient setting. This presentation will 1. summarize the development and experiences with the StäB-concept in several rural regions of southern Germany, 2. it will also give a first glance into the results of the interrogation study.

Methods: The patient data, experiences and aspects of four hospitals will be presented in detail. The interrogation-study will show preliminary data of a planned number of 100 enrolled patients from two of these four hospitals, one responsible for a rural region and one for an urban region.

Results: During few weeks we transferred the previously determined criteria of the StäB-concept into a highly

functioning treatment routine that delivers on a daily basis face-to-face psychiatric care, weekends and holidays included. To make this work the treatment teams had to decide about many structural and functional questions, had to invent and develop new attitudes and approaches to organizing and delivering psychiatric care. The attitude towards the patient had to change since the patient should get clinic-like treatment and is hosting the treatment-sessions at the same time. The ways of documenting and communicating treatment-relevant information had to be adapted.

Conclusions: All in all, StäB represents a very exciting and successful alternative to inpatient treatment. Finally, the underlying concept is in a permanent state of revision, most of all, to make transitions between different therapeutic settings more fluent and flexible.

2 • PRACTICAL EXPERIENCES OF IMPLEMENTING HOME-TREATMENT IN AN URBAN CATCHMENT AREA

S. Weinmann[1], A. Bechdolf

[1] *Klinikum Vivantes - Berlin*

Aims: Home treatment (= HT) according to the new German law is a new approach and paradigm shift for German psychiatry. With the possibility to get assertive outreach treatment reimbursed, there now exists some incentives for hospitals to build such teams and offer HT to some patients. HT according to StäB however, is provided only by a minority of hospitals, most of which have already collected experiences with cross-sectoral care within pilot projects or structural contracts. Most teams have been established in addition to existing structures without reduction in the total number of psychiatric beds. This contribution reports experiences of a in implementing a new team in an urban district of Berlin.

Methods: As this contribution is a report of first practical experiences, there are no methods to declare.

Results: The establishment of a HT team in an urban district of Berlin took six months and required a special recruiting process, the development of a specialized manual, hiring cars and integration into the hospital information system. Due to strict reporting requirements of the StäB-concept, a set of standard operation procedures had to be established. Recruitment of patients was difficult in the beginning, as patients to be included in HT should be in a situation to require inpatient treatment with many therapists being reluctant to admit acute patients to HT or to shorten inpatient treatment with the presence of severe symptoms. With growing positive experiences there was more openness to start HT in acute episodes.
Therefore, some gatekeeping regulations are considered useful. HT did allow much better to include the social environment compared to inpatient treatment with the possibility to contextualize symptoms. The focus often shifts from symptoms to social functioning and coping. Patients often feel more appreciated. Most patients had a psychotic disorder (50%), followed by affective disorders (31%) and substance disorders (10%). Mean length of stay was 22 days. More patients with psychotic disorders benefitted from HT compared to those with other disorders.

Conclusions: The establishment of a HT team in an urban district of Berlin took six months and required a special recruiting process, the development of a specialized manual, hiring cars and integration into the hospital information system. Due to strict reporting requirements of the StäB-concept, a set of standard operation procedures had to be established. Recruitment of patients was difficult in the beginning, as patients to be included in HT should be in a situation to require inpatient treatment with many therapists being reluctant to admit acute patients to HT or to shorten inpatient treatment with the presence of severe symptoms. With growing positive experiences there was more openness to start HT in acute episodes.
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Patients often feel more appreciated. Most patients had a psychotic disorder (50%), followed by affective disorders (31%) and substance disorders (10%). Mean length of stay was 22 days. More patients with psychotic disorders benefitted from HT compared to those with other disorders.

3 • HOME-TREATMENT IN GERIATRIC PSYCHIATRY – ADVANTAGES AND CHALLENGES IN DEALING WITH PEOPLE WITH DEMENTIA

S. Spannhorst[1]

[1] *Klinikum Stuttgart – Stuttgart Germany*

Aims: Acute care hospitals entail a range of risks for people with dementia, such as delirium, increased mortality, loss of independence and admission to full inpatient nursing homes. In January 2018, home treatment (= HT) equivalent to in-hospital care in Geriatric Psychiatry (= StäbGER) was introduced by law to reduce or even avoid such risks. Because there are no relevant pilot projects or concrete experiences in Germany, the implementation results of StäBGER at the Clinic of Psychiatry and Psychotherapy of the Elderly, Klinikum Stuttgart, are to be presented.

Methods: After a multiprofessional theoretical development stage, the structures for StäBGER in the Geriatric Psychiatry department at Klinikum Stuttgart have been established in February 2018. For this purpose, existing treatment concepts of a psychogeriatric nurse's visiting round were fundamentally modified and expanded by daily multiprofessional domestic treatment and care. A separate StäBGER team (consisting of 2 physicians, 4 caregivers, and specialist therapists), closely linked to the Geriatric Psychiatry's outpatients' clinic, carries out daily on-site diagnostics and therapy as well as 24-hour on-call service.

Results: For 63 % of StäBGER-patients (n = 82 as of 31st December 2018) the secondary diagnosis was dementia. The admission diagnosis for 60 % of cases was delirium. Approximately 62 % of patients were treated in nursing homes. The median length of stay was 14 days and the median age was 81 years. StäBGER-patients benefitted from preventing changes of location and need-based treatment, especially of bio-psycho-social problems by actively involving the patients' environment.

Conclusions: These advantages clearly outweigh the challenges of the increasing multimorbidity in old age, frequent complications such as falls and diagnostic procedures for somatic symptoms. To ensure a smooth cooperation with professional geriatric nursing staff at nursing homes, which is essential in dealing with acute illnesses, structures must be optimally developed.

4 • OBSTACLES TO IMPLEMENTATION OF HOME-TREATMENT – A QUALITATIVE EXPLORATION OF THE STAFF EXPERIENCES

J. Schwarz[1], S. von Peter[1]

[1] *Medizinische Hochschule Brandenburg, Immanuel Klinik Rüdersdorf - Berlin*

Aims: Almost two years after passing the law for the implementation of HT in Germany, there are still only few hospitals that have implemented these new forms of service. The current study seeks to investigate the conditions of and obstacles to implementation of this German variation of HT, called "Stationsäquivalente Behandlung" (= StäB). Findings of the ongoing study aim at serving to inform mental health policy about potential needs for legislative amendments.

Methods: All psychiatric hospitals with a catchment area in the federal state of Berlin and Brandenburg were questioned about their motivations to introduce HT (according to §115d, social security code V). Qualitative expert interviews and focus groups were led with HT team members and medical directors of certain hospitals, exploring the obstacles to implementation of the new service. A thematic analysis was conducted.

Results: Out of 34, three hospitals stated that they are providing for HT, while two hospitals were in process of its implementation. Three focus groups and three interviews were led with 24 participants in these hospitals. As part of the qualitative analysis, four key topics could be identified: 1. Lack of flexibility: The fulfilment of HT performance requirements and the daily patient attendance impede a flexible and need-adapted care provision; 2. Team organisation: Implementing cross-sector team continuity is a challenge; 3. Recruitment: Regardless of profession, finding suitable staff is difficult; 4. Financing: Reservations on the part of health insurances and hospital management are detrimental to implementation.

Conclusions: For a more need-adapted, flexible and nationwide introduction of HT according to StäB, improvements to the underlying concept are necessary. Further research is needed to convince payers, in particular, randomized controlled trials, to examine the efficacy and efficiency of StäB compared to treatment as usual.

S11 • INVOLVEMENT IS THE KEY: RESEARCH-BASED IDEAS TO IMPROVE FORENSIC OUTPATIENT CARE

Short general introduction symposium: *Providing forensic outpatient care is challenging. Forensic outpatients suffer from complex psychiatric, addiction and/or personality problems, intellectual disabilities and social disadvantages. Due to earlier experiences, motivation and treatment alliance are often low. At Inforsa, forensic mental health care, we studied our outpatient population to find new ways to improve treatment. In this symposium we will explain, using research data, how "involvement" can be used as a key to improve treatment. First, we will show that involvement over a longer period and a better therapeutic alliance are associated with better treatment outcomes. Furthermore, we will discuss preliminary results on feasability and effectiveness of two innovative research projects: one aimed to enhance mental wellbeing and the social network by involvement of the community using volunteer forensic network coaches, and one targeting treatment involvement by providing a real-time biofeedback app to strenghten physiological awareness and to support skills to prevent aggressive behaviour.*

1 • FACTORS INFLUENCING TREATMENT RESPONSIVENESS IN FORENSIC OUTPATIENT CARE

R. van Bemmelen[1]

[1] *Inforsa, Amsterdam, The Netherland*

Providing forensic mental health care is challenging because of the diversity of complex problems underlying delinquent behaviour. Forensic treatment focusses on the prevention of future delinquent behaviour by working on these related psychiatric problems and problems on multiple important life areas such as housing problems, financial problems and poor supportive social networks.
Therefore, forensic treatment must be customized to patients needs. Inforsa – a forensic outpatient mental health organisation in Amsterdam and surroundings – offers different type of treatment programs for a complex forensic outpatient population. Firstly, the aim is to further improve and customize forensic outpatient care by investigating the problems and possible needs of the patientpopulation of Inforsa. Besides, predictors of treatment progress are investigated.
Data from a longituninal study and Routine Outcome Monitoring (ROM) will be presented. The results of the ROM data suggests that patients who are treated more than a year show a much higher percentage of improvement than patients who are treated less than a year.
Data of the longitudinal study suggests that the therapeutic alliance (TA) between the patient and the therapist is very important for improvement.
Patients who experience a high or mediocre TA show much more improvement than patients with a low TA in forensic outpatient treatment.

2 • FORENSIC NETWORK COACHING: IMPROVING SOCIAL NETWORKS AMONG A FORENSIC PSYCHIATRIC OUTPATIENT POPULATION

L. Swinkels[1], A. Popma, J. Dekker, T. van der Pol

[1] *Arkin Institute for Mental Health, Amsterdam, The Netherland*

Aims: A large group of forensic outpatients is not satisfied with the support in their social network and poorly embedded in society. At the same time a healthy social network is known as an important protective factor in decreasing the risk of delinquent behavior. In order to further improve forensic treatment, mental health institutions should involve informal care or other initiatives of care within the community. In this study we will examine the effectiveness and time course of a supportive social network intervention in improving treatment outcome such as mental well-being, psychiatric problems and criminal recidivism.

Methods: A carefully selected volunteer trained by an informal care organization will be added to treatment as usual. The so called forensic network coach will cooperate together with the patient following a supportive network intervention. Currently, we are conducting a RCT in two parallel groups (N=75 in each group) comparing treatment as usual with and without the addition of a forensic network coach. Forensic outpatients in the age of 16 years and older diagnosed with addiction problems, personality disorders or psychiatric disorders will be included in this study. To participate subjects should experience poor support in their social network.

Results: At the 5th European Conference on Integrated Care and Assertive Outreach we will present preliminary results of the baseline and follow-up assessments. Besides, we will give an overview of the challenges in the collaboration between formal mental health care and informal care.

Conclusions: At the 5th European Conference on Integrated Care and Assertive Outreach we will present preliminary results of the baseline and follow-up assessments. Besides, we will give an overview of the challenges in the collaboration between formal mental health care and informal care.

3 • SENSE-IT: BIOFEEDBACK IN FORENSIC OUTPATIENTS WITH PROBLEMATIC AGGRESSIVE BEHAVIOUR

A. ter Harmsel[1], A. Popma, A. Goudriaan, M. Noordzij, T. vander Pol

[1] *Arkin Institute for Mental Health, Amsterdam, The Netherland*

Aims: Aggressive behaviour is causing a wide range of problems for victims, offenders and the society. Given the current trend to prefer outpatient interventions over residential treatment, and the high treatment drop-out rates in forensic populations, further improvement of forensic outpatient treatment methods is needed. In this, biofeedback – informing psychiatric patients about their physiological state – is a promising intervention for clinical practice. Real-time biofeedback, provided in real-life, is expected to help patients to signal heightened arousal in response to emotional events in an early stage.
By strengthening physiological awareness and supporting use of prevention skills, we suppose that biofeedback can aid to reduce aggressive behaviour.

