requesting toxic lab tests) or higher sample percentage of confounding comorbid diagnoses.
However, is undoubtable the several risks that drugs bring to our health and so the authors aim to raise awareness among the medical community to the importance being alert for signs of use or psychiatric symptoms to avoid reaching a no turning point. It's known that doctors frequently fail to diagnose SUD in hospitalized patients and given the linkage between use of certain substances and particular medical reasons for admission, it would be well-advised to search for SUD in certain admission diagnoses (Weintraub E *et al.* Am J Addict 2001;10(2):167-77). Knowledge of substance use behavior may help reducing relapse rates and to reduce the risk of developing a SUD (Andersson HW *et al.* Nordic Journal of Psychiatry, 75:3, 160-169).

Disclosure of Interest: None Declared

EPP0810

Alcohol related dementia and Brain Imaging

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Introduction: Alcohol is considered a social evil worldwide owing to its vast array of associated problems and complications, which may manifest in medical, legal or social domains. Excessive and prolonged alcohol use may lead to permanent structural and functional damage to the brain. The evidence from neuroimaging, neuropathological reports and autopsy evaluations suggest some degree of brain pathology in individuals diagnosed with an alcohol related disorder.
Objectives: The aim of this study is to characterize the structural imaging findings on computed tomography (CT) and magnetic resonance (MR) imaging of our sample and provide an overview of the literature on the subject.
Methods: Retrospective observational study with inpatients of Coimbra Hospital and University Centre (CHUC), who had alcohol use disorder diagnosis associated with dementia or cognition deficit. Patients were admitted from 2017 to 2021 and submitted to neuroimaging: CT and MR. Data was collected in May 2021 at informatic system.
Results: Among 38 participants, the median age was 64 years; 86,8% were male. 35 realize CT, 34 with alterations: 23 with microvascular lesions, 17 with cortical atrophy, 8 with white matter hypodensities and 7 with subcortical atrophy. From all patients, only 14 realize MR, 13 with alterations, the most common vascular leukoencephalopathy and cortical atrophy.
Conclusions: Our results support the hypothesis of neuroimaging changes resulting from alcohol consumption. The severity of alcohol dependence also correlates with neuropathophysiological and neuroimaging changes. Volume shrinkage, altered glucose metabolism and perfusion along with evidence of markedly decreased neuron density are commonly reported. The evidence of neurocircuit disturbances is seen in form of significant loss of white matter (most prominent in the prefrontal cortex, cerebellum and corpus callosum) on functional imaging. Greater cognitive impairment has been associated with multiple and repeated withdrawal due to greater neuronal damage, and can limit the psychotherapeutic intervention, the adherence to pharmacological therapy and abstinence maintenance. The sheer presence of alcohol use disorder should encourage a neuroimaging evaluation.

Disclosure of Interest: None Declared

EPP0811

The PANDA Unit: Responding to complexity and comorbidity in acute mental health

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Introduction: Acute mental health presentations such as suicidality or psychosis are frequently accompanied by intoxication, substance use disorder, deliberate self-poisoning and social crises. There is a need to break down silos and provide integrated multidisciplinary acute care for such individuals.
Objectives: Here we describe outcomes of the Psychiatry And Drug ANd Alcohol (PANDA) Unit, a unique physical space collocated with the emergency department (ED) along with a unique model of care, providing multidisciplinary care to individuals presenting with acute mental health concerns plus complex comorbidity.
Methods: A description of the PANDA model of care and Service characteristics along with process and outcome measures across the first 12 months that the PANDA Unit was operational. These include number of patients admitted, patient demographics and characteristics, length of stay, referral destinations and impact on the occurrence of behavioural disturbance across the ED.
Results: PANDA opened in November 2020 and since then has admitted an average of 122 patients per month (15% Aboriginal) with an average bed occupancy of 79% and average length of stay of 1.3 days. An average of 12% of patients were scheduled under the mental health act and an average of two patients were stepped down from ICU each month, with the remainder being admitted via the ED. An average of 80.7% of these were discharged home directly while 7.2% were transferred for inpatient withdrawal management and 8.9% to inpatient mental health services. The top three substances of concern were alcohol methamphetamine and heroin and an average of 16.5% of people reported injecting drugs in the prior 3 months. An average of 37.8% patients had been seen by an emergency physician and admitted to the PANDA Unit within 4 hours, one of the best performing units hospital-wide. In the 6 months prior to PANDA becoming operational there was a median of 20 episodes of behavioural disturbance requiring restraint per month across the ED. This dropped to 12 episodes in the six months following the PANDA Unit opening.
Conclusions: The PANDA Unit model of care has proven feasible to implement and has made a positive impact on a previously underserved patient population. It has also contributed to improving the integration of care for mental health patients with comorbidity as well as reducing behavioural disturbance and improving patient flow across the emergency department.

Disclosure of Interest: None Declared