challenges include limited inpatient and outpatient mental health services at the regional and district levels, shortage of well-trained professionals, poor funding by the government and difficulties for the patients to pay for medical costs, poor telecommunication services and the lack of adequate infrastructure.
Objectives: We present a novel model of professional psychiatric mobile clinic, Gye Nyame Mobile Clinics, in remote areas in Ghana. This comprehensive service package connects the current loose ends of existing structural efforts in the subdistricts, trains regularly district hospital teams and bridges the gap between district hospital, primary health posts down to every patient.
Methods: In this retrospective descriptive study we collected demographic data of all the patients who visited the Gye Nyame professional mobile clinic in Psychiatry (GNMC) from November 1, 2008 to October 31, 2019 in the ten health posts of Ghana's Ashanti Region
Results: Between November 2008 and October 2019, we counted 16.370 visits of patients with psychiatric/ neurological diagnosis. The patients suffered mostly from schizophrenia in 24,1%, general convulsions in 40,8 % and other psychotic disorders in 5,9% of the visits. 78,5% returned to our mobile clinic for follow-up, 100% could be treated on outreach.
Conclusions: This community-based approach delivers psychiatric services to subdistrict and district levels and to patients who have no other access to these professional services. According to the results, a wide spectrum of pathologies and quantity of patients are seen – especially patients with no former treatment- the most common diagnosis in the rural area are schizophrenia, other psychotic disorders and generalized convulsions, followed by intellectual disabilities/autism spectrum disorder and cerebral malaria neuropsychiatric complications.
This is the first study to evaluate the implemented impact of integrated psychiatric services into existing structures in remote areas of LMIC`s.

Disclosure of Interest: None Declared

EPP0440

Outcomes of a community-based wellness screening tool administered by mental health professionals and religious leaders in the Ketu South Municipality in Ghana

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Introduction: Ghanaian community members with mental health conditions are usually not identified until their families cannot handle their care at home anymore, for example, due to mistrust in medical institutions. From community-based and global mental health research, we know *why* we should act (for example, early interventions improve the treatment outcomes) and *what* we should do (for example, task-sharing in community settings). *How* any of these activities can be implemented on the community level to decrease the delay of access to evidence-based care remains unclear.
Objectives: The study explored the "how" for a specific identified problem (collaboration between mental health professionals and religious leaders) in the Ketu South Municipality in Ghana; additionally, the study explored the feasibilty and the results of a community-based wellness screening.
Methods: We used a human-centered design approach to tackle this challenge in the Ketu South Municipality in Ghana. We invited 80 mental health professionals, religious leaders, and service users to participate in this exercise. The participants innovated the so-called *Brain Spirit Desk*, which builds collaboration between mental health professionals and religious leaders. The participants also designed a 9-question wellness screening tool, including four validated screening scales in Ghana: PHQ-2, GAD-2, one question about suicidality, and CAGE-AID. The participating religious leaders were trained to use this screening tool and administer it by themselves or allow mental health professionals to administer it in their respective institutions. Referral pathways were established for community members who screened positive on the wellness screening tool.
Results: 1065 community members (787 females, 278 males, mean age: 32.42 years) were screened using the wellness screening tool over five months (January - May 2022); 215 of these community members were already connected to mental health clinics in hospitals. 60 community members out of 203 who screened positive on the PHQ-2 were not receiving treatment at the time of screening and were referred for further assessment and treatment. Another 52, 53, and 142 community members were referred for further evaluation and treatment based on their answers to the GAD-2, suicidality, and CAGE-AID screening questions, respectively. Completed referrals across conditions averaged around 55%.
Conclusions: Our activities explored, guided through principles of a human-centered design approach, how the delay in access to evidence-based mental health care in the Ketu South Municipality in Ghana can be decreased through a collaborative effort of mental health professionals and religious leaders. A developed screening tool identified potential cases of mental health conditions. Importantly, religious leaders' involvement and endorsement built trust in the activities.

