Royal College of Psychiatrists
Faculty of General Adult Psychiatry
Conference 2015

08 – 09 October
The Millennium Gloucester Hotel & Conference Centre,
London

ABSTRACT BOOK
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PRESENTATION ABSTRACTS AND BIOGRAPHIES
(LISTED BY PROGRAMME ORDER)

Thursday 8 October

Introduction

09:30-09:45
Introduction
Lenny Cornwall

Dr Lenny Cornwall is the current Chair of Faculty of General Adult Psychiatry, Royal College of Psychiatrists 2015. He is Consultant Psychiatrist in CMHT in Redcar, Teesside since 2001 and Deputy Medical Director (Teesside), Tees, Esk & Wear Valleys NHS Trust since 2011.

PLENARY 1

09:45-10:15
The fragility of knowledge in psychiatry
Edward Shorter

Professor Edward Shorter, PhD, FRSC Edward Shorter has held the Hannah Professorship in the History of Medicine at the University of Toronto’s Faculty of Medicine since 1991, and in 1996 was cross-appointed as Professor of Psychiatry in recognition of his contributions to the history of the specialty.

A Harvard-trained social historian who joined the university’s history department in 1967, he has published widely on subjects ranging from the evolution of the modern family and the doctor-patient relationship to histories of psychosomatic illness and psychiatric diagnosis and treatment. His two latest publications explore the troubled history of psychiatric classification. How Everyone Became Depressed (2013) traces the rise of “major depression” as the leading current diagnosis. What Psychiatry Left Out of the DSM-5 (2015), explores the history of diagnoses that should have been left out along with conditions that should have been included.

PLENARY 2

10:15-10:45
Bipolar Disorder: Past, Present and Future?
Nicol Ferrier

This talk will review the development of the concept of Bipolar Disorder from the past to the present which will include a discussion on the up sides and downsides of our current classification systems. Suggestions for ways to improve our classification and diagnostic system in the future will be outlined. The talk will also look critically at past and current treatments of Bipolar Disorder. We have learned a great deal about how to manage Bipolar Disorder but still have largely serendipitous treatments which can cause major physical problems. The issue of the interplay between treatment and medical co-morbidities in Bipolar Disorder has a lot of echoes from 19th century treatments. The presentation will highlight positive developments in management which centre on the integration of pharmacological and psychological components and pointers to future developments along these lines will be outlined. One area where great strides have been made is in understanding the neurobiology of Bipolar Disorder and its impact on symptoms. This research will be reviewed followed by a consideration of how this information may shape and improve treatments in the future.

Professor Nicol Ferrier is Emeritus Professor of Psychiatry at Newcastle University. Professor Ferrier worked in a clinical capacity for the Regional Affective Disorders Service. His research
interests are in psychopharmacology and the neurobiology and treatment of severe affective disorders. He has published over 230 papers on these topics.

Professor Ferrier was the pharmacological lead on the NICE Guidelines for Unipolar Depression and was Chairman of the NICE Bipolar Disorder Guideline. He has served on the MRC Clinical Fellowship and Wellcome Trust Neuroscience and Mental Health Grant Committees and is Past-President of the British Association for Psychopharmacology. He was Lead of the North East Hub of the Mental Health Research Network from 2005 to 2014.

Parallel 1: Policy Updates  
Chair: Denise Coia

11:30-11:55  
Presidential address  
Simon Wessely

Professor Sir Simon Wessely MA BM BCh MSc MD FRCP FRCPsych FMedSci FKC FMedSci (born Sheffield, 1956) is a British psychiatrist. Simon is professor of psychological medicine at the Institute of Psychiatry, King's College London and head of its department of psychological medicine, vice dean for academic psychiatry, teaching and training at the Institute of Psychiatry, as well as Director of the King's Centre for Military Health Research. Simon is also honorary consultant psychiatrist at King's College Hospital and the Maudsley Hospital, as well as civilian consultant advisor in psychiatry to the British Army. In his academic career Simon has authored over 750 scientific papers on a variety of subjects. In 2014 Simon was elected president of the Royal College of Psychiatrists.

11:55-12:20  
Do we have enough beds? Update on the work of Commission to review provision of acute inpatient care  
Ranga Rao

This presentation will focus on acute inpatient care in the UK, trends over time exploring issues underlying the current challenge of demand for beds in adult psychiatry.

Dr Ranga Rao works as a Consultant Psychiatrist in Adult Psychiatry. His current clinical work is on an acute assessment ward (Triage ward) and has championed the development of this model of care which has been rolled across other parts of United Kingdom. He is the college lead on acute inpatient care and in this role supports the work of the Commission on acute inpatient care.

Parallel 2: Resilience: the key to a long and happy career  
Chair: Mary Jane Tacchi

11:30-11:55  
It's a marathon not a sprint  
Alan Currie

The world of sport might seem a long way removed from the trials and tribulations of a psychiatric career. Nonetheless sport gives us many helpful parallels and lessons that can be applied to career management in our chosen profession. Dr. Currie will review several of these and offer related tips and advice on sustaining a rewarding career.

Dr Alan Currie has been a Consultant Psychiatrist in full time NHS practice since 1997. He currently works in the Regional Affective Disorders Service in Newcastle.

His research interests include eating disorders, recovery, social inclusion, mood disorders and movement disorders.

He is an active member and fellow of the Royal College of Psychiatrists. For 4 years he sat on the executive of the General & Community faculty within the college and developed projects on social
inclusion and user and carer involvement. In the last 5 years he has organised 5 symposia on sports psychiatry topics at the Royal College of Psychiatrists International Congress.

He has extensive experience in NHS management and for 3 years was Medical Director within the Newcastle Adult Psychiatry Services during the development and implementation of specialist community teams in the early 2000s.

