not prescription numbers, imply that new patients on average received larger benzodiazepine prescriptions. The increase in incident prescription DDDs could be indicative of decreased accessibility to (psychiatric) healthcare. It could also have been driven by an increase of the incidence and/or severity of sleep and anxiety symptoms during the second and third lockdown. A better understanding of exact causes and mechanisms behind these changes is relevant in order to limit the psychiatric repercussions of future (inter)national emergencies.

Associations Between Pathways Into Care and Service Use and Involuntary Hospitalisation Among Children and Young People

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Aims. There is evidence that children and young people (CYP) of Black ethnicity are more likely to experience involuntary hospital admission. This is not explained by clinical and sociodemographic factors. One possible explanation are differences in pathways into, and/or use of mental health services (MHS). This study investigates the associations between ethnicity, pathways into MHS, MHS use and involuntary hospitalisation in CYP.
Methods. Using data from the Clinical Record Interactive Search (CRIS) system for (South London and the Maudsley) SLaM services we identified 652 CYP under 18 years admitted to inpatient units between 2008 and 2021 living within the SLaM catchment; 458 (70.2%) were admitted informally and 194 (29.7%) were detained. We conducted univariable logistic regression to investigate the association between pathways into MHS (referral source, S.136 presentation), MHS use (time known to services, recent appointment prior to admission, and presence of a care plan), clinical factors (diagnosis, severity, risk) and social factors (gender, age, ethnicity, deprivation) with the outcome i.e. involuntary admission. We then conducted multivariable logistic regression to investigate the association between the clinical and social factors and involuntary admission.
Results. In multivariable analyses we found evidence that adverse pathways into MHS such as S.136 presentation (OR 6.25, 95%CI 2.06-19.01, p = 0.001), and referrals from social services (OR 4.92, 95%CI 1.49-16.19, p = 0.009) and police/legal services (OR 4.22, 95%CI 1.03-17.31, p = 0.045) were associated with involuntary hospitalisation. There was no evidence that the duration of contact with MHS, having had an appointment in the 28 days prior to admission or a care plan in the 12 months prior to admission were associated with involuntary hospitalisation after adjusting for other factors. There was evidence that being of Black ethnicity (OR 2.04, 95%CI 1.19-3.50, p = 0.010), older age (13–15 years: OR 4.46, 95%CI 1.57-12.72, p = 0.005; age 16–17 years: OR 8.67, 95%CI 3.08-24.41, p < 0.001) and having a diagnosis of a psychotic disorder (OR 4.21, 95%CI 2.21-8.02, p < 0.001) were associated with involuntary admission after accounting for pathways into and use of MHS.
Conclusion. In this cohort of child and adolescent inpatients living in South East London, we found that CYP who experience adverse pathways into MHS are more likely to experience involuntary hospitalisation. Prior contact with MHS did not appear to influence involuntary admission. We found that Black CYP remained more than twice as likely to be admitted involuntarily after accounting for MHS use and pathways into MHS as well as social and clinical factors.

Self-Stigma and Quality of Life in Patients With Depressive Disorder in Psychiatric Outpatient Setting

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Aims. Self-stigma is common among patients suffering from depressive disorders and negatively affects their quality of life. Quality of life reflects individuals' general well-being, an important measure of treatment outcomes. However, local research on the relationship between self-stigma and quality of life in patients with depressive disorder is lacking. Information on clinical and personal characteristics associated with self-stigma in depression is also limited.

The primary aim of this cross-sectional study was to examine the relationship between self-stigma and the quality of life of patients suffering from depressive disorder in an outpatient department. The secondary aim was to identify socio-demographic, clinical, or personal characteristics associated with self-stigma in these patients.
Methods. One hundred and thirty-one patients with depressive disorders were recruited from the outpatient clinic of a psychiatric centre in Hong Kong. Depressive disorder was diagnosed with the Chinese-bilingual version of the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Axis I Disorders. Socio-demographic and clinical information were obtained. Self-stigma was measured with the Self-Stigma Scale-Short Form. The quality of life was evaluated with the World Health Organization Quality of Life-BREF Hong Kong Version. Self-esteem, coping strategies, personality traits, and social functioning were evaluated. Bivariate analyses were performed to explore the association between the above factors with self-stigma or quality of life. Regression analyses were conducted to explore the relationship between self-stigma and quality of life, and to identify the factors independently associated with self-stigma.
Results. Self-stigma was independently associated with the four main quality of life domains after controlling for socio-demographic, clinical, and personal characteristics among patients with depressive disorder. A multiple regression model showed that high levels of neuroticism and low self-esteem were independently associated with higher levels of self-stigma.
Conclusion. This cross-sectional study supported the negative association between self-stigma and quality of life among individuals with depressive disorder. Neuroticism and self-esteem were found to be independently associated with self-stigma in depressive patients. Considering the associations found, identifying and focusing on depressive patients with a higher risk of