Methods: In this study, we will examine the feasibility and the effectiveness of the addition of real-time biofeedback (using a biosensor and a mobile application, named Sense-IT) to treatment as usual on reduction of aggressive behaviour. Right now, we are conducting a pilot study with pre- and posttests around an intervention-period of two weeks, to test feasibility among 10 patients (Study 1). The main study (Study 2) will be a randomized controlled clinical trial or, depending on the results of the first study, a single case experimental design. Our primary outcome variable is the amount of self-reported aggression after the intervention.

Results: At the 5th European Conference on Integrated Care and Assertive Outreach we will present the feasability results of Study 1 and discuss the implications with the public.

Conclusions: Furthermore, we will clarify the potential benefits and risks of the use of a real-time biofeedback system in forensic outpatients with aggressive behaviour. We will discuss the pitfalls and challenges that might confront us in future research and clinical practice.

S32 • HOUSING FIRST FIDELITY SCALE IN A NORWEGIAN CONTEXT A SHIFT IN THE SERVICES TOWARDS RECOVERY

Short general introduction symposium: *Since 2012, 21 Housing First teams have been a part of the housing services in Norway. NAPHA has since 2012 been in charge of bi-annual network meetings where case-workers, team-managers, and other stakeholders have participated.*
In 2018 NAPHA took part in an international study concerning the use of a fidelity scale in Housing First. One of the aims was to see whether a fidelity-scale developed in the USA would be possible to transfer to a Norwegian context.

1 • THE ORIGINAL MODEL COMPARED TO THE NORWEGIAN WELFARE STATE

A.B. Gimmestad Fjelnseth[1]

[1] *Norwegian Resource Center for community Mental Health - Trondheim Norway*

Aims: We aim to highlight how the fidelity scale changes the service for homeless by looking at - The original model compared to the Norwegian welfare state. -The use of a fidelity scale in Housing First Norway. -Inclusion of peer-workers in the Housing First-teams as a result of fidelity scoring. - A change in the services as an outcome of the fidelity scale.
Program fidelity measures a program in terms of compatibility to the original model. Housing First is using a fidelity scale developed by Dr.Sam Tsemberis, the founder of the organization, Pathways to Housing, founded in USA in 1992.

Methods: In collaboration with researchers, peer-workers and case-managers, Pathways developed a fidelity scale which identifies facilitators that contributes to either high or low fidelity. Sam Tsemebris and Pathways to Housing identifies four principles in Housing First: 1) Immediate offer of housing and consumer-centered services, 2) separation of housing and support services, 3) delivery of support guided by a recovery-orientation, 4) focus on community integration.

Housing First is challenging the traditional staircase-model where homeless people must qualify for housing after proving to be ready for it.

Results: The fidelity scale changes the views on the service in terms of awareness of services, inclusion of participants and the recovery-process.

Conclusions: The fidelity scale does not only identify factors for high or low Fidelity, but also develops the services to recovey-based services. In order to reach its full potential for high fidelity, peer-workers must be included both in the Housing First-teams and in advisory boards.

2 • THE USE OF THE FIDELITY SCALE IN HOUSING FIRST NORWAY

A.B. Gimmestad Fjelnseth[1]

[1] *Norwegian Resource Center for community Mental Health - Trondheim Norway*

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Results: The fidelity scale changes the views on the service in terms of awareness of services, inclusion of participants and the recovery-process.

Conclusions: The fidelity scale changes the views on the service in terms of awareness of services, inclusion of participants and the recovery-process.

3 • INCLUSION OF PEER-WORKERS IN THE HOUSING FIRST-TEAMS AS A RESULT OF FIDELITY SCORING

P. Dahle[1]

[1] *Norwegian Resource Center for community Mental Health - Trondheim Norway*

Aims: We aim to highlight how the fidelity scale changes the service for homeless by looking at - The original model compared to the Norwegian welfare state. -The use of a fidelity scale in Housing First Norway. -Inclusion of peer-workers in the Housing First-teams as a result of fidelity scoring. - A change in the services as an outcome of the fidelity scale. Program fidelity measures a program in terms of compatibility to the original model.

Housing First is using a fidelity scale developed by Dr.Sam Tsemberis, the founder of the organization, Pathways to Housing, founded in USA in 1992.

Methods: In collaboration with researchers, peer-workers and case-managers, Pathways developed a fidelity scale which identifies facilitators that contributes to either high or low fidelity. Sam Tsemebris and Pathways to Housing identifies four principles in Housing First: 1) Immediate offer of housing and consumer-centered services, 2) separation of housing and support services, 3) delivery of support guided by a recovery-orientation, 4) focus on community integration. Housing First is challenging the traditional staircase-model where homeless people must qualify for housing after proving to be ready for it.

Results: The fidelity scale changes the views on the service in terms of awareness of services, inclusion of participants and the recovery-process.

Conclusions: The fidelity scale does not only identify factors for high or low Fidelity, but also develops the services to recovey-based services. In order to reach its full potential for high fidelity, peer-workers must be included both in the Housing First-teams and in advisory boards.

S25 • BARRIERS TO PERSONAL RECOVERY AND PARTICIPATION: PREVALENCE, PERSPECTIVES, AND INTERVENTIONS

Short general introduction symposium: *Mental health professionals of outpatient teams aim to support their clients in their personal recovery process. Several types of psychosocial interventions have been developed to support this aim, and there is increasing evidence for the effectiveness of those interventions on several outcomes. However, despite those efforts, persons with long term and severe mental health problems experience several difficulties in societal participation and on their road to recovery. Additionally, professionals encounter problems in supporting clients to deal with these difficulties. These barriers can relate to the organization of services or working alliance, but also to external factors, such as victimization, discrimination and stigmatization. This symposium aims to enlarge our understanding on several barriers and difficulties that persons with long term and severe mental health problems experience in rehabilitation and personal recovery, in order to move forward and increase success of rehabilitation methods and recovery-oriented interventions.*

1 • RECOVERY INTERVENTIONS FOR PERSONS WITH SEVERE AND PERSISTENT MENTAL ILLNESS: A SCOPING REVIEW

D. Roeg[1], N.A. Bitter[1], C. van Nieuwenhuizen[1], J. van Weeghel[1]

[1] *Tilburg University – Tranzo Netherlands*

Aims: Several types of psychosocial interventions have been developed to support people with severe mental illness in their rehabilitation, including methods to realize personal goals and wishes regarding daily life and participation, and methods that focus on specific areas, including competitive employment, cognitive functioning or practical skills. More recently, interventions have been developed to enhance personal recovery processes in which basic human needs including connectedness and hope for the future receive attention.

Although research on these interventions shows promising results, little is yet known about the rehabilitation

and recovery interventions for clients with persisting, disfunctioning and demotivating mental health issues, that currently are dependent of housing or clinical facilities. This study aims to achieve insight in the availability and results of recovery and rehabilitation-focused interventions for this group.

Methods: We conducted a systematic scoping literature review following the framework of Arksey and O'Malley (2005). PubMed, Psycinfo, Embase, and Cinahl were searched for publications between January 2000 and December 2017 that reported on the evaluation of psychosocial interventions focusing on daily life (skills), cognitive enhancement, healthy behaviour, social relations, goal attainment, personal recovery and/or societal functioning in adult clients dealing with severe mental illness receiving services from housing services or comparable long-term sheltered/ residential facilities. We included peer-reviewed articles published in English only, without restrictions in design.

Results: The search yielded 2,585 articles, of which 45 articles were included after scanning the titles, abstracts, and full texts on relevance, and after removing duplicates. Five categories could be formed. Three were based on often distinguished dimensions of the recovery process: societal, personal and functional recovery; two were formed data driven: lifestyle, and cultural and spiritual. Most studies (n=19) focused on societal recovery, addressing psychiatric rehabilitation, occupational therapy and skills trainings. Five studies focused on personal recovery, including peer-run programs, illness management and recovery, and interventions aiming to increase empowerment and all had promising results or added value. The five functional recovery studies were on cognitive training or remediation. Lifestyle studies (n=9) aimed at a healthy lifestyle, i.e. physical exercise and healthy eating. The last category contained studies (n=7) focussing on creative and spiritual interventions as tai chi, musical therapy and art therapy. Overall, a quarter of the interventions showed added value and almost half: promising results. Of the other quarter, no evidence for effectiveness was shown or available yet. Of all interventions, the characteristics were compared.
Conclusions: The results indicate that recovery and rehabilitation services for persons experiencing persistent disfunctioning mental illness is limited, but growing. This study provides new insights in the opportunities for implementation, further development and evaluation of recovery and rehabilitation interventions for these persons.

2 • PREVALENCE AND RISK FACTORS OF VICTIMIZATION IN PATIENTS WITH A PSYCHOTIC DISORDER

M. Pijnenborg[1], B. de Vries[1], J.T. van Busschbach[1], E.C.D. van der Stouwe[1], A. Aleman[1] et al.

[1] *Tilburg University – Tranzo Netherlands*

Aims: People with a psychotic disorder are often perceived as dangerous, and associated with criminal and violent behavior. However, studies show that people with a psychotic disorder are more often victim than perpetrator of violence. The objective of this study was to review the prevalence rates for different types of victimization and perform meta-analyses to identify consistent significant risk factors that are associated with victimization.

Methods: A search was performed in three bibliographic databases: MEDLINE, PsycINFO and Web of Science. Studies were included when the sample consisted of adults with a psychotic disorder and victimization occurred during adulthood. Four categories of victimization were distinguished: 'violent victimization', 'sexual victimization', 'non-violent victimization', and 'victimization not otherwise specified (NOS). For the meta-analysis the Mantel-Haenszel method or the generic Inverse Variance was used.

Results: The electronic database search yielded 2821 references. After screening 23 studies were included. The median prevalence rate for violent victimization was 22%, for sexual victimization 32%, for non-violent victimization 20%, and for the victimization NOS category it was 18%. Meta-analyses showed that the following risk factors were significant associated with victimization: unemployment (OR 1.23), homelessness (OR 2.35), hallucination (OR 1.68), manic symptoms (OR 1.66), drugs (OR 1.90) or alcohol (OR 2.05) misuse ore abuse and perpetration (OR 4.33).

Conclusions: The electronic database search yielded 2821 references. After screening 23 studies were included. The median prevalence rate for violent victimization was 22%, for sexual victimization 32%, for non-violent victimization 20%, and for the victimization NOS category it was 18%. Meta-analyses showed that the following risk factors were significant associated with victimization: unemployment (OR 1.23), homelessness (OR 2.35), hallucination (OR 1.68), manic symptoms (OR 1.66), drugs (OR 1.90) or alcohol (OR 2.05) misuse ore abuse and perpetration (OR 4.33).

3 • DEVELOPING A WORKING ALLIANCE INSTRUMENT FOR CLIENTS OF OUTPATIENT MULTIDISCIPLINARY TEAMS WITH SHARED CASELOADS

M. van Haaren[1], D.P.K. Roeg[1], S. de Jong[1]

[1] *Tilburg University – Tranzo Netherlands*

Aims: Existing instruments were unable to find a strong relationship between the strength of the working alliance and treatment outcome for clients with severe mental illness receiving care from multidisciplinary teams with shared caseloads including (F)ACT teams. If the working alliance is able to predict treatment outcome, interventions specifically targeting the quality of the working alliance can be installed in the teams. Improving the working alliance by supervision and training can have a direct effect on treatment outcome and recovery, but it can also lead to a stronger motivation for treatment, or a client becoming more sensitive to and receptive for treatment. If the quality of the working alliance does not predict outcome, possibly other factors than the working alliance need to be targeted in treatment.
The aim is to develop a Working Alliance instrument that is sensitive to specific characteristics outpatient multidisciplinary teams with a shared caseload.

Methods: We conducted two concept map sessions following the framework of Trochim (1989) with professionals and clients. Also, a systematic literature review was conducted, searching for publications that reported on the measurement of working alliance in relation to treatment outcomes for persons with severe mental illness. The results led to the development of a Working Alliance questionnaire for shared caseload teams. This questionnaire was piloted among the participants of the concept map sessions and adjusted according to their feedback.