He is an ex-athlete who remains active in recreational sport, coaching and administration. He is a board member of the International Society for Sports Psychiatry (ISSP). He has acted as a consultant to a number of national sports organisations and supported them in developing policy and practice guidelines and educational materials. In 2006/2007 he chaired the group that developed UK Sport’s guidelines on eating disorders.

11:55 - 12:20
Know yourself
Mary Jane Tacchi

This presentation looks at the concept of resilience and its relevance to career management. The talk will focus on practical ways to increase self-awareness as a tool to promote resilience. This is part of a group of presentations about managing a successful career.

Dr Mary Jane Tacchi is Deputy Medical Director in NTW NHS FT, she has a special interest in medical development and leads on this for the Trust. She has held a number of management positions in the Trust, has extensive experience of service redesign and implemented crisis services in 2000-2005 and researches into medication adherence interventions.

12:20 - 12:45
How to embrace (and cope with change)
Carole Kaplan

This talk will describe the imperatives for and process of service transformation in NTW NHS Foundation Trust.

The design process will be described which included most importantly Users and Carers, staff and partners. A frank description of the challenges for staff of all disciplines will be given and the imperative to support staff and users to embrace the changes. There will be reflections on how we would do it now if given the time again. An overview of the benefits and challenges of the process will be described and suggestions about further Transformation discussed.

Dr Carole Kaplan has been a consultant Child and Adolescent Psychiatrist and Senior Lecturer at the University of Newcastle upon Tyne. Following her retirement as Group Medical Director, Specialist Care, she has returned to work as a Director of the Transformation Program NTW. She also chairs the Relate National Policy and Research Advisory Group and is involved in other national and charitable work.

Parallel 3: Clinical update on unipolar depression
Chair Nicol Ferrier

11:55 - 12:20
NICE depression guidelines - useful for general psychiatrists in the UK?
Dr Andrea Malizia

People with depressive disorders that are seen in secondary care in the UK usually have treatment refractory depression and co-morbid conditions. In addition there are specific constraints related to working in the NHS. Are NICE guidelines fit for purpose? Should we strive to produce documents that are more focused on secondary care? Are there other guidelines that can be of help?

Dr Andrea Malizia provides a service for people with severe and persistent affective disorders at the Rosa Burden Centre, Southmead hospital, Bristol. He has worked in this area since the late 1980s having maintained this clinical interest while working in research, in academia, in industry
and in secondary care. His activity focuses on clinical neuropsychopharmacology, neuromodulation and neurosurgery.

**Parallel Masterclasses**

**14:15-15:15**

**M1 Social Media for psychiatrists (‘Getting started’)**
Chris Pell

This workshop is aimed at those interested in learning about the potential uses and pitfalls of the main social media technologies such as YouTube, Facebook and Twitter. We will discuss what each platform is and look at the emerging legal frameworks and concepts of digital professionalism, including the recent GMC guidance on the topic. We will also touch on some of the more useful Apps (downloadable applications) for use by clinicians and service users alike.

**Dr Chris Pell** is a Consultant General Adult In-patient Psychiatrist, working at the Susan Carnegie Centre in Angus, Scotland for NHS Tayside. He has presented and written on the topic of digital professionalism and doctors’ use of social media. He has an interest in how psychiatrists can best create and use online tools to improve psychiatric practice, whilst avoiding the potential pitfalls as the legal and ethical frameworks take shape around these new technologies. Other areas of interest include Mental Health Informatics, Medical Education and the History of Psychiatry. On Twitter he goes by the username @egosyntonically.

**M2 Doing with not doing to: the challenges of co-production and Recovery in a CMHT**
Helen Crimlisk and Rachel Warner

Mental health professionals have been trained to think of recovery in terms of “clinical recovery”, working to offer diagnosis, clinical formulation and treatment with the aim of reducing symptoms and or curing people. Mental health policy now requires services to build on a personal version of recovery with the focus on fostering hope, opportunity and an openness to listen and acknowledge service users as experts in their own care - individual “personal” recovery. The workshop describes an approach to MDT working and care planning we have developed in Sheffield to support collaborative care and change the conversation between staff and service users. The workshop offers an opportunity to experience how the approach works and to discuss the possible benefits and challenges this raises in a CMHT.

**Dr Helen Crimlisk** is a Consultant Psychiatrist in an adult CMHT in Sheffield. She has worked in General Adult Psychiatry in Sheffield since 2004, and as Director of Undergraduate Psychiatry in Sheffield since 2014. She collaborated on the RCPsych workshops on personalized health and has an interest in working with service users to co design services, particularly youth mental health services. In her undergraduate role she has been developing service user involvement in undergraduate education.

**Dr Rachel Warner** is a Consultant Psychiatrist in an adult CMHT in Sheffield. She has worked in General Adult Psychiatry in Sheffield since 1998, becoming Clinical Director for Acute Care in 2005 and Deputy Medical Director in 2014. She has an interest in working with service users to co design services. Together with service users she has led the development of a collaborative care plan and training program across inpatient services and now in the CMHTs. She co-chairs, with a service user, a sub committee of the Trust Board which delivers the Trust strategy on understanding service user experience, the development of peer support, values based recruitment, the education exchange and service user involvement in training.

**M4 Formulating the revolving door borderline PD patient from different perspectives**
Janet Feigenbaum, Peter Fonagy and Jay Dudley

**Mr Jay Dudley** is a Psychotherapist, Supervisor and Trainer. He is Clinical Lead for the CAT Service in Somerset Partnership NHS Foundation Trust where he is course co-director for the CAT Practitioner Psychotherapy Training. Trustee of ACAT and member of ACAT’s Ethics committee. He has taught widely in the South West.
Professor Peter Fonagy, PhD, FMedSci, FBA, OBE, is Freud Memorial Professor of Psychoanalysis and Head of the Research Department of Clinical, Educational and Health Psychology at University College London; Chief Executive of the Anna Freud Centre, London; and Consultant to the Child and Family Programme at the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine. He is a Senior Investigator for the National Institute of Health Research and holds a visiting professorship at Harvard. He is a clinical psychologist and a training and supervising analyst in the British Psychoanalytical Society in child and adult analysis. He is also National Clinical Lead of the NHS Children and Young People’s Improving Access to Psychological Therapies and Director of the UCLPartners Integrated Mental Health and Wellbeing Programme. His clinical interests centre on issues of borderline psychopathology, violence and early attachment relationships. His work attempts to integrate empirical research with psychoanalytic theory.

