Job satisfaction (β = 0.154, p < 0.001) and self-rated health (β = 0.175, p < 0.001) were the most strongly associated with happiness. Organizational commitment, region of work, average monthly income, education level, and number of guaranteed leaves were also strongly associated with happiness and life satisfaction. Life satisfaction had the highest adjusted R^2 at 0.423. The adjusted R^2 for happiness and the ladder approach were 0.283 and 0.213, respectively. The variance inflation factor was below 10, and residuals were below 0.1 for all predictor variables.

Conclusions: Our results indicated that personal and work-related factors were associated with the happiness and life satisfaction of workers. Among work-related factors, subjective, intrinsic rewards such as job satisfaction and organizational commitment were more strongly associated than external rewards such as average monthly income or guaranteed vacations. These findings may be useful foundational data in devising policies and interventions to promote workers' happiness and life satisfaction.

Disclosure of Interest: None Declared

EPP0333

A systematic review on the link between adverse childhood experiences (ACE) and later involvement in gang violence and extremist groups

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Introduction: Adverse childhood experiences are common and have been linked to a number of physical illnesses, as well as socioeconomic problems. Moreover, it has been proven that ACEs can increase chances of people showing criminal behaviour. The question arises whether people with ACEs also have an increased chance of joining extremist groups or violent gangs.

Objectives: The aim of this systematic review is to measure the ACE rates in violent extremists and gangs and to establish whether there is a pattern linking ACEs to violent extremist organizations and gangs.

Methods: The following databases were searched to retrieve relevant studies: the ProQuest Social Science database, Pubmed, Scopus. Eligible studies were articles of any study design that reported ACE rates in either extremists or gang members. Data was extracted and organized into a table and a quality assessment was performed using standardized tools (CASP and NHLBI). A narrative synthesis of the evidence was conducted. A meta-analysis could not be performed due to the heterogeneity of the studies.

Results: 22 studies (eight on extremists and fourteen on gang members) were included. The studies varied in terms of research design, sample size, location and measured ACEs. Quality also varied across the studies. The prevalence rates were heterogenous and ranged from 0% to almost 100%.

Physical abuse was the most addressed ACE (5 studies on extremists and 11 on gang members). Sexual abuse was the second most explored ACE (4 studies on extremists and 9 studies on gang members). Neglect and caregiver loss were also common ACEs, while the other ACEs were less represented in the two subpopulations. A comparison between the two subpopulations was difficult due to the differences in the studies.

Conclusions: While overall ACE rates were high in the two groups and some ACEs were salient in the two subpopulations, quality of evidence varied across the studies. No solid ACE pattern across the studies could be found. Moreover, there were only two prospective studies on gang members and none on extremists, so a causal relationship between ACEs and involvement in violent gangs or extremist organizations could not be established. Future research should concentrate on studies of this design, as well as on improving the quality of the evidence.

As ACEs are extremely common, researchers should also look beyond them when searching for causes of extremism or violent gang membership. Other negative events (bullying, racism) should also be explored.

Disclosure of Interest: None Declared

EPP0334

Long-term prediction of multidimensional social inclusion among patients with schizophrenia spectrum disorder

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Introduction: Poor social inclusion, as a cause and consequence simultaneously, has been associated with schizophrenia spectrum disorder (SSD). It can bring a substantial burden to individual families and the society. Previous studies lack 1) the quantitative exploration of (multidimensional) social inclusion which can enable the measurement and monitor of the level of social integration, 2) longitudinal and multivariate study designs, and 3) methodological comparison between the traditional and data-driven approaches for a better clinical suitability of monitoring and managing social inclusion.

Objectives: To build and compare 3-year models predictive of multidimensional social inclusion (mSI) among the SSD patients, using standard and data-driven approaches.

Methods: We used the baseline and 3-year follow-up data of 1,119 patients from the Genetic Risk and Outcome in Psychosis. Social functioning (Social Functioning Scale, SFS) and quality of life (the brief version of the World Health Organization Quality of Life,

WHOQOL-BREF) were used as a proxy of mSI. K-means clustering over the 13 subscales of SFS and WHOQOL-BREF was applied to identify mSI subgroups. Prediction models were built and internally validated via multinomial logistic regression (MLR) and random forest (RF). The MLR and RF model performance was compared by accuracy and the discriminability of mSI subgroups (i.e., p-value of one-sided binomial test between the accuracy and no information rate).