Results: Concepts that arise from both the concept map session as the focus groups are on the one hand the pantheoretical concepts as posed by Bordin (1979). The bond (the affective relationship between professional and client) is mentioned, as well as the task and goal dimension.
On the other hand, two new concepts emerge from the data. First, there is a team dimension with specific elements that come into place when working with teams, such as team culture and trust in the team. Second, there is a dimension in which the specifics of working with a multidisciplinary team with shared caseloads are mirrored. Elements are for example flexibility in time and place and being able to share concerns with more than one professional.

Conclusions: The working alliance's operationalization differs across groups of clients. This study presents an instrument which provides insight in the specific elements of this working alliance and can be used in future research to test the relation with patient outcomes.

4 • VICTORIA: EVALUATION OF A VICTIMIZATION AND DISCRIMINATION INFORMED INTERVENTION TO RE-BOOST REHABILITATION AND PERSONAL RECOVERY

W. Albers[1], D.P.K. Roeg[1], Y.A.M. Nijssen[1], J. van Weeghel[1], I.M.B. Bongers[1]

[1] *Tilburg University – Tranzo Netherlands*

Aims: Persons with severe mental illness have a six time higher risk on victimization, discrimination, and stigmatization. Outpatient teams experience difficulties in addressing this systematically. The Victoria intervention is developed for professionals to increase awareness and acknowledgement of these negative experiences, and enlarge personal recovery and societal participation.
Objectives To evaluate this novel intervention an extensive process evaluation and a first effect study are performed. This study aims to investigate the effectiveness of the Victoria intervention on victimization, discrimination and stigmatization, perceived safety, and social functioning.

Methods: A cluster randomized controlled trial was conducted on 8 flexible assertive community treatment teams on two sites in the Netherlands. Four intervention teams received a three half-day group training on the Victoria intervention and an average of 8 supervision meetings. Four control teams provided care as usual. Measurements included baseline, 10, and 20 months questionnaires. In total, 409 clients agreed to participate in the interviews.

Results: Preliminary results showed significant differences between the intervention and control group on experienced discrimination, anticipated stigmatization, and acknowledgement of difficulties. Professionals' knowledge on difficulties decreased over time, with a higher decrease in the control group. Self-efficacy slightly increased over time in both groups.

Conclusions: Results indicate that training in the Victoria intervention does not lead to large changes in everyday working. Slight improvements on discrimination on client level after 20 months were found. Further innovation and study into this highly relevant topic are needed.

S35 • THE ROLE OF PSYCHIATRIC EPIDEMIOLOGY FOR COMMUNITY MENTAL HEALTH POLICIES

1 • THE CARE GAP IN COMMUNITY MENTAL HEALTH SERVICES

F. Starace[1]

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Mental health sector gets allocated about 3,5% of national health expenditure, with a large regional variability. In the European context, Italy's investment in mental health sector is far below other countries such as Germany, France, UK. Given this picture, it is not surprising that in the last years community mental health services struggled with many difficulties to provide an adequate response to users' needs. In the past decade staff allocated to community services faced a significant reduction, whereas the number of persons in contact with public mental health services is continuously growing. These figures confirm that a problem of accessibility does exist, causing the so-called "treatment gap". However, this term implies almost exclusively biomedical treatments, leaving aside psychosocial interventions such as family psychoeducation, supported employment, social skills training, and a specific attention to physical comorbidity, so frequent in people attending mental health services to be considered the main cause for early mortality in persons with severe mental illness. Pathare et al. (2018) proposed a more comprehensive measure called "Mental Health Care Gap", encompassing all the above domains. On the basis of Ministry of Health data on public mental health system, we calculated the "Mental Health Care Gap" as the rate between mental health needs and mental health workforce capacity, finding that just 50% of these needs can be addressed by current workforce. The choice that lies ahead to fill the care gap is to turn the current trend by investing in mental health services.

2 • PLANNING FUTURE CAMHS: LESSONS LEARNT FROM CHILDREN & ADOLESCENT PSYCHIATRIC EPIDEMIOLOGY

P. Stagi[1]

[1]*Department of Mental Health and Drug Abuse, AUSL Modena*

During the last decade Italian Child and Adolescent Mental Health Services (CAMHS) underwent relevant epidemiological changes, regarding general and specific parameters. Prevalence (Children and Adolescents in contact with CAMHS) increased steadly by nearly 8% every year. In the same period incidence (new contacts) doubled. In 2018 the general caseload accounted for 10% of the overall pediatric population (0-17 years), with a peak corresponding to preadolescent males (18%). Most relevant morbidity modifications concern Neurodevelopmental Disorders (ND), especially Specific Developmental Disorders of Scholastic Skills (x4), Autism Spectrum Disorders (x3), Language Disorders, Intellectual Disabilities and ADHD (x2).
Actually, in 2018 ND accounted for 83% of the entire caseload. Also schizophrenia, mood disorders and other psychopathological disorders increased, more for inpatients than for outpatients. These disorders, as a whole, accounted for nearly 10% of the caseload. We can argue that these changes will affect transition rates from CAMHS to Adult Mental Health Services (AMHS) in the next years, shaping the future of community mental and social care. Transition from CAMHS to AMHS affects 19,5% of adolescents with psychopathological disorders (Stagi, 2015), but transition rates of ND from CAMHS to social services remain unknown. Intellectual Disability prevalence is 1,4-1,6% among the pediatric population. Autism Spectrum Disorders (ASD), with or without comorbid cognitive impairment, is rapidly increasing to a similar level. Moreover, the risk of developing psychopathological disorders in ID and ASD is three or four times higher than in general population. In order to tackle such highly demanding, lifelong health

problems, lack of resources is a general concern, in particular at the end of compulsory school programs.

3 • USING BIG DATA FOR EVALUATING THE QUALITY OF MENTAL HEALTH CARE IN ITALY

A. Lora[1]

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In 2014, the Italian Ministry of Health identified a set of clinical indicators designed to evaluate the quality of clinical pathways for severe mental illnesses. In 2018, the QUADIM project, financed by the Italian Ministry of Health, assessed this set of clinical indicators in four Italian Regions (Lombardy, Emilia-Romagna, Lazio and Sicily), which account for about one third of the Italian population.
These clinical indicators were applied to the regional health care utilization (HCU) databases covering publicly-funded mental health activities, non-psychiatric hospital admissions, health interventions and medical diagnostic tests at the ambulatory level, and pharmaceutical prescriptions. The data, extracted from different administrative information sources available at the regional level, were merged through a record-linkage procedure, using unique, blinded patient identification codes. The Mental Health Departments of the four participating Regions identified a final cohort of about 260,000 patients with schizophrenic, bipolar, personality disorders or depression among all individuals accessing mental health services in 2015. These selected patients were followed for one year in order to assess the above-mentioned clinical indicators, evaluate the quality of care delivered and measure the use of resources.

4 • EPIDEMIOLOGY OF RIGHTS AND MENTAL HEALTH POLICIES

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The UN CRPD is increasingly seen as the benchmark for a rights-based mental health system, an aspiration of many mental health policies. However, UN CRPD is largely 'silent' on the commonest breaches of the "individual will, autonomy and preferences" in mental health namely the ubiquitous and universal use of coercion as part of mental healthcare. Coercion in its various guises is embedded in mental healthcare. The most explicit form of coercive intervention is involuntary hospitalization and treatment of persons with mental health problems. The extent and nature of involuntary treatment vary but it would appear that mental healthcare is becoming more coercive across the world. We argue that it is ethically, clinically and legally necessary to address the problem of coercion and make mental healthcare more consensual. We consider the epidemiology of coercion in mental health and appraise the efficacy of attempts to reduce coercion. We make specific recommendations to reduce coercive care. Our contention is that this will require more than legislative tinkering and will necessitate a fundamental change in the culture of psychiatry. In particular, clinical practice must always ensure that people's human rights are not compromised.

S27 • DEVELOPMENT OF COMMUNITY MENTAL HEALTH CARE DURING DEINSTITUTIONALIZATION: FROM POLICY TO PEOPLE AND BACK

Short general introduction symposium: *Since 2012 a renewed deinstitutionalization process is initialised in the Netherlands. Four years of national monitoring has shown that the use of psychiatric hospitals and sheltered housing has decreased. However, only a slight increase of intensive community based care could be detected. And no (positive or negative) changes were found in participation and quality of life of people with serious mental illness. We elaborate on different perspectives of good ambulatory care: 1) The Dutch policy in terms of ambitions & outcomes in provision and use of services, and 2) quality of life and service satisfaction of people with serious mental illnesses (using panel data of 1700 respondents). 3) An ethnographic study of values that are at stake in daily care. The study also includes field work in Trieste (Italy). 4) Finally, priorities in next steps of the development of community care will be discussed.*

1 • POLICY OF DEINSTITUTIONALIZATION AND CARE IN THE COMMUNITY IN THE NETHERLANDS: A NATIONAL MONITORING EVALUATION

A. Knispel[1], L. Hulsbosch[1], A. de Lange[1], H. Michon[1], H. Kroon[1]

[1] *Trimbos Institute Utrecht Netherlands*

Aims: From an international point of view, the Dutch capacity of clinical mental health services has been relatively high. In 2012 a 'national agreement on mental health care' was drafted in the Netherlands which stipulates that outpatient treatment and community care should be the starting point for people with complex needs for mental health care. Part of this agreement was the reduction of clinical capacity by one third by 2020. The Trimbos institute monitors this deinstitutionalisation process since 2013, commissioned by the Ministry of Health, Welfare and Sport. Primary aim of this study is to nationally monitor and analyse the development of the capacity of clinical and residential services on the one hand, and the capacity of community mental health care on the other. In order to get a better understanding of what is happening nationally but also regionally, to increase community mental health care and reduce clinical capacity.

Methods: This study started in 2013 and was widened in 2015. In order to monitor and analyse the capacity of clinical and community mental health services, data on production are gathered from integrated mental health organizations and specialized regional residential care providers annually. National data from health insurers on care use and expenditure are also analysed. Besides quantitative analyses, qualitative studies are done each year to get a better understanding of how all involved parties collaborative regionally and what the promoting and impeding factors are in creating a more community mental health care oriented service-system

Results: Our results show that the capacity of clinical mental health services was reduced between 2012 and 2017 with 19%. The capacity for sheltered housing was also reduced, though not as strong, with 6 %. Although the number of beds for the first year of admission was reduced, the number of people admitted, was stabile until 2016. In 2017 this number also decreased.
According to our analyses, the reduction of beds was primarily accomplished by reducing the number of admissions per person. Analyses also show that, although the number of clinical beds was reduced, the expenditure on clinical mental health care has not. Because the number of beds with persons with very intensive care has increased. Only since 2017 there are national indications that the expenditure on community mental health care is increasing and the out-patient care paths are becoming more intensive. The qualitative studies show that regionally community care for people with severe problems, is being elaborated, in different ways, such as collaborations between specialized mental health teams en municipal social teams and organizing intensive home treatment in order to prevent admission. But fragmentation of financing can be detrimental in accomplishing change.

Conclusions: Although clinical capacity has been reduced, the capacity of community mental health care for people with complex mental health problems has not increased to the same extent. Our qualitative studies show that regionally changes are taking place but impeding factors such as fragmentation of financing are affecting the process.

2 • SOCIAL INCLUSION AND QUALITY OF LIFE IN PEOPLE WITH SEVERE MENTAL ILLNESSES: A PANEL STUDY

L. Hulsbosch[1], H. Michon[1], A. de Lange[1], A. Knispel[1], H. Kroon[1]

[1] *Trimbos Institute Utrecht Netherlands*

Aims: Innovations in community mental health care aim at better social inclusion and quality of life in people with serious mental illness people. However, no national basic figures were available yet in people of this target group regarding these topics. Therefore, a national panel was established to provide a better picture and analyse trends in inclusion and quality of life as part of a national community mental health care monitor. Two more specific objectives in the past year were to gain insight in the relationship between participation and quality of life, and more in-depth understanding of the concept of loneliness.

Methods: Longitudinal panel study of 1700 persons with serious mental illness, with data on service use, quality of life and societal participation e.g. work. Trend analyses were conducted of four yearly panel waves of self-report

measures of several inclusion indicators (e.g. employment, loneliness), and subjective quality of life. An in-depth longitudinal multilevel analysis was conducted to explore associations of occupational participation and quality of life.

