care providers were required to ponder over ethical dilemmas or decisions. Several challenges were reported, such as: taking into account and articulating personal freedom or needs with collective functioning or organizational constraints before, during and after the assisted suicide; reconciliating self-determination with protection towards vulnerable people (beneficere, non maleficere).
*Conclusions* Assisted suicide challenges and changes professional end-of-life practices. Education and support should be provided to health and social care providers faced with it.
*Disclosure of interest* The authors have not supplied their declaration of competing interest.

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## Symposium: Is it possible to prevent Alzheimer's disease?

### S014

### Setting the scene: The evidence for pre-clinical change, projections of the impact of intervention, and implications for public health

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Alzheimer's disease has long been considered a neurodegenerative disorder of late life for which there is currently no disease-modifying treatment. This view is now being revised as increasing evidence suggests a long pre-clinical phase extending back into mid-life during which there is exposure to multiple potentially reversible risk factors. Further thought is now being given to the possibility of both early life intervention programs and development of new drug treatments focusing on the pre-dementia period. But how can the impact of such treatments be measured at this early stage since overt dementia may not be diagnosed for decades? In the four talks in this symposium, we will discuss evidence for pre-clinical change, theoretical models which have been used to project the possible impact of risk factor modification in mid-life and their integration into a future public health strategies. The development of new statistical risk models to determine the impact of such prevention measures will be outlined. We will consider the possibilities for drug development targeting the pre-clinical period before presenting the PREVENT Project and EPAD (http://ep-ad.org/), a multi-million euro IMI-Horizon 2020 funded project for the development of pre-clinical proof of concept trials. Titles of the four presentations: 1. Setting the scene: the evidence for pre-clinical change, projections of the impact of intervention, and implications for public health (TCR) 2. New statistical risk models for determining the impact of prevention measures in the pre-dementia period (GMT) 3. The PREVENT Study: a prospective cohort study to identify mid-life biomarkers of late-onset Alzheimer's disease (KR) 4. The European Prevention of Alzheimer's Dementia (EPAD) Project: developing interventions for the secondary prevention of Alzheimer's dementia (CWR)
*Disclosure of interest* The authors have not supplied their declaration of competing interest.

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## Symposium: Upscaling mental healthcare - Implementing guidance and mental health care recommendations in Europe

### S015

### How can guidance recommendations contribute to better mental health?

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*Introduction* In European countries, the quality of mental healthcare services is often limited due to scarce and inequitable distributed resources, and inefficient use of existing resources. Against this background, the EPA Guidance provides recommendations on how to optimize quality of mental healthcare for all European countries.
*Objectives* Provision of guidance recommendations in order to support optimization and harmonization of mental healthcare services in European countries.
*Methods* By means of evidence and consensus-based methods EPA guidance papers are developed by experts in psychiatry and related fields [1].
*Results* As of 2012, five EPA guidance series have been developed and published [2]. They focus on various aspects of mental healthcare and clinical situations that have not been covered by medical guidelines yet but are considered important to deliver high quality mental healthcare. Papers deal amongst others with topics relating to quality assurance of mental health services, as quality of mental health service structures and processes, and building trust in mental health services.
*Conclusions* EPA guidance recommendations can improve mental healthcare provision and thereby contribute to better mental health of persons receiving mental healthcare. For this purpose, recommendations need to be widely disseminated and implemented in European countries.
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### S016

### Implementation of EPA guidance - One way for all countries?

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The European Psychiatric Association (EPA) guidance project launched in 2008 has the aim of providing European psychiatry with guidance in topics, which are relevant for European mental health care. Guidance from a European perspective can be favorable against the background of a growing sense of Europe and the desirable associated harmonization on all levels of health care policy.

