

cognitive training and/or adjunctive rehabilitation were excluded. A box-score analysis of predictor variables was conducted and the quality of the predictor evidence was assessed.

**Results:** Of 417 records extracted, 37 articles considering 1,499 overlapping CRT participants (2,423 full sample) were included in the final synthesis. On average, participants were in their mid-thirties, majority male, with approximately 12 years education. CRT trial arm size averaged 41.64 participants. Overall, 72 distinct predictors of cognitive response were identified, with an average 4.89 predictor variables considered across an average 3.95 cognitive domains per article. Of these, 42 were analysed once and 10 twice. Discussion focused on the 20 predictors examined a minimum 3 times. Highlighting the exploratory nature of predictor research to-date, few studies were theory driven or evidence based and fewer still were undertaken with a priori hypotheses. Only a handful of analyses included tests of interaction.

**Discussion:** Few of the currently examined predictors of cognitive response to CRT are significant when examined as a systematic review. The influence of age was the most frequently examined predictor, with a majority of articles finding no association. The strongest category level trend was found in baseline cognition, especially in reasoning and problem solving and working memory domains, which was more strongly predictive of within domain improvement. Training task improvement or "learning potential" was the most notable cross-domain predictor of cognitive outcome, though this was limited to three articles and warrants further investigation. It remains unclear why up to 60% of participants do not receive benefit from CRT. There is a need to look beyond the usual candidates, to pool data both to support methodologically robust, large-scale investigations and to better account for cross-population variability.

## S209. PATIENT EXPERIENCES OF THE EARLY SIGNS ACTION PLAN

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**Background:** Coercive psychiatric care in Sweden has been criticized by the UN and alternative therapies are called for upon from Swedish politicians. The Early Signs Action Plan was developed to reduce force and promote cooperation between patients and their healthcare providers.

**Aim:** Describe the patients' experience of care when the Early Signs Action Plan is activated in connection with an exacerbation of psychotic illness.

**Methods:** Qualitative research study. Semi-structured interviews (anticipated N=10) will be conducted with patients for whom Early Signs Action Plans were activated. Interviews are recorded and transcribed verbatim. Content analysis is used to analyze the data.

**Results:** Preliminary results from the first five interviews suggest that the action plan facilitates shared decision making and encourages safety measures, and compulsory inpatient care can thus be avoided. The results from the entire study will be presented at the Conference.

**Discussion:** Preliminary findings suggest that the Early Signs Action Plan seemed to be a useful tool to improve patient participation and reduce the need for compulsory inpatient care when exacerbations occur.

## S210. MULTIDISCIPLINARY LIFESTYLE-ENHANCING TREATMENT FOR INPATIENTS WITH SEVERE MENTAL ILLNESS (MULTI-STUDY): EFFECTS ON PHYSICAL HEALTH, PSYCHOTIC SYMPTOMS, QUALITY OF LIFE AND FUNCTIONING

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**Background:** Patients with severe mental illness (SMI) are characterized by an unhealthy lifestyle, which contributes to the widening mortality gap with the general population [1] Changing high levels of sedentary behaviour (SB) and lack of physical activity (PA) is very challenging [2–4].

Effective interventions improving lifestyle in inpatients are still limited, while of all patients with SMI, the hospitalized do have the worst health status.

We implemented a MULTidisciplinary Lifestyle Enhancing Treatment for Inpatients with SMI (MULTI), mainly including a daily structure, tailored sports- and work-related activities, attention to dietary habits, psycho-education and participation of staff. It involved a culture change which was implemented based on a 'change-from-within'-principle, using multidisciplinary\* cooperation within the current context and resources of inpatient mental healthcare.

\* Psychiatrists, activity coordinators, nurse practitioners, dietician and nurses, some of them trained as lifestyle coach.

**Aim:** Evaluate changes in physical and mental health and functioning after 18 months compared to treatment as usual (TAU).

**Methods:** Observational controlled design including long-term hospitalised inpatients with SMI. We used data from routine screening and a previous cross-sectional study (2013), supplemented by a repeated accelerometer measurement (2015). Patients were included if they received no other intervention related to lifestyle within 18 months after the start of MULTI and if baseline accelerometer data was available. Patients were excluded from analysis if they had a lack of data after 18 months because they (1) were deceased, (2) moved or were discharged from the hospital or (3) had insufficient follow-up accelerometer data.

