

gender, father's low level of education, divorce, and mother's and father's internet usage time being between 0-1 hour/day. When the diagnoses of the patients were examined, 39 (22%) adolescents were diagnosed with neurodevelopmental disorders, 37 (21%) adolescents with mood disorders, and 68 (39%) adolescents with anxiety disorders. When the diagnosis groups were examined and the status of being a cyberbully or cybervictim, no significant difference was found in any diagnosis group. No significant relationship was observed between the adolescent's diagnosis of any mental disorder and being a cyberbully or victim.

Conclusions: Cyberbullying is not an issue to be taken lightly, and because it often co-occurs with traditional bullying, prevention and intervention programs need to address both contexts. In our study, it was determined that the majority of cyber victims were also cyberbullies. This situation shows the importance of evaluating bullying situations even though adolescents apply as victims in the clinic interviews. The results suggest that parents do not have enough knowledge about safe internet use and cannot control and guide their children properly. Therefore, during clinical interviews, cyberbullying/victimization issues should be discussed with mothers and fathers and how they can provide information to their children on this issue and safe internet use should be discussed.

Disclosure of Interest: None Declared

EPV0290

Is there a connection between Mental Health issues and poverty? A service evaluation in East Norfolk and Suffolk, UK

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doi: 10.1192/j.eurpsy.2025.1118

Introduction: It is well established that living, or growing up, in poverty has a negative impact on both physical and mental health. The area our service covers includes Great Yarmouth and Lowestoft, 2 of the most economically impoverished areas of the UK. The vast majority of our patient group will have grown up in relative poverty. While there are associations between poverty and impaired physical health and increased risk of some mental health conditions, the actual causal link is unclear.

Objectives: To explore if there appears to be a link between growing up in poverty and developing a significant mental illness.

Methods: Data analysis from Consultant caseload list.

We do know that there are some factors associated with both poverty and increased risk of mental illness and these include;

- Parental drug or alcohol abuse
- Parental mental health problems (if these are not well managed)
- Early/premature death of a parent
- Exposure to domestic violence
- Physical abuse
- Going into the Care System
- Early drug or alcohol use
- Early separation or loss of a parent

Results: Findings

Total number of patients = 122

Number who have a specific factor associated with poverty = 56
This equates to 46% of my current caseload.

Gender = 35 female (62.5), male 21 (37.5%)

Conclusions: Summary of Findings – “*The poor bear the greatest burden of mental illness*” (2)

This would certainly seem to be the case, from the findings of this service evaluation. Our findings show that a significant percentage of our patient group have mental health issues directly related to poverty.

It is worth noting that the vast majority of my patient case load grew up in poverty, due the demographics of the area we work in (a quick analysis suggests about 97% of my case load are from working class, impoverished backgrounds). We abandoned recording “parental unemployment” in this analysis, because for all but a few, this was the case. Unemployment is an entrenched issue in this area, with the demise of the shipping and offshore industries, currently standing at 5.4% in Yarmouth and 3.5% in Lowestoft (3) (National average 3.8%). For those that are employed, poverty is a significant issue with many in low paid jobs. I have also not included here factors associated with poverty, such as poor diet, smoking, malnutrition, poor dentition, and obesity, but we know these are the case for many patients seen here.

Disclosure of Interest: None Declared

EPV0291

Affective, Behavioural, and Cognitive Disorders (ABCD) of Childhood and Adolescence: Renaming and Regrouping

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doi: 10.1192/j.eurpsy.2025.1119

Introduction: Psychiatry focuses on disorders of affect, behavior, and cognition (ABC), with half of all psychiatric disorders emerging by age 14 and three-quarters by age 24. Disorders are categorized into four types: Type 1 (affective disorders like depression and anxiety), Type 2 (behavioral disorders like ADHD and ODD), Type 3 (developmental disorders like mental retardation and speech/language issues), and Type 4 (dysfunctional disorders, including psychotic illnesses and mood disorders). These categories—emotional, behavioral, cognitive, and dysfunctional—form the ABCD framework in child psychiatry.

Objectives: The study aimed to categorize childhood and adolescent mental and behavioral disorders into four groups: developmental, disruptive, emotional, and dysfunctional. It also sought to examine intra- and inter-group comorbidities, and analyze the clinical variables of these groups and their comorbidities by age and sex.

Methods: This was an observational cross-sectional study conducted at Gauhati Medical College Hospital (GMCH), Guwahati, Assam, from September 7, 2018, to September 6, 2019. Existing diagnostic systems do not distinguish between child/adolescent and adult mental health, and there is a lack of a unified “common language” for childhood and adolescent mental and behavioral disorders. The study aimed to address this gap, particularly in the