More precisely, the mission of the EPA guidance is defined as 'to improve quality of mental health care in Europe by disseminating written information based on best evidence and psychiatric practice, to facilitate countries learning from each other'.
In consonance with this need of a wider multinational perspective of European psychiatry, EPA adopted in 2012 through a deep change of its statutes a new membership structure that allows National Psychiatric Societies/Associations (NPAs) in Europe the possibility to become full members of EPA. Up to 40 NPAs corresponding to 37 countries and representing over 80.000 psychiatrists have responded positively to the offer and are now part of the Council of National Psychiatric Societies, the body within EPA that integrates them.
The Council of NPAs has become, in this way, a forum for its members to meet, discuss and work on issues concerning European psychiatry. One of the major issues is about the implementation of European guidance in mental health policy, teaching and learning psychiatry, best clinical practice in different areas, and quality indicators. This presentation provides further details on how participating societies could put these policies and recommendations into practice.
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## Symposium: The natural history of bipolar disorders: from the age of onset to the long-term course

### S017

### How long is the interval between the onset and the initial management of bipolar disorder? A meta-analysis

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*Objective* To evaluate the length of the interval between the onset and the initial management of bipolar disorder (BD).
*Method* We conducted a meta-analysis using the preferred reporting items for systematic reviews and meta-analyses guidelines. Systematic searches located studies reporting estimates of the age of onset (AOO) and indicators of the age at initial management of BD. We calculated a pooled estimate of the interval between AOO and age at management. Factors influencing between-study heterogeneity were investigated using sensitivity analyses, meta-regression, and multiple meta–regression.
*Results* Twenty-seven studies, reporting 51 samples and a total of 9415 patients, met the inclusion criteria. The pooled estimate for the interval between the onset of BD and its management was 5–8 years (standardized difference, .53; 95% confidence interval, .45 to .62). There was very high between-sample heterogeneity (I2 ¼ 92.6; Q ¼ 672). A longer interval was found in studies that defined the onset according to the first episode (compared to onset of symptoms or illness) and defined management as age at diagnosis (rather than first treatment or first hospitalization). A longer interval was reported among more recently published studies, among studies that used a systematic method to establish the chronology of illness, among studies with a smaller proportion of bipolar I patients, and among studies with an earlier mean AOO.
*Conclusions* There is currently little consistency in the way researchers report the AOO and initial management of BD. However, the large interval between onset and management of BD presents an opportunity for earlier intervention.
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### S018

### Cognitive impairment in bipolar: Neurodevelopmental or neuroprogressive?

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*Background* Bipolar Disorders (BD) are common and complex diseases. Recent findings have provided evidence that impairments in cognition are evident in the various sub-groups of Bipolar Disorder and persist after resolution of acute episodes.
*Method* An opinion paper based on a narrative review of the field.
*Results* Quantifiable cognitive deficits are clearly found in Bipolar 1 and Bipolar 2 Disorders. These persist after recovery from acute episodes. The aetiopathogenesis of these phenomena is likely to be multifactorial. It seems clear that these cognitive impairments are not in general neurodevelopmental and for most are related to repeated episodes of illness [1]. However, the issues of subgroups with differential profiles of impairment and the trajectory of cognitive change remain to be fully established. The effects of putative treatments (e.g., pharmacological, neurostimulation, cognitive remediation) are at an early stage of evaluation.
*Conclusions* Future efforts should focus on further integrating the current and emerging research findings into a coherent model, which generates testable hypotheses and allows treatment effects to be tested.
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Paid lectures and advisory boards for all major pharmaceutical companies with drugs used in affective and related disorders
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*Reference*
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### S019

### Impact of age at onset on the long-term course of bipolar disorder

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*Introduction* Bipolar disorder (BD) typically starts in adolescence or young adulthood (early-onset; EO-BD), which may have different backgrounds and consequences than late-onset (LO) BD. There are controversies over pre-pubertal age of onset (AoO).
*Objectives* To give an overview of the various concepts of AoO in BD, the impact of AoO on subsequent illness course, and findings of the Stanley Foundation Bipolar Network (SFBN) with relationship to AoO.