A major focus of Professor Fonagy’s research has been an innovative research-based dynamic therapeutic approach, called Mentalization-Based Treatment, which was developed in collaboration with a number of clinical sites both in this country and in the US. Professor Fonagy is also engaged in major collaborative programmes exploring developmental psychopathology from an attachment–mentalization perspective. Another thread of his work involves UK research collaborations concerned with the effectiveness of psychosocial treatments. He has published over 400 papers and has authored or edited 17 books.

M5 “Soldiers to Veterans, a journey of seamless transfer of Mental Health Care”
Walter Busuttil, Wayne Kirkham, David Powell and Jeya Balakrishna

“Soldiers to Veterans, a journey of seamless transfer of Mental Health Care”

A joint presentation from DCMH Colchester, Combat Stress and Veterans First, about how this unique three way collaborative group was set up in 2011 and the progress we have made to date, in maintaining the mental health of our soldiers when they become Veterans.

Dr Busuttil will highlight the general literature on Military Veterans’ Mental Health with reference to the needs of help seeking Veterans and the work and clinical services offered by the NHS and the Third Sector Charity Combat Stress which is the largest Third Sector service provider in this field with some 6000 veterans receiving care currently.

The clinical needs of help seeking veterans are ill understood by non specialist mental health services. These veterans fare worse in treatment compared to civilian populations. Veterans with serious mental health disorders engage poorly and drop out early from treatment. Stigma issues and the military culture are barriers into care. Mainstream services are not geared up to the specific needs of veterans. Some limited NHS veterans clinical services are available. Combat Stress works collaboratively with NHS and other service providers to deliver community based services including a substance misuse case management service, residential programmes including an intensive treatment programmes and a Wellbeing and Rehabilitation Programme.

Combat Stress is linked in to the Kings Centre for Military Health. Dr Busuttil will highlight treatment research outcome studies.

Wing Commander Walter Busuttil MBChB MPhil MRCGP FRCPsych RAF (Retd) qualified in Medicine in Manchester in 1983. He joined the Royal Air Force as a medical student cadet and served for 16 years qualifying as a general practitioner and consultant psychiatrist serving in the United Kingdom and Germany and on operational tours. He retired from the RAF in 1997. He was part of the team that rehabilitated the British Beirut Hostages and was instrumental in setting up rehabilitation services for personnel returning from the first Gulf War I with Post Traumatic Stress Disorder. He then worked setting up tertiary general adult and forensic psychiatric services for adult survivors of sexual abuse suffering from Complex PTSD. He was appointed Director of Medical Services to Combat Stress the National Charity that provides mental health care to Veterans in 2007. He has led he development of clinical services for veterans’ mental health including residential programmes, outreach and community clinical services nationally expanding the clinical capability of Combat Stress attaining National Specialist Commissioning for an Intensive Treatment Programme in 2011. He has been active in the media and has campaigned and encouraged statutory NHS services to be set up for Veterans’ mental health.

Walter was the Chair of the UK Trauma Group for five years until 2013 and was a founder Board
member of the UK Psychological Society until 2013. He has published and lectured extensively about rehabilitation of chronic and complex presentations of PTSD.

Mr Wayne Kirkham was appointed as the National Lead for the National Veterans’ Mental Health Network in October 2012; The management of the National Network was taken over by NHS England in early 2014 and the post was moved to London.

Wayne works very closely across Government departments to ensure that Veterans’ Welfare remains high on the political agenda and Veterans and their families get the right services in the right place at the right time.

Wayne is himself a Veteran and brings considerable experience and understanding to this role, which gives him the drive and passion to help deliver an excellent service for all.

Mr David Powell is Clinical Nurse Specialist with Veterans First. Veterans First is an award winning community mental health team based in Essex that works with Military Veterans and service personnel in transition.

I am a veteran who was initially a “chosen man” a royal Green Jacket and very quickly transferred to the Royal Electrical and Mechanical Engineers whe I found out how often the Light Division feel the need to run everywhere. and saw service in Northern Ireland, Canada, Germany and served with the British Mainland.

Was part of the project team that initiated the Veterans mental health team in North Essex in 2012 and this led to the team taking its first client in March 2012.

As a Clinical Nurse Specialists I provide expert advice related to specific military related conditions and treatment pathways.

Destressors involve fast motorcycles and Archery.

A doctor of 28 years and a psychiatrist, Dr Jeya Balakrishna has worked mainly in the NHS in forensic and general services, both inpatient and in the community. He has been involved in psychotrauma work throughout his career - domestic violence clinics in Sussex, working with refugees and emergency services personnel at the Institute of Psychotrauma in St Barts, and dealing with mental health issues at Immigration Removal Centres.

Jeya served as an infantry medical officer in Singapore before coming to the UK in 1992 to embark on postgraduate psychiatric training. He finds himself returning to the military, as civilian Consultant Psychiatrist in the MOD leading the national Veterans & Reserves Mental Health Programme (VRMHP) based in Chilwell, Nottingham. He is also Honorary Consultant Psychiatrist with the mental welfare charity Combat Stress.

Jeya has worked in clinical, advisory and management roles in all three sectors in mental healthcare. He is active in teaching, public education and professional development.

He is a big fan of multi-disciplinary team-working. He appreciates the art of listening in professional practice – the story and the storyteller matter - to help put a coherent thread to an individual's life experiences.

