

among religious immigrants, including eliciting experiences within the mental health care system.

Methods: To meet these aims, we employed a qualitative community-based approach, conducting in-depth semi-structured interviews with 58 first- or second-generation immigrants to Canada who identified as people of religious faith, comprising Christians, Muslims and Jews. All participants had used a mental health service in recent years, and they reported a variety of mental disorders, mostly depression and anxiety. Interviews were transcribed and data was analyzed using thematic analysis techniques.

Results: Analysis revealed three core barriers to service utilizations. First, participants often reported that some people in their social circle (such as parents and clergy) held stigmatizing views of mental illness, including sceptical views about the reality of mental illness. This contributed to self-stigma, inhibited disclosure and delayed help-seeking. Second, participants stated that service providers typically had a very limited understanding of the cultural and religious context of their lives, and sometimes conveyed a dismissive or ignorant attitude towards their deeply-held religious beliefs and practices. This negatively affected service utilization and the development of a therapeutic alliance. Third, some participants noted that they (and other members of their communities) lacked knowledge about mental illness, available treatments, and effective therapies, meaning they were unaware of potential services and supports.

Conclusions: The results suggest an urgent need for a multi-pronged approach to better engage religious minorities with mental distress. On the clinical side, there is a need for more religious and cultural competence training for Canadian clinicians. On the community side, culturally-appropriate anti-stigma and mental health literacy interventions may need to be co-created and implemented in partnership with different immigrant communities in Canada.

Disclosure of Interest: None Declared

Others

EPP046

Clinical and psychosocial variables associated to higher costs in schizophrenia spectrum disorders

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Introduction: In Italy, in 2000, the estimated annual economic burden of schizophrenia was 25.000 € per patient, of which 30% were direct costs and 70% indirect costs (Tarricone et al., 2000). Yet, a steep growth has been observed throughout the years: a study showed a yearly expenditure of 41.290 € per patient in 2020 (Latorre et al., 2022).

Objectives: The aim of this study was to better characterize the association between direct costs and clinical and psychosocial variables in schizophrenia spectrum disorders (SSD).

Methods: A total of 276 individuals with schizophrenia spectrum disorders receiving treatment from the Community Mental Health Centers of Brescia (Italy) were included in the study: for each participant socio-demographic, clinical and functional characteristics were assessed, and data related to the use of services in 2022 (then converted to costs) were collected. Clinical and functional characteristics were assessed using the Clinical Global Impression-Severity (CGI-S) scale, the Personal and Social Performance Scale (PSP) scale and the Positive and Negative Syndrome Scale (PANSS). Correlations between the included variables were performed using SPSS v28; values of $p < 0.05$ were considered statistically significant.

Results: Our analyses identified a direct healthcare expenditure of 16477.23 € per patient per year. A positive correlation was observed between higher costs and higher scores at the CGI-S ($p < 0.001$), the PANSS total ($p < 0.001$) and all the PANSS subscales (all $p < 0.001$). Moreover, a negative correlation between higher costs and age of onset ($p = 0.010$) and PSP total score ($p < 0.001$), were observed.

Conclusions: An earlier age of onset, a more severe clinical presentation and a worse psychosocial functioning are associated to a higher expenditure in terms of direct costs associated to use of services in SSD. These results prompt to the implementation of interventions that aim at improving not only clinical aspects, but also functional ones: a full functional recovery would not only benefit patients, but also lead to a lower impact of SSD on healthcare systems. One limitation of the present study is that the estimation of the costs was based on a direct analysis of costs related to the use of services, therefore excluding indirect costs. Future studies should include data on pharmacological treatments, comorbidities and other clinical variables central to the disorder, such as cognition.

Disclosure of Interest: None Declared

EPP047

The Role of Religiosity in Anxiety and Life Satisfaction: Insights from Sociodemographic Data

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Introduction: The connection between well-being and various sociopsychological factors such as age, gender, education level, and more is a growing and significant area of interest in today's studies.

Objectives: The aim of this study is to examine the relationship between sociodemographic factors, life satisfaction, levels of anxiety, and religiosity. To achieve this goal, the study explored whether religiosity has an effect on anxiety and life satisfaction on the one hand, and whether sociodemographic variables influence the centrality of religion in participants' lives on the other.

Methods: To ensure honest responses, the surveys were filled out anonymously. Statistical analyses were conducted using the SPSS program, applying Pearson Correlation and Analysis of Variance