Disclosure of Interest: None Declared

EPP0441

Barriers and facilitators towards recovery and health service utilization among Haredi Jews with mental illness

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Introduction: Evidence suggests that minorities tend to underutilize mental health services, and may face specific barriers and facilitators towards recovery. One community which remains particularly under-researched in the Western World are Haredi Jews — a diverse group of individuals characterized by a shared devotion to traditional Talmudic and Halakhah teachings and observances.
Objectives: The overarching aim of this study is to document and analyze barriers and facilitators towards recovery and mental health

service utilization among Haredi Jews with a history of mental distress. Specific objectives include: (i) eliciting and understanding participants' mental health knowledge, beliefs, behaviours & attitudes; (ii) exploring their pathways and barriers to mental health care, especially examining the role of religiosity, religious community and rabbinical advice; and (iii) investigating their experience within the official mental health care system.
Methods: To gain an in-depth understanding, we conducted a qualitative study. This involved semi-structured interviews with 24 participants who (i) identified as Haredi Jews; (ii) had used mental health services; and (iii) were 18+ years of age. It also included interviews with several key stakeholders, for example local Rabbis and other community leaders. Data was analyzed using thematic analysis techniques.
Results: Participants typically had experienced mild to moderate mental distress, and tended to view mental health services in a positive light, mainly expressing satisfaction with services received. The analysis revealed three important facilitators and three important barriers to recovery. Facilitators comprised of (i) high levels of social support within the community, including specific well-being support groups; (ii) a positive relationship and connection with G-d, considered to provide guidance and support during troubled times; and (iii) the presence of many bridges and resources within the local Haredi community, including community-run health services, and Rabbis who encouraged mental health care utilization where appropriate. Barriers comprised of (i) stigma related to marriageability of self and offspring, inhibiting disclosure and mental health care use; (ii) acknowledged lack of awareness and knowledge about mental health, mental illness, treatments, and therapies; and (iii) generic health service issues, including long waitlists, limited availability and lack of appropriate therapists.
Conclusions: Study participants tended to have positive views of psychiatric services, and utilized different health care and community-based resources to help foster recovery. However, ongoing issues of stigma and low levels of mental health literacy may inhibit mental health care use and recovery. This implies a need for religiously-informed and community-grounded mental health literacy campaigns among Haredi Jewish communities.

Disclosure of Interest: None Declared

EPP0442

Translation and cross-cultural validation of the Turkish, Moroccan Arabic and Moroccan Berber versions of the 48-item Symptom Questionnaire (SQ-48)

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Introduction: First generation immigrants in many European countries have insufficient mastery of the host language to complete self-report questionnaires. To address this problem, we translated and validated Turkish, Moroccan Arabic and Moroccan Berber versions of the Dutch 48-item Symptom Questionnaire (SQ-48), which is a validated and clinical useful measure of psychopathology.
Objectives: Therefore, this study describes the translation and cross cultural validation of the Turkish, Moroccan Arabic, and Moroccan Berber versions of the 48-item Symptom Questionnaire.
Methods: Four samples were used: 1) psychiatric outpatients with Turkish or Moroccan background (n=150); 2) non-psychiatric subjects with Turkish or Moroccan background (n=103); 3) native Dutch psychiatric outpatients (n=189); 4) native Dutch non-psychiatric subjects (n=463). Data were analysed by confirmatory factor analysis and receiver operating characteristic curves.
Results: The 253 psychiatric non-native patients and controls were on average 38,3 years old (SD 12,4), and 61% were women. Internal consistency of SQ-48 subscales across groups was adequate to high, the seven-factor structure of SQ-48 fitted the data adequately in the total sample and in each separate group, and AUC values showed acceptable to excellent discrimination. However, the mean severity scores for all SQ-48 subscales were significantly higher in the immigrant groups than those of the Dutch native group. We found full configural, metric and partial scalar invariance.
Conclusions: Psychopathology measured by SQ-48 can largely be interpreted in the same way for persons from different immigrant backgrounds. However, cut-off values for Dutch natives should be ascertained using larger samples as these are likely higher than in Dutch psychiatric patients.

Disclosure of Interest: None Declared

Depressive Disorders 03

EPP0443

Major Depressive Disorder Across Development and Course of Illness: A Functional Neuroimaging Meta-Analysis

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Introduction: Functional magnetic resonance imaging (fMRI) has been used to identify the neural activity of both youth and adults diagnosed with major depressive disorder (MDD) in comparison to healthy age-matched controls. Previously reported abnormalities in depressed youth appear to mostly align with those found in depressed adults; however, some of the reported aberrant brain activity in youth has not been consistent with what is observed in adults, and to our knowledge there has not yet been a formal, quantitative comparison of these two groups. In addition, it is not known whether these observed differences between youth and adults with depression are attributable to developmental age or length-of-illness.