

Results: The mean PHQ-9 score was 3.2 (SD 3.8). The value is highly comparable with other general population studies. At the cut-off score of 8, sensitivity was .85 and specificity was .91. At the cut-off value of 10, sensitivity dropped to .74, suggesting that the optimal cut-off score was 8. ROC analysis showed that the area under the curve was .95, indicating that the Serbian PHQ-9 can discriminate very well between persons with and without depression (Figure 1).

Table 1. Sensitivity, specificity and likelihood ratio tests at various cut-off points of the PHQ-9

Cut-offs	Sensitivity	Specificity	LR+	LR-
≥ 5.5	.96	.82	5.33	0.05
≥ 6.5	.89	.87	6.73	0.13
≥ 7.5	.85	.91	9.06	0.16
≥ 8.5	.74	.94	11.95	0.28
≥ 9.5	.74	.96	16.84	0.27
≥ 10.5	.63	.96	17.03	0.39
≥ 11.5	.59	.97	21.18	0.42
≥ 12.5	.59	.98	31.21	0.42

Conclusions: PHQ-9 is a highly useful screening tool, but the same cut-off score might not be appropriate in all settings. In European countries, studies of the general population that determine optimal cut-off PHQ-9 value against a validated interview to detect depression are rare. We demonstrated that the cut-off of ≥8 balances best its sensitivity and specificity when assessed against the structured diagnostic interview in the general population.

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O0018

Parent-child nativity, race, ethnicity, and mental health conditions among U.S. children

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Introduction: Over a quarter of U.S. children have at least one immigrant parent. Mental health disparities in children need to be assessed to better identify disproportionate burdens and promote health equity.

Objectives: To assess the associations between race, ethnicity, and parent-child nativity, and mental health conditions in the U.S.

Methods: Data were from the 2016-2019 National Survey of Children's Health (n=114,476 children aged 3-17 years), a nationwide, cross-sectional survey. Outcome variables included three mental

health conditions (depression, anxiety, and behavior or conduct problems) reported by the parent/guardian. Additional measures included questions about healthcare access and use, demographics, and nine household challenge adverse childhood experiences (ACEs) used to quantify a total ACE score (0-9). Information on nativity was used to define immigrant generation (1st, 2nd, and 3rd+). Weighted logistic regression was used to assess the associations between race/ethnicity (Asian, Black, Hispanic, White, and Other), household generation, and outcome variables, among children who reported access to or utilized health services, adjusting for demographics. Multiple imputation was used to handle missing data.

Results: Asian, Black, Hispanic, and White 3rd+ generation children had increased odds of depression compared to their 1st generation counterparts, same as among White, 2nd generation children. Race/ethnicity was not associated with depression among 1st and 3rd+ generation children, but Asian, Black, and Hispanic children had lower odds of depression compared to White children among 2nd generation children. Asian, Black, Hispanic, and Other-race 3rd+ generation children had increased odds of anxiety compared to their 1st generation counterparts, with similar findings also observed for Black and Other-race 2nd generation children. Being racial/ethnic minorities was generally associated with decreased odds of anxiety among 1st and 2nd generation children compared to White children from the respective generations. Asian, Black, Hispanic, and Other-race 3rd+ generation children had increased odds of behavior/conduct problems compared to their 1st generation counterparts. The observed associations remained significant after adjusting for the modified ACE score.

Conclusions: We found significant differences in several mental health conditions in children by parent-child nativity, race, and ethnicity that could not be explained by demographics, childhood adversity, and healthcare access and use. Lower odds of mental health conditions among minority children could represent differences due to factors such as differential reporting, and higher odds of mental health conditions, including in third- and higher generation children, need further investigation to develop approaches to promote mental health equity.

Disclosure of Interest: None Declared

O0019

Borderline personality disorder in Irish Travellers: a cross-sectional study of an ultra-high-risk group

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Introduction: Irish Travellers are recognised as a minority ethnic group in Ireland. While mental health services are available to Travellers, these services are often perceived as inadequate at addressing the mental health needs of this population. Studies have shown that there is a higher prevalence of mental disorders in the Traveller community in Ireland compared to the general Irish

public. However, it is unclear if Travellers are at a higher risk of developing personality disorders, particularly borderline personality disorder.

Objectives: This study will examine the prevalence of borderline personality disorder and other mental disorders in Travellers attending a community mental health service in Tuam, County Galway. This study will also investigate the biopsychosocial interventions delivered to this cohort and the clinical outcome following the interventions.