**Measures:**

Accelerometer-measured physical activity (PA) [ActiGraph GT3X+]  
Metabolic health [weight, abdominal girth, blood-pressure and -levels and metabolic syndrome criteria]

Psychotic symptoms [PANSS-r]

Quality of life (QoL) [EQ-5D & WHOQoL-Bref]

Psychosocial functioning [HoNOS]

**Analysis:** hierarchical multilevel regression using change-scores, correcting for baseline outcome-value, age, diagnosis and baseline illness-severity.

**Results:** We had sufficient data of 65 patients receiving MULTI and 49 within TAU.

Significant ( $p < 0.05$ ) improvements in total PA ( $B = 0.5$ ), moderate-to-vigorous PA ( $B = 1.8\%$ ), weight ( $B = -4.2\text{kg}$ ), abdominal girth ( $B = -3.5\text{cm}$ ), systolic blood-pressure ( $B = -8.0\text{mmHg}$ ), HDL-cholesterol ( $B = 0.1\text{mmol/l}$ ) and psychosocial functioning on sums score ( $B = -3.6$ ), impairment ( $B = -0.7$ ) and social problems ( $B = -3.0$ ). No improvements were observed in PA/metabolic health within TAU. Patients receiving MULTI had higher odds to recover from  $\geq 1$  metabolic syndrome criterion ( $OR = 2.06$ ). There was no significant effect on psychotic symptoms. QoL improved significantly in both groups.

**Discussion:** Striking results for clinical practice, as much effort and attempts on lifestyle within inpatients with SMI failed to achieve desired improvements, especially in longer term.

A turnaround in inpatient mental healthcare: the negative trend of deterioration within these patients can be stopped, relevant parameters can even be positively reversed and negative effects are absent.

TAU does not improve physical health A sustainable solution towards a healthier lifestyle in inpatients with SMI at our fingertips, as MULTI was implemented using current context and resources.

## S211. SCHIZOTYPY IN PATIENTS FROM A CLINICAL HIGH RISK SERVICE: TRAIT OR STATE?

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**Background:** Schizotypy is considered to assess psychosis-proneness in terms of a rather stable (personality) trait. For the psychometric assessment of schizotypal traits, the Wisconsin Schizotypy Scales (WSS) are widely used. They consist of four subscales, Physical Anhedonia, Social Anhedonia, Perceptual Aberration and Magical Ideation. The latter 2 positive scales were reported to load on the same factor as delusion- and perception-related attenuated positive symptoms that are used to define a clinical high risk (CHR) state. Results from non-clinical samples showed relatively good invariance of the WSS across time. Yet, it is unknown, if a CHR state influences report on WSS and if the stability of schizotypy measures is equally good in a clinical sample.

**Methods:** This was examined in naturalistic follow-up data of an early detection of psychosis service in Switzerland (N=30 at the time of writing). At baseline (t0), the mean age of the sample was 19 ± 5 years and 45% were male and the mean follow-up duration was 16 ± 10 months (range 5–42 months).

**Results:** Analyses indicated a change in risk status at first follow-up (t1) in 59% (42% decrease, 17% increase of risk), yet Friedman tests revealed no significant differences in WSS mean sum scores for each subscale between t0 and t1: Physical Anhedonia 16.74 vs. 15.23 ( $\chi^2(1)=2.133$ ,  $p=.144$ ), Social Anhedonia 13.81 vs. 12.61 ( $\chi^2(1)=3.0$ ,  $p=.083$ ), Perceptual Aberration 5.81 vs. 5.19 ( $\chi^2(1)=2.286$ ,  $p=.131$ ), Magical Ideation 6.48 vs. 6.19 ( $\chi^2(1)=0$ ,  $p=1.0$ ).

**Discussion:** These preliminary results indicate that, even in the presence of significant changes in CHR symptomatology, schizotypy scores seem to be relatively stable over time and therefore strengthen the assumption of schizotypy as a trait marker.

