

In theory and practice early intervention has an indisputable role in the treatment of patients with psychotic disorders, however modern psychiatrists face challenges in their clinical work to find the balance between the best practice and available treatment options in their environment. One of the biggest challenges remains the implementation of high-cost treatment approaches in healthcare systems of middle-income countries. Moreover, one very important aspect to consider when implementing early intervention is to prepare your team for resistance against the innovation. In countries where psychiatric treatment is more hospital-oriented and out-patient care is limited to short face-to-face visits with psychiatrists, the system is rigid and unwilling to step up to more expanded treatment option, such as a team approach of more than 6 members to treat one patient. In Latvia we started our early intervention programme in 2019 (LAT-EIP), 34 patients enrolled, and 27 finished the programme. When we compared results between standard treatment and LAT-EIP, psychiatrist out-patient visits were comparable to LAT-EIP, but the rate of rehospitalization and assigned disabilities at 12 months follow-up differ dramatically: in LAT-EIP 7.4% had been readmitted and 7.4% were assigned with disability vs 36.1% and 34.4% of patients in standard treatment group, respectively, $p < 0.05$. Nevertheless, the only hospital which continues to provide early intervention is the one which first established it. This presentation will try to explain step-by-step what enhances and what holds back innovation in psychiatry in one middle-income countries.

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Keywords: early intervention; Health care systems; psychosis; schizophrénia

S0030

The trough of disillusionment: A critique of the “transition” paradigm

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I will attempt to address the issues surrounding the CHR concept in light of novel data and briefly discuss emerging alternatives. The root problem of the CHR early intervention strategy is the exertion of reducing early nonspecific (pluripotent) psychopathology to a unidimensional model restricted only to positive psychotic symptoms, which define the binary categories of CHR and “transition” in help-seeking populations. This major conceptual handicap undermines the validity and clinical utility. The core predictor of the “transition” rate is the degree of the risk-enrichment and not the CHR status. Even with a significant pretest risk enrichment, the prognostic accuracy is mediocre. The incidence and “transition” rates of CHR in the community are very low; therefore, CHR does not represent a cost-effective clinical target—prevention paradox. CHR succeeding early pluripotent psychopathology is already late for intervention. “Transition” is not a categorical progression but a unidimensional shift in psychotic symptoms, and therefore, influenced by the fluctuation of psychotic symptoms, leading to both false positives and underestimation of nonpsychotic psychopathology. There exists no evidence for a specific effect of any intervention in preventing “transition”; therefore, CHR is not an ideal treatment target. Binary “transition” outcome does not represent a valid

phenotype for research as “transition” rates are primarily driven by the sampling heterogeneity. The multidimensional psychopathology and functioning are more clinically relevant, overarching, and service-user-centered measures to define individual risk and outcome. Guided by the public health perspective, a universal early intervention framework, underscoring improved access to care, may represent a better strategy.

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Keywords: psychosis; early intervention; public health; clinical high-risk

E-mental health and the future of psychiatric diagnosis

S0037

Past, present and future of psychiatry

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Over the past few decades, psychiatry and mental health sciences have reached several major goals. The importance of mental health and the huge contribution to the burden of disability produced by mental and neurological disorders has been recognized by all and most recently also by the United Nations. Treatment technology has developed and permits the effective management of most mental disorders. Progress has also been made in the recognition of human rights of people with mental illness and those who care for them. More has to be done in these areas but there are also new tasks that are before psychiatry. These include the addition of primary prevention of mental disorders to previous efforts to ensure secondary and tertiary prevention of mental health problems; the development of appropriate ways of work in order to cope with problems of comorbidity of mental and physical disorders; and a fundamental reorientation of training in psychiatry and related sciences.

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S0038

Reconceptualising the DSM: Neuroanalysis and digital brain profiling

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Recent years have seen a great advancement in the emerging field of Neural Computation, a study of the brain using neuronal network models. As a consequence, another field of science is being developed titled 'Computational Psychiatry' where neuronal network models of psychopathology help understand the possible etiology for mental disorders. With Computational Psychiatry we can begin and reformulate mental disorders as brain disorders. Etiological diagnosis in psychiatry will be the next