Results: Compared to people in general, people with severe mental illnesses participate substantially and significantly less often in paid work (20% against 70% in the general population); express stronger loneliness (40% reports strong loneliness) and a lower quality of life (6.4 average on a 10-point scale where 10 is the highest QoL-score, versus 7.6 for the general population) and sense of belonging.
No significant trends in changes were detected, neither positive nor negative. Percentages of people wishing for a substantial change in societal participation e.g. work, vary from one third to 40%. In-depth longitudinal analysis. 767 respondents (50%) participated in each wave. With all four participation definitions main analyses revealed that 'better' participation levels appeared to be longitudinally significantly positively associated with a higher quality of life (crude B's were respectively .26, .37, .44 & .48). All associations remained significant in the same directions after adding sex, age and Mental Health Inventory score as confounders in all four analyses. Furthermore, in the final part of this presentation, major experienced barriers revealed by the cohort study such as stigmatisation will be discussed.

Conclusions: Compared to people in general, people with severe mental illnesses participate substantially and significantly less often in paid work (20% against 70% in the general population); express stronger loneliness (40% reports strong loneliness) and a lower quality of life (6.4 average on a 10-point scale where 10 is the highest QoL-score, versus 7.6 for the general population) and sense of belonging. No significant trends in changes were detected, neither positive nor negative. Percentages of people wishing for a substantial change in societal participation e.g. work, vary from one third to 40%. In-depth longitudinal analysis. 767 respondents (50%) participated in each wave. With all four participation definitions main analyses revealed that 'better' participation levels appeared to be longitudinally significantly positively associated with a higher quality of life (crude B's were respectively .26, .37, .44 & .48). All associations remained significant in the same directions after adding sex, age and Mental Health Inventory score as confounders in all four analyses. Furthermore, in the final part of this presentation, major experienced barriers revealed by the cohort study such as stigmatisation will be discussed.

3 • 'DOING RELATIONS': A FOCUS ON THE DAILY PRACTICE OF COMMUNITY MENTAL HEALTH CARE

C. Muusse[1], H. Kroon[1], N. Mulder[2], J. Pols[1]

[1] Trimbos Institute Utrecht Netherlands - [2] Erasum University Rotterdam

Aims: In the presentation we want to shift the focus from the 'bricks and mortar' of deinstitutionalization towards the daily practice of care. It is a shift from how 'deinstitutionalization' is organized to how deinstitutionalization is done: what deinstitutionalization entails for the daily practice of care giving, and which ideas & ideals about 'good care' are embedded in these practices. As we understand deinstitutionalization as a broader concept than the organizational change of replacing one form of care (the hospital) by others (community care), working on and with relations is at the heart of this. To further understand and to develop community based care it is of importance to get a thorough understanding of what this relational approach entails in practice. Trieste is an interesting case here, because of the radical form of the process of deinstitutionalization it went through.

Methods: We applied an empirical ethics approach to care. This approach has its focus on how ideas about good care are enacted in daily practice and how people involved deal with the tensions that sometimes arise. The author joined professionals on their daily routines for a period of two months. She attended meetings at a community mental health center (CMHC), went on house visits and interviewed operators, service users and other people involved. Drawing on this ethnographic fieldwork, we explore what the process of deinstitutionalization entails for the practice of care giving.

Results: The analysis of the fieldwork shows that in the mental health care services of Trieste the ideal of deinstitutionalization is translated into a praxis in which creating networks is seen as a key element of providing good care. From this perspective on 'good care' follows a specific task description of mental healthcare: it is less about

reducing the symptoms of a psychiatric disease of an individual, as it is about creating and sustaining networks, and making a place in the community for people with psychiatric problems by engaging in projects to strengthen the link between service users and the local community. These networks and relationships are an ideal and an instrument at the same time: they can function as a 'buffer' in case of a crisis. This emphasis on relationships puts to the foreground that we need to go beyond a conception of care as a binary relation of dependency between an active caregiver and a passive receiver of care, towards a broader concept of a 'care collective' in which different actors and things are involved and interrelated, together making up care practices.

Conclusions: The focus of this study on the daily care practice of deinstitutionalization, shows that in the case of Trieste working with relations and creating networks are key elements. The results from this study can help us to reflect on the proces of deinstitutionalization in the Netherlands.

4 • PRIORITIES AND CHALLENGES IN DEVELOPING COMMUNITY MENTAL HEALTH CARE

H. Kroon[1], A. Knispel[1], H. Michon[1]

[1] *Trimbos Institute Utrecht Netherlands*

Aims: The future of community mental health care in the Netherlands faces controversies and challenges, such as 1) community integration by networks (of services) and/or all-in-one integrated care teams; 2) implementing evidence-based interventions in times of limited resources and job stress; 3) changing the focus from crisis resolution to recovery support. We discuss the current state of community mental health care in the light of these controversies and challenges.

Methods: Synthesis of findings of the Dutch deinstitutionalisation monitor and discussion of implications.

Results: There is a broad consensus about the endpoint of community integration and quality of life of persons with severe mental illnesses, but not about the best way to organize community mental health services to promote this endpoint.

Conclusions: Although the Netherlands is relatively rich in resources, broad dissatisfaction exists about the current state of community mental health care. The current situation calls for innovation, monitoring, and bridging of controversies.

S4 • YOUNG EAOF GROUP - SHAPING MENTAL HEALTH COMMUNITY CARE FOR THE FUTURE ACROSS EUROPE

Short general introduction symposium: *Italy, Germany and the Netherlands are European countries with different historical backgrounds for mental health. Through national and local compared experiences on mental health community care, this symposium opens the chance to reflect about the role that young professionals might have in creating networks among countries in order to learn from each other's experiences.*

1 • DUTCH COMMUNITY MENTAL HEALTH CARE - ORGANIZATION AND RECENT DEVELOPMENTS

S. de Haan[1]

[1] *Specialistisch Centrum Ouderenpsychiatrie Regio Alkmaar Midden en Zuid*

Aims: Description of development of Dutch mental health care since ACT

Methods: Qualitative narration of Dutch community mental health care organization

Results: Since ACT, a flexible ACT model was developed. Recently, recovery-aimed treatment locally led to a different model community mental health care.

Conclusions: The vision of improved care for adults with SMI in a world of changing treatment and care leads to interesting changes in mental health care organization.

2 • CHANGES AND FUTURE VISIONS IN TREATMENT MODELS IN GERMANY – THE HAMBURG PERSPECTIVE

A.C. Rohenkol[1], F. Ruppelt, M. Lambert, A. Bussopulos & IV Team

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Aims: In the recent years there is a shift in the treatment of severe mental illness in Germany to force the ambulant system of care. Thereby the mental health system faces enormous structural, therapeutic, and health economic challenges, enabling innovative models of healthcare with more efficient and effective treatment. In Germany innovative models have not been implemented sufficiently: neither early psychosis services nor assertive community treatment are part of standard care; crisis resolution teams can now be funded by health insurances as defined by a new German law. We will focus on changes and future plans from out the Hamburg perspective.

Methods: Starting in 2007, a newly model of integrated care "the Hamburg model" including need adapted therapeutic ACT the first steps were made towards an outpatient centered health-care model for patients with SMI focusing on affective and non-affective psychosis.

Results: Through the eyes of young professionals, we will discuss the challenges for young colleagues working in an outpatient centered health care model versus a regularly implemented ward. Are there conditions and needs to be considered in the daily work flow and working are to reduce beds? Answers of young professionals regarding the ministry supported way of ambulant care will be discussed.

Conclusions: Through the eyes of young professionals, we will discuss the challenges for young colleagues working in an outpatient centered health care model versus a regularly implemented ward. Are there conditions and needs to be considered in the daily work flow and working are to reduce beds? Answers of young professionals regarding the ministry supported way of ambulant care will be discussed.

3 • THE ITALIAN COMMUNITY-BASED MENTAL HEALTH CARE SINCE DEINSTITUTIONALISATION - THE VERONA EXPERIENCE

A. Martinelli[1], M. Ruggeri[1]

[1] *Section of Psychiatry, Department of Neurosciences, Biomedicine and Movement Sciences, University of Verona*

Aims: To describe the development of Italian community-based service since Law 180 in 1978.

Methods: A qualitative narration of the Italian community care.

Results: Italian regional committees developed different community services, mostly comparable to assertive community treatment and without long-term beds.

Conclusions: The Italian community care is a model for not deinstitutionalised countries but can learn from new experiences of community care.

S22 • IMPLEMENTING ACT/FACT IN NORWAY THROUGH EDUCATION, NETWORKS AND MANUALS

Short general introduction symposium: *Implementing ACT/FACT teams has been ongoing in Norway since 2009. By 2012 14 ACT teams were operative. Supported by Ministry of Health and care services funding, at present 8 ACT teams and 38 FACT teams are established and 16 FACT teams are under establishment. The national educational program has gone through substantial changes in recent years. A national network of team leaders has been operative throughout the entire period. As a result of the growing number of teams, regional networks have been established in cooperation with County governors. As the main external bodies in the development of these teams we will describe three components of the overall commitment to establish such teams.*

1 • REGIONAL NETWORKS AS TOOLS IN THE IMPLEMENTATION PROCESS

G. Strand[1]

[1] *Norwegian Resource Centre for Community Mental Health (NAPHA) Trondheim Trøndelag Norway*

Aims: To present the prosess and scope of regional ACT/FACT networks

Methods: The author has been involved in designing, establishing and running a number of national and regional networks.

Results: At present five regional networks has been established, with differences and similarity of traits and development processes. While some networks primarily have team leaders and/or project leaders (in the early stages of team establishment) participating, in others also leaders from municipalities and specialist health services involved in team development participates. Some regions also arrange yearly seminars for all team members as part of the regional network construction. Staff from the two national resource centers arranging this symposium is also closely linked to the regional networks, and in most instances staff from the relevant County governor participate.

Conclusions: Regional networks are beneficial when implementing ACT/FACT on a national scale.

2 • A NATIONAL EDUCATION PROGRAM FOR ACT/FACT TEAMS

G. Evensen[1], K. Nysveen[1]

[1] *Norwegian Resource Centre for Community Mental Health (NAPHA) Trondheim Trøndelag Norway*

Aims: To present the content and experiences of a national education program for ACT/FACT teams

Methods: The content of the current national education program was developed based on experiences from earlier, more extensive education program for ACT-teams. Each seminar and course is evaluated by the participants, and the results are used to improve consecutive courses and seminars.

Results: The education program has been running since 2015. The course consists of five seminars over two days, spread over two semesters. Each course have from 60-80 participants. Participation is funded through All professions in an ACT/FACT team participate. The prime target groups are professionals both working in new and established teams. The content is a combination of theory, practice and lived experience. There are two-three group sessions in each seminar; composed between teams, within each team and by different roles/specialist functions. The two first seminars focus on the ACT/FACT models; the theory, research and how they work. The three last seminars focus on the different roles within the team and evidence based methods for use in ACT/FACT teams.

Conclusions: The education program has been running since 2015. The course consists of five seminars over two days, spread over two semesters. Each course have from 60-80 participants. Participation is funded through All professions in an ACT/FACT team participate.
The prime target groups are professionals both working in new and established teams. The content is a combination of theory, practice and lived experience. There are two-three group sessions in each seminar; composed between teams, within each team and by different roles/specialist functions. The two first seminars focus on the ACT/FACT models; the theory, research and how they work. The three last seminars focus on the different roles within the team and evidence based methods for use in ACT/FACT teams.

3 • DEVELOPMENT AND USE OF A MANUAL FOR ESTABLISHING ACT/FACT-TEAMS

L. Håvard Bakke[1]

[1] *Norwegian Resource Centre for Community Mental Health (NAPHA) Trondheim Trøndelag Norway*

Aims: To describe the process of developing the content of and current use of a manual for establishing ACT/FACT-teams.

Methods: The authors have been participating in team leader network meetings and in the national education program. The manual is also based on interviewing and corresponding with ACT/FACT team leaders and team members and document analysis.

Results: A manual decribing three core elements when establishing ACT/FACT teams was developed; 1. What are the ACT/FACT models - described through 19 subtopics, 2. How do ACT/FACT teams work in practice - described

though 18 subtopics and 3. How to adapt the FACT model to rural regions - described through four subtopics.