Results: Five mSI groups were identified: 1) "very low (in SFS)/very low (in WHOQOL-BREF)" (8.58%), 2) "low/low" (12.87%), 3) "high/low" (49.24%), 4) "medium/high" (18.05%), and 5) "high/high" (11.26%). Both MLR and RF models included 22 predictors and demonstrated accuracies of 59.16% (95CI%: [55.75%, 62.58%], p = 0.994) and 61.61% (95%CI: [54.90%, 68.01%], p = 0.013) correspondingly. The mSI was robustly and mainly and robustly predicted by genetic predisposition, premorbid social functioning, symptoms (i.e., positive, negative and depressive), number of met needs and baseline satisfaction with the environment and social life.

Image:

Figure 1. Centroid feature of subgroups of multidimensional social inclusion
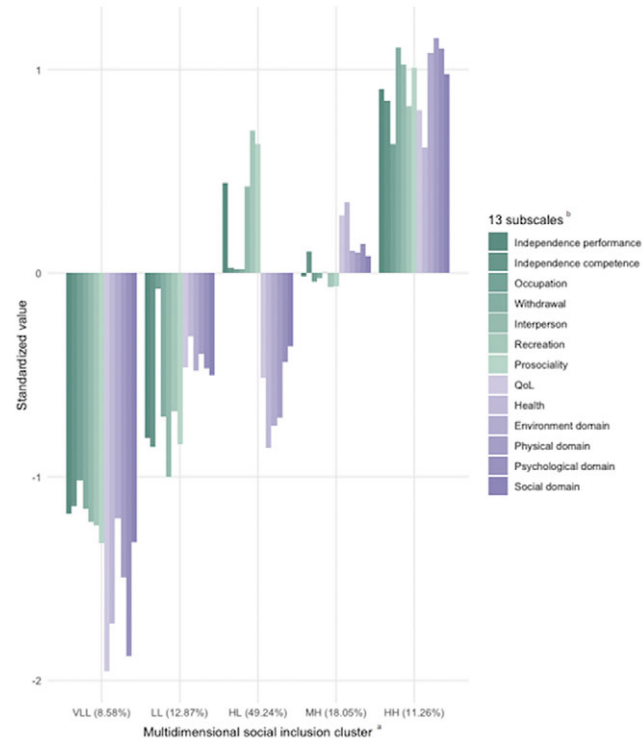
Note: ª VLL refers to the "very low/very low" mSI subgroup characterized by the lowest levels of social functioning and quality of life while the quality of life is even worse; LL refers to the "low/low" mSI subgroup featured by low levels of social functioning and quality of life but moderately better quality of life; HL refers to the "high/low" mSI subgroup with a high social functioning but low quality of life; MH refers to the "medium/high" mSI subgroup with a middle-level social functioning but a relatively high level of quality of life; and HH refers to the "high/high" mSI subgroup featured by the highest level of both social functioning and quality of life. ᵇ Green color represents the 7 subscales from SFS (Social Functioning Scale) and purple color represents the 6 subscales from WHOQOL-BREF (the abbreviated version of World Health Organization Quality of Life).

Image 2:

