developing solely in RISK hold—might indeed predispose to the development of psychotic symptoms.
Policy of full disclosure: None.

S-39-003
Age as a source of heterogeneity in psychosis high risk research

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Objective: Objective: Currently available reports on conversion rates show a broad heterogeneity. Several reasons have been discussed, including a lacking consideration of the dynamic character of the interaction of environmental factors with the individual vulnerability/resilience. One aspect which may reflect this dynamic is the interaction between risk indicators and age. The transitory phase from early adolescence to adulthood is associated with a whole bunch of biological, cognitive and social changes. The increasing risk is demonstrated by the rise of first manifestations from up to 1 % of all schizophrenia cases below age of 13 to up to one-third of all cases below age of 18. On this background, it seems noteworthy that the age structure of high risk differs markedly. Age effects, however, may remain undetected, as samples may not span the critical range or lack sufficient statistical power. We therefore analyzed age effects on conversion rates and outcome of intervention studies across samples.
Methods: Two meta-analyses were performed (http://www.europsy.net/publications/guidance-papers/), one on prediction, finally including 45 studies, one on prevention, finally including 15 studies. Categories for age distribution included: almost entirely minors ($\leq$18 years; CAD), almost entirely adults (minimum age 18 years or mean >18 with lower sd only spanning $\geq$18 years; ADULT), $\geq$50 % minors (median or mean age $\leq$18 years or mean $\leq$18 with upper sd still spanning $\leq$18 years; YOUTH).
Results: When ultra-high risk criteria defined inclusions, the two-year conversion rates in CAD were more than 50 % lower than those in ADULT ($p < .05$). Regarding intervention studies, effects were less clear, yet no CAD group was available.
Conclusion: Age composition of samples seems to be an important source of heterogeneity. CHR criteria should be used in children and early adolescents, but only with utmost care. Primarily psychosis preventive interventions in this age range are not supported by current evidence.
Policy of full disclosure: None.

S-39-004
Social environment as a risk factor for psychosis proneness

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Objective: To test whether spatial and social neighbourhood patterning of people at ultra-high risk [UHR] of psychosis differs from first episode psychosis [FEP] participants or controls, to determine whether exposure to different social environments is evident before disorder onset.
Methods: We tested differences in the spatial distributions of representative samples of FEP, UHR and control participants, and fitted two-level multinomial logistic regression models, adjusted for individual-level covariates, to examine group differences in neighbourhood-level characteristics.
Results: The spatial distribution of controls (n = 41) differed from UHR (n = 48; $p = 0.04$) and FEP participants (n = 159; $p = 0.01$), whose distribution was similar ($p = 0.17$). Risk in FEP and UHR groups was associated with the same neighbourhood-level exposures: proportion of single-parent households (FEP adjusted odds ratio [aOR]: 1.56 95 %CI 1.00–2.45; UHR aOR: 1.59; 95 %CI 0.99–2.57), ethnic diversity (FEP aOR: 1.27; 95 %CI 1.02–1.58; UHR aOR: 1.28; 95 %CI 1.00–1.63), and multiple deprivation (FEP aOR: 0.88; 95 %CI 0.78–1.00; UHR aOR: 0.86; 95 %CI 0.76–0.99).
Conclusion: Similar neighbourhood-level exposures predicted UHR and FEP risk, whose residential patterning was closer to each other's than controls. Adverse social environments are associated with psychosis before FEP onset.
Policy of full disclosure: None.

S-40 Current state and perspectives of policies for schizophrenia care

S-40-001
Quality assurance in schizophrenia treatment and care: state of the art and policy developments

W. Gaebel (Heinrich-Heine-University, Department of Psychiatry and Psychotherapy, Düsseldorf, Germany)

Objective: This lecture will address the relevance of quality assurance and different quality assurance tools in mental healthcare for people suffering from schizophrenia. Requirements for the evaluation and assurance of quality in mental healthcare will be outlined as well as the need to include quality assurance on policy agendas.
Methods: Quality assurance programs and instruments in mental healthcare for people suffering from schizophrenia will be reviewed. Specific examples of such programs and instruments as well as their methodological characteristics and goals will be outlined.
Results: In general, a first step to assure quality in mental healthcare for people suffering from schizophrenia is to include quality assurance in political agendas and plans in order to outline its scope and foster the development of adequate instruments. Quality assurance can address the structures, processes and outcomes of care. It is approached by different stakeholders, such as policy-makers, health insurers, care providers and people with schizophrenia themselves. Quality assurance tools, such as quality indicators and clinical practice guidelines, should be developed in systematic processes and on the basis of evidence-based literature.
Conclusion: In order to optimize and assure qualitative care delivery a systematic development, implementation and evaluation of quality assurance programs and instruments is necessary. Not only indicators on the structures and processes of care inform about quality but also outcome measures that focus on patients'perspectives, expectations and needs.
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S-40-002
Bridging the gap between neuroscience and policy care in schizophrenia

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Abstract: Psychiatry has profited considerably by new developments in molecular biology and imaging over the last 20 years. Our