Methods: In this study, we included 66 hospitalized patients (57.6% female; mean age, 52.7 years) from the University Department of Psychiatry, University of Münster. Prior to iTBS treatment, 10 patients were treated with esketamine (60% female; average age, 49.8 years) and 56 were not (57% female; average age, 53.25 years). A Chi-squared test was utilized to investigate the impact of history of esketamine treatment on response to iTBS.
Results: The overall response rate was 51.5%. Prior to iTBS, 15% of the patients were treated with esketamine in the current episode. In the patient group with history of esketamine treatment (ESK+), 40% of the patients responded to iTBS. In the patients without history of esketamine treatment (ESK-) in the current episode, the response rate to iTBS was 53.6 %. However, history of esketamine treatment in the current episode had no significant impact on iTBS outcome ($P = 0.505$; $\chi 2 = 0{,}626$; $df = 1$). The difference in baseline disease severity between the groups was not statistically significant (CGI-S 6.3 (ESK+) vs 6.1 (ESK-), $P = 0.281$; $F = 1.184$; $df = 64$). The total rate of treatment dropouts was 3%.
Conclusions: History of esketamine treatment in the current episode was associated with worse outcome of iTBS. This finding was not statistically significant. iTBS may be an effective (40% response rate) and safe treatment for patients who did not respond to esketamine therapy.

Disclosure of Interest: M. Tonkul: None Declared, B. Baune Consultant of: Received speaker/consultation fees from AstraZeneca, Lundbeck, Pfizer, Takeda, Servier, Bristol Myers Squibb, Otsuka, LivaNova, Biogen, Angelini, and Janssen-Cilag., E. Kavakbasi Consultant of: Received speaker and advisor honoraria from LivaNova and Janssen-Cilag.

EPP402

Self-Assessment Scales for Depression Screening: A Review of Recent Trends

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Introduction: Depression significantly impacts quality of life, and the growing global mental health burden necessitates effective strategies for early detection. Traditional diagnostic methods often involve clinician-led interviews and assessments, which can be time-consuming and may not always be accessible to individuals in underserved or remote areas. As a result, self-assessment scales have emerged as a valuable tool for initial depression screening, offering a cost-effective and timely alternative that empowers individuals to monitor their mental health independently.
Recent trends in self-assessment tools for depression highlight the development of digital platforms, such as smartphone apps and web-based applications, which allow for greater reach and real-time data collection.
Objectives: The primary objective of this study is to systematically review recent trends in the development and use of self-assessment scales for depression screening. With the growing global prevalence of depression and the necessity for early detection, self-assessment tools have become a widely adopted method for screening, offering the advantage of accessibility, cost-effectiveness, and user autonomy. This study aims to evaluate these tools in terms of their psychometric properties, including reliability, validity, and sensitivity, which are crucial for ensuring accurate and dependable depression detection.
Methods: A systematic review methodology was employed, focusing on studies published between 2015 and 2024. The sample included 40 peer-reviewed articles sourced from academic databases, with studies chosen based on their relevance to self-assessment depression screening tools. The sampling strategy involved selecting scales used in diverse settings, including clinical environments, schools, and online platforms. Key tools such as the Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI), and the Depression Anxiety Stress Scales (DASS-21) were analyzed.
Results: Results indicated an increase in the utilization of digital and app-based self-assessment tools, with advancements in adaptive testing and machine learning-based algorithms improving the accuracy and sensitivity of depression screening. Additionally, the results showed promising psychometric reliability and validity across different cultural contexts. However, the study also highlights challenges, including the potential for over-reliance on self-reporting and the underrepresentation of marginalized populations in the development of these tools.
Conclusions: Despite the significant advancements in self-assessment scales for depression screening, challenges remain in ensuring that these tools are both equitable and inclusive. One critical area for future research involves addressing cultural and demographic biases that may limit the effectiveness of these scales in diverse populations.

Disclosure of Interest: None Declared

EPP404

Examining the needs, outcomes, and current treatment pathways of 2461 people with Treatment-Resistant Depression: A mixed-methods study

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Introduction: Major Depressive Disorder (MDD) is a pervasive global health issue, contributing significantly to disability and impaired quality of life. A substantial proportion of individuals with MDD develop Treatment-Resistant Depression (TRD), characterised by the failure to respond to at least two adequate antidepressant treatments (at an adequate dose and duration). TRD poses additional challenges due to its complex clinical presentation and limited treatment options, making it crucial to better understand its impact and develop more effective care strategies.
Objectives: To investigate the prevalence and clinical profiles of TRD in a large NHS Mental Health Trust and explore the treatment experiences and perceptions of TRD patients and healthcare professionals (HCPs) involved in their care.