Conclusions: The manual is widely used by local projects in the early phases of establishing ACT/FACT teams.

S26 • FLEXIBLE ASSERTIVE COMMUNITY TREATMENT IN NORWAY. RESULTS FROM A NATIONAL RESEARCH BASED EVALUATION

Short general introduction symposium: *We will present preliminary results from the national based evaluation of the seven first FACT-teams in Norway: 1) Study design, research questions, setting, characteristics by the teams, patient characteristics and target group, 2) Results from model fidelity assessments conducted 24 months after the teams started, 3) Results from a longitudinal observational study of patients (outcome measures: functional level, quality of life, hospital admissions), 4) service users' experiences with FACT.*

1 • THE STUDY DESIGN OF THE EVALUATION AND THE CHARACTERISTICS OF THE TEAMS AND THE PATIENTS

H. Clausen[1], S. Odden[1], E. Kvam[1], A. Landheim[1]

[1] *Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust Ottestad Innlandet Norway*

Aims: To present the study design for the research based evaluation with the research questions for the different parts of the evaluation. To present the characteristics of the teams and their settings and the teams' target groups and the characteristics of the patients.

Methods: Different methods were used in the Norwegian evaluation of the FACT model; longitudinal observational study of patients, fidelity measurement of the teams, focus group interviews with team members and partners of the teams and individual interviews with service users.

Results: Results regarding characteristics of the FACT teams and characteristics of the patients will be presented.

Conclusions: There were differences between the teams in the characteristics of their setting, organization and target group.

2 • MODEL FIDELITY OF FLEXIBLE ASSERTIVE COMMUNITY TREATMENT TEAMS IN NORWAY

S. Odden[1], A. Landheim[1], H. Clausen[1], E. Kvam[1]

[1] *Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust Ottestad Innlandet Norway*

Aims: To investigate to what extent the FACT teams in the Norwegian evaluation had implemented the FACT model.

Methods: The Dutch FLEXIBLE ACT scale, FACTs 2010 (www.ccaf.nl) was used to assess the model fidelity for the seven FACT teams participating in the evaluation.

Results: Results from the fidelity assessments will be presented for the main-categories of the fidelity scale and differences between the teams.

Conclusions: Results from the fidelity assessments will be presented for the main-categories of the fidelity scale and differences between the teams.

3 • RESULTS FROM A LONGITUDINAL OBSERVATIONAL STUDY OF PATIENTS

A. Landheim[1], S. Odden, E. Kvam[1], H. Clausen[1]

[1] *Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust Ottestad Innlandet Norway*

Aims: To present preliminary results from a longitudinal observational study of patients who were included the first

year of enrolment in seven FACT teams

Methods: Patients were assessed by using clinical-rated and self- reported questionnaires. Main outcome measures were: functional level (Global assessment of Functioning/GAF S, Practical and Social Functioning Scale(PSF), Health of the Nation Outcome Scale (HONOS), Quality of Life (MANSA) and hospital admissions two years before and after enrollment to the team.

Results: Preliminary results will be presented.

Conclusions: Results will be discussed and compared with results from the Norwegian research on ACT.

4 • EXPLORING USER EXPERIENCES WITH FACT: RESULTS FROM A NORWEGIAN INTERVIEW STUDY

E. Adams Kvam[1], S. Odden[1], H. Clausen[1], A. Landheim[1]

[1] *Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust Ottestad Innlandet Norway*

Aims: To present preliminary results from an interview study with users enrolled in FACT for two years or more.

Methods: Co-researchers were involved in developing and carrying out interviews including open-ended as well as closed questions. Besides Client Satisfaction Questionnaire (CSQ), topics covered included experienced collaboration between user and team, medication practices and assertiveness.

Results: Preliminary results will be presented.

Conclusions: Similarities and differences between closed and open-ended questions as well as implications of the results will be discussed.

S5 • FIRST RESULTS ON THE EVALUATION OF CROSS-SECTORAL AND PATIENT-CENTERED TREATMENT MODELS IN GERMANY

Short general introduction symposium: *Cross-sectoral and patient-centered treatment models in psychiatry have been tested internationally and in Germany. A specific form of such treatment models follows a capitation budget, i.e. a total per patient budget of inpatient and outpatient care in psychiatric clinics. Providers are able to choose the treatment form and adapt the treatment to the needs of the patients. Several studies have been started in Germany to investigate the effects, costs and efficiency of such flexible and integrative treatment (FIT) model projects. A nationwide evaluation of 18 of 21 FIT projects has been started in 2015 using data from a consortium of more than 70 statutory health insurance funds (EVA64). In a health insurance data-based controlled cohort study data on inpatient and outpatient care, pharmaceutical and non-pharmaceutical treatments and sick leave have been analyzed for a period of seven years. In addition, a prospective, controlled multi-center observation study (PsychCare) funded by the German Innovationsfonds uses a broad methodological approach combining patient reported outcomes (PROs) with routine health insurance claims data. The process of model implementation is studied using qualitative methods. Both studies will yield important new evidence using the advantages of different data sources. If the model projects are deemed effective, they can be the basis for a restructuring in routine care for mentally ill patients in Germany. The study designs of EVA64 and PsychCare were presented at the last EAOF congress in 2017. In 2019, first results will be presented and discussed.*

1 • CROSS-SECTORAL AND PATIENT-CENTERED TREATMENT MODELS IN GERMANY – BACKGROUND

H-J. Salize[1]

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Due to the so-called fragmentation of the German health care system with rigid interfaces between the sectors and splitting of financing, the development of new cross-sectoral health care models has been the focus of discourse for more than ten years.

In the current development of legislation, the new law §64 b of the fifth German Social Code Book (SGB V) has set the course for establishing flexible and integrated mental health care models (FIT64b) in Germany to overcome this fragmentation. FIT 64b services are offered by hospital-based teams in contract with statutory health insurance (SHI) funds to overcome sector boundaries between in- and outpatient treatment within the hospital service provision. This constellation also offers the opportunity to provide complex psychiatric treatments including home treatment. The reimbursement of hospital services in the form of a capitation model enables a decoupling from the setting.
Currently, 21 individual model projects for networking inpatient and clinical outpatient care are being implemented in 9 federal states.
Evaluations of individual model projects are available and an overarching parallel group study based on claims based data (EVA64) has been initiated. Though, there is a lack of model-spanning and patient-centred surveys to evaluate demand-oriented and setting-spanning care and the use of available care resources in comparison to standard care. Against the background of steadily rising health expenditure, the cost-efficient use of existing resources plays an important role in addition to improving the quality of treatment.

2 • FIRST RESULTS ON EFFECTS, COSTS AND COST-EFFECTIVENESS OF A HEALTH INSURANCE DATA-BASED CONTROLLED COHORT STUDY (EVA64)

A. Neumann[1], F. Baum[1], O. Schoffer[1], R. Kliemt[2], S. March[3], D. Häckl[2], E. Swart[3], A. Pfennig[4], J. Schmitt[1]

[1]Center of Evidence-based Health Care, Medizinische Fakultät Carl Gustav Carus, University Hospital Carl Gustav Carus, Technische Universität Dresden, Germany - [2] WIG2 - Scientific Institute for Health Economics and Healthcare Science, Leipzig, Germany - 3 Institute of Social Medicine and Health Economics (ISMHE), Magdeburg, Germany - [4] Clinic for Child and Adolescent Psychiatry, University Hospital Carl Gustav Carus at the TU Dresden, GermanyIntroduction: From 2015 to 2025, the evaluation EVA64 will investigate 18 flexible and integrative treatment models (FIT64b) established in Germany between 2013 and 2017 for the care of mentally ill patients.

Aims and objectives: To evaluate the effectiveness, costs and efficiency of 18 FIT64b models.

Methods: We use a health claims data based controlled cohort study using data from more than 70 statutory health insurance (SHI) funds for a period of 7 years. We compare all patients insured by any of the participating SHI funds and treated in one of the FIT64b hospitals with patients in routine care using a difference-in-difference approach. We analyze sick leave and utilization of inpatient care as primary outcomes, as well as utilization of outpatient care, continuity of contacts in (psychiatric) care, physician and hospital hopping, re-admission rate, comorbidity, mortality, disease progression, and guideline adherence as secondary outcomes. We further estimate cost and effectivity of FIT64b treatment. We compare all results between patients in FIT64b hospitals and routine care. We conducted all analyses separately for hospital-new and hospital-known patients. During the EAOF conference 2019, we will present first results of a 3-year follow-up.

Results: First interim reports with a three-year follow-up are available. Their results point to a lower increase of fully inpatient days among hospital-new patients in FIT64b hospitals compared to the increase among patients in routine care within the first year after study inclusion. However, in the following two years the number of inpatient days among patients in FIT64b models decreased in both group to a comparable level. The number of fully inpatient days among hospital-known patients was lower among FIT64b patients compared to routine care in all three follow-up years.

Conclusions: The evaluation will yield important new evidence to guide the future provision of routine care for mentally ill patients in Germany and possibly beyond.

3 • FIRST EXPERIENCE IN THE PROSPECTIVE, CONTROLLED MULTI-CENTER OBSERVATION STUDY (PSYCHCARE)

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Objectives: "PsychCare" follows the approach of combining quantitative and qualitative primary data with routine health insurance data for the evaluation of flexible and integrative psychiatric care models (FIT64b). The effects, costs and cost-effectiveness of §64b SGB V model projects from the perspectives of patients, relatives and care providers are to be compared with routine care.

Methods: A controlled prospective multicenter cohort study is conducted with three data collection points (baseline assessment, follow-up after 9 and after 15 months). A total of 18 clinics (10 FIT64b model clinics and 8 matched control clinics) have consecutively recruited in- and outpatients with addiction, affective or schizophrenia spectrum disorders, children with behavioral disorders and adolescents/young adults with eating disorders. Primary endpoints are differences in change of health-related quality of life and treatment satisfaction. Sociodemographic and service receipt data of the primary data collection are linked with routine health insurance data. Furthermore, a cost-effectiveness analysis, a process evaluation by means of qualitative surveys and an identification of quality indicators takes place.
Results: First experiences from the recruitment beginning in 2018 and data handling as well as first results of the quantitative primary data collection at baseline will be presented.

Discussion and practical implications: The results based on data from different methodological approaches will provide essential conclusions for the optimization of mental health care. This should result in potential re-structuring of care strongly aligned to patient needs and identification of elements of integrated and continuous care that can be efficiently implemented into routine care in Germany.

4 • WHAT ROLE DOES THE CROSS-SECTORAL HOSPITAL BUDGET PLAY? – RESULTS OF TWO PROCESS AND OUTCOME EVALUATION STUDIES

J. Schwarz[1]

[1] *Immanuel Klinik Rüdersdorf, Brandenburg Medical School Theodor Fontane (MHB), Germany*

Background: Evaluation of flexible and integrative treatment (FIT) models in Germany according to §64b SGB V.

Objectives: The multi-centre and mixed method evaluative studies EvaMod64b (2015-2017) and its successor PsychCare (2017-2020) aimed to assess the implementation of flexible and integrative treatment models according to §64b Book V German Social Law in several German mental health hospitals.

Methods: Processes and effects of FIT projects from a patient and a staff-oriented point of view were assessed using quantitative (routine clinic data, standardized surveys) and qualitative methods in 13 German-wide mental health departments. In order to assess the implementation of treatment models, FIT specific components and FIT-related EEG-PREMS (= Experiential Expert Generated – Patient Reportes Experience Measures) were developed, using Grounded Theory Methodology. These components were integrated into a sum FIT score.

Results: The projects differed widely. 11 operationalized and quantifiable specific components could be identified, describing the specific structures and processes of FIT models. Further 12 EEG-PREMS were developed. The sum FIT score was positively associated with patient's experiences. The cumulated patient's FIT experiences were associated with positive assessment of continuity of care component, length of treatment and grade of implementation of FIT models. Whereas doctors and psychologists showed positive assessments of FIT, the assessment of nurses was rather negative.

Conclusions: The variety of German FIT projects can be described through specific components. Corresponding EEG-PREMS present the users' perspective and articulate their form of knowledge. In addition to their role in describing lived experiences with FIT, our EEG-PREMS include generalizable aspects of good psychiatric care.

