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Introduction Anxiety, depression, and stress in pregnancy are risk factors for adverse outcomes for mothers and children (Glover, 2014). There is good evidence showing a decrease in psychological distress when pregnant women participate in interventions comprising mindfulness and self-compassion practices (Dunn et al., 2012). However, there are few studies on the relationship between mindfulness, self-compassion and psychological distress variables in pregnancy, without being within the scope of intervention trials (Cohen, 2010; Zoeterman, 2014).
Objective To explore the association between mindfulness, self-compassion and psychological distress/PD in pregnant women.
Methods Four hundred and twenty-seven pregnant women (mean age: 32.56 ± 4.785 years) in their second trimester of pregnancy (17.34 ± 4.790 weeks of gestation) completed the Facets of Mindfulness Questionnaire-10 (FMQ-10; Azevedo et al., 2015; to evaluate Non-udging of experience/NJ, acting with awareness/AA and observing and describing), Self-Compassion Scale (SCS; Bento et al., 2015; to evaluate self-kindness/SK, self-judgment, common humanity, isolation, mindfulness and over-identification) and Depression Anxiety and Stress Scale-21 (DASS-21; Xavier et al., 2015). Only variables significantly correlated with the outcomes (Total DASS-21, Stress, Anxiety and Depression) were entered in the multiple regression models.
Results FMQ-10 and SCS Total scores were both significant predictors of DASS-21 ($B = -.335, -.296$). Stress predictors were NJ, AA, SK and isolation ($B = -.164; -.196; -.087; .353$); Anxiety predictors were NJ, SK and isolation ($B = -.198; -.124; .268$); depression predictors were NJ, SK and Isolation ($B = -.277; -.128; .232$) (all $P < .01$).
Conclusions Mindfulness and self-compassion dimensions, particularly non-udging of experience and self-Kindness are protective for PD in pregnancy. Isolation is a correlate of PD in pregnancy.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV792

Non-Attendance at initial appointments in an Outpatient Mental Health Centre

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Introduction Non-attendance at initial appointments is an important problem in outpatient settings and has consequences, such as decreased efficient use of resources and delayed attention to patients who attend their visits, and that compromises quality of care.
Objectives To identify and describe the characteristics of patients who do not attend the first appointment in an adult outpatient mental health center, located in Barcelona.
Method Retrospective study. The sample was made up from all patients who had a first appointment during 2014 in our outpatient mental health centre. Socio-demographic and clinical data (type of first appointment, reason for consultation, origin of derivation, priority, history of mental health problems) were described. The results were analyzed using the SPSS statistical package.
Results A total of 272 patients were included. Twenty-six per cent did not attend their first appointment; with mean age 39.75 years and 51.4% were male. Most frequent problems were anxiety (41.7%), depression (26.4%) and psycosis and behavioural problems (11.2%). The origin was primary care (83.3%), social services (4.2%) and emergencies (2.8%). Most of them were not preferent or urgent (86.1%). The 51.4% of non-attendees had history or psychiatric problems and 13.9% nowadays are patients of our mental health centre.
Conclusions It is important to develop mechanisms that can reduce the incidence of first non-attended appointments. In our case, most of them are attended by primary care so we can establish better communication with our colleagues and try to contact to the patients prior to the date of the appointment.
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Medical comorbidity related risk factors for hospital-based mortality in psychiatric disorders of ICD-10 classes F1–F4: A comparative overview of five studies in general hospital admissions

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Introduction Up to 60% of the non-suicide related premature mortality of individuals with major psychiatric disorders is said to be mainly due to medical diseases.
Objectives and aims Based on five representative studies in general hospital admissions over 12.5-year observation, we will represent a comparative overview of medical comorbidity related risk factors for general hospital-based mortality in prevalent psychiatric disorders of ICD-10 major classes F1–F4.
Methods In the original studies, medical comorbidities that increased the risk for hospital-based mortality were identified using multivariate forward logistic regression analysis. In secondary analysis, independent risk factors for general hospital-based mortality were compared between studies using the OR and the 95% CI.
Results A total of fifteen medical comorbidities represented independent risk factors for general hospital-based mortality in more than one psychiatric disorder of ICD-10 major classes F1–F4. Infectious lung diseases and chronic obstructive pulmonary disease were mortality risk factors in all diagnostic classes. Type 2 diabetes mellitus represented a risk factor for general hospital-based mortality in individuals with schizophrenia (SCH), bipolar disorder (BD), and major depressive disorder (MDD). Atrial fibrillation was a mortality risk factor in individuals with MDD, anxiety disorder (ANX), and alcohol dependence (AD). In addition, nineteen medical comorbidities represented independent mortality risk factors in only one of the diagnostic classes, i.e. two in individuals with SCH, three in individuals with MDD, three in ANX, and eleven in AD.
Conclusions In general hospitals, the pattern of medical comorbidities that explain the outcome of in-hospital deaths differs considerably between psychiatric disorders of ICD-10 major classes F1–F4.
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