Figure S3: Boxplot of 13 subscales by multidimensional social inclusion clusters
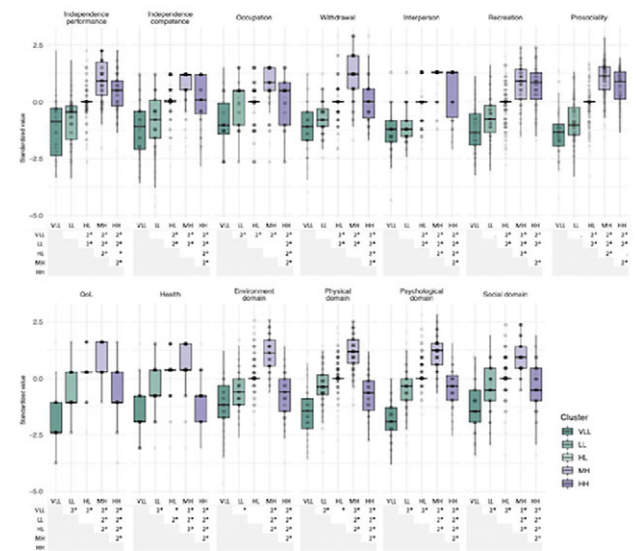
Note: Significance level of Dunn's multiple comparison test is represented by "3 • " = 0; "2 • " (0,0.001]; " • " (0.001,0.01]; "." (0.01,0.05). Following is a short description of each subscale for better understanding the difference among clusters: 1) Independence performance refers to the performance of using a set of skills for independent living; 2) Independence competence refers to the capability of using a set of skills for independent living; 3) Occupation refers to the engagement in the labor market or structured daily activities; 4) Withdraw refers to how socially engaged a person is such as time spent alone and initiation of conversations; 5) Interperson refers to interpersonal behaviors such as number of friends and communication quality; 6) Recreation refers to the engagement of leisure activities such as hobbies and interests; 7) Prosociality refers to the engagement of social activities; 8) QoL refers to perceived quality of life; 9) Health refers to perceived overall health; 10) Environmental domain includes facets such as freedom and safety, home environment, financial resources, accessibility and quality of health and social care, opportunities for acquiring new information and skills, transport and so forth; 11) Physical domain includes facets such as discomfort, rest, fatigue, mobility, work capacity, medication dependence and so forth; 12) Psychological domain includes facets such as positive and negative feelings, self-esteem, bodily image, personal beliefs and so forth; 13) Social domain includes facets such as personal relationships, social support and sexual activity. Abbreviations: VLL: the "very low/very low" mSI subgroup characterized by the lowest levels of social functioning and quality of life while the quality of life is even worse; LL: the "low/low" mSI subgroup featured by low levels of social functioning and quality of life but moderately better quality of life; HL: the "high/low" mSI subgroup with a high social functioning but low quality of life; MH: the "medium/high" mSI subgroup with a middle-level social functioning but a relatively high level of quality of life; HH: the "high/high" mSI subgroup featured by the highest level of both social functioning and quality of life.

Image 3:

Figure S5. Individual-level of prediction results
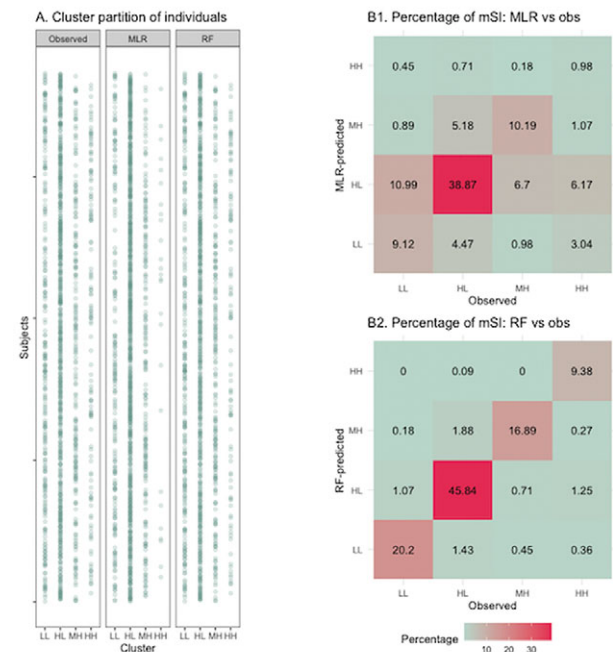
Note: The figure used the complete data of 1,119 patients to assess the model on an individual level. Fig. 5-A plotted pattern overview from the observed, MLR-model predicted, and RF-model predicted mSI clusters. Fig. 5-B demonstrated the overall model accuracy (i.e., secondary diagonal sum) and the percentage of each mSI cluster which was correctly and incorrectly predicted by the MLR and RF models compared to the observations. From the figure above, we observed comparable distributions between the observed and RF-model predicted mSI clusters. Dissimilarly, the MLR-predicted mSI clusters display a higher proportion in HL in trade of apparent lower percentages in LL and HH. Abbreviations: LL: mSI subgroup with both low social functioning and quality of life; HL: mSI subgroup with high social functioning and low quality of life; MH: mSI subgroup with medium social functioning and high quality of life; HH: mSI subgroup with both high social functioning and quality of life; MLR: multinomial logistic regression; RF: random forest; obs: observations.

