Image:

Variables	Mean or %		Statistic	p-value
	Relapse	No Relapse		
Cases (n)	9 (8.7)	94 (91.3)		
Women (%)	66.7	38.3		.154[a]
Age	37.22±9.88	36.70±11.74	U=402.5	.811
Onset age	25.89±7.28	22.84±6.97	U=299.5	.159
Diagnosis			χ^2 = 1.55	.213
SS	8 (88.9)	65 (69.1)		
BD	1 (11.1)	29 (30.9)		
Comorbidity	6 (66.7)	33 (35.1)		.079[a]
Substance abuse	2 (22.2)	25 (26.6)		1.0[a]
Family history (%)			χ^2= 1.07	.585
Any psychiatric diagnoses	1 (11.1)	16 (17.0)		
Schizophrenia	3 (33.3)	18 (19.1)		
Untreated illness: DUI (mos)	45.77±90.7	17.25±48.16	U= 359.5	.419
Treatments before LAI (%)				
Any antidepressant	2 (22.2)	17 (18.1)		.670[a]
Mood-stabilizer	4 (44.4)	54 (57.4)		.499[a]
First gen. antipsychotic	3 (33.3)	26 (28.0)		.711[a]
Second gen. antipsychotic	9 (100)	67 (72.0)		.107[a]
Hospitalized ≤12 mos before LAI	5 (62.5)	20 (21.7)		.022*
Hospitalized at start of LAI (%)	3 (33.3)	24 (25.8)		.696[a]
Suicide risk ≤12 mos before LAI (%)				
Ideation	3 (37.5)	5 (5.4)		.015*
Attempt	2 (25.0)	3 (3.2)		.049*
Suicide risk at start of LAI (%)				
Ideation	1 (11.1)	4 (4.3)		.373[a]
Attempt	0 (0.0)	2 (2.1)		1.0[a]
Side effects of LAI during 12 mos treatment			χ^2 =38.45	<.001***
Parkinsonism	2 (25.0)	1 (1.1)		
Tremor	2 (25.0)	0 (0.0)		
Hyperprolactinemia	0 (0.0)	3 (3.3)		
Metabolic disorders	0 (0.0)	2 (2.2)		
Post Injection Syndrome	0 (0.0)	1 (1.1)		

Conclusions: In conclusion, our observations confirm the importance of LAI therapy in real word. However, our results indicate that these drugs might not prevent subsequent exacerbations for a proportion of individuals whose illness is stabilised on continuous antipsychotic treatment. Extra pyramidal symptoms in particular might have pathophysiological implications for relapse.

Disclosure of Interest: None Declared

Sleep Disorders and Stress

EPP0730

Evaluation of daytime sleepiness and insomnia symptoms in OSA patients with a characterization of symptom-defined phenotypes and their involvement in depression comorbidity

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Introduction: Recent studies have emphasized the importance of clinical manifestations, such as insomnia and sleepiness, in defining phenotypes of obstructive sleep apnea (OSA), shifting from a focus on OSA severity and sleep structure.

Objectives: The study aimed to characterize insomnia and sleepiness associated with OSA phenotypes and assess their involvement in depression symptoms (DS) in OSA.

Methods: A total of 181 participants undergoing polysomnography (PSG) were asked to fill out questionnaires, including Epworth Sleepiness Scale (ESS), Insomnia Severity Index (ISI), Pittsburgh Sleep Quality Index (PSQI), and Back Depression Index (BDI). They were categorized into phenotypes: insomnia-sleepiness (I+S; ESS≥11; ISI≥15; n=20), sleepiness (S; ESS≥11; ISI<15; n=22), insomnia (I; ESS<11; ISI≥15) and asymptomatic (A; ESS<11; ISI<15; n=55).

Results: A linear regression model for BDI score (R^2=0.357, p<0.001) included ISI score and subjective to objective sleep latency ratio. ISI score was a predictive factor for mild and moderate DS (OR=1.226, p<0.001 and OR=1.392, p=0.002, respectively). I and I +S phenotypes are characterized by higher BDI scores (p<0.001 and p=0.015), longer subjective sleep latency (p=0.008 and p=0.041), and shorter subjective total sleep time (TST; p=0.049 and p=0.006), compared to A. Furthermore, the I and I+S groups had shorter subjective TST than S (p=0.028 and p=0.047). I and I+S had higher BDI scores than A (p<0.001 and p=0.015, respectively) and S (p<0.001 and p=0.017, respectively). I phenotype was associated with the risk of mild and moderate DS (OR=5.614, p<0.001 and OR=9.550, p=0.008 respectively). Moreover, the I+S phenotype presented an even greater risk for mild DS (OR=10.286, p<0.001).

Conclusions: The study suggests that using clinical features for OSA phenotyping holds promise for finding OSA individuals with increased risk for the occurrence of DS.