M6 Faculty research prize oral presentations

Outcome according to day of admission in mental healthcare: implications for a seven-day NHS
Dr Edward Chesney

Recent research in physical healthcare has suggested that outcomes are worse for patients admitted over the weekend. This has contributed to a clinical and political drive to move to a ‘seven-day’ NHS. In this study, we aim to investigate outcomes according to day of admission in mental healthcare.

The study was conducted using the South London and the Maudsley Biomedical Research Centre Case Register. It included all individuals aged over 16 who were admitted to an inpatient unit between 1st April 2006 and 31st March 2015, comprising 45448 consecutive admissions.
The number of admissions and discharges varied according to day of the week, as did the length of admission. Mental healthcare service factors were more predictive of weekend admission than patient factors. Additional analysis suggested that mean duration of admission has been reducing over time and that there is also variation in mortality according to day of the week and day of admission.

Admission length is shorter for patients admitted on non-working days. This is likely to reflect differences in the populations of patients admitted on these days rather than service related factors. Further investigation into the underlying reasons for these variations is warranted, as is research into other outcomes such as re-admission, use of seclusion, and violence.

Dr Edward Chesney is a Foundation Year 2 doctor at the Royal London Hospital in Whitechapel. Having completed his medical training at the University of Oxford, he worked as FY1 doctor in Essex.

Inflammatory cytokines and neuronal integrity in patients with Obsessive Compulsive Disorder (OCD)
Dr Sundar Gnanavel

This abstract is based on our study titled ‘An imaging genetic study and immunology profiling of patients with Obsessive Compulsive Disorder (OCD)’. The association between level of inflammatory cytokines and neurochemical markers of degeneration in brain has been explored. Proton magnetic resonance spectroscopy technique has been employed to quantify level of brain neurochemicals. Our aim to postulate a comprehensive model of OCD (biological model) based on neurogenerative hypothesis. The clinical implications of the study include identification of bio markers as well as novel therapeutic targets for intervention.

Dr Sundar Gnanavel is an International Training fellow under the Medical training initiative of the Royal College of Psychiatry, UK currently posted with the Northamptonshire NHS trust. He obtained his postgraduate degree, MD (Psychiatry) from the prestigious All India Institute of Medical Sciences, New Delhi, India in 2012. He continued to work as a senior resident in Psychiatry at the same institute prior to his current assignment. He also simultaneously worked as a senior research fellow under the INCRE (Initiative in neuroclinical research education) scheme of the Government of India. He has won international awards to his credit including the Royal College Psychiatry (UK) trainee researcher of the year (2014) and Young Psychiatrist award of the World Psychiatric Association (twice in 2013, 2015). He has a number of peer reviewed international publications to his credit and is a peer reviewer for a number of national and international journals primarily in the area of biological psychiatry.

He is an active member of reputed international scientific organizations including the ISMRM (International Society for magnetic resonance in medicine), ISN (International society for neurochemistry) and ASME (Association for study of Medical Education). His primary areas of research interest include neuroimaging in psychiatry, psychiatric genetics and psychoneuroimmunology pertaining to Obsessive Compulsive Disorder (OCD). His clinical interests include general adult and consultation-liaison psychiatry. He is also interested in medical education and academic psychiatry.

Underlying neural mechanisms linking risk factors for psychosis and emotion processing
Dr Rob McCutcheon

Psychotic disorders are associated with environmental risk factors such as migration, urbanicity, childhood adversity and current life stressors. Individuals with psychotic disorders have also been shown to have differences in emotion processing. The neurobiological basis for this difference in emotion processing has been studied, and it has been shown that individuals with schizophrenia display hypoactivation of the amygdala when viewing emotional faces compared to healthy controls.

It is not known if altered emotional perception develops as a secondary consequence of the emerging symptoms and neurobiological changes associated with the development of schizophrenia, or whether these alterations are independently linked to environmental risk factors. This is an important distinction, as if the changes are directly linked to exposure to the risk factors, this suggests that they are an early neurobiological change in the mechanistic pathway leading to the onset of the disorder.
The aim of the study was to determine whether individuals with a history of stress exposure showed a different pattern of amygdala activation during emotion processing compared to those with no such history. 12 individuals with a history of high exposure to psychosocial stressors (HPSS) and 12 with a low exposure (LPSS) were scanned using a 3T MRI scanner while viewing faces displaying various emotions. Individuals in the LPSS demonstrated increased amygdala and insula responses to fearful faces compared to the HPSS group (p<0.001, uncorrected). The maximum between group difference was in the right amygdala (d=1.63).

These results support the hypothesis that environmental risk factors play a role in some of the neurobiological features observed in schizophrenia. Furthermore, they suggest that these changes occur prior to the onset of any form of mental disorder.

**Dr Rob McCutcheon** is currently an academic clinical fellow based at South London & the Maudsley/Institute of Psychiatry, Psychology and Neuroscience. My research focuses on the neurobiological effects of stress and the social environment, and in particular the relevance this has for psychotic disorders.

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**Sleep and Circadian Disturbances in Bipolar Disorder**
Rebecca Webb Mitchell, AJ Bradley, KN Anderson

**Aims and Hypotheses:** To objectively assess the patterns of sleep and circadian disturbance in BD and assess the factors associated with these patterns.

We hypothesise a higher proportion of BD patients will exhibit abnormal sleep patterns and self-report poorer sleep quality when compared to controls.

**Background:** Sleep disturbances are commonly reported in Bipolar Disorder (BD) and poor sleep is known to reduce quality of life and impair cognitive function. Better characterization of sleep is needed to help guide treatment in BD. Accelerometry measures sleep and circadian rhythm over time and can help characterise sleep patterns in these patients.