Conclusions: Notwithstanding comparable accuracies, we cautiously consider the RF model outperforming primarily due to its better discriminability. As the baseline conditions of the patients with SSD could indicate the 3-year mSI level, customized amount and types of resources and interventions can be designed to improve the level of multidimensional social inclusion of all SSD patients.

Disclosure of Interest: None Declared

EPP0335

Nutritional Markers and Perinatal Maternal Mental Health: A Network Analysis

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Introduction: Perinatal maternal depression and anxiety are associated with adverse maternal outcomes, and nutrition may play an important role in their emergence. Previous research shows that certain micro and macronutrients found in different dietary patterns may influence perinatal mood disorders.

Objectives: This study aims to explore relationships between nutrition during pregnancy and perinatal maternal depression and anxiety symptoms using network analyses.

Methods: Using data from the French EDEN mother-child cohort, the sample consisted of 1438 women with available perinatal mental health outcomes (CES-D, STAI and EPDS) and nutritional markers collected from food frequency questionnaires. Four networks were constructed to explore the relationships between prenatal nutrient status, dietary patterns, and perinatal mental health, while accounting for important confounders.

Results: The Healthy dietary pattern was associated with the presence of vital micronutrients, while the Western dietary pattern was consistently associated with poorer intake of vital micronutrients and contained an excess of certain macronutrients. Western dietary pattern and symptoms of postnatal depression were connected by a positive edge in both the macronutrient and micronutrient networks. Lower education levels were associated with higher Western dietary pattern scores, from which a positive edge linked to postnatal depression symptoms in both models.

Conclusions: A Western dietary pattern was associated with increased symptoms of postnatal depression in our adjusted network models; The Healthy dietary pattern was associated with essential micronutrients but not with symptoms of depression or anxiety. Perinatal mental health might be impacted by specific dietary patterns in the context of psychosocial and physical stress associated with pregnancy.

Disclosure of Interest: None Declared

EPP0336

Measuring the professional social capital of psychiatrists: adaptation and validation of the Resource Generator for Psychiatrists (RG-Psy)

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Introduction: Psychiatrists need access to professional resources to care for their patients. In mental health settings, clinical innovations such as a new therapeutic approach, clinical guidelines or new drugs can diffuse more or less, depending on the social capital of these clinicians. The Resource Generator developed by Snijders & Van Der Gaag (2004) measures access to resources within a social network for the general population. It may therefore not capture access to social capital in the professional field of psychiatry.

Objectives: We aimed to develop and validate the Resource Generator for Psychiatrists and to detect factors influencing the social capital of clinicians.

Methods: The development of the final 11-item questionnaire followed multiple steps. First, the items were selected and adapted by an expert in the sociology of mental health to match the sector of psychiatry. Content validity and detection of important issues or misunderstandings were ensured by cognitive interviews with a panel of 6 clinicians. Each item has a 6-point response scale, rated from 0 to 6. Answers were coded "0" when the respondent did not need a certain resource or it was not applicable to their situation, while answering the closest resource was coded "6". The online self-completion questionnaire was administered through a link sent by email to all adult psychiatrists and psychiatric residents licensed to work in Belgium. Additional warm contacts were performed for psychiatrists working in ambulatory care. An exploratory factor analysis was conducted. Internal consistency was ensured with Pearson's correlation, item-total correlation and Cronbach's alpha. Test-retest reliability was also measured. Multivariable linear regression analysis assessed the association between psychiatrist demographics and the RG-Psy total score.

Results: The Resource Generator for Psychiatrists questionnaire completed by 152 psychiatrists showed a normal distribution with a mean of 32.5 (SD=12), good test-retest reliability (ICC=0.81), and good total Cronbach's alpha (0.74). Exploratory factor analysis revealed two main subtypes in psychiatrists' social capital: "attention and access to advice" and "practical assistance, knowledge and expertise", with Cronbach's alpha of 0.62 and 0.7 respectively. Clinicians attending institutional seminars (β=5.5221, p=0.013) and working in multidisciplinary settings such as hospitals (β=4.7448, p=0.023) or a mobile team (β=8.7475, p=0.014) were more likely to have higher social capital.