Objectives: Prevalence of gambling disorders varies according to the screening instruments, measurement used as well as accessibility of gambling opportunities but it is believed that gambling disorders affect 0.2–5.3% of adults worldwide. In addition, considering that the gambling disorders are highly comorbid with other substance use and mental health disorders, for both the causes and treatment implications of this disorder a further understanding is needed.
Methods: This research has been conducted at the Addiction and Psychotrauma Department of the Insula County Hospital over a period of two months on a sample of 150 people using a questionnaire that was distributed to patients whose primary diagnosis was substance use disorder but did not have a diagnosed gambling addiction with the aim of early detection of it.
Results: Substance abuse may include minimizing one's use, hiding other comorbid addictions including gambling, and an underestimation of the effect one's use has on life areas as well as family members.
Conclusions: This article highlights the prevalence of comorbid unrecognised pathological gambling in substance use disorders, but also reviews definition, clinical similarities and differences and treatment approaches.

Disclosure of Interest: None Declared

EPP0911

Gambling Disorder and suicide risk – a clinical case

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Introduction: Pathological gambling is an addictive disorder and a current important issue with substantial social and personal costs. It is associated with impaired functioning, criminal record, bankruptcy and mental health problems. There is a significant comorbidity between gambling disorder, mood disorders and other addictive behaviors like alcohol use. Suicidality is common, impulsivity being a major risk factor for suicidal acts.
Objectives: Case presentation of gambling disorder associated with a suicide attempt
Methods: Review of the clinical file of a patient diagnosed with gambling disorder and non-systematic review on the topic on PubMed
Results: A 35 old male patient is brought to our psychiatrical emergency unit by means of ambulance as he attempted to commit suicide by inflicting multiple deep cuts on his forearms. He has a positive history of gambling disorder, no prior suicide attempt, or criminal record. He has a precarious economic status, the trigger for his acts being the loss of a substantial financial amount. The risk factors in his case were a positive familial history of addictive disorders (his father was diagnosed with alcohol use disorder), aversive childhood events, comorbid depression, alcohol misuse and low income. The patient resumed his gambling behavior 7 months prior to admission, after a 5 year abstinence, motivated by the desire to rapidly pay a loan he recently took. The addictive behavior worsened after his wife experienced a miscarriage. He started borrowing money, engaging in antisocial acts like stealing money from his wife's bank account, neglecting his job and ending up in financial debt. He experienced feelings of alienation and isolation from his social network and family, unable to verbalize his burden. He also feared a divorce. Psychological coping strategies such as thought and emotional suppression were present and also an important tendency to minimize the severity of the events. Cluster B traits were present but not clinically significant. The suicide attempt is described by the pacient as being impulsive, with no prior planning, as a mean of problem solving for his desperate situation of high financial and social burden.
In the hospital setting, pharmacological treatment with SSRI Escitalopram and opiate antagonist Naltrexone was initiated. The patient was referred to psychological counseling during hospitalisation and to CBT after he left the hospital. He had excellent social support.
Conclusions: Although suicide is initially seen as an impulsive act, in fact it includes a constellation of thoughts, emotions and behaviors which lead to the hopelessness and desperation preceding the suicidal attempt. Gambling disorder tends to have a chronic evolution, impacting many important life domains, complex management such as pharmacotherapy, psychological interventions and social support being necessary for a favorable outcome.

Disclosure of Interest: None Declared

EPP0912

The effectiveness of electroconvulsive therapy in substance use disorder at pharmacological treatment failure major depression

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Introduction: Treatment resistant depression (TRD) is common with substance use disorder (SUD) and few studies demonstrated the effectiveness of medication-psychotherapy treatments in this population
Objectives: To compare the effeictiveness of ECT in the treatment resistant depression patients vs TRD with SUD patients.
Methods: 14 TRD patients with 14 TRD-SUD patients compared in terms of ECT treatment response rates at baseline, thhree months and six months of the follow up periond. Pateints completed Hamilton anxiety, Hamilton depression-21 items, Barrat 11 impulsivity and visual analog scales each follow up visit.
Results: Both groups completed ECT treatment between 2011-2018 with follow up of 12.3+4.1 months following the ECT procedure. Patients received average 11.7+2.6 bilateral ECT treatments per series. Both groups responded well to ECT treatment in terms of response rates and side effects however there were higher rates of relapse at intermediate to long term follow up period at TRD-SUD group.