S8 • TRAUMA, DOMESTIC VIOLENCE AND VICTIMIZATION IN THERAPIST-CLIENT INTERACTION

Short general introduction symposium: *The majority of persons with a psychiatric diagnosis have experienced or are currently experiencing violence or victimization experiences, and many are consequently suffering from trauma. Similarly, therapist are not immune from victimization and trauma. In fact, figures suggest that professionals working in mental health care are more likely to have experienced early childhood traumatization than professionals working in other sectors.*
In this symposium we will address how early childhood trauma and recent victimization impacts professional functioning and well-being of mental health care professionals, as well as the mental health of the clients. Risk profiles of clients will be explored, with a special focus on gender and ethnicity.
Finally, we will present the results of a randomized trial to improve the detection and referral of current domestic violence of clients in mental health care.

1 • A LATENT CLASS ANALYSIS OF PTSD SYMPTOMATOLOGY AND IT'S RELATIONSHIP WITH GENDER AND CURRENT VICTIMIZATION

A.M. Kamperman[1], H. Schlesinger, R. Ruijne, S. Bogaerts, C.L. Mulder

[1] *Erasmus Medical Center, Rotterdam, Netherlands*

Introduction: Prevalence of post-traumatic stress disorder in patient with severe mental illness (SMI) is reported to be higher than in the general population and is associated with several adverse mental health consequences. Despite this, co-morbid PTSD is currently neglected in clinical settings and underresearched. Therefore, the first aim of this study is to determine the prevalence of PTSD in SMI patients. The second is to determine how PTSD symptoms manifest in SMI patients using Latent Class Analysis (LCA).
This statistical analysis has not previously been conducted in an SMI sample. In a previous LCA study in a general population cohort a 3-class solution of symptom severity, providing evidence for partial-PTSD. This study aimed to uncover whether PTSD symptoms manifest similarly in SMI patients. Finally, there is significant research into PTSD risk factors but limited amounts in SMI. Being female, childhood sexual assault and violent assault are consistently reported as being PTSD risk factors. Therefore we will test whether gender, childhood trauma, recent violent assault and their interaction effects are predictors of PTSD class membership.

Methods: 945 out- patients with chronic mental health illnesses completed the Zelfinventarisatielijst ZIL self-report PTSD questionnaire, the Childhood Trauma Questionnaire & Dutch Crime and Victimisation Survey to determine recent assaultive violence. Analysis determined 19% of participants meet the criteria for PTSD. The LCA produced a 3-class system of symptom severity, 50% of the sample were in the Low class, 34% in the Medium & 16% in the High; supporting the idea of partial PTSD. The regression analysis found that childhood sexual and physical assault predicted class membership with victims reporting higher PTSD symptom severity. Furthermore, the interaction effect of recent assault and gender was found to be significant. Therefore, women who had suffered recent assault were suffering from more severe PTSD symptoms.

Results: This data suggests that being female is not an innate PTSD risk factor regardless of trauma, instead that different trauma carry different levels of risk for women and men. Although childhood trauma was found to be a potent risk factor in both genders. This calls for increased acknowledgement, assessment and treatment of PTSD in SMI patients, a reigniting of the concept of partial PTSD, an increased focus on childhood trauma in PTSD theory, diagnosis, and treatment as well as a more proactive approach in reducing the female diagnosis bias.

2 • MIGRATION, TRAUMA AND RECOVERY FROM PSYCHOSIS: PRELIMINARY RESULTS OF THE UP'S COHORT

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Background: Patients who suffer from schizophrenia and other psychotic disorders face cognitive and social adversities which have a negative influence on their quality of life. Immigrants and their descendants are more likely to develop a psychotic disorder than the majority ethnic group. The increased incidence of psychotic disorders

in first-generation and second-generation immigrants is a highly replicated finding. A possible explanation for this phenomenon is that these minority groups experience an increased level of (social) adversities or trauma during their lifetime. This can result in an added vulnerability for developing a psychotic disorder. However, it remains unclear what mechanisms underlie this phenomenon, and research on the effect of this increased vulnerability on measures of recovery from psychosis is very limited. This study therefore aims to clarify the relationship between migration status, adversity, trauma and recovery (personal, functional, social and clinical) from psychotic disorders.

Method: Currently a systematic review is being made on the influence of migration status on recovery (personal, functional, social and clinical) from psychotic disorders. The current study is part of a larger cohort study, UP'S, in which data on four dimensions of recovery and a multitude of determinants are collected annually among patients with a psychotic disorder.

Results/Conclusion: results of the systematic review will be discussed, as well as preliminary results of the UP'S Study.

3 • SCREENING AND DETECTION OF DOMESTIC VIOLENCE IN PSYCHIATRIC PATIENTS: A CLUSTER RANDOMIZED CONTROLLED STUDY

R.E. Ruijne[1], L.M. Howard, K. Trevillion, C. Garofalo, S. Bogaerts, C.L. Mulder, A.M. Kamperman

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Aims: The BRAVE study aims to increase detection of DVA(domestic violence and abuse) in outpatient patients with a severe mental illness.

Methods: We conducted a cluster randomized controlled trial in the Rotterdam Rijnmond and The Hague area of the Netherlands. We included clinical mental health teams (CMH) working with patients with severe mental illness. A group of CMH teams was randomized for the BRAVE intervention which included: a training for mental health professionals on knowledge and skills of DVA , knowledge and skills training on mental illness for DVA practitioners and the provision and implementation of a direct care referral pathway between CMH services and DVA services for victims of DVA with severe mental illness. The control teams gave care as usual. The number of detection of DVA was obtained using key words in an electronic search in the electronic patient files. After this initial search, each patient file was manually assessed by two of the researchers. We used the detection rate of DVA a year before start of the intervention as baseline. Detection rates were compared using Poisson regression.

Results: We included 24 CMH teams. 12 teams were assigned to the intervention group and 12 teams to the control group. There were no significant differences between the intervention and control teams. From the initial electronic search, more than 4000 individual patient records were derived. From those individuals about a 1000 patients were victim or perpetrator of DVA in either the past or the present. These results are preliminary, but will be clear at the time of the symposium.

Conclusions: Results of this study will be analyzed. The conclusions will be given at the symposium.

S33 • SYMPOSIUM: CHALLENGING SITUATIONS IN DIAGNOSTICS AND TREATMENT

Short general introduction symposium: *Assertive Outreach Teams in the University Medical Center Hamburg-Eppendorf offer integrated care including diagnostics and treatment for different kinds of mental illnesses. In this symposium, challenging situations with patients are outlined and options to diagnose and treat these demanding patients are shown in a clinical pragmatic manner. In the first talk, we focus on the diagnostics of patients with schizophrenia and autism-spectrum disorder and discuss special features of the treatment when both diagnoses are present. The second talk will emphasize difficult situations in assertive outreach - when therapists are confronted with aggressive behaviors of patients. We will discuss ways to assess and encounter aggression in patients with severe mental disorders. The last talk will focus on something highly specialized mental health services as well as many low threshold services have been using for many years: emergency telephone services in Crisis Resolution Teams (CRTs).*

1 • SCHIZOPHRENIA AND AUTISM-SPECTRUM-DISORDERS

D. Schöttle[1], H. Krause[1], T. Apitz[1], C. Müller[1]

[1] *Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf (UKE), Hamburg, Germany*

Aims: Autism-Spectrum- and Schizophrenia-Spectrum disorders share many common genetic and clinical features that are increasingly recognized in diagnostics and treatment of both disorders. Furthermore, some individuals diagnosed with Autism-Spectrum-Disorder subsequently develop schizophrenic symptoms. Both disorders co-occur more frequently than would have been expected regarding their life-time prevalences. In this talk, clinical aspects of diagnosing the two disorders are presented and special features to be considered in treatment are discussed.

Methods: An update of current literature on co-occurrence of both disorders is given. Diagnostic assessment of Autism-Spectrum-Disorder in Schizophrenia-Spectrum-Disorders is presented and pitfalls in diagnosing and treatment are discussed.

Results: Both disorders have high rates of co-occurrence and apart from Autism-Spectrum-Disoders being frequently underdiagnosed, because of certain similarities, there is often misdiagnosis when both disorders are present in one patient. The methods of the diagnostic assessment of Autism-Spectrum-Disorders can be applied on patients with Schizophrenia-Spectrum-Disorders and vice versa, but therapists have to be careful not to misinterpret autistic symptoms and being part of a psychotic spectrum. In treatment, psychopharmacological therapy should be applied in lower doses than in “pure” Schizophrenia-Spectrum Disorders due to significantly higher rates of side effects in patients with comorbid Autism-Spectrum-Disorders.

Conclusions: Both disorders co-occur frequently but are often overseen or misdiagnosed. Special consideration should be given to these demanding patients, especially when it comes to psychopharmacological and psychotherapeutic treatment.

2 • AGGRESSIVE + VIOLENT BEHAVIOR:IDEAS HOW TO PREDICT AND HOW TO INTERVENE IN AN OUTPATIENT SETTING

R. Schröter[1], A. Karow[1], M. Lambert[1], D. Lüdecke[1]

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Aims: Aggressive and impulsive behavior is associated with various mental illnesses such as mood disorders, personality disorders and psychotic disorders. These problems present a special clinical challenge in inpatient and outpatient settings. While several guidelines recommend the use of standardized diagnostics and the implementation of instruments to predict violent behavior in patients at risk their use remains rudimentary.
Although these factors might be of special interest for Crisis Resolution Teams (CRTs) there is only little research on the implementation of appropriate measures. The talk will focus on the implementation of risk prediction assessments and a special group therapy concept to cope with aggressive and violent behavior. Furthermore we would like to present several case reports, which demonstrate the possibility to successfully address aggressive and violent behavior in patients treated by a CRT.

Methods: In an ongoing investigation we examined aggressive and violent behavior in more than 400 patients with the Freiburg Aggression Inventory and in cooperation with the Oxrisc Project (OxMIV). Patients with a high risk profile for aggressive behaviors were referred to a special group therapy intervention and evaluated during the course of treatment.

Results: We would like to present first data of an ongoing investigation on aggressive and violent behavior of people with different mental illnesses. Additionally we would like to show first promising results considering a reduction of aggressive and violent behavior in outpatients referred to a special group therapy programme.

Conclusions: We would like to present first data of an ongoing investigation on aggressive and violent behavior

of people with different mental illnesses. Additionally we would like to show first promising results considering a reduction of aggressive and violent behavior in outpatients referred to a special group therapy programme.

3 • LET´S TALK ABOUT... CALLING AND TEXTING IN MENTAL HEALTH CRISES.

D. Lüdecke[1], R. Schröter[1], L. Tlach[1]

[1] *Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf (UKE), Hamburg, Germany*

Aims: Emergency telephone services for people in mental health crises are often used in highly specialized therapeutic teams as well as in lower threshold services such as suicide prevention hotlines all over the world. Little is known about practical implementation of these services and even less is known about how these services actually operate. In this talk we would like to discuss possible implications for emergency telephone services, necessary clinical standards as well as adverse events of these services in a therapeutic context. Moreover we would like to address the therapeutic resource of text messaging.

Methods: We will present current findings on the implementation, guidelines and limits of crisis telephone services in therapeutic contexts. Furthermore we would like to share experiences of the implementation process of a 24 hour-telephone service for people in a mental health crisis regardless of diagnosis in our Crisis Resolution Team (CRT).

Results: There is hardly any research on emergency telephone services in people in mental health crises. Although these services are often promoted by health care professionals and their benefit might seem intuitive, standardized procedures are rare.

Conclusions: Today telephone and text-messaging play major parts of people´s daily life communication. Therefore it seems inevitable to discuss these forms of communication and their impact on people with mental health crises as well as raising the question for necessary standards.

