Results. A total of 450 articles were found (319 post-deduplication), of which seven met criteria (samidorphan = 4, naltrexone = 3, naloxone = 0) including n = 1,416 patients. On meta-analysis, change in body weight (kg) for CORAs as a class was statistically significant (RE = 1.37 kg; 95% CI: 0.51, 2.24). However, change in BMI was not statistically significant (RE = 0.61kg/m^2; 95% CI: −0.56, 1.78). Remaining analysis was only available for samidorphan, which showed statistically significant improvement in change in body weight (%) (RE = 1.81%; 95% CI: 1.07, 2.55), absolute risk of weight gain ≥7% (RE = 12.41%; 95% CI: 6.55, 18.27), absolute risk of weight gain ≥10% (RE = 10.83%; 95% CI: 5.46, 16.21), and change in waist circumference (RE = 1.50 cm; 95% CI: 0.32, 2.67).
Conclusion. Evidence is strongest for samidorphan, though CORAs as a class remains poorly researched and the benefits are modest. Additionally, samidorphan is currently only available in the combination medication olanzapine-samidorphan and the literature reflects this. Further research is needed to examine its efficacy in AIWG from other antipsychotics.

Correlation of Heart Rate Variability and Subjective Withdrawal Symptoms in Patients With Opioid Dependence, and Its Comparison in Patients Undergoing Detoxification With Patients Maintained on Opioid Agonist Treatment

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doi: 10.1192/bjo.2024.266

Aims. Patients with opioid dependence seek treatment for the discomforting withdrawal symptoms. Accurate clinical assessment is essential as medications are optimized based on these withdrawal symptoms. However, subjective reporting can present challenges. Heart rate variability (HRV) can enhance clinical assessment and has taxonomic and therapeutic implications. This study aimed to explore the correlation between HRV and subjective withdrawal in patients with opioid dependence and to compare the HRV parameters in patients undergoing detoxification to those maintained on opioid agonist treatment and healthy controls.
Methods. 3 groups of adult male participants were included. Group 1 included 40 patients with opioid dependence undergoing inpatient detoxification. Group 2 included 40 patients with opioid dependence receiving stable doses of buprenorphine on outpatient basis. Group 3 included 49 healthy controls. The Subjective Opiate Withdrawal Scale (SOWS) was used for withdrawal symptoms. For Group 1 and Group 2, HRV was assessed twice – before administration of morning dose of buprenorphine, and then 2 hours post administration. For Group 3 HRV was assessed once.
Results. At baseline, resting heart rate differed significantly between the 3 groups ($p < 0.001$), it was highest for Group 2 (92.4) and lowest for Group 3 (79.4). In time domain parameters of HRV, the beat-to-beat variability was highest for Group 1 with standard deviation of all normal RR intervals (SDNN) = 134.8, root mean square of successive differences between normal heartbeats (RMSSD) = 181.7 and RR tri index = 8.9 ($p < 0.005$). In frequency domain parameters of HRV, total power was highest for Group 1 (98334.1, $p < 0.001$) while relative power did not differ significantly among the groups. The SOWS had a weak negative correlation with RMSSD in Group 2 ($r = -0.312$, $p < 0.05$) but did not have any correlation with HRV parameters in Group 1. Post administration of morning buprenorphine, the HRV parameters did not show a significant change in either of the groups (except reduction in very low frequency percentage in Group 1 from 12.013 to 7.196, $p < 0.05$).
Conclusion. A higher degree of subjective withdrawal is associated with lower beat-to-beat variability in patients on stable doses of buprenorphine. However, this exploratory study did not find a robust relationship between HRV and subjective withdrawal symptoms. Higher RMSSD (representative of higher vagal tone) in patients undergoing detoxification may suggest greater physiological adaptation to withdrawal symptoms. This study provides additional insights into HRV in patients with opioid dependence.

Increases in Daily Defined Doses of Incident Benzodiazepine Prescriptions in the Netherlands During the Second and Third COVID-19 Lockdowns

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doi: 10.1192/bjo.2024.267

Aims. The aim of this study is to investigate incident and total benzodiazepine prescribing in the Netherlands during the COVID-19 pandemic, including the impact of lockdown periods.
Methods. A national Dutch pharmacological registry was used, investigating extramural psychiatric drug prescriptions, between March 2020 and March 2022. Data included incident and total prescriptions as well as daily defined doses (DDDs) of benzodiazepines. The data covered 96% out of a total Dutch population of 17.5 million people. This was compared with the previous calendar year as a reference expressed as a monthly risk ratio (RR) and was corrected for population growth. Changes over time will be discussed if the RR was above 1.1 or below 0.9.
Results. A total of 13.4 million prescriptions over a period of three years were included of which 5.8% were incident prescriptions. Three lockdown periods were identified during pandemic.

When analysing the total benzodiazepine prescription group, prescriptions and DDDs remained mostly stable throughout the pandemic. A brief relative increase in prescription DDD amounts was found during the second lockdown (RR: 1.11). When viewing the incident benzodiazepine prescriptions, there was a short period between the first and second lockdown when both prescription numbers and DDDs decreased (RR: 0.86 and RR: 0.83 respectively). The DDDs of incident prescriptions increased sharply during the second and third lockdown period and remained elevated between both, with an average RR of 1.13.
Conclusion. Total monthly benzodiazepine prescriptions and DDDs remained mostly stable during the COVID-19 pandemic in the Netherlands. COVID-19 related lockdowns seem to have mainly influenced incident benzodiazepine DDDs dispensed during the second and third lockdown. Increased incident DDDs, but

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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doi: 10.1192/bjo.2024.268

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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doi: 10.1192/bjo.2024.269

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 sociodemographic, 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 sociodemographic, 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