**Methods:** 30 BD patients and 30 age- and sex-matched controls completed sleep questionnaires (Pittsburgh Sleep Quality Index and Epworth Sleepiness Scale), 21 days of sleep diaries and 21 days of accelerometry. Mood was assessed using the Hamilton Depression Rating Scale and the Young Mania Rating Scale. We screened for comorbid primary sleep disorders and excluded participants with severe obstructive sleep apnoea and severe restless legs syndrome from the sleep phenotype analysis. Accelerometry data from 26 BD patients and 26 controls were visually analysed for the sleep phenotypes: normal sleeper, long sleeper, short sleeper and irregular sleeper.

**Results:** The BD participants exhibited more abnormal sleep phenotypes than the controls ($\chi^2=9.899$, p=0.007) with over a quarter of the BD patients exhibiting irregular sleep-wake cycles. In the BD patients, abnormal sleep phenotypes were associated with higher depressive mood scores (p=0.045) and unemployment (p=0.021). Depressive mood also correlated with poorer self-rated sleep quality (rho=0.662, p<0.001).

**Conclusion:** There is objective and subjective evidence that BD is associated with abnormal sleep patterns. Irregular sleep-wake cycles, as seen in circadian rhythm sleep disorders, were exhibited by many of the BD participants and suggest an underlying circadian disturbance. Further research is needed to better understand what causes these abnormal sleep phenotypes and how they affect BD patients and their treatment.

**Rebecca Webb-Mitchell** is a final year medical student at Newcastle University with an interest in academic medicine. Last year, she intercalated in a Neuroscience Masters by Research during which she assisted with the ASCRIBE study (the Association between Sleep and Cognitive Function in Bipolar Disorder and Insomnia study) at the Institute of Neuroscience at Newcastle University. For her Masters project, she analysed the patterns of sleep in Bipolar Disorder patients with funding from the Association of British Neurologists Interceded Degree Award. During her time at medical school, she has assisted with a variety of research projects including an investigation into the effect of relaxation techniques on Non-REM Parasomnias and a laboratory-based project differentiating mouse embryonic stem cells into dopaminergic neurons, funded by the Newcastle University Vacation Scholarships. She is currently looking into the sleep quality of patients on psychiatric wards in Newcastle upon Tyne.
How do we manage high risk borderline PD patients in the community?
Chair: Dr Daniel Armstrong

Dr Daniel Armstrong works as a General Adult Community Psychiatrist in North Tyneside. I am also Consultant Psychiatrist for Northumberland, Tyne and Wear NHS Foundation Trust’s Specialist Personality Disorder Team.

16:35-17.00
Mentalization based outpatient treatments for personality disorders
Peter Fonagy

Professor Peter Fonagy, PhD, FMedSci, FBA, OBE, is Freud Memorial Professor of Psychoanalysis and Head of the Research Department of Clinical, Educational and Health Psychology at University College London; Chief Executive of the Anna Freud Centre, London; and Consultant to the Child and Family Programme at the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine. He is a Senior Investigator for the National Institute of Health Research and holds a visiting professorship at Harvard. He is a clinical psychologist and a training and supervising analyst in the British Psychoanalytical Society in child and adult analysis. He is also National Clinical Lead of the NHS Children and Young People’s Improving Access to Psychological Therapies and Director of the UCLPartners Integrated Mental Health and Wellbeing Programme. His clinical interests centre on issues of borderline psychopathology, violence and early attachment relationships. His work attempts to integrate empirical research with psychoanalytic theory.

A major focus of Professor Fonagy’s research has been an innovative research-based dynamic therapeutic approach, called Mentalization-Based Treatment, which was developed in collaboration with a number of clinical sites both in this country and in the US. Professor Fonagy is also engaged in major collaborative programmes exploring developmental psychopathology from an attachment–mentalization perspective. Another thread of his work involves UK research collaborations concerned with the effectiveness of psychosocial treatments. He has published over 400 papers and has authored or edited 17 books.

Parallel 5: Sleep Disorders and Psychiatry
Chair Billy Boland

Chair: Billy Boland

Dr Billy Boland is a consultant psychiatrist in community psychiatry and an elected member of the general adult faculty executive committee at the Royal College of Psychiatrists.

15:45-16:10
Insomnia
Professor Jason Ellis

Insomnia is the most reported sleep complaint globally with a prevalence of approximately 10% and annual incidence of 7%. Moreover, over a third of the UK population will suffer an acute bout of insomnia in any given year. The costs of insomnia to the UK health service alone are estimated in the region of £49.2M per annum. More importantly, insomnia has been linked to the development and worsening of several chronic illnesses and conditions (e.g. depression, suicide, obesity, cancer). The aim of this presentation is to introduce the audience to the various definitions of insomnia and critically examine the evidence with regard to the etiology and pathophysiology of insomnia with special emphasis on the relationship between insomnia and depression. Finally, he will introduce both the theory and evidence surrounding the treatment of insomnia using Cognitive Behavioural Therapy for Insomnia (CBT-I).

Jason Ellis is Professor of Sleep Science and Director of the Northumbria Centre for Sleep Research at Northumbria University. He is a Practicing Health Psychologist (HCPC), Chartered Health Psychologist (BPS) and Somnologist: Expert in Behavioural Sleep Medicine (EBSM) and
holds honorary positions at The University of Pennsylvania: Division of Sleep Medicine and Newcastle University: Fatigue Research Centre. He splits his time between his basic research interests: the pathophysiology of sleep disorders (Insomnia, Restless Legs Syndrome, and Circadian Rhythm Disorders) and specifically the natural history of Insomnia, and his applied work on Cognitive Behavioural Therapy for Insomnia (CBT-I). Within the former framework he examines the temporal link between stress-related sleep loss and sleep-related stress by examining changes in biological, physiological, psychological and behavioural factors. Within the latter framework he examines the impact of novel adjunct therapies for sleep disorders, the influence of social factors on adherence to treatment for insomnia, and the effective delivery of CBT-I in complex cases.

