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.

This work was supported by the Science Fund of the Republic of Serbia, grant number #7528289. The special research program on Covid-19 is financed by a World Bank loan through Serbia Accelerating Innovation and Entrepreneurship Project – SAIGE.

Disclosure of Interest: None Declared

O0018

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

K. Zarei[1]*, L. Kahle[2], D. Buckman[2], K. Choi[1] and F. Williams[1]

[1]National Institute on Minority Health and Health Disparities, Bethesda and [2]Information Management Services, Inc., Calverton, United States

*Corresponding author.

doi: 10.1192/j.eurpsy.2023.226

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

K. Tong[1]*, S. Costello[2], E. McCabe[2] and A. M. Doherty[3,4]

[1]National Forensic Mental Health Service, Central Mental Hospital, Dundrum, Dublin; [2]Department of Psychiatry, University Hospital Galway, Galway; [3]Department of Psychiatry, School of Medicine & Medical Science, University College Dublin and [4]Department of Psychiatry, Mater Misericordiae University Hospital, Dublin, Ireland

*Corresponding author.

doi: 10.1192/j.eurpsy.2023.227

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