S17 • YOUTH-FRIENDLY MENTAL HEALTH & WELFARE SERVICES

Short general introduction symposium: *Youth-friendly welfare services in Norway. For several years services in Oslo have tried to use knowledge based practices to innovate services. Knowledge based practice involves research, clinical practice and user experience in a context. We started the first FACT-team in Norway and looked for new ways to establish better services for adolescents in District Gamle Oslo. We started Youth Arena (Ung Arena) in collaboration with users and their organizations. Together with the County Governor in Oslo & Viken we also started a project on youth-friendly welfare services and a network for young peer support workers. In this symposium we will present some of our experience and findings.*

1 • YOUTH ARENA - BACKGROUND. A NEW PROMISING COLLABORATIVE MODEL FOR YOUTH BETWEEN 12-25

T.H. Tjelta[1]

[1] *District Gamle Oslo Municipal mental health services – Oslo Norway*

Aims: In 2011 we were introduced to a new collaborative model in Australia: headspace. This is a service model for young people between 12-25. We studied the model and looked at similar models in Denmark (headspace Denmark) and Irland (Jigsaw).

Methods: We joined forces with the user organization Mental Health Norway and a research center. We also joined forces with the user organization Mental Health Youth Norway and tried to get a collaboration with headspace in Australia. headspace Australia had to concentrate on their one expanding commitment so we didn't succeed with that. We looked at headspace in Denmark and Jigsaw in Ireland, but we decided to make our own model. Together with KS we established a team for improvement in a learning network. We also ordered a summary review from the national knowledge center (Kunnskapssenteret).

Results: We decided to develop our own model for youth between 12-25, and started the first Young Arena (Ung Arena) in Norway.

Conclusions: Youth Arena is a promising service model for youth between 12-25 years. Norwegian Ministry of Health and Care services recommends the service model and would like to have more centers established.

2 • YOUTH ARENA (UNG ARENA) IN NORWAY

N. Mahendran Berge[1], M. Sulejmanova[1]

[1] *District Gamle Oslo Municipal mental health services – Oslo Norway*

Aims: Youth Arena (YA) is a free low threshold service for young people in the age group 12 - 25 in need of support and practical help. It is a new model for developing and offer services to young service users (model development project). A Youth Arena Center offers easily available and comprehensive help on young peoples own terms. The main aims of the project are to make it easy for young people to get help they need when they need it, and give the right help to those at risk for substance abuse and mental health problems early on before the problems develop and to increase the cooperation between different welfare services in the municipality of Oslo.

Methods: YA is different from traditional services and we do a lot to adapt the service to local youths wishes and needs. We have developed a set of 8 principles that summarize the core of what YA is all about: These are: 1. User Complicity, 2. Low threshold (it's free, drop in support the same day). 3. Anonymity 4. Young peer support workers. 5. Volunteers working from the local community and organizations). 6. Collocation of different services 7. Seamless transition to specialized health care. 8. Permanent contact person.

Results: In the three year period, the YA-Center has been open 680 youth have got support from the center. We have spread information about mental health and drug abuse in schools, through social media like Snap Chat, Facebook and Instagram. We have good relations with a range of different services aimed at the target group (12 - 25 years). We have also made cooperation agreements with several of them. The University of South Eastern Norway has done qualitative research on the Center for 1,5 years, the number of young peer support workers has increased from 3 to 9 and service user satisfaction was measured at 90 % in 2018.

Conclusions: In the three year period, the YA-Center has been open 680 youth have got support from the center. We have spread information about mental health and drug abuse in schools, through social media like Snap Chat, Facebook and Instagram. We have good relations with a range of different services aimed at the target group (12 - 25 years). We have also made cooperation agreements with several of them.
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3 • THE USE AND SUPPORT FOR YOUTH TO YOUTH PEER SUPPORT WORKERS IN OSLO

T. Mohn-Haugen[1], M. Sulejmanova[1]

[1] *District Gamle Oslo Municipal mental health services – Oslo Norway*

Aims: As a result of the growing number of young peer support workers, the Health Department at the County Governor`s office started a network for the peer supporters to develop their skills, knowledge, and role. The main aim of the network has been to further develop established knowledge and skills relating to being a young peer support worker. The goal has also been to develop a framework for what it means to be a young peer supporter and how this can be an effective way to meet young service users. Further, it has also been an aim to develop an understanding within the services about what positive impact the services using young peer supporters can have on young service users.

Methods: The network meets six times pr. year and consists of about 30 – 40 young peer support workers from seven different projects in Oslo County. During the network-meetings, the peer supporters engage in workshops, conversations and different professionals give lectures on a wide range of topics like ethics, radicalization, worker´s rights, and presentation-technics.

Results: The results show that a network for young peer support workers help them develop both personally and professionally. It also gives authorities, professionals and the City of Oslo a resource when they are developing new services aimed at young service users. The presentation will go in depth on how this has worked and what the results from the network meetings have been.

Conclusions: The network is an important arena for young peer supporters to develop their skills, knowledge, and role as peer supporter workers.

4 • MAPPING WHAT IT MEANS TO DELIVER YOUTH-FRIENDLY WELFARE SERVICES

S.H. Nygård[1], M. Pettersen[1], M. Sulejmanova[1]

[1] *District Gamle Oslo Municipal mental health services – Oslo Norway*

Aims: The County Governor of Oslo & Viken wanted to investigate what it means to deliver welfare services that are youth-friendly.

Methods: The County Governors Health department recruited a team of leaders and peer support workers from welfare services with experience from working with young service users. The team developed a workshop-module together with professional service designers and used the module to interview young service users, professionals working with service users in the age group 12 - 25 and Youth welfare service scientists.
The qualitative data were then analyzed and condensed and published on a website and in a booklet (www.ungdomsvennlig.no) designed by the peer support workers in the project group.

Results: The results show that young service users need services that are flexible, available for free, that they are met with respect and that young people wish for a Hub or Center where many different welfare services are located. The project showed that today´s welfare services in Norway have a long way to go before they can be called Youth-friendly. The project has in a short time got a lot of traction and there have been several projects born out of the original one. There will be several applications for funds to develop more knowledge about Youth-friendly welfare services and the peer support workers have been asked to hold presentations for different Municipalities in Oslo.
Conclusions: The conclusions are that the wishes young service users have for welfare services adapted to their needs don't need to cost a lot in money or new resources, but that the services should be organized differently to more efficiently meet young service users needs.

S28 • FROM FLEXIBLE ASSERTIVE COMMUNITY TREATMENT TO COLLABORATIVE MENTAL HEALTH CARE IN THE COMMUNITY

Short general introduction symposium: *F-ACT is a flexible version of Assertive Community Treatment to deliver care in a changing intensity depending on needs of individuals with severe mental illnesses (Van Veldhuizen, 2007). In 2016 a number of the FACT-teams in the Dutch region of Utrecht moved to locations in neighborhoods and started to work as one network team together with neighborhood based facilities in primary care (GP's) and in the social domain (supported living, social district teams, etc.). This should create better chances on clinical, social and personal recovery of patients.*

1 • FROM FACT TO COLLABORATIVE MENTAL HEALTH CARE IN THE COMMUNITY; THE IMPLEMENTATION PROCESS

L. Beverloo[1]

[1] *Altrecht Utrecht The Netherlands*

Aims: In 2016 a new form of collaborative mental health care in the community for patients with serious mental illnesses was implemented in four neighborhoods in the city of Utrecht (350.000 inhabitants) and surroundings in the Netherlands. This presentation discusses the implementation process.

Methods: The aim of this presentation is to give a description and process evaluation of the implementation of

collaborative mental mealth care in the community and of the factors promoting and impeding implementation.

Results: Treatment is characterized by a close collaboration of a network of psychiatric care, somatic care (i.e. general practitioner, nurse practitioner), supported housing and other facilities, i.e. the police officer, and is provided in the direct neighborhood of the patients

Conclusions: This neighborhood-based collaborative mental health care should not contribute solely to clinical recovery, but also specifically to social and personal recovery.
Working in a mental health network organization enhances a more patient oriented and demand driven care.

2 • FROM FACT TO COLLABORATIVE MENTAL HEALTH CARE IN THE COMMUNITY; QUALITATIVE AND PROCESS EVALUATION

A. van Keijzerswaard[1], A. Kuipers[1], D. van Rijswijk[1], W. Swildens[1]

[1] *Altrecht Utrecht The Netherlands*

Aims: In this presentation the experiences are discussed of both mental health care workers and of patients with serious mental illnesses themselves with this new form of neighborhood-based collaborative mental health care. More specific the question is studied if and how collaborative neighborhood-based mental health care supports clinical, personal and social recovery.

Methods: The presentation is based on process evaluation and participation research during collaborative case discussions of the network team and qualitative interviews about their experiences with patients, family members and mental health care workers.

Results: The results, a description of the collaborative care methodology offered and experiences of mental health care workers and patients, and conclusions will be presented. Collaborative mental health care in the community leads to new forms of inter collegial consultation and a clearer division of tasks of mental health workers, somatic care workers and rehabilitation specialists. Together they establish a care offer on the broad spectrum of needs for care of patients.

Conclusions: The results, a description of the collaborative care methodology offered and experiences of mental health care workers and patients, and conclusions will be presented. Collaborative mental health care in the community leads to new forms of inter collegial consultation and a clearer division of tasks of mental health workers, somatic care workers and rehabilitation specialists. Together they establish a care offer on the broad spectrum of needs for care of patients.

3 • FROM FACT TO COLLABORATIVE MENTAL HEALTH CARE IN THE COMMUNITY; PATIENT EXPERIENCES AND OUTCOMES

W. Swildens[1], D. van Rijswijk[1], L. Beverloo[1], A. van Keijzerswaard[1], G. Schijven[1]

[1] *Altrecht Utrecht The Netherlands*

Aims: This study describes the outcomes for service users. The main question is whether this collaborative mental health care in the community produces better outcome than regular FACT. Measures include (met and unmet) needs for care, quality of life, clinical, functional and personal recovery, and hospital admission days.

Methods: Data on care utilization regarding the innovation are compared to regular FACT. Qualitative interviews are conducted to gain insight in the experiences of patients, family members and mental health care workers. Changes in outcome measures of patients in pilot areas (N=400) were compared to outcomes of patients (matched on gender and level of functioning) in regular FACT teams in the period 2015-2018 (total N=800).

Results: Data-analyses will take place from January to March 2019. Initial analyses point at a greater feeling of holding and safety for patients in the pilot areas and less hospital admission days.

Conclusions: Preliminary results support the development from FACT to a community based collaborative care service.

S30 • UNITED WE STAND - DIVIDED WE FALL

Short general introduction symposium: A collaborative treatment model for persons with concurrent abuse disorders and mental illness. Description of the model and results from the evaluation of the model.

1 • UNITED WE STAND - DIVIDED WE FALL

B. Grønstøl[1]

[1]*Clinical psychologist, Vestfold Hospital Health Authority, Tønsberg, Norway*

Aims: The model we want to present is a collaborative, out-reaching team consisting of seven co-workers based at the county hospital. The main purpose is to ensure that dual diagnosis patients (hard to reach-patients) are getting proper integrated treatment. The model is suited for treating patients with both severe personality disorders and psychosis disorders.

Methods: The model differs from ACT and FACT in some central aspects as ROP Vestfold does not provide all of the services the patient need. Rather, the model aims to utilize resources already present in the primary and secondary health services and underlines the importance of joint responsibility for different services in the local community in treating persons with dual disorders, through organizing local treatment teams for every patient in the program.

Results: This is an integrated treatment model. The local treatment teams are based on four main organization principles: Availability, continuity, syncronizity and individual treatment plans.

Conclusions: The model offers a better flexibility than ordinary health services in retaining patients in treatment over a long time-span which is deemed necessary to achieve significant improvements in the patients well-being

2 • RESULTS FROM THE EVALUATION: HOW DOES THE TEAM WORK?

S. Odden[1]

[1] *Researcher, the Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Hamar, Norway*

Aims: This study aims to describe the teams typical features in a dayly clinical setting, and to describe the type of activities both in the individual follow up of patients, but also the role of interactions with other service providers, from other specialized health services as well as community bases services.

Methods: The team (seven co-workers) was assessed with the same tools previusly used in assesment of ACT-teams in Norway. Assessments of staff contact with patients was registered in a “weekly contact form” over a two-years period. For each contact the staff member entered: Patient ID number, tem members involved, content of the contact, other service providers taking part, location, time spent and travel time.

Results: The results indicate that the team was heavily involved in both coordination of others help services and in the individual treatment of every patient. The results further shows that - although a main part of the treatment was conducted by the team members alone - that other service providers were active participants in the day-to-day treatment of the patients.

