

patient received individual guidance on healthy food and on how to live a physically active life.

Results Extensive problems with obesity, especially among the women, were observed, and low level of physical activity among the patients was demonstrated. The included patients were in a high risk of developing cardio vascular diseases and diabetes type 2. The main outcomes were reduction in waist circumferences and in consumption of soft drinks and an increase in coffee drinking. Furthermore, an increase in time spent on moderate and light physical activities was observed. The patients showed great interest in the programme, and it was unproblematic getting the patients to participate in the entire programme. Moreover, they willingly followed the health guidance and achieved a healthier life.

Conclusions The intervention seems relevant and manageable in an outpatient setting. The results are promising in the ongoing process of improving physical health among patients with schizophrenia. We recommend implementation of the programme in daily practice.

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

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EW522

A mirror image study of the utility of long acting aripiprazole

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Aims and background Ablify Maintena (AM) is a long acting injection of aripiprazole that received marketing authorisation in the UK in January 2014. It is costly compared to first generation antipsychotics (FGAs) LAIs and there are no robust trials comparing AM with FGAs. We examined the effectiveness and use of AM in a mental health trust.

Methods We identified all patients prescribed AM in North Staffordshire (population: 470,000) since launch and examined records for demography, diagnosis, bed and medication use. We examined the effectiveness of AM using a mirror image design.

Results Thirty patients received AM in a time frame allowing a 1-year follow-up. Sixty-nine percent were male and the mean age was 39 years. Over half were detained under the 1983 Mental Health Act and 30% were inpatients on a psychiatric intensive care unit when AM was started. Twenty-eight patients had a psychotic diagnosis. There was a significant reduction in bed occupancy (63 v 6 days, $P=0.0001$) and admissions (1.6 v 0.5, $P=0.0001$). The median dose was 400 mg. Lack of effectiveness/poor adherence with prior treatments were the main reason for starting AM in 84%. Eighty-six percent of patients clinically improved on AM. Blood parameters were in the normal range.

Discussion Within the limitations of the methodology, our results show a reduction in psychiatric bed use in the year following AM initiation on an intention to treat basis. The reduction in bed use equates to a minimum annual saving of £14,250 per patient. AM at the median study dose costs £2645 per year.

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

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EW523

Coping strategies and quality of life in schizophrenia outpatients treated by Psychopharmacs - cross-sectional study

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Introduction The modern psychiatric view of schizophrenia spectrum disorders and their treatment has led to an increasing focus on coping strategies and quality of life of these patients.

Objectives Understanding the relationship between quality of life and coping strategies can help in finding those coping strategies that enhance the quality of life. It is important to study the inner experience and striving of patients because of connection with well-being and treatment adherence.

Aims : In the present study, the authors examined the relationship between demographic data, the severity of symptoms, coping strategies, and quality of life in psychotic outpatients.

Methods Psychiatric outpatients who met ICD-10 criteria for a psychotic disorder (schizophrenia, schizoaffective disorder, or delusional disorder) were recruited in the study. Questionnaires measuring the coping strategies (SVF-78), the quality of life (Q-LES-Q), and symptoms severity (objective and subjective clinical global impression-objCGI; subjCGI) were assessed. Data were analysed using one-way ANOVA, Mann-Whitney U-test, Pearson and Spearman correlation coefficients, and multiple regression analysis.

Results One hundred and nine psychotic outpatients were included in the study. The QoL was significantly related to the Positive and Negative coping strategies. The severity of disorder highly negatively correlated with the QoL score. Stepwise regres-

