Table 1 Description of the sample, demographic and clinical data.

Table 1: Description of the sample, demographic and clinical data

VARIABLE	PATIENTS (n=103)	CONTROLS (n=91)	STATISTICS
Age	41.96 ± 10.231	36.23 ± 13.40	Mann Whitney test; MW U= 3519; **p<0.0005**
Gender (M: F)	41:62	36:55	Fisher exact test; ns.
Age of disease onset	26.12 ± 8.974		
Lifetime duration of treatment	15.38 ± 9.519		
Number of hospitalizations	4.13 ± 3.968		
Psychiatric heredity			
Same disorder	15 (14.6%)		
Other disorder	39 (37.9%)		
Without	47 (45.6%)		
Education:			
elementary	9 (8.7%)	1 (0.9%)	Pearson chi-square; ns.
vocational training	25 (24.3%)	3 (2.8%)	
secondary school	52 (50.5%)	38 (34.9%)	
university	16 (15.5%)	9 (8.3%)	
not completed	1	40	
Marital Status:			
single	61 (59.0%)	28 (25.7%)	Pearson chi-square; ns.
married	24 (23.1%)	21 (19.3%)	
divorced	15 (14.3%)	1 (0.9%)	
widowed	1 (0.9%)	1 (0.9%)	
not completed	3 (2.7%)	40	
Employment Yes/No	33/70		
objCGI severity	4.14 ± 0.971		
subCGI severity	2.75 ± 1.392		
objCGI-subCGI severity	1.67 ± 1.56		
Q-LES-Q			
Physical health (max 65p)	41.81 ± 9.74	43.53 ± 10.43	unpaired t-test: t=4.098 df=180; **p<0.0001**
Feelings (max 70p)	46.33 ± 10.63	52.36 ± 9.70	unpaired t-test: t=4.107 df=192; **p<0.0001**
Work (max 65p)	27.82 ± 18.13	37.78 ± 19.47	Mann Whitney test: MW U= 3377; **p<0.001**
Household (max 50p)	34.99 ± 9.04	33.84 ± 13.72	unpaired t-test: t=0.6997 df=192; ns.
School / study (max 50p)	13.47 ± 8.77	20.05 ± 12.97	Mann Whitney test: MW U= 3451; **p<0.005**
Leisure (max 30p)	20.15 ± 5.42	25.22 ± 4.05	unpaired t-test: t=7.290 df=191; **p<0.0001**
Social activities (max 55p)	35.69 ± 9.22	43.02 ± 8.24	unpaired t-test: t=5.808 df=192; **p<0.0001**
General (max 80p)	51.49 ± 12.08	56.88 ± 9.69	unpaired t-test: t=3.400 df=192; **p<0.001**
SUM O-LES-Q (max 465p)	271.5 ± 58.03	312.68 ± 46.11	unpaired t-test: t=5.419 df=192; **p<0.0001**
SUM Q-LES-Q in percent	58.42 ± 12.47 %	67.24 ± 9.91 %	unpaired t-test: t=5.401 df=192; **p<0.0001**
ISMI			
Alienation	13.31 ± 3.89		
Stereotype agreement	14.01 ± 3.42		
Perceived discrimination	11.01 ± 3.30		
Social withdrawal	13.03 ± 3.77		
Stigma resistance	12.63 ± 2.34		
Overall score	63.98 ± 13.74		

Table 2 Relation between Q-les-Q domains and facets of ISMI.

Domain	Overall score of ISMI	Alienation	Stereotype agreement	Perceived discrimination	Social withdrawal	Stigma resistance
Physical health	-0.496***	-0.397***	-0.509***	-0.372***	-0.454***	-0.349***
Feelings	-0.633***	-0.535***	-0.588***	-0.469***	-0.561***	-0.413***
Work	-0.261**	-0.202*	-0.246*	-0.141	-0.258**	-0.106
Household	-0.355***	-0.278**	-0.350***	-0.294**	-0.311***	-0.268**
School / study	-0.099	-0.069	-0.073	-0.078	-0.103	-0.100
Leisure	-0.457***	-0.430***	-0.411***	-0.347***	-0.410***	-0.293**
Social activities	-0.507***	-0.391***	-0.438***	-0.390***	-0.555***	-0.235*
General	-0.550***	-0.487***	-0.487***	-0.444***	-0.504***	-0.316***
SUMA O-LES-Q	-0.581***	-0.477***	-0.540***	-0.429***	-0.548***	-0.355***

*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.

Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.642

EW525

Cognitive function in early psychosis patients from a low-income country

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Background Cognitive impairments are well established findings in schizophrenia and are associated with significant impairment of social functioning. Episodic memory, working memory and executive function test scores are typically 1 standard deviation below healthy controls. There are reports suggesting the presence of neurocognitive deficits prior to illness onset, opening the possibility of using cognitive profiles as disease markers. Interest in exploring cognitive functioning in early stages schizophrenia has continued to grow, as earlier treatments could possibly lead to improved outcomes.
Methods This is a cross-sectional assessment of cognitive profiles in patients with early psychosis. A total of 51 patients suffering from psychosis in the age group of 18–65 years were recruited and matched with 51 healthy controls. A wide range of neurocognitive domains were assessed using standardised neuropsychological tests.
Results There was evidence of statistically significant impairments in cognitive functioning across a broad range of cognitive domains in early-psychosis patients, as compared to healthy controls. More pronounced deficits were seen in executive function tests.
Conclusions To our knowledge, this is the first study to report cognitive deficits across a range of domains in patients with first episode psychosis from a low-income country. This study found deficits across multiple domains, including language, memory, attention, executive function, and visuospatial function in patients with early psychosis. Evidence of neuropsychological deficits in the early course of the disease may highlight crucial therapeutic windows for both pharmacological treatments and cognitive rehabilitation. This may improve functional outcomes in this patient group in the longer term.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2016.01.643

EW526

Short-term compliance in first-episode psychosis

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Introduction Non-compliance is a significant problem in patients with first-episode psychosis (FEP), representing a challenge for mental health professionals due to the heterogeneous course and functional outcomes.
Objectives The aim was to describe the short-term compliance in FEP and analyze the demographics, clinical features, and management issues potentially associated with non-compliance.
Methods This observational and retrospective study included all consecutive FEP admitted to our psychiatry unit from January to June 2015, belonging to our catchment area. To be categorized as compliant, patients had to attend month-1 and month-3 follow-up visits. Characteristics of compliant and non-compliant were compared using a bivariate analysis.
Results We included 18 patients whose characteristics are shown in the table. Overall, 8 (44.4%) were non-compliant. Patients who were non-compliant had a significantly shorter length of stay (10.3 [6.3] vs. 18.5 [8.9] days). Most patients (66.7%) had cannabis abuse, being slightly more frequent among non-compliant (75% vs. 60%, P = NS); in addition, the diagnosis of substance-induced psychotic disorder was also more common among non-compliant (50% vs 20%, P = NS). There were 2 patients who were readmitted, both in the non-compliant group (Table 1).
Conclusions Short-term non-compliance is high among patients with FEP. Despite the limitations of our study, our results suggest that, beside other factors (e.g. substance abuse), non-compliance could be associated with management-related factors.