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3 • RESULTS FROM THE EVALUATION: PATIENT OUTCOMES TWO YEARS AFTER ENROLLMENT INTO THE TEAM

A. Landheim[1]

[1]*Head of research, the Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Hamar, Norway*

Aims: The objective of the study was to assess the outcome of two year follow-up of patients. Outcome measures was: Housing and main source of income, psychiatric symtoms, functional level, use of substances, quality of life and hospital admissions in mental health services.

Methods: The patients were assessed at the time of inclucion and after to years of follow-up. Patient assesment included: Life situation form, BPRS, GAF-S, GAF-F, Audit, Dudit, PSF and Mansa. Data collected from patient records: Admissions to hospitalization in mental health care. Data on admissions and inpatient days two years before and to years after intake by the team.

Results: Better housing situation (12-2 homeless), More with social benefits as main source of income (21%-42%), Decreased problematic use of illegal substances (96%-72%),Lower Dudit score for those scoring above cut-off (33-23), Lower symptom severity as measured by GAF-S (43-51), Improvement in severe anxiety symptoms and tendency towards improvement in depression (BPRS), Tendency towards higher level of functioning on GAF-F (39-45), Improvement in PSF (total score on practical and social functioning, health, cooking, behaviour during dialogue) Significantly higher quality of life in several areas (MANSA/Manchester Short Assessment of Quality of Life):Life as a whole, Everyday activities, Housing, Neighbours, Personal security, Physical health, Mental health, Total score Furthermore, there was a decrease of number of amdmissions to inpatient days in mental healtth services, as well as amount of inpatient days.

Conclusions: Although two years is a small amount of time regarding measures of improvement for this patient group, the results are promising. The tema has established and still maintain contact with people the regular services have not adequately reached.

4 • AN ANCHOR IN NORMALITY

E. Adams Kvam[1]

[1]*Psychologist/researcher, the Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Hamar, Norway*

Aims: The objective of this study was to elaborate on the core psychological concepts of change and recovery by exploring change processes from patients' perspectives. An important motivation was to expand existing knowledge on recovery among those of us who struggle with co-occuring substance use disorders (SUD) and severe mental illness (SMI), a demographic which by exclusion criteria in care systems as well as research traditions is often not given due attention.

Methods: The method chosen was semi-structured interviews with eight users of an outreach treatment team for people struggling with co-occurring SUD and SMI, six of which were subjected to a grounded theory analysis.

Results: The core category, an anchor in normality, describes change-facilitating aspects of interactions with health care and public services, as well as clients' identity work. The results highlight that what users experienced as facilitating recovery in change processes is twofold.
Social inclusion was described as "being offered an anchor in normality", while patients also described "feeling more normal" as idiosyncratic identity processes.

S31 • INTEGRATED MENTAL HEALTH CARE IN THE COMMUNITY: A NEW MODEL IN THE NETHERLANDS, GGZ NHN

Short general introduction symposium: *GGZ Noord-Holland-Noord (GGZ-NHN) developed a new model for integrated mental health care in communities. This model combines the best of the two former 'worlds', intended to offer patients integrated high quality treatment. We call it: FACT like FACT is intended. The implementation of this new model is subject of current research. In our symposium we present the characteristics and the aim of the new model. We talk about the process of implementation; we inform the audience about the evaluation of the process; and we present the results of our research, using the new developed fidelity-scale.*

1 • FOCUS ON RECOVERY IN INTEGRATED MENTAL HEALTH CARE IN THE COMMUNITY

R. Keet[1]

[1] *Director Community Mental Health Service Noord-Holland-Noord Chair of the European Community Mental Health Service providers network (EuCoMS)*

Aims: Recovery is a principle of our reform of the whole mental health service and its stakeholders, emphasizing a service that builds on personal goals and strengths. Recovery is seen as the journey of the client, a unique and individual process. The professional can be seen as a companion on this journey for as short a time as possible but as long as is necessary.

Methods: Based upon the literature and interactive sessions we developed a vision on how the mental health professionals can collaborate with service users and support their recovery.

Results: We summarized the vision on a bookmark with these 10 principles: 1. Support recovery of health, functioning and identity 2. Offer hope 3. Ask ourselves: do we help or do we hinder 4. Focus on what's strong, not on what's wrong 5. Decide with not about the service user 6. Acknowledge that the expertise of the service user 7. Collaborate with our stakeholders 8. Acknowledge the service user's right to take risks 9. Collaborate with the family and network as a resource and partner 10. Share and integrate knowledge and life experience

Conclusions: Recovery has become the grounded vison of our mental health service.

2 • SPECIALISTS TOGETHER IN THE COMMUNITY (SSIW): AIMS OF THE NEW MODEL

A. Miedema[1]

[1] *GGZ Noord-Holland-Noord, Heerhugowaard, The Netherland*

Aims: GGZ NHN developed a new model and program for integrated mental health care in communities. This model combines the best of the two former models of Flexibele Assertive Community Care and mental health care for the common mental health disorders. Our goal is to offer patients integrated high quality treatment.

Methods: We developed a new vision and a program for training and implementation. We started with the training in mai 2017. At the same time we started with so called expert networks for the mental health workers for sharing knowledge.

Results: In the beginning the implementation was more or less a struggle for the mental health teams. Now, two years later, we see positive results: integrated mental health care with a focus on recovery.

Conclusions: In the beginning the implementation was more or less a struggle for the mental health teams. Now, two years later, we see positive results: integrated mental health care with a focus on recovery.

3 • IMPLEMENTATION AND EVALUATION OF SSIW

S. van Rooijen[1], M. van Dijk

[1] *GGZ Noord-Holland-Noord, Heerhugowaard, The Netherland*

Aims: The implementation of this new model is subject of current research. In our presentation we present the characteristics and the aim of the new model. We talk about the process of implementation; we inform the audience about the evaluation of the process; and we present the results of our research, using the new developed fidelity-scale.

Methods: In our research we combine different methods: - a baseline-measurement with the fidelity-scale (spring 2018) and follow up measurement (autum 2019) - a proces evaluation (interviews within GGZ NHN, 2018/2019) - routine outcome measurement (ROM)

Results: We will present the results of our research, with a focus on the baseline-measurement and the proces evaluation. Some findings of the baseline-measurement: - crisis care is rather good developed (like in the FACT-

teams) - it turns out that it is difficult to offer goal oriented mental health care with a focus om recovery

Conclusions: - Implementation and changes take time - it is difficult to integrate different methods in one team, at the same time for clients it is very important - it is important to offer professionals tools and clear guidelines - it is important to support the implementation in the teams.

S29 • COMMUNITY IN THE LEADING ROLE FOR ITS MENTAL HEALTH WHAT NEW ROLES FOR PSYCHIATRIC SERVICES?

Short general introduction symposium: *The relationship of psychiatric services with the community is imbued with ambiguities due to the institutional paradigm where psychiatry and current welfare dwell: i. one tend to mistake Community Psychiatry with decentralized services in the territory ii. decentralized services typically address individual patients, their carers or organizations, as users, not as members of the "community". iii. When the services relate to groups or associations of their catchment area, the former maintain the leadership while the latter are conceived as instrumental and subsidiary; We advocate a shift from an institutional paradigm to a relational and subsidiary one in order to refashions the relationships among society at large, the community and care institutions. Such paradigm conceives mental health as a common good produced by the citizens themselves through interpersonal and community relations. Psychiatric services should support this process with a subsidiary approach. Examples of such approach will be presented in the symposium.*

1 • THE CONTRIBUTION OF COMMUNITY MENTAL HEALTH SERVICES TO THE MORAL CAREER OF THE MENTAL PATIENT

L. Burti[1]

[1] *Professor of Psychiatry, University of Verona*

To assess how extensive is the contribution of today's community mental health services in Italy to the moral career of the mental patient as defined by Erving Goffman In his 1961 book Asylums. The inmates were stripped of their individuality. The institution created a population of inmates reduced to obedience and standardized in their needs that could be managed with few resources.
This study investigates whether the present organization of Italian community-based psychiatric services presents similar detrimental effects The appraisal of the type of organization of community services, current procedures, and guidelines, direct observation of services, the scrutiny of clinical records and case histories are employed.
Though no longer concentrated in a total institution, the asylum, our system of community psychiatry is institutionalized in discrete structural components which belong to different systems: health care, social care, nonprofit. They are linearly connected and arranged in a downward pattern through which the patient, once stumbling into the system because of what Goffman defines 'career contingencies', descends further into his career as a mental patient.
Since additional remedies grafted on existing institutions, such as recovery strategies, cannot be effective in removing the 'intrinsic' components of current psychiatric practices, structural and functional developments of our model of community mental health must be devised.

2 • MENTAL HEALTH AS COMMON GOOD. THE RELATIONAL PARADIGM

E. Guerriero[1], J. Vanzini[2]

[1] *Social Worker, member of the Association: "Self-Help San Giacomo", Verona -* [2] *Mental Health Worker of the Social Cooperative "Self-Help", Verona*

To expose the limits of the current model of community psychiatry, which incorporates many institutional features, and to look for an alternative paradigm. Mental health is a precious common good whose preservation has increasingly been entrusted to medical care. Attention has been focused on the disease and on the centrality of psychiatric diagnosis. The majority of resources has been committed to creating a system that is rigid, standardized,

piecemeal, conditioned by administrative constraints, whose backbone is formed by physical facilities, i.e. psychiatric buildings. The lack of resources has become the alibi for being unable to provide custom and sensible responses. The individual is more and more becoming the object of study and treatment rather than a subject-within-a-relation.
Review of recent international and domestic literature in sociology and social psychiatry, case histories, qualitative research. Current psychiatric culture and practices that are consistent with an institutional paradigm of reference, have been channeled into the one-sidedness of the procedural approach to health and have severely lost touch with a humanistic approach to the suffering person. Such culture and practices have spread through all stakeholders: public and private services, social services, families, volunteers, the same patients.
We need new ethics, culture, and methods, and a new paradigm of reference. Citizens must be central in the promotion of their mental health, and the formal system of services must take on a subsidiary role open to new perspectives in terms of prevention and of wise use of resources

3 • HOUSING: FROM THE RESIDENTIAL CONTINUUM TO THE COMPLEXITY OF LIVING

J. Mannu[1]

[1] *Director of the unit "Residences and Mental Health", Asl Roma 2*

To investigate how housing represents an essential component of the quality of life, especially in the case of mental patients who have always been excluded from dwellings in a normal, social environment. The "ship of fools" is the classical expression of the exclusion of madness from the human consortium and of its seclusion in the asylum. The closure of mental hospitals has not completely phased out the process of institutionalization which still continues in smaller residences disseminated in the territory. We launched a multicenter European project (HERO: "Housing: an educational European road to civil rights) to assess the feasibility of planning alternative residential facilities and of educating staff to support residents' independence and self-determination. The project has been approved, financed and completed. Paths and guidelines have been formulated to help community mental health staff to complement and integrate all stakeholders involved in supporting residents' independent living.
Results show that it is possible to lay the groundwork for the establishment of normal dwelling environments in mental health.

4 • SELF-HELP AS A RELATIONAL AND SUBSIDIARY COMMUNITY

P. Vanzini[1]

[1] *Psychiatrist, Program Coordinator, Self Help Network, Verona*

To assess how a Self-help community, based on relations of mutual subsidiarity, may support members' self-determination and function as a permanent interface with broader society. Verona Self Help initiative was founded in the early 90s to promote the emancipation of members from the risk of chronic dependency form psychiatric services. It incorporated the methodology of psychiatric self-help, based on the principles of self-determination and mutual help in the fields of work, housing, leisure, hospitality, culture, arts, and sports.
An association, and eventually, a social cooperative, were established to provide social identification, corporate citizenship, and to contrast the stigma of mental illness. The social cooperative was instrumental in channeling subsidiarity resources, including financial ones, to support the aims of the program.
The self-help network initiated in the field of Psychiatry, then extended itself to include the broader area of marginalization and/or disability in general, by acknowledging the common element at the base of social exclusion: human frailty in general.
The self-help approach, founded on relations of mutual subsidiarity, is effective in supporting self-determination its members, to offer a place in life to the most disadvantaged people, and to act as a permanent interface with society at large.

Authors Index

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