

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

D. Collins¹ and J. Beezhold^{2*}

¹CFYP, NHS, Norwich and ²CYFP, NSFT, Great Yarmouth, United Kingdom

*Corresponding author.

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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

S. Das^{1*}, S. Ghosh², S. S. Bhandari³ and M. N. Tripathi⁴

¹Psychiatry, Dhubri Medical College & Hospital, Dhubri; ²Psychiatry, Assam Medical College & Hospital, Dibrugarh; ³Psychiatry, Sikkim Manipal Institute of Medical Sciences, Sikkim Manipal University, Gangtok and ⁴Psychiatry, Tripathi Clinic, Varanasi, India

*Corresponding author.

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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

local geo-cultural context, where data for a new classificatory system is scarce. Participants included children and adolescents admitted to the Child Psychiatry Unit or attending the Child Guidance Clinic. Demographic (age, sex) and clinical variables (ICD-10 diagnoses) were studied, with diagnoses categorized into types 1–4.

Results: Total sample size was 137. Adolescents (ten to 18 years of age) were almost double in numbers to that of children (below ten years of age). Boys outnumbered girls. Adolescents were more than children in both among girls and boys (even the single third gender was an adolescent). Most of the children and adolescents were having type 3 disorders, followed by type 1 and type 2 disorders. While majority had type 3 disorders below ten years of age (children), type 1 disorders were highest in the adolescents. Type 1 and type 3 disorders were almost equally distributed among girls, while boys predominantly had type 3 disorders. Within group comorbidity was maximum with type 3 disorders. Across group comorbidity was found mostly in type 2-type 3 disorders.

Conclusions: John Lennon “imagined” of having no countries and no religion too; thus, there will be nothing to kill and die for! Bono of U2 wanted to be there “where the streets have no name”! Likewise, we too dream of a land for child and adolescent psychiatry where if we cannot live without names then let us at least have a few and simple ones: ABCD!

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EPV0292

Obsessive-compulsive disorder in a child with poor tolerance to psychotropic drugs, the efficacy of psychotherapy

M. De La Fuente^{1*}, L. Cayon¹, M. Ruiz¹, P. Llano¹, M. Polo¹, R. Obeso¹, M. Hoyuelos¹, P. Hernandez¹, C. Sevilla¹, J. Romay¹, I. Ibarra¹, J. Posada¹ and M. Martinez¹

¹HUMV, Santander, Spain

*Corresponding author.

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Introduction: Obsessive-compulsive disorder (OCD) in children and adolescents presents similarly to that in adults, but with some particularities. In children, the most common obsessions are usually related to fears of contamination, harm to others, or catastrophic situations. The compulsions associated are often: excessive hand washing, repetitive checking, and the need for order. Treatment of OCD is based on both pharmacological measures and psychological therapies. At the pharmacological level, it focuses on the use of selective serotonin reuptake inhibitors (SSRIs). In terms of psychological treatment, cognitive behavioural therapy (CBT) is the psychotherapeutic intervention of first choice for the treatment of OCD, and is considered the most effective intervention, both in monotherapy and in combination with pharmacological treatment. Within CBT, the most effective is Exposure with Response Prevention (ERP).

Objectives: To present the adaptation of the different therapeutic interventions so that they are effective when applied to children, through a clinical case of a 10-year-old child with OCD.

Methods: Our patient first came to the emergency department due to intense anxiety, secondary to obsessive thoughts about suicide and sexual identity. Due to the incoercible anguish caused by these egodystonic thoughts and the secondary low mood, he was

admitted to hospital. At the pharmacological level, sertraline was progressively administered up to a dose of 100mg/day and psychoeducation was provided. Despite the initial improvement in anxiety and hospital discharge, after a couple of weeks there was a further worsening, which persisted despite increasing the dose of sertraline. In successive outpatient consultations, psychoeducational intervention and review of confrontation techniques were carried out. The patient began with clinical symptoms typical of hypomanic turn, so SSRIs was lowered back to the initial dose, and aripiprazole 5mg was added. The importance of CBT was emphasised, teaching the parents to practice it daily with their child. In the next visits, psychotherapy work continued in the form of role-play, explaining the difference between distraction and confrontation, lowering the SSRI to 50mg and maintaining aripiprazole. Clinical stabilisation was achieved and has been maintained since.

Results: We see with this case that pharmacological treatment, although necessary to obtain changes at the neuro-biological level, is not sufficient for clinical remission, and that intensive psychotherapy is the cornerstone of the intervention

Conclusions: In conclusion, in the treatment of childhood OCD, the combination of pharmacological and psychological interventions is essential. Although pharmacological treatment is important, it alone does not always guarantee complete remission, highlighting the need for a comprehensive therapeutic approach to achieve sustained results over time.

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EPV0295

Scaling A Positive Parenting Intervention from an Institutional Service to the Community Practice: A Qualitative Study of Net PAMA Classroom's Success Factors and Challenges

Q. Dejatiwongse Na Ayudhya^{1*}, C. Pornnoppadol¹, S. Chanpen¹ and W. Musikaphan²

¹Psychiatry, Siriraj Hospital, Mahidol University, Bangkok and

²Institution for Population and Social Research, Mahidol University, Nakhonprathom, Thailand

*Corresponding author.

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Introduction: Mental health issues in children and adolescents are often influenced by ineffective parenting strategies such as poor communication, harsh punishments, lack of positive reinforcement, and imbalance between relationship and regulation. Although effective parenting interventions exist, access is typically limited to institutional services. Net PAMA, an internet-based parent management training program, was created to improve access. However, only city-dwelling, educated parents were able to effectively learn from the platform. A combination of local facilitators and the internet-based program, called ‘Net PAMA Classroom’, was then proposed as means to reach out to underserved communities.

Objectives: This study examines the success factors and challenges of ‘Net PAMA Classroom,’ a community-based Parent Management Training intervention conducted by non-professional facilitators, with the use of the internet-based standardized program.

Methods: We interviewed fifteen Net PAMA Classroom facilitators. We then performed data triangulation and thematic analysis using Braun and Clarke’s six-step approach.