Background: Preventive measures to decrease aggressive incidents in psychiatric care range from friendly responses to advanced de-escalation techniques. But interventions have not often been systematically evaluated and often have different emphasis. There is also large variation in the outcome measurements used.

A method that has been used in Sweden is an interactive training approach, which aims to establish and maintain calmness and security for patients with cognitive impairments. Experiences from Gothenburg indicate decreased levels of coercive measures after training staff and providing supervision. The in-patient unit where such training and application has been carried out most consistently, won a national award in 2016 for having no coercive measures taken in six months, despite 90 percent of the patients receiving compulsory care.

The intervention is a well defined 3-day-course, with two trainers and twelve participants. The main part of the course is devoted to the role playing of conflict situations with patients, based on the participants’ own experiences and examples. Visual analysis tools are used to make the role plays into learning situations.

Aim: We describe here the study protocol for a planned project that will test the Interactive Training approach in four regional hospitals. In addition, group interviews will be applied to increase understanding of staff experiences, as well as the evaluation of the implementation process.

Methods: Planned sub-studies:

1. Staff’s experience of using interactive methods will be analyzed through focus-groups; four group interviews with 5 people in each group. (Assisting nurses and nurses working full-time, who have been educated in interactive conflict-handling and worked according to the method for at least one year).

2. Intervention study. The staff at the psychiatric departments of four different hospitals will receive training in interactive conflict handling, and after the course, supervision. The purpose is to compare the number of aggressive events before and after the intervention.

The instruments that will be used for measurement of the effect are the Staff Observation Aggression Scale - revised (primary outcome), the Social Dysfunction Aggression Scale and the Clinical Global Impression - Severity Scale.

We will also document the type of care (voluntary or compulsory), the number of psychiatric hospital beds, the number of inpatient patients, the number of staff employed, if the patient was affected by alcohol or illegal drugs and several other variables. Diagnoses will be retrieved from patient records.

3. Evaluation of implementation. The purpose is to analyze the implementation of the intervention at four hospitals. Group interviews will be conducted and the data will be analyzed qualitatively by using Normal Process Theory (NPT) as a framework. NPT is an action research perspective that focuses on what actors actually do and discerns between, implementation, embedding integration as different levels of change.

Results: Data collection for the first sub-study will be completed in June 2018 and results from the second and third are anticipated to be available by March 2019 and December 2019, respectively.

Discussion: Patients with prevailing paranoid symptoms not only lack insight into positive symptoms, but tend to underestimate their negative symptoms such as motivation and apathy. Clinically this can be described by overestimated strengths, overstated expectations, exaggerated hopes, mistakenly overrated beliefs. These phenomena often biases the recovery process and need to be addressed during motivational enhancement therapy. Patients with more difference between the results in AES-C and AES-S are less critical to their conditions and less committed to therapy while being more paranoid in their beliefs. It is also harder to identify problems and targets for these patients as they often see no reasons for treatment at all. Probably with some of these patients indirect methods (metacognitive training) would be preferable rather than psychoeducation-based approaches when choosing psychological therapies. Interestingly no relationship of insight and social cognition was revealed. That needs further investigation as motivation is often considered to be a mediator for neurocognitive and social cognitive functions while there is still little works on the role of insight in relation to social cognition.

T247. INSIGHT INTO NEGATIVE SYMPTOMS AS AN IMPORTANT TARGET FOR PSYCHOSOCIAL REHABILITATION IN RELATION TO CLINICAL CHARACTERISTICS

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Background: Apathy and amotivation are considered as the core features of negative symptoms in patients with schizophrenia spectrum disorders. It’s well known that schizophrenia patients often lack insight into their symptoms. Insight bias affects self-representation, social functioning and social outcomes, reduces effects of psychosocial treatment and rehabilitation.

Objective: To research key aspects of insight into apathy depending on diagnostic categories in patients with schizophrenia spectrum disorders.

The aim of the study was to analyze correlations of insight into apathy/amotivation with clinical symptoms, compliance with treatment and social cognition.

Methods: 103 patients with schizophrenia and schizophrenia spectrum disorders were recruited to participate in the study. Only patients in stabilized state that met criteria of PANSS total score ≤ 80 points were included. Demographic data was collected along with the clinical description on prevailing symptoms during acute phase. Discrepancy score for Apathy Evaluation Scale clinical (AES-C) and self-rated (AES-S) versions was used to assess insight into amotivation syndrome. Hinting Task, Ekman-60 and RAD-15 were used to assess social cognition and BACS was used for neurocognition.

Results: Overall, moderate positive correlations between AES-C and PANSS amotivation subscale N2 and N4 items, N6 item with total PANSS negative subscale were revealed. No significant correlations with G16 item were registered. AES-C/AES-S discrepancy ratio also modestly correlated with paranoid schizophrenia (r=0.29) and prevailing delusional symptoms during acute phase (r=0.33) of manifest psychoses, age of onset (r=0.28) and inpatient only treatment intake (r=0.27). It was negatively correlated with number of hospital admissions (r=0.43). It is worth noting that we found no correlation between AES discrepancy ratio and social cognition and neurocognition.

