Apathy is prevalent across many neurodegenerative, neurological, and psychiatric disorders. It represents the most common behavioural and psychological symptom in people with Alzheimer's Disease and is often observed in Parkinson's disease, vascular dementia, stroke, traumatic brain injury, amyotrophic lateral sclerosis/motor neuron disease, frontotemporal dementia, progressive supranuclear palsy, major depression, and schizophrenia. However, the definition and terminology employed to refer to apathy can vary in the context of different conditions and specialities and the diagnostic criteria have evolved. Additionally, the term apathy is employed to describe both a symptom and a syndrome. Indeed, little progress has been achieved in assessing the validity of the same construct across different disorders (eg. neurodegenerative disorders, schizophrenia or affective disorders). In 2018, a new version of the diagnostic criteria for apathy (DCA) in neuropsychiatric disorders was published. The validity of this new consensus has yet to be assessed among all relevant populations, including schizophrenia. Six European centres (Naples, Geneve, Nice, Rennes, Barcelona, Cambridge) aimed to test the prevalence of apathy, measured with the 2018 DCA, in patients diagnosed with schizophrenia. As a second aim, we focused on the relationship between DCA and other measures of apathy and negative symptoms in schizophrenia (BNSS and PANSS). In this talk, we will compare the preliminary findings of this pan-European study in schizophrenia patients with previous studies on neurodegenerative disorders.

**Disclosure:** No significant relationships.
**Keywords:** motivation; negative symptoms; reward; apathy

## W0022

## Apathy in patients with schizophrenia: Treatment perspectives

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Apathy occurs in many neuropsychiatric disorders and is a central negative symptom of schizophrenia. Apathy has severe functional consequences for patients with schizophrenia and the development of evidence-based treatments is a major challenge. There is now increasing evidence that dysfunctions in reward processing underly apathy, in particular regarding reward anticipation, cost-benefit computation and reward learning. In addition, metacognitive processes such as defeatist performance beliefs modulate reward processing. Psychological interventions for negative symptoms target these processes. While the evidence for cognitive-behavioral therapy for negative symptoms remains limited, recent findings suggest that specifically targeting reward-related dysfunctions may improve efficacy of these interventions. On the neurobiological level, there is now considerable evidence that a dysregulation of the dopaminergic reward system is related to reward processing dysfunctions. Regarding pharmacological treatment approaches, psychostimulants have successfully been used for apathy in dementia to target the reward system. Pro-dopaminergic drugs to target apathy in schizophrenia seem to be safer than anticipated, but their efficacy remains to be established. At the current state of knowledge, there is no evidence-based treatment that specifically targets apathy in patients with schizophrenia today. However, there are encouraging results from research inspired by basic research in neuroscience and clinical research in patients with other neuropsychiatric disorders.

**Disclosure:** SK has received royalties from Schuhfried (Austria) for cognitive test and training software.
**Keywords:** schizophrénia; negative symptoms; apathy; Treatment

# Educational

## (Assisted) suicide in the elderly

## W0026

## What interventions work for suicide prevention? and do they work for the elderly?

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**Background:** Suicides occur more often in the young and in the elderly. However, although several studies have been performed to evaluate the effect of suicide prevention in the young, no studies have explored this in the elderly. Somatic comorbidity is associated with elevated suicide risk, especially in case of pain, which occurs often in the elderly.
**Objective:** To explore if suicide prevention interventions might be applicable in the elderly and if somatic comorbidity might be relevant for their application.
**Method:** Evidence synthesis of controlled studies evaluating suicide prevention interventions and of collaborative care trials for depressive disorder in patients with and without somatic comorbidity.
**Results:** Elderly living alone and with multimorbidity are more prone to suicide risk. Hence interventions involving admission in a general hospital after a suicide attempt, short intervention and follow up might be well applicable in the elderly. In terms of outpatient interventions, and IPD analysis found that collaborative care for depressive disorder is effective in reducing suicidality, especially in the elderly. This effect is independent of somatic comorbidity.
**Conclusion:** There is potential to develop and evaluate suicide prevention interventions for the elderly. Such interventions should address depression, multimorbidity and social isolation and may be provided at general hospital and at outpatient level.