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

VARIABLE	MEAN AND STANDARD DEVIATION
Age	41.96 ± 10.23
Gender (M: F)	41:62
Age of the disease onset	26.12 ± 8.97
Lifetime duration of treatment	15.38 ± 9.52
Minimum	1
Maximum	45
Number of hospitalizations	4.13 ± 3.97
Psychiatric heredity	
Same disorder	15 (14.6 %)
Other disorder	39 (37.9 %)
Without	47 (45.6 %)
Education:	
elementary	9 (8.7 %)
vocational training	25 (24.3 %)
secondary school	52 (50.5 %)
university	16 (15.5 %)
Marital Status:	
single	61 (59.2 %)
married	24 (23.3 %)
divorced	15 (14.6 %)
widowed	1 (2.9 %)
Employment Yes/No	33/70
Retirement	87
Full invalidity	60
Partial invalidity	20
Old-age	7
From parent family	66
From incomplete family	31
Brother/sister Yes/No	90/13
Birth order	
First-born	44
Second-born	36
Third-born	10
Using psychiatric medication Yes/No	101/2
Regular use	94
Regularly, more than prescribed amount	2
Irregularly use	6
ObjCGI severity	4.14 ± 2.75
SubjCGI severity	2.75 ± 1.39

Table 2 Description of using coping strategies and quality of life in schizophrenic outpatients.

COPING STRATEGIES	T-score mean	QUALITY OF LIFE	Points
Underestimation	47.77 ± 12.87	Physical health (max 65p)	41.81 ± 9.74
Guilt denial	54.35 ± 12.2	Feelings (max 70p)	46.33 ± 10.63
Diversion	50.88 ± 9.88	Work (max 65p)	27.82 ± 18.13
Compensatory satisfaction	55.57 ± 10.2	Household (max 50p)	34.99 ± 9.04
Situation control	44.95 ± 11.08	School / study (max 50p)	13.47 ± 8.77
Reaction control	47.76 ± 10.8	Leisure (max 30p)	20.15 ± 5.42
Positive self-instruction	41.37 ± 11.95	Social activities (max 55p)	35.69 ± 9.22
Need for social support	50.98 ± 11.02	General (max 80p)	51.49 ± 12.08
Active avoidance	55.76 ± 8.9	SUMA Q-LES-Q (max 465p)	271.5 ± 12.47
Escape tendency	61.82 ± 9.42	Q-LES-Q in percent	58.42 ± 12.47 %
Perseveration	49.9 ± 12.5		
Resignation	60.44 ± 10.95		
Self-accusation	53.29 ± 12.61		
Using negative coping	59.04 ± 11.24		
Using positive coping	49.5 ± 11.8		

Abbreviations: Average use of coping 40-60 T-score, more than 60 overusing, less than 40 reduced using of coping strategy

Average use of coping 40-60 T-score, more than 60 overusing, less than 40 reduced use of coping strategy.

Table 3 Correlations between quality of life and coping strategies.

Coping / Domain	Total Q-LES-Q	Physical health	Feelings	Work	Household	School	Leisure	Soc. activities	General
Underestimation	0.466***	0.318**	0.477***	0.269**	0.322***	0.098	0.332**	0.328**	0.473***
Guilt denial	0.246*	0.256**	0.348***	0.145	0.085	-0.093	0.182	0.136	0.292**
Diversion	0.486***	0.417***	0.444***	0.297**	0.360***	0.134	0.285**	0.291**	0.444***
Compensatory satisfaction	0.283**	0.305**	0.310**	0.147	0.181	0.004	0.251*	0.184	0.250**
Situation control	0.284**	0.180	0.272**	0.141	0.322**	0.030	0.226*	0.260**	0.218*
Reaction control	0.477***	0.366***	0.473***	0.247*	0.359***	0.153	0.299**	0.354***	0.434***
Positive self-instruction	0.639***	0.505***	0.667***	0.356***	0.503***	0.148	0.419***	0.430***	0.563***
Need for social support	0.019	0.056	0.001	-0.050	0.097	-0.188	0.026	0.133	0.051
Active avoidance	-0.034	0.027	0.013	-0.051	0.008	-0.220*	0.020	0.025	-0.002
Escape tendency	-0.274**	-0.133	-0.275**	-0.236*	-0.172	-0.228*	-0.146	-0.148	-0.158
Perseveration	-0.397***	-0.305**	-0.454***	-0.163	-0.194	-0.150	-0.369***	-0.266**	-0.415***
Resignation	-0.518***	-0.467***	-0.613***	-0.244*	-0.377***	-0.133	-0.353***	-0.319**	-0.455***
Self-accusation	-0.319**	-0.283**	-0.397***	-0.262**	-0.140	-0.028	-0.201**	-0.069	-0.322**
Negative coping	-0.468***	-0.364***	-0.543***	-0.267**	-0.275**	-0.153	-0.344***	-0.264**	-0.434***
Positive coping	0.588***	0.481***	0.615***	0.323**	0.438***	0.085	0.417***	0.407***	0.547***

