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Supporting Physical Health in Addiction Recovery - No Wrong Door

Dr Olubunmi Arogunmati*, Dr Emily Jackson, Mrs Claire Buzzeo and Dr Andrea Hearn

Cumbria Northumberland, Tyne and Wear NHS Foundation Trust, Newcastle upon Tyne, United Kingdom

*Corresponding author.

doi: 10.1192/bjo.2023.85

Aims. Substance use disorders are associated with significant physical health comorbidities, necessitating an integrated treatment response. However, service fragmentation can preclude the management of physical health problems during addiction treatment. (Osborne et al, 2022). Northeast England continues to have the highest morbidity/mortality with regards to substance use (ONS, 2022). Therefore, it is essential that staff in addiction health settings innovate to address physical health.

Methods. A review of the literature identified little research relating to physical health care in addiction and recovery settings. Our service protocol for blood testing was used to set the audit standards. The blood testing assessed electronic communication and electronic records. Physical health nurses take blood on request and email blood results to a medical/clinician inbox. The total sample was 1128 since pathway inception in March 2022. A sample size of 70 was selected via systematic sampling using n-15th person. Descriptive analyses of data followed by qualitative exploration with the physical health team was completed. The audit was registered locally.

Results. Of the sample size of 70 whose records were reviewed, we noted that blood tests were reviewed by medics (100%) with 98.6% of these reviews being within 6 hours of notification by the physical health team. Action plans were documented for blood results requests and communicated by email to physical health team (100%). 84.3% of the action plans were completed by physical health team on receipt of emails. Non completion of action plans in 15.7% of cases was related to client being hospitalised or disengaging from services (which might include relocation out of area or transfer into the criminal justice system).

Conclusion. Within our service, we have patients who struggle to attend conventional pathways e.g., GP. In view of the previously stated morbidity and mortality it is important that we are able to offer blood testing with timely follow up and action plans when appropriate to these patients.

Our service has good liaison with local services and bespoke partnerships to cater for the homeless amongst other subgroups. We used this audit to also improve processes and patient safety with plans for a re-audit. There was no previous nor national comparison for these data.

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Sleep Problems and Gambling Disorder: Findings in Non-Treatment Seeking Young Adults

Dr Holly Austin^{1*}, Professor Samuel Chamberlain¹, Professor Jon Grant² and Professor David Baldwin^{1,3}

¹Clinical and Experimental Sciences, Faculty of Medicine, University of Southampton, Southampton, United Kingdom; ²Department of Psychiatry & Behavioral Neuroscience, University of Chicago,

Chicago, USA and ³University Department of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa

*Corresponding author.

doi: 10.1192/bjo.2023.86

Aims. The aim of the study was to investigate the potential association between gambling disorder and symptoms of sleep problems including insomnia and hypersomnolence. Gambling disorder is a behavioural addiction featuring persistent, recurrent gambling resulting in distress and impairment of function. Lifetime prevalence of gambling disorder is estimated at 0.6–0.9%, though high quality data in the UK are lacking. Psychiatric comorbidity is common; as are physical health problems such as hypertension. The association between sleep problems and other addictions such as alcohol misuse disorder, smoking and substance misuse has been established; however, research into gambling disorder and sleep problems is limited. It was hypothesised that, compared to controls, individuals with gambling disorder would have significantly greater disturbance of sleep, as indicated by increased scores in: 1) specific sleep items on the Hamilton Anxiety Rating Scale (HAMA) and Hamilton Rating Scale for Depression (HAMD), 2) total score on the HAMA and HAMD and 3) the Epworth Sleepiness Scale (ESS).

Methods. A secondary analysis of a subset of previously published data by Grant and Chamberlain (2018) on gambling and impulsivity. A total of 152 non-treatment seeking adults, aged 18–29 years, who had gambled at least five times in the past year were recruited. Individuals were stratified into three groups: controls, those at risk of gambling disorder, and those with gambling disorder, as per DSM-5 criteria. One-way ANOVAs with post-hoc tests were conducted. These were used to show whether the three groups differed significantly in their scores in the sleep items and total scores of the HAMA and HAMD, and the ESS.

Results. The HAMD scale demonstrated a significant increase in all patterns of insomnia for members of the disorder group, when compared to controls. The increase was particularly marked for middle and late insomnia. The HAMA item score demonstrated significantly worse sleep quality in the disorder group, compared to at risk and control groups. Total scores on the HAMA and HAMD scales were also significantly higher in the disorder group, reaching the thresholds for clinical significance for anxiety and depression. ESS scores were not significantly different between groups.

Conclusion. Global disruptions in sleep, as well late- and middle-insomnia, were found to be significantly higher in gambling disorder than controls. Symptoms of anxiety and depression were also significantly higher in the gambling disorder group. Further research could have implications for the identification and treatment of sleep disorders and psychiatric comorbidities in gambling disorder.

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Outcomes of Pre-Existing Diabetes in People With/without New Onset Severe Mental Illness: A Primary-Secondary Mental Healthcare Linkage in South London, United Kingdom

Dr Nikeysa Bell^{1*}, Dr Gayan Perera¹, Professor Mark Ashworth², Mr Matthew Boradent¹, Dr Brendon Stubbs^{1,3}, Professor Fiona Gaughran^{1,3} and Professor Robert Stewart^{1,3}

¹Kings College London (Institute of Psychiatry, Psychology and Neuroscience), London, United Kingdom; ²Kings College London (Faculty of Life Sciences and Medicine, School of Life Course and Population Sciences), London, United Kingdom and ³South London