**Disclosure:** No significant relationships.
**Keywords:** Suicide prevention; Elderly

## W0027

## Media and suicidal behaviour

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Media coverage of suicidal behaviour can induce copycat suicides. This has been clearly confirmed by analysis of suicides following the huge media coverage of the railway suicide of the German national goal keeper in 2009. A socalled 'Werther effect' was not only visible

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in Germany, but also in neighbouring countries (1). Even more disturbing is the fact that these effects were not only short-lived, but a higher number of railway suicides was observed compared to baseline over a two year period (2). Increased cognitive availability of railway suicides might explain this finding. It adds to the important discussion concerning the risks and benefits of public anti-suicidal campaigns. Destigmatisaton and normalisation of suicidal behaviour will on the one hand, facilitate helpseeking behaviour of people at risk, but on the other hand, will lower the threshold for committing suicide. Even when the wording within a antisuicide campaign is in line with recomendations of media guidelines, secondary reporting e.g. within social media will not be controllable. Social media are likely to contribute to the spreading and the choice of more lethal suicide methods, as has been shown for carbon monoxide poisoning and poisoning by other gasses (3). An increase of knowledge about and access to more lethal poisoning methods will have a major impact on suicide rates. 1) KOBURGER et al (2015), J Affect Disord 185:38-46 2) HEGERL et al (2013), J Affect Disord. 146: 39-44. 3) PAUL et al (2017), PLoS One 12: e0190136.

**Disclosure:** No significant relationships.

## Mental Health Policy

## Adaptations of the project echo model of tele-education to address child mental health disparities internationally

### W0029

### Introduction to project ECHO (extension for community heathcare outcomes)

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Introduction:
Nationally and internationally, there is a gap between the need and availability of child mental health services. This gap stems from a lack of trained specialists, workforce misdistribution, variations in insurance and financing, and family concerns about the benefits of existing services. Of the possible solutions to these problems, expansion of the child mental health capacity of primary care providers (PCPs) has been proposed as a feasible and scalable approach. The Extension for Community Healthcare Outcomes (ECHO) model was originally conceived and executed by Dr. Sanjeev Arora at the University of New Mexico for Hepatitis C. It serves to de-monopolize medical expertise by extending knowledge from specialists to PCPs
**Objectives:** After attendance at this session, the learner will be able to: 1. describe the history and expansion of the ECHO model worldwide, 2.name the components and structure of ECHO sessions, 3. discuss ECHO as a force multiplier.
**Methods:** Dr. Harrison will briefly present the history and expansion of ECHO. She will then describe the program, which consists of a "hub and spokes" model with "tele-clinics" consisting of a "hub" of specialists and "spokes" of clinicians in rural, underserved areas who present cases for discussion, generating treatment recommendations.
**Results:** The ECHO model has been replicated in a variety of disciplines across the United States and internationally. Its success has been well documented. There are currently 920 active ECHO programs worldwide.
**Conclusions:** Project ECHO is a viable model to address the workforce shortage of child psychiatrists worldwide.

**Disclosure:** No significant relationships.
**Keywords:** child and adolescent psychiatry; mental health care; mental health disparities

### W0030

### KKI-NECT: Kennedy krieger institute's network for early childhood tele-education (US)

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**Introduction:** The Kennedy Krieger Institute Network for Early Childhood Tele-Education (KKI-NECT) is a federally funded ECHO project. Its hub consists of a child psychiatrist, developmental pediatricians and a behavioral psychologist. Its community partners are primary care providers(PCPs) in underserved areas. Its goal is to create local experts in early childhood behavioral, emotional and developmental disorders.
**Objectives:** After attendance at this session, the learner will be able to: 1. report the rates of co-occurring developmental, behavioral and emotional disorders presented by primary care participants 2. explain the efficacy of case based learning and a structured curriculum as a mechanism for expanding the workforce. The goal of this presentation is to build awareness of and interest in ECHOs specifically targeted to child behavioral, emotional and developmental issues.
**Methods:** Dr. Leppert will discuss KKI-NECT, particularly the process of procuring funding, setting up an ECHO, and getting institutional "buy-in". She will describe the use of case based learning and a structured curriculum in a longitudinal CME program, report the comorbidities in cases that participants present for discussion, and demonstrate the impact on participants' practice.
**Results:** Data from four cohorts demonstrate that PCPs showed increased comfort levels, improved knowledge of behavioral, emotional and developmental disorders. PCPs expanded the scope issues they could address in their practice as a result of participation in KKI-NECT.
**Conclusion:** KKI-NECT is a viable response to the workforce shortage of child psychiatrists by confidently increasing the role of the PCP in treating childhood developmental and mental health disorders.

**Disclosure:** No significant relationships.
**Keywords:** mental health disparities; child and adolescent psychiatry; mental health care

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