Conclusions: ECT seems to be an effective treatment for patiens of TRD-SUD. Moreover the response rates are equal to treatment reisstant depression cases without substance use disorder.

Disclosure of Interest: None Declared

EPP0913

Role of substance use status in determining how caregivers of patients with opioid use disorders perceive positive aspects of caregiving and burden

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Introduction: Substance dependence affects an individual as well as the family and is considered as a complex biopsychosocial phenomenon. Family members can act as a social and emotional support in the treatment engagement and recovery of the patient with substance use disorder. Caregiving is a multidimensional construct. Caregiving process to an individual with substance use disorder can help in either positive or negative outcome and is often challenging. Positive aspects of caregiving has gathered some attention in mental health literature in recent past, data for the same is limited across substance use disorder.
Objectives: To determine whether substance use status is associated with differences in positive aspects of caregiving and burden among the caregivers of patients with opioid use disorders.
Methods: A cross-sectional observational study with purposive sampling was used to recruit 199 caregivers of patients with opioid use disorders. The sample was divided based upon the current substance use status of the patients. Scale for Positive Aspects of Caregiving Experience (SPACE) and Family Burden Interview Schedule (FBIS) were used to assess positive aspects of caregiving and family burden respectively
Results: The study included 199 caregivers of patients with opioid use disorder. Table 1 describes the socio-demographic profile of the patients and caregivers. Of 199 caregivers recruited, 135 (67.8%) reported that the patient was using opioids, while 64 (32.2%) reported that the patient was abstinent on treatment. The mean SPACE domain score of caregivers abstinent on treatment was highest for motivation for caregiving role (2.73 versus 1.76) followed by self-esteem and social aspect of caring (2.42 versus 1.87), caregiver satisfaction (2.41 versus 1.29) and caregiving personal gains (2.40 versus 1.45). Details of SPACE domain score and FBIS are depicted in table 2. It was seen that caregivers of patients currently abstinent on treatment experienced greater positive aspects of caregiving (SPACE mean score 128.3 versus 80.1, $t = 9.383$, $p < 0.001$), and lesser burden (FBIS mean score 13.4 versus 29.3, $t = 10.419$, $p < 0.001$). Overall the mean SPACE domain score had a negative correlation with FBIS ($r = -0.57$, $p<0.001$).

Image:

Table 1- *Socio-demographic profile of the opioid use disorder patients (n= 199) and caregivers(n=199)*

	Patient	Caregiver
Age (range) [years]*	28 (18-55)	42 (18-70)
Gender **		
Male	199(100%)	57(28.6%)
Female	-	142(71.4%)
Occupation**		
Employed	119 (59.8%)	108(54.3%)
Unemployed	80(40.2%)	91(45.7%)
Family type **		
Nuclear	114(57.3%)	-
Extended	85(42.7%)	-
Locality **		
Urban	161(80.9%)	-
Rural	38(19.1%)	-
Relationship with patient **		
Mother	-	72(36.2%)
Father	-	37(18.6%)
Spouse	-	64(32.2%)
Sibling	-	17(8.5%)
Other relatives	-	9(4.5%)

**Data are shown as mean (range)*

***Data are shown as frequency(percentage)*

Image 2:

Table 2- *Scores of SPACE and FBIS domain for assessment of caregivers*

	Abstinent on treatment	Active use	p value
Scale for Positive Aspects of Caregiving			
Caregiving personal gains	2.40 ± 0.71	1.45 ± 0.86	p<0.004
Motivation for caregiving role	2.73 ± 0.61	1.76 ± 0.84	p<0.001
Caregiver satisfaction	2.41 ±0.73	1.29 ± 0.78	p<0.378
Self-esteem and social aspect of caring	2.42 ± 0.61	1.87 ± 0.69	p<0.137
Total SPACE score	128.31 ± 30.81	80.81 ± 38.17	p<0.014
Family Burden Interview Schedule	13.44 ± 10.84	29.33 ± 8.12	p<0.003

**Data are shown as mean ± standard deviation*

Conclusions: In our study it was found that caregivers of patients who are currently abstinent on treatment experience lower burden of care, and also experience greater positive aspects of caregiving. Clinicians should be aware of the caregiver experiences as well as they engage both patients and caregivers in the treatment process.