Disclosure of Interest: None Declared

Training in Psychiatry

EPP0732

Psychiatric brain gain in Switzerland. Competency-based onboarding.

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Introduction: In the last 30 years, Switzerland has been established as a destination country for psychiatric trainees. The needed competences for the work as a trainee deviate regarding colleagues from foreign countries though, hindering a viable solid development professional without specific on-boarding program. A similar approach to the figure of tutor anchored in the Spanish postgraduate medical training is still missing in the Swiss medical System. Hereby we performed a survey in the new colleagues who are part from the medical team in an observer status before beginning with the responsibilities as a trainee.

Objectives: Recognizing competences and needs of the onboarding in current trainees that are still allocating because of the work

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conditions as stated in the following paper, (Bischof et al. Swiss Arch Neurol Psychiatr Psychother. 2021;172:w03198)
Methods: Survey with open questions collecting needs and competences expected to fulfil in Switzerland were distributed in 5 different medical colleagues in an observer status between August 2022 and September 2023.
Results: Response rate was 62,5 %. Main reasons for the migration were considering better perspectives in education and professional development in the goal country, coming push factors as the current work situation in the original country to the fore. Support regarding the local language and an overview of the interprofessional communication were outlined as the advantage of the internship prior to the duties as a psychiatric trainee.
Conclusions: An structured on-boarding program is a demand for the newcomers - majority of trainees from foreign countries - to step in better in the Swiss health system. Elements of the Spanish trainee system could be adapted for a suitable allocation and integration process in the goal country.

Disclosure of Interest: None Declared

Sleep Disorders and Stress

EPP0733

The Impact of Sleep Deprivation in the Treatment of Depression: A Literature Review

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Introduction: Depression is a pervasive and debilitating mental health disorder that affects millions of individuals worldwide. Despite the availability of various treatment modalities, a significant proportion of patients continue to experience inadequate symptom relief and persistent emotional suffering. Sleep disturbance is a common symptom of depression, and emerging evidence suggests that manipulating sleep patterns through sleep deprivation may hold potential therapeutic benefits. This literature review aims to explore the role of sleep deprivation as an adjunctive treatment for depression, shedding light on its mechanisms and potential outcomes.
Objectives: To investigate the historical context and theoretical underpinnings of sleep deprivation in depression treatment; to examine the methods and protocols used in studies involving sleep deprivation as a therapeutic intervention for depression; to analyze the empirical evidence regarding the efficacy of sleep deprivation in ameliorating depressive symptoms; to assess the safety and feasibility of implementing sleep deprivation in clinical practice; to discuss the potential mechanisms underlying the antidepressant effects of sleep deprivation.
Methods: A systematic review of the literature was conducted.
Results: The review identified a diverse body of literature exploring the potential benefits of sleep deprivation in depression treatment. Preliminary findings suggest that acute sleep deprivation may lead to rapid and transient improvements in mood among individuals with depression. Various protocols, including total and partial sleep deprivation, have been investigated, demonstrating differential effects on depressive symptoms. Additionally, potential mechanisms underlying these effects, such as alterations in neurochemical pathways and circadian rhythms, have been proposed.
Conclusions: Sleep deprivation as an adjunctive treatment for depression is a promising but complex intervention that requires further investigation. While some studies have reported significant improvements in mood following sleep deprivation, the sustainability of these effects and the potential long-term consequences remain uncertain. Moreover, the optimal protocols, safety guidelines, and patient selection criteria need to be established for clinical application. Future research should focus on elucidating the mechanisms involved and conducting well-designed randomized controlled trials to determine the efficacy and safety of sleep deprivation in the context of depression treatment. This review underscores the importance of considering sleep as a modifiable factor in the comprehensive management of depression.

Disclosure of Interest: None Declared

Training in Psychiatry

EPP0734

Psychiatry resident physician duty hours, resting times and European Working Time Directive compliance in Spain

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Introduction: There is a growing interest in understanding the impact of duty hours and resting times on training outcomes and the well-being of resident physicians. Psychiatry resident's duty hours in Spain comprise a regular working schedule of 37.5h per week and a minimum of 4 mandatory on-call shifts. The most recent duty hours regulations in Spain were transposed from the European Working Time Directive (EWTD). According to Spanish Law, doctors cannot work for more than 48h per week and need to have resting times per day (at least 12h), per week (at least 36h) as well as annual leave (at least a month). However, there is practically no data on this situation in psychiatry resident physicians.
Objectives: Our aim is firstly, to describe the number of shifts performed by psychiatry resident physicians in Spain. Secondly, to describe compliance with the daily and weekly rests compared to those set in national and European law. Finally, to analyse the difference by demographic variables (gender and year of residency), in both the number of on-call duty shifts and compliance with rests.