16:35-17:00
Parasomnias
Paul Reading

Parasomnia are defined as undesirable events that occur from sleep and are very common, both in childhood and adult life. Childhood sleepwalking is considered as an “arousal disorder” which reflects an abnormality of deep non-REM sleep regulation. It persists into adulthood in at least 2% of subjects, with nocturnal disturbances often becoming more agitated and goal-directed. Treatment options are poorly defined and often focus on alleviating any triggering factors.

Parasomnias also frequently arise from REM sleep. The best characterized REM parasomnia is REM sleep behavior disorder (RBD) in which the normal mechanism for profound voluntary muscle paralysis during REM sleep fails. The consequent dream enactment can produce injury and merit treatment. Late middle-aged men are most at risk of RBD which, for the majority, is a likely prodrome for developing a parkinsonian neurodegenerative disease, often years later. A variety of rare parasomnias are not confined to any particular sleep stage and are often of more concern to the bed partner than the sleeping subject.

After completing his PhD in Cambridge, Dr Paul Reading completed his neurological training in Edinburgh and Newcastle before moving to the James Cook University Hospital in Middlesbrough ten years ago. Since then he has been running a bi-weekly Neurology Sleep Clinic with a particular interest in narcolepsy, abnormal sleep in neurodegenerative disease, and parasomnias. He is President of the British Sleep Society, the largest body in the UK for professionals involved in sleep medicine and science.

Parallel 6: Adult ADHD – Developing its place
Chair Rob Baskind

15:45-16:10
Developing the Adult ADHD network
Nick Kosky

This presentation will provide a brief overview of neurodevelopmental disorders, their epidemiology within a prison setting and approaches to management.

Dr Nick Kosky is a Consultant Psychiatrist working in the Prison Inreach Team in Dorset. He is interested in providing mental healthcare in secure settings and is currently chair of the NICE Guideline Development Group ‘Mental Health of Adults in the criminal justice system’

16:35-17:00
Spotting ADHD in a general psychiatry clinic
Robert Baskind

Adult ADHD is not only one of the commonest child mental health disorders, but has a higher prevalence that many adult mental health conditions, with a world-wide prevalence of between 2.5-4%. ADHD rarely presents as a sole mental health condition, with up to 70% of cases having at least one co-morbid condition. Numerous studies in general adult outpatient clinics have repeatedly estimated the prevalence of Adult ADHD in outpatient clinics to be between 10-20%. ADHD is associated with significant impairment in a wide range of areas, including education, employment and the management of daily life tasks.
Those working in Adult ADHD are seeing an increasingly high number of cases of patients whom have been managed in outpatient clinics with limited treatment effect for co-morbid or other conditions, possibly misdiagnoses, and in which underlying ADHD has not been identified. It is vitally important that ADHD if present is identified, as without doing so the patient is being withheld from a range of a range of highly effective treatment interventions.

Dr Robert Baskind has worked as a Consultant Psychiatrist in Leeds since gaining his CCT in general adult psychiatry in 2009. Since being a Consultant, he has been the Clinical Lead in Mental Health at Leeds Prisons covering a very busy local remand and a Category C prison. He has also worked in community and home treatment teams. In 2011, he developed a new service for adults with ADHD in Leeds and has been the Clinical Lead ever since. This service continues to develop. He has also developed pathways for assessment and treatment for ADHD in Leeds adult prisons.

He has participated in a number of multi-centre trials in ADHD including researching the prevalence of ADHD in general adult psychiatry clinics and the neurocognitive effects of ADHD. He has delivered training locally and nationally on Adult ADHD to primary care and a range of mental health and criminal justice services.

**Friday 9 October**

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<th>PLENARY 2</th>
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<td>09:30-10:10</td>
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<td><strong>The physical consequences of depression: what, why and who should care?</strong></td>
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Prof.dr. Brenda Penninx (1970) is professor of Psychiatric Epidemiology and since member of the management team of the Neuroscience Campus Amsterdam. She has been involved in several Dutch and international longitudinal cohort studies for the last 15 years. Central themes in her research are risk factors and consequences of depression and anxiety disorders and the interaction of these disorders with physical health. She has published over 600 international articles on these subjects.

Brenda Penninx studied Health Sciences at the Catholic University of Nijmegen. She obtained her PhD in Epidemiology at the VU University in 1996. Afterwards she stayed in the USA for several years as Visiting Fellow at the American National Institute on aging in Bethesda, MD, and as Assistant/Associate Professor at Wake Forest University in North Carolina.

In 2004 she returned to the VU University Medical Center in the Netherlands to become the principal investigator of the NESDA study; the Netherlands Study of Depression and Anxiety (www.nesda.nl).

Brenda Penninx has been a member of the Young Academy of the KNAW and has received several national and international funds for her research. In her current researchgroup junior researchers (4 assistant professors, 3 postdocs and more than 20 PhD students) with diverse backgrounds study the etiology, treatment and consequences of depressive and anxiety disorders from multidiciplinary perspectives. Brenda Penninx works for the department of Psychiatry of the VU University Medical Center Amsterdam. The neurobiological component of her research is embedded in the neurobiology of mental health programme of the Neuroscience Campus. The rest of her research group is largely embedded in the EMGO+ Institute VUmc.

**CURRENT PROJECTS**

Brenda Penninx is Scientific Director of the Netherlands Study of Depression and Anxiety (NESDA): www.nesda.nl.

The Netherlands Study of Depression and Anxiety (NESDA) started in august 2004 with the recruitment of almost 3000 people with and without symptoms. They will be monitored for a long period of time. An inventory of the depression and anxiety symptoms is made by using questionnaires and by examining biological and genetic factors.
Parallel 7: Debate - “This house believes that risk assessments have no place in contemporary psychiatry”
Chair: Marios Adamou
11:10-12:40

Speakers For:
Dr David Christmas will argue that risk assessment cannot ever predict outcome for an individual patient and that there are no tools that will enable the clinician to do this. I will present some data on the predictive validity of risk assessment and frame it around a familiar scenario. Essentially, risk assessment is an unwelcome distraction from the ‘core business’ of psychiatry which is assessing, diagnosing, and treating mental illness. I will also argue that risk assessment leads to perverse clinical decision-making which affects patient care.