## S212. CONVERSING WITH PEOPLE WITH THOUGHT DISORDER

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**Background:** Thought disorder is a common symptom in psychotic disorders such as schizophrenia. In the research and training literature, thought disorder is assumed to prevent any useful conversation (Galletly & Crichton, 2011). It is depicted as something to be sampled and analysed, rather than as a factor that modifies, but does not prevent, meaningful communication. Psychiatrists routinely interact with their thought disordered patients as part of day-to-day clinical care. The study investigates the skills and strategies used by psychiatrists in clinical interviews with patients with thought disorder. The importance of this study is that identification and detailed description of these specific interview techniques will enable them to be used in the training of psychiatrists and other mental health clinicians.

**Methods:** Twenty-four routine interviews between inpatients with thought disorder and their treating psychiatrists were recorded and transcribed. All participants gave written informed consent and this study was approved by the institutional ethics committees.

The transcripts were examined by the research team (an applied linguist, two psychiatrists and mental health social worker). Excerpts were subsequently presented at two workshops, attended by psychiatrists, trainee psychiatrists and junior medical staff. Participants were asked to identify and describe the techniques used by the psychiatrists in the course of their interviews with thought disordered patients.

**Results:** The interviews were generally quite brief (mean duration 19.24 (SD 7) minutes), and had many characteristics in common. The tone was

conversational, with a normal turn-taking structure, few repairs and an easy flow despite the often-disjointed content. The psychiatrists were not confrontational or judgemental. During the first half of the interview, there was often a period of delusional, thought disordered discourse, in which psychiatrists engaged through close attention to the patient's language, navigating this while commenting and sometimes asking questions. The purpose seemed to be to build rapport by ensuring the patient felt they had been listened to, and this period of relatively uninterrupted speech provided the psychiatrist with the opportunity to assess the patient's mental state. Rather than comment on the content, psychiatrists often engaged with the feelings (e.g. 'stressed') that arose in response to the psychotic experiences described by patients.

It was clear that both parties contributed to the agenda for the conversation. The patients were active participants, often with specific questions or concerns, and these were answered carefully and respectfully regardless of content. Psychiatrists observed that they were also powerless about some matters of particular concern to patients (e.g. the no-smoking policy). Discharge planning was a substantial component of the interviews, as patients wished to leave hospital as soon as possible, and psychiatrists have institutional pressures to reduce the length of stay. The psychiatrists generally assessed insight, but did not undertake formal risk assessments. They provided explanations of the patient's legal status, current treatments, and planned treatments (such as ECT).

**Discussion:** Thought disorder does not exist in isolation, as a phenomenon to be sampled; rather it modifies but does not prevent meaningful conversation and exchange of ideas and information. Experienced psychiatrists are able to undertake meaningful, useful interviews with people with thought disorder. The skills involved have not been described previously. These findings can be used to develop training resources for mental health clinicians who will be working with people with psychotic disorders.

## S213. CAN PATIENTS WITH TREATMENT RESISTANT SCHIZOPHRENIA RELIABLY REPORT NEGATIVE SYMPTOMS? A PILOT STUDY USING THE SELF-EVALUATION OF NEGATIVE SYMPTOMS SCALE

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**Background:** The Self-Evaluation of Negative Symptoms (SNS), a 20-item self-rating scale, was developed to assess the subjective experience of negative symptoms by schizophrenia patients. The reliability and validity of the translated French version of the SNS was examined in a sample of outpatients in an US site with schizophrenia and schizoaffective disorders (Dollfus et al., 2015). The author found that the SNS had good psychometric properties and demonstrated that the patients' ratings were highly correlated with observer ratings, which contradicts the expected lack of reliability of patient reported symptoms in patients with schizophrenia. However, the patients included in the study were stable outpatients with high levels of functioning as compared to lower functioning patients. It remains to be explored whether patients with lower levels of functioning are equally able to identify their negative symptoms in a reliable fashion. The aim of the present study was to first evaluate the reliability of the novel tool of self-evaluation of Negative Symptoms (SNS) and to examine its correlation with observer ratings of negative symptoms in a sample of inpatients with ICD 10 schizophrenia or schizo-affective disorder who function at a low level of overall cognition. It was our goal to examine if chronic, low functioning patients are able to complete the instrument without assistance, providing clinically meaningful information with respect to their own perception of negative symptoms.

**Methods:** Patients who met DSM-5 criteria for schizophrenia or schizoaffective disorder were included in the study. All patients will provide written