[2] Dalhousie University, Community Health and Epidemiology, Halifax, Canada
* Corresponding author.

Introduction Depression is among the most common mental illnesses in Canada. Although many factors contribute to depression, stress is among the most commonly reported. Studies suggest that marginalized groups often experience high levels of stress.
Objective To examine associations between ethnicity and depressive symptoms among university students.
Aim To identify if ethnic groups, particularly Aboriginal students, are at greater risk of depression.
Methods Online survey data were collected from students attending eight universities in the Canadian Maritime Provinces ($n = 10{,}180$). Depressive symptoms were assessed using the 12-item version of the Center for Epidemiological Studies Depression Scale. Ethnicity was organized into five groups: Caucasian only, Aboriginal only, Aboriginals with other ethnicities, Mixed Ethnicity (not including Aboriginal), and Other (single ethnicity not including Aboriginal or Caucasian). Unadjusted and adjusted logistic regression models were used to assess associations between ethnicity and elevated depressive symptoms. Adjusted models accounted for demographic, socioeconomic, and behavioural characteristics.
Results In adjusted analyses for men, Mixed (OR: 2.01; 95% CI: 1.12–3.63) and Other ethnic students (OR: 1.47; 95% CI: 1.11–1.96) were more likely to have elevated depressive symptoms than Caucasians. There were no differences between those who were Aboriginal and those who were Caucasian. In unadjusted and adjusted analyses for women, depressive symptoms in ethnic groups (including Aboriginals) were not significantly different from Caucasians.
Conclusion Among male university students in the Maritime, ethnicity (other than being Aboriginal) was associated with depressive symptoms in comparison to Caucasians, after adjusting for covariates. However, among women, ethnicity was not significantly associated with depressive symptoms.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV549

Effect of a single nights' wake followed by bright light therapy on agitation

M. Widmark-Jensen[1,*], S. Steingrimsson[2], Z. Szabó[1]
[1] Sahlgrenska University Hospital, Clinical Department of Psychiatry, Gothenburg, Sweden
[2] Institute of Neuroscience and Physiology, Sahlgrenska Academy, Gothenburg, Sweden
* Corresponding author.

Introduction Wake-therapy (or "Sleep deprivation") has the potential of providing a fast anti-depressive response as add-on treatment to pharmaceutical intervention. Agitation in a depressive state is well known and is often associated with interrupted sleep. Although hypomanic symptoms have been reported following a single nights wake, agitation has not been examined.
Objective To examine if agitation increases among inpatients undergoing wake-therapy compared to treatment as usual (TAU).
Methods Admitted patients suffering from a depressive episode will be randomized to either wake-therapy combined with bright light therapy in addition to TAU, including medication, or to TAU alone. Before wake-therapy, patients are assessed using PANSS-EC, aimed at measuring only agitation. The day after a single nights wake, the assessment will be repeated. Likewise, agitation will be assessed in the control group directly after randomization as well as the day after.
Results In this trial, 50 patients will be randomized for treatment. Results concerning agitation among patients that have undergone the trial will be presented.
Conclusions Agitation as a side effect of wake-therapy has been scarcely investigated and this randomized trial will contribute to the knowledge of agitation following wake-therapy.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV552

Consensus statements on cognitive dysfunction in depression in the UK: Rationale and process for gaining consensus

A.H. Young[1,*], K. Bones[2], G. Goodwin[3], J. Harrison[4], C. Katona[5], H. McAllister-Williams[6], J. Rasmussen[7], S. Strong[8]
[1] Institute of Psychiatry, Psychology and Neuroscience IoPPN, Psychological Medicine, London, United Kingdom
[2] Sussex Partnership NHS Foundation Trust, Occupational Therapy and Recovery Practice, Sussex, United Kingdom
[3] Oxford University, Department of Psychiatry, Oxford, United Kingdom
[4] VU University Medical Center, Alzheimer Center, Amsterdam, Netherlands
[5] University College London, Psychiatry of the Elderly, London, United Kingdom
[6] Institute of Neuroscience, Newcastle University, Academic Psychiatry and Regional Affective Disorders Service, Newcastle, United Kingdom
[7] Moat House Clinic, General Practice, Surrey, United Kingdom
[8] Depression Alliance, Support Group, Croydon, United Kingdom
* Corresponding author.

Introduction Cognitive dysfunction is an important aspect of depression that includes problems with thinking, concentration and memory. Research suggests that the cognitive aspect of depression is highly prevalent and has a significant impact on patient functioning. Currently, cognitive dysfunction in depression is largely unrecognised, unmonitored and untreated.
Aims We aim to define cognitive dysfunction in clinical depression (major depressive disorder) and explore its detection and management in the UK, highlighting priority areas to be addressed.
Methods A modified Delphi method was used as the process to gain consensus. A multi-stakeholder steering committee of depression experts (including psychiatrists, psychologists, primary care physicians, and representatives from occupational therapy and a depression charity) provided the key themes and, through round-table discussion, developed draft statements. The main areas of focus were burden, detection and management of cognitive dysfunction in depression. These statements formed a questionnaire to be reviewed by 150–200 health-care professionals with an involvement in the management of depression, with level of agreement noted as 'strongly disagree', 'disagree', 'don't know/uncertain', 'agree' or 'strongly agree'. Responses to the questionnaire will be analysed (very high agreement [>66%] or very low agreement [<33%]) and the steering committee will revise and finalise the consensus statements, and identify priority areas for future consideration. The steering committee was initiated and supported by the pharmaceutical company Lundbeck Ltd, through an educational grant. Lundbeck Ltd did not influence content.
Results Results of the questionnaire and the evolution of the final consensus statements will be presented.
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