Dr David Christmas is a Consultant Psychiatrist in the Advanced Interventions Service, a Scottish National Specialist Service for the assessment and treatment of chronic, treatment-refractory depression and Obsessive-Compulsive Disorder (OCD). He works in Dundee and has been a consultant since 2006. Prior to this, he was a clinical lecturer in the University of Dundee (2003-2006), and he did his basic specialist training in Forth Valley.

His research interests include the neuroimaging of mood disorders, and the neurosurgical treatment of chronic, treatment-refractory mood disorders and OCD. He often speaks about the use of antidepressants, the management of treatment-refractory mood disorders, and the importance of evidence-based approaches to the treatment of mental disorder. He believes in assessing the patient rather than ticking boxes and accepts the uncertainties in psychiatric practice.

Parallel 8: Training and recruitment
Chair: Helen Crimslisk

11:10-11:35
Shaping the undergraduate curriculum to increase recruitment
Ania Korszun

Professor Ania Korszun PhD, MD, FRCPsych is Professor of Education and Psychiatry at Barts and The London Medical School, Queen Mary University of London and Chair of the Undergraduate Leads Forum of the Royal College of Psychiatrists. Her educational research is on teaching and assessment of medical professionalism and overcoming stigmatizing attitudes to mental illness.

12:00-12:25
Mentorship for psychiatrists in training
Declan Hyland

The Liverpool Psychiatry Mentoring Scheme was set up in 2013 as a means of promoting psychiatry as a career choice to medical students at Liverpool Medical School. The scheme continues to run to this day and has now been expanded to involve Mersey Foundation Trainees interested in psychiatry. The scheme involves medical students / Foundation Trainees being paired up with Mersey Core Trainees in psychiatry, who then maintain regular contact with their allocated medical student / Foundation Trainee over the course of the academic year.

Dr Declan Hyland graduated from the University of Sheffield in June 2008 and then completed 2 years of Foundation Training at Aintree University Hospital, Liverpool. He commenced Core Training in psychiatry in the Mersey region in August 2010. After completing Core Training, he was then successful in gaining a post in Higher Training in General Adult Psychiatry also in the Mersey region.

He has had a long interest in medical education, particularly undergraduate teaching. He is heavily involved in the delivery of psychiatry teaching to Liverpool medical undergraduates. He is currently undertaking a Postgraduate Certificate in Teaching and Learning in Clinical Practice. He is also have a keen interest in recruitment into psychiatry, and was responsible for setting up the
Liverpool Psychiatry Summer School for undergraduates and the Liverpool Psychiatry Autumn School for Foundation Trainees. He is the Deputy Lead for Recruitment in the North West Division.

**Parallel 9: Recent Developments in Research of the Obsessive-Compulsive Spectrum (OCS) Disorders**

**Chair Lynne Drummond**

11:35-12:00

**Potential use of Pregabalin for profound, enduring OCD**

Lynne Drummond

Obsessive compulsive disorder (OCD) generally responds to treatment with either Cognitive Behaviour Therapy (CBT) involving graded exposure or to treatment with serotonin reuptake inhibiting (SRI) drugs. Whereas the majority of people respond well to treatment, a sizeable minority remain refractory to standardised interventions. In the past the standard treatment for refractory OCD was the addition of a dopamine blocking agent alongside SRI and CBT. Unfortunately there are many potential side-effects from treatment with these Dopamine Blockers and they are only effective in a proportion of refractory patients. Recent research has started to examine the possible role of glutamine metabolism in OCD. Many agents which effect glutamate transmission have been or are being explored. One such agent is pregabalin, a novel analogue of the inhibitory neurotransmitter gamma amino butyric acid (GABA). Pregabalin has been shown to be efficacious in other anxiety disorders and in a recent open-label trial was found to lead to a significant improvement in clinical symptoms in treatment-resistant OCD patients. In this talk I will present this evidence as well as findings from a case series of inpatients with severe, complex, and resistant obsessive-compulsive disorder (OCD) who were treated by the National inpatient Service.

**Dr Lynne M Drummond** has been a Consultant Psychiatrist and Senior Lecturer with South West London and St George’s NHS Mental Health Trust since 1985. She is lead clinician for the English nationally commissioned service for severe, enduring obsessive-compulsive and body dysmorphic disorders (OCD/BDD) and also for trustwide services for OCD/BDD and other severe neurotic conditions.

Specialising particularly in CBT she has published widely in the fields of OCD; anxiety disorders; communication skills; learning and acquisition of skills and is the author of 2 books. Her most recent book “CBT for Adults” was published by the Royal College of Psychiatrists in September 2014. Dr. Drummond has a longstanding involvement in medical education and was involved as a clinical tutor and course leader for 20 years. More recently, she has become involved in management and leadership training and has published in these areas. She is frequently asked to speak at national and international conferences about OCD, BDD and CBT as well as medical management and leadership.

