Supporting Physical Health in Addiction Recovery - No Wrong Door

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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.

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

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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.

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

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Aims. To compare people with diabetes developing severe mental illness (SMI) to those with diabetes alone with respect to risk status, diabetes care receipt, and diabetes-relevant outcomes in primary care.
Methods. Data from mental health care (Clinical Record Interactive Search; CRIS) linked to primary care (Lambeth DataNet; LDN) were used. From patients with a type 2 diabetes mellitus (T2DM) diagnosis in primary care, those with a new SMI diagnosis were matched (by age, gender, and practice) with up to five randomly selected controls. Mixed models were used to estimate associations with trajectories of recorded HbA1c levels; Poisson regression models compared total and cardiovascular comorbidity levels and number of diabetes complications; linear regression models compared BMI and total cholesterol levels; conditional logistic regression models investigated microalbuminuria, receipt of a foot or retinal examination, use of statins and receipt of insulin; Cox proportional hazards were used to model incident microvascular and macrovascular events, foot morbidity and mortality.
Results. In a cohort of 693 cases with SMI (122 bipolar disorder, 571 schizophrenia and related) and T2DM compared to 3366 controls, all-cause mortality was increased substantially in the cohort with SMI (adjusted hazard ratio 4.52, 95% CI 3.73–5.47; for bipolar 5.59, 3.37–9.28; for schizophrenia 4.42, 3.60–5.44). However, for all the other outcome comparisons, the only significant findings were of reduced foot examination (adjusted odds ratio 0.75, 0.54–0.98) and reduced retinal screening (0.77, 0.61–0.96).
Conclusion. Higher mortality suggests increased risk of adverse outcomes for people with pre-existing T2DM who develop SMI, and reduced foot/retinal examinations suggest disadvantaged healthcare receipt. However, other potential explanations for the mortality difference could not be identified from the outcomes analysed, so further investigation is needed into underlying causal pathways.

Service Provider Views on Mental Healthcare Access for UK Asylum Seekers Residing in Home Office Contingency Accommodation: A Qualitative Research Study

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Aims. Since 2020, the number of asylum-seekers residing in hotels sourced by the UK Home Office, termed Contingency Accommodation, has increased by over 20,000. Reports suggest that the risk of poor mental health in this population is high. The aim of this study was to help inform improvements to mental healthcare provision for UK asylum-seekers living in contingency accommodation by gaining a greater understanding of perceived barriers and facilitators to accessing care.
Methods. Seventeen semi-structured interviews were conducted remotely with Healthcare Service Providers between June and August 2022. Study Participants were recruited using purposive and snowball sampling to include stakeholders from primary care, secondary care, and third sector organisations. Data were analysed initially using deductive analysis based on the Levesque et al Conceptual Framework. Further emergent themes were identified using inductive analysis conducted sequentially on the data.
Results. Twelve themes relating to barriers and three to facilitators to mental healthcare access were identified. The most dominant themes were language barriers and long referral wait times, particularly to access specialist services for torture survivors. Other emergent themes included differing explanatory models of mental distress between Service Users and Providers and fear of authorities and data sharing. Within hotels, there was a lack of standardisation to facilitate mental healthcare access and a reliance on outreach organisations to explain the structure of the health system. Digital exclusion was described in the form of poor reception in hotel rooms and lack of privacy for remote consultations. Perceived mental health complexity was found to act as a barrier to referrals for low intensity psychological therapies such as IAPT being made and accepted. There was a lack of consensus amongst stakeholders about the appropriate time in the asylum journey to refer for trauma-focused therapy. Voluntary and community services (VCS) were described as plugging gaps in mental healthcare, but their role was ill-defined and concerns were expressed about sustainability.
Conclusion. This study identified complex and intersecting barriers at individual, community, health-system, and structural levels which, if addressed, could improve access to mental healthcare. Further work is required to quantify the burden of mental ill health amongst this group and to triangulate findings from this study with views of the asylum-seeking population. Specifically, this study highlights the need to establish exactly how VCS are meeting mental healthcare needs and how they can be better integrated into the healthcare system. Further research exploring the timing of trauma-focused therapy is also warranted.

Providing the Right Support at the Right Time for People With Learning Disabilities: A Mixed-Methods Study to Identify Change Goals for a Demand, Capacity and Flow Quality Improvement Project

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Aims. 1. To evaluate demand, capacity and flow of an integrated community learning disability service in a peri- and post-COVID-19 pandemic setting. 2. To improve flow of a community learning disability service. 3. To improve staff and service user satisfaction by engaging them and identifying common priorities.
Methods. We collected demand and capacity data of all disciplines in a community learning disability service for 2021–2022.

We carried out focus groups with service users and their carers (N = 5) and surveyed them with a questionnaire consisting of 6 quantitative and 2 qualitative questions (N = 63), investigating the impact of waiting times on service user experience.