Abbreviations: * p<0.05; ** p<0.01; *** p<0.001

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

sion analysis showed that symptoms severity (subjCGI), Positive coping strategies (especially Positive Self-instruction), Difference between the objCGI and subjCGI and Negative coping strategies explain totally 53.8% of variance of the QoL (Tables 1–3).

Conclusions Our study suggests the importance of utilizing the Positive coping strategies in improving the quality of life in patients with psychotic disorders.

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

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EW524

Self-stigma and quality of life in Psychopharmacs treated outpatients with schizophrenia and related disorders - A cross-sectional study

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Introduction Self-stigma is a maladaptive psychosocial phenomenon that can disturb self-image and quality of life in psychiatric outpatients and may lead to dysphoria, social isolation and reduced adherence to treatment.

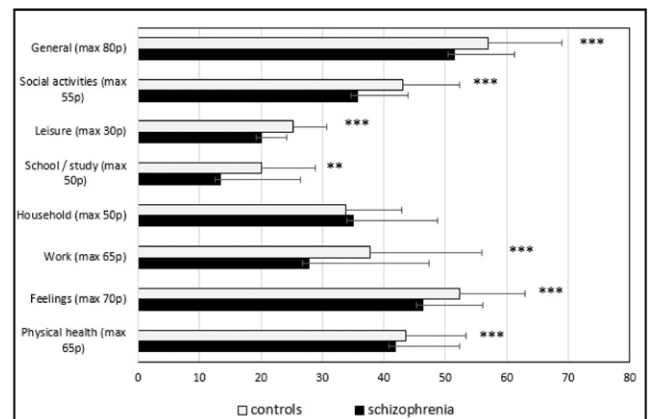
Objectives Self-stigma and QoL could be reflected as important factors for patients, who suffer from schizophrenia spectrum disorders, their caregivers and mental health specialists. Focus on reducing the self-stigma in supportive and educational therapy could be an important factor in promoting a higher QoL.

Aims Current research moved attention to the relationship between demographic data, the severity of symptoms, self-stigma and quality of life in schizophrenic outpatients compared to the QoL in healthy controls.

Methods Patients who met ICD-10 criteria for schizophrenia spectrum disorder were recruited in the study. The Quality of Life Satisfaction and Enjoyment questionnaire (Q-LES-Q), Internalized Stigma of Mental Illness (ISMI) and severity of the disorder measured by objective and subjective Clinical Global Impression severity scales (CGI) were assessed.

Results One hundred and nine psychotic patients and 91 healthy controls participated in the study. Compared to the control group, there was a lower QoL and a higher score of self-stigma in psychotic patients. We found the correlation between the self-stigma, duration of disorder and QoL. The level of self-stigma correlated positively with total symptom severity score and negatively with the QoL. Stepwise regression analysis revealed that the objective severity and self-stigma score were significantly associated with the quality of life (Tables 1 and 2, Fig. 1).

Conclusions Our study suggests a negative impact of self-stigma level on the quality of life in patients suffering from schizophrenia spectrum disorders.



Notes: Statistically significant relation was marked by *; Abbreviations: * p<0.05; ** p<0.01; *** p<0.001

Fig. 1 Q-les-Q domains in the controls and the patients. Statistically significant relation was marked by *. *P<0.05; **P<0.01; ***P<0.001.