**Parallel 10: Ethical Dilemmas in Psychiatry**

**Chair: Paul Rowlands**

13:50-14:15

**Conflicts of Interest**

Fiona Godlee

**Dr Fiona Godlee** has been Editor in Chief of The BMJ since 2005. She qualified as a doctor in 1985, trained as a general physician in Cambridge and London, and is a Fellow of the Royal College of Physicians. She first joined The BMJ in 1990 and has written and lectured on a broad range of issues, including health and the environment, the ethics of academic publishing, evidence based medicine, access to clinical trial data, research integrity, open access publishing, patient partnership, conflict of interest, and overdiagnosis and over treatment. As Editorial Director for Medicine from 2000-2002, she helped to establish the open access publisher BioMedCentral. She is on the advisory or executive boards of Alltrials (alltrials.net), the Peer Review Congress, the International Forum for Quality and Safety and Healthcare (http://internationalforum.bmj.com/about), Evidence Live (http://evidencelive.org/), Preventing Overdiagnosis (http://www.preventingoverdiagnosis.net/?p=830), and the Climate and Health Council (climateandhealth.org). She was a Harkness Fellow (1994), President of the World Association of Medical Editors (WAME) (1998-2000), Chair of the Committee on Publication Ethics (COPE) (2003-5), and PPA Editor of the Year (2014). She is
There are many people in different settings who are deprived of their liberty by virtue of the arrangements made for their care and treatment, but who lack the capacity to give consent to their confinement. The legal framework for the authorisation of deprivation of liberty of such individuals in the health and social care context is complex, involving (depending on the setting) consideration of both the Mental Capacity Act and the Mental Health Act 2005. In this presentation, Alex Ruck Keene will outline the framework and the key developments in the area with specific reference to the particular issues that arise in practice for psychiatrists.

Mr Alexander Ruck Keene is a leading expert in the field of mental capacity law, appearing in cases involving the Mental Capacity Act 2005 at all levels up to and including the Supreme Court. He also writes extensively about mental capacity law and policy, works to which he has contributed including 'The Court of Protection Handbook' (2014, LAG); 'The International Protection of Adults' (2015, Oxford University Press) and Jordan’s ‘Court of Protection Practice.’ He edited the Law Society’s 'Deprivation of Liberty: A Practical Guide' (2015), and is the general editor of the fourth edition of 'Assessment of Mental Capacity' (Law Society/BMA, forthcoming). He is an Honorary Research Lecturer at the University of Manchester, and the creator of the website www.mentalcapacitylawandpolicy.org.uk

In recent years recurrent attempts have been made, via various routes, and across the different jurisdictions of the UK, to legalise some form of assisted dying. Although the law has not been changed so far, the issue keeps returning to Westminster and Holyrood (if not yet Stormont or Cardiff.)

In 2010 the late Margo Macdonald’s Bill to legalise euthanasia and assisted suicide was debated at length in the Scottish Parliament. Because it laid down prominent roles for psychiatrists at various stages in the process, the RCPsych in Scotland submitted a detailed written response, supplemented by oral evidence at the committee stage.

The Bill was heavily defeated; but in 2015 another Bill, this time limited to assisted suicide, reached the same stage. By contrast with its predecessor, it made no reference to roles for psychiatrists, and so drew forth a minimalist written response from RCPsychIS. Nevertheless the committee considering the Bill invited oral evidence on possible roles for psychiatrists. This bill too was defeated, if less heavily.

This presentation summarises the experience of RCPsychIS in responding to these very different Bills, to illustrate the varying ways in which legislators envisage roles for psychiatrists in assisted dying.


Working part time to pursue parallel career as novelist and screenwriter, specialising in historically set adaptation. Seven works of fiction published, one screenplay produced, four optioned.
Cognition in Mood Disorders
Allan Young

Major depressive disorder and bipolar disorder are associated with poor performance in several cognitive domains which are often correlated with clinical factors including number of episodes and length of illness. Functional neuroimaging has revealed key brain networks associated with the regulation of cognitive performance. The objective of this presentation is to review the neurobiology of cognition in mood disorders.

Professor Allan H Young MB, ChB, MPhil, PhD, FRCPC, FRCPsych holds the Chair of Mood Disorders and is Director of the Centre for Affective Disorders in the Department of Psychological Medicine in the Institute of Psychiatry at King’s College London, United Kingdom (UK). He has held academic appointments at Oxford University; Newcastle University (latterly holding the Chair of General Psychiatry at Newcastle), University of British Columbia in Vancouver, Canada, where he held the Leading Edge Endowment Fund Endowed Chair in Research in the Department of Psychiatry and was also the Director of the Institute of Mental Health, and Imperial College London, where he held the Chair of Psychiatry and was Director of the Centre for Mental Health.

Professor Young’s research interests focus on the cause and treatments for severe psychiatric illnesses, particularly mood disorders. He has received research grant funding from the UK Medical Research Council, the Wellcome Trust, the Stanley Medical Research Institute, the Canadian Institutes for Health Research (CIHR), the National Institutes of Health (USA), and numerous other funding agencies. He has published over 300 peer-reviewed publications and a number of books about psychopharmacology and affective disorders including Bipolar Disorders: Basic Mechanisms and Therapeutic Implications (2nd Ed) with J.C. Soares, and Practical Management of Bipolar Disorder with I.N. Ferrier and E. Michalak (Cambridge University Press, 2010).

Professor Young was recently ranked as one of the world’s leading scientific minds in the field of Psychiatry and Psychology, according to the 2014 Thomson Reuters Highly Cited Researchers list. In all of science, a total of over 3,000 researchers worldwide earned this distinction and the academics listed rank among the top 1% most cited for their subject field and year of publication, a mark of exceptional impact. (see: http://www.kcl.ac.uk/iop/news/records/2014/July/Three IoP academics ranked as worlds leading scientific minds.aspx)

Professor Young is a member of a number of editorial boards and is a member of numerous professional and scientific societies. He is currently President of the International Society for Affective Disorders and Chair of the Psychopharmacology Committee of the Royal College of Psychiatrists.

allan.young@kcl.ac.uk

Open Dialogue
Dr Russell Razzaque

Open Dialogue is a network based approach to mental health care in which staff of all disciplines are trained in family therapy and related skills, in order to work with the whole network instead of just the individual alone. We all know that so many of the underlying issues that bring patients to see us exist on a systemic level, in the relationships between people, and this is why focusing on that sphere has the potential to produce very positive results. Indeed, where it started, in Finland, their recovery rates were reported to have soared, compared to treatment as usual and, as a result, it has now been adapted in Germany, New York City, Italy and much of Scandinavia with new services developing globally all