Methods: A concurrent mixed-methods approach, incorporating patient and public involvement (PPIE), was used. Quantitative analysis of anonymised electronic health records (EHRs) identified the TRD cohort and key characteristics (e.g. age, gender, employment status). Binary logistic regression explored predictors such as comorbidities and service use. The qualitative component included semi-structured interviews with TRD patients (n=7) and HCPs (n=8), analysed using thematic analysis to explore lived experiences and treatment barriers. Findings from both approaches were integrated to provide a comprehensive understanding of TRD.
Results: TRD was prevalent in 48% of patients diagnosed with MDD. Predictors of TRD included recurrent depression (OR=1.24, CI 95%=1.05–1.45), comorbid anxiety (OR=1.21, CI 95%=1.03–1.41), personality disorders (OR=1.35, CI 95%=1.10–1.65), and cardiovascular diseases (OR=1.46, CI 95%=1.02–2.07). Qualitative findings highlighted the severe emotional impact of TRD on patients' lives and revealed significant dissatisfaction with treatment options, particularly frustration with the "trial and error" approach of pharmacological treatments. HCPs echoed concerns about the lack of standardised treatment pathways, with both groups emphasising the need for more holistic and personalised care, citing limited access as a serious barrier to effective treatment.
Conclusions: This study highlights the significant burden of TRD, affecting nearly half of MDD patients within the examined NHS Trust. By combining quantitative and qualitative methods, it offers a comprehensive understanding of TRD's prevalence and complexities. The findings support a shift toward holistic, patient-centred care, addressing institutional barriers and enhancing healthcare provider resources to improve outcomes.

Disclosure of Interest: None Declared

EPP405

Changes in depression medication following the initial assessment by specialised psychiatry services in the Helsinki-Uusimaa Region

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Introduction: Depressive disorders often require specialised psychiatric services. Timely, appropriate medication initiation and/or change plays a crucial role in improving patient (pt) outcomes (Kraus *et al.* Transl Psychiatry 2019;9 127).
Objectives: Describe the type of, and time to, medication changes within 12 months of the initial assessment of pts with depression recorded by specialised psychiatric care (SPC).
Methods: This cohort study leveraged Finnish pt data from 19 registries from 2014– 2020. Adult pts with a depression diagnosis recorded by SPC in the Helsinki and Uusimaa region in 2015 (with no depression diagnosis given by SPC within the previous year) were included. All treatments were recorded as monotherapy or combination/augmentation therapy. The Kaplan-Meier method was used to analyse time to treatment change (TTC).
Results: 9305 pts were included; baseline characteristics are reported (**Table 1**). There was no change to the baseline treatment status in 39.7% of pts (**Table 2**). The most common change was from no medication to monotherapy (2138 pts [45.6% of those with no treatment before]). 2202 (23.7%) pts remained untreated throughout the study. Median (95% confidence interval) TTC following the initial assessment by SPC was 53 (50–56) days (**Figure 1**).
Image 1:

Table 1. Baseline characteristics

	Total (N=9305)
Age, years, mean (standard deviation)	43.7 (14.6)
Gender, male, n (%)	3420 (36.8)
Medications before first SPC assessment, n (%)	
0	3581 (38.5)
1	3984 (42.8)
2	1452 (15.6)
3+	288 (3.1)

Medications before first SPC assessment were used for ≥4 weeks in the 12 months prior.
SPC: specialised psychiatric care.

Image 2:

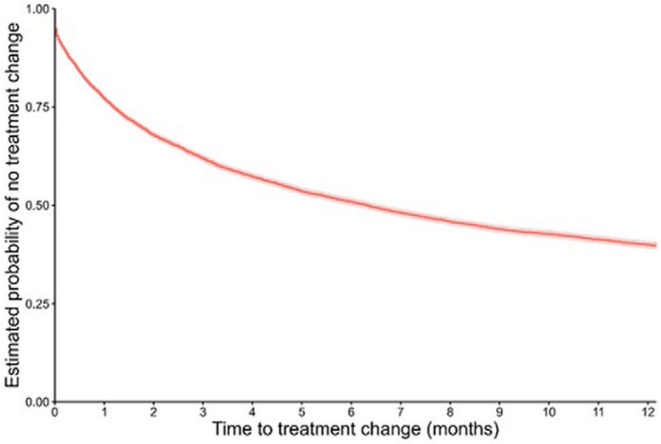
Table 2. Medication changes[a] following first SPC assessment, n, (%, calculated per 'treatment before' category)

From\To	No ongoing medication[b]	Monotherapy	C/A therapy[d]	No change
No ongoing medication[b]		2138 (45.6)	348 (7.4)	2202 (47.0)
Monotherapy	1417 (37.3)	261 (6.9)[c]	810 (21.3)	1312 (34.5)
C/A therapy[d]	75 (9.2)	414 (50.7)	150 (18.4)[c]	178 (21.8)

Treatment before/after: the latest ongoing treatment ≤12 months before consultation/the first treatment initiated ≤12 months since consultation.
[a]Medications were categorised as selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, TCAs, monoamine oxidase inhibitors, mood stabilisers, atypical antipsychotics or "other antidepressants"; [b]For 30 days prior to first SPC assessment; [c]Substance class changes: changes within therapy type; [d]Combination: use of ≥2 medications simultaneously for ≥30 days; Augmentation: addition of atypical antipsychotics, quetiapine, lithium or lamotrigine to existing antidepressant therapy for ≥30 days. C/A: combination/augmentation; SPC: specialised psychiatric care; TCA: tricyclic antidepressants.

Image 3:

Figure 1. Time to treatment change



Treatment change reported as a composite of all possible changes. For the full population (N=9305), median (95% CI) TTC was 189 (178–200) days. For pts experiencing treatment change within 365 days after consultation (N=5613), TTC was 53 (50–56) days.
CI: confidence interval; TTC: time to treatment change.