Methods: This is a cross-sectional study. Travellers who were active caseloads on the register of the community mental health service in Tuam were included in this study. Chart reviews were carried out on all samples included in this study.

Results: A total of 59 active patients were included in this study. The Traveller community formed 14.4% (59 out of 410) of the active caseloads of the Tuam mental health service. There were more male than female Travellers who attended the service. Mean age was 36 years old. The most common mental disorder in this study cohort is depressive episode (F32). This is followed by mixed anxiety and depressive disorder (F41.2). A significant minority (9, 15.3%) of the study participants were given a diagnosis of borderline personality disorder. 9 study participants await diagnostic clarification. Nearly one-fifth (18%, n=9) of the study participants with a diagnosis had been given a diagnosis of borderline personality disorder. Over 50% of the study participants were on at least 3 different medications from at least 2 different classes of psychotropics.

Conclusions: This study shows that there is a significant overrepresentation of Travellers attending the community mental health service in Tuam. The findings from this study can be used to plan future service development projects to better meet the needs of this unique population.

Disclosure of Interest: None Declared

O0020

From contact coverage to effective coverage of community care for patients with severe mental disorders: a real-world investigation from Italy. Methodology and results from the QUADIM project

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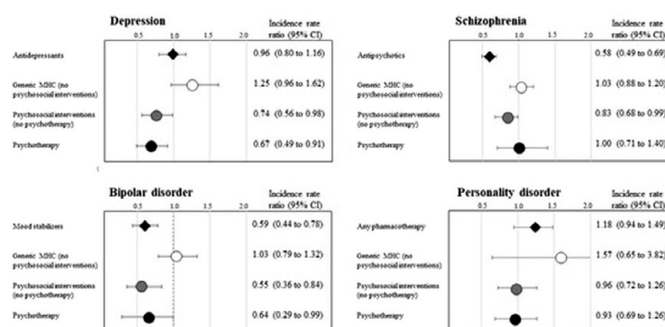
Introduction: The evaluation of healthcare pathways must be considered of fundamental importance. The quality of care provided to patients with severe mental disorders (SMD) does not correspond to the standards set by the recommendations. Therefore, measures such as the real coverage rate of psychiatric patients' needs (*contact coverage*), by comparing epidemiological prevalence rates and the number of patients receiving adequate care, could be a valuable resource for implementing the transition to community mental health. However, simple assessment and reporting of rates of contact with mental healthcare potentially overestimate the full expected health benefits of services. Therefore, in addition to monitor the coverage rate achieved by the services, the evaluation of the *effectiveness* of the care provided (*effective coverage*) [De Silva *et al.* Int J Epidemiol 2014;43(2):341–53] is also of relevant importance.

Objectives: To measure the gap between contact and *effective coverage* of mental healthcare, i.e., the *effectiveness* of interventions provided by services for the treatment of SMD in preventing an exacerbation of psychiatric symptoms.

Methods: Data were retrieved from Healthcare Utilization databases of four Italian Regions (Lombardy, Emilia-Romagna, Lazio, Sicily). 45,761 newly taken-in-care cases of depression, schizophrenia, bipolar, and personality disorder were included. A variant of the self-controlled case series method was used to estimate the incidence rate ratio (IRR) for the relationship between exposure (use of different types of mental healthcare such as pharmacotherapy, generic contacts with the outpatient service, psychosocial interventions, and psychotherapies) and relapse episodes (mental illness emergency hospital admissions).

Results: 11,500 relapses occurred. Relapse risk was reduced (**Figure**) during periods covered by (i) psychotherapy for patients with depression (IRR 0.67; 95% CI, 0.49 to 0.91) and bipolar disorder (0.64; 0.29 to 0.99); (ii) psychosocial interventions for those with depression (0.74; 0.56 to 0.98), schizophrenia (0.83; 0.68 to 0.99) and bipolar disorder (0.55; 0.36 to 0.84), (iii) pharmacotherapy for those with schizophrenia (0.58; 0.49 to 0.69), and bipolar disorder (0.59; 0.44 to 0.78). Coverage with generic mental healthcare, in the absence of psychosocial/psychotherapeutic interventions, did not affect the risk of relapse.

Image:



Conclusions: Psychosocial interventions, psychotherapies and specific pharmacotherapies can be considered particularly effective in treating patients with bipolar, depressive, and schizophrenic