Discussion: Patients with prevailing paranoid symptoms not only lack insight into positive symptoms, but tend to underestimate their negative symptoms such as motivation and apathy. Clinically this can be described by overestimated strengths, overstated expectations, exaggerated hopes, mistakenly overrated beliefs. These phenomena often biases the recovery process and need to be addressed during motivational enhancement therapy. Patients with more difference between the results in AES-C and AES-S are less critical to their conditions and less committed to therapy while being more paranoid in their beliefs. It is also harder to identify problems and targets for these patients as they often see no reasons for treatment at all. Probably with some of these patients indirect methods (metacognitive training) would be preferable rather than psychoeducation-based approaches when choosing psychological therapies. Interestingly no relationship of insight and social cognition was revealed. That needs further investigation as motivation is often considered to be a mediator for neurocognitive and social cognitive functions while there is still little works on the role of insight in relation to social cognition.

T248. PSYCHOPATHOLOGY IN F2X.X-UNAFFECTED CO-TWINS AS A VULNERABILITY INDICATOR OF PSYCHOSIS

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Background: The psychosis vulnerability hypothesis states that a genetic component is present and that the environment may contribute to the expression of psychosis. The risk of psychosis is increased in relatives of patients with psychosis. It is therefore important to investigate the expression of psychopathology in unaffected co-twins.

Objective: The aim of this study is to investigate the psychopathology in unaffected co-twins of patients with first-episode psychosis.

Methods: A questionnaire was distributed to all patients referred to the Kopenhagen 2011-2018 screening team. Patients referred to the screening team are considered to have a psychosis vulnerability. The questionnaire included questions about psychiatric symptoms, medication, family history, and demographic data. The psychopathology was measured using the Structured Clinical Interview for DSM-IV TR axis 1 (SCID-I) and the Structured Clinical Interview for DSM-IV TR axis 2 (SCID-II). The SCID-I and SCID-II were used to assess the presence of psychiatric symptoms and comorbidities.

Results: A total of 101 patients were included in the study. The mean age of the patients was 23.4 years (SD=5.6). The majority of the patients were men (67%). The most common psychiatric symptoms were anxiety (39%), depression (38%), and schizophrenia spectrum disorders (34%). The most common comorbidities were bipolar disorder (38%) and anxiety (39%). The prevalence of psychiatric symptoms and comorbidities in the unaffected co-twins was significantly higher than in the general population.

Discussion: The results of this study indicate that unaffected co-twins of patients with first-episode psychosis are at high risk of developing psychiatric symptoms and comorbidities. This suggests that the psychosis vulnerability hypothesis is supported by these findings.

Abstracts for the Sixth Biennial SIRS Conference
T249. THE ROYAL AUSTRALIAN AND NEW ZEALAND CLINICAL PRACTICE GUIDELINES FOR SCHIZOPHRENIA AND RELATED DISORDERS (2016) – A STEP TOWARDS BETTER CARE?

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Background: Clinical Practice Guidelines are developed to improve clinical standards, encourage use of evidence-based treatments, and provide a foundation for audits, service evaluation, and research. This presentation by the expert writing group responsible for the updated RANZCP Clinical Practice Guidelines for Schizophrenia and Related Disorders describes the process, the challenges and the barriers in writing these new clinical guidelines. Once published, dissemination, discussion and utilisation of new clinical practice guidelines is crucial.

Methods: The RANZCP Clinical Practice Guidelines (CPG) for Schizophrenia and Related Disorders were developed using the existing RANZCP and international guidelines, research evidence, and in the absence of clear evidence, expert consensus. The NHMRC levels of evidence for intervention studies were used as a benchmark for each recommendation. A clinical staging model was proposed. There was an increased emphasis on physical health comorbidities, psychological treatments, and vocational recovery. The draft document was subjected to extensive review and revision involving independent psychiatrists, other clinicians and stakeholders, consumer groups, RANZCP committees and reviewers for the ANZJP. The Guidelines are available for open access on the RANZCP website at https://www.ranzcp.org/Publications/Guidelines-and-resources-for-practice.aspx.

Results: The Guidelines have been widely cited. The RANZCP has developed a Consumer Guide and Clinical Audit Tools based on the CPG recommendations. The recommendations made in the guidelines have resulted in some controversy – most notably about the use of depot antipsychotics, and antipsychotic medication discontinuation after recovery from first episode psychosis. As with most CPGs, there is no mechanism for ongoing updating of treatment recommendations in response to new evidence, so regular revisions of CPGs will be needed.

Discussion: The Guidelines provide a comprehensive summary of the evidence for interventions to treat schizophrenia and related disorders, set out a recommended standard of care to be adopted by clinicians in Australia and New Zealand, and create a benchmark against which individual practice and services can be compared. The debate generated by the publication of the guidelines has highlighted the gap between the recommended standard of care and existing practice, especially as it relates to the physical care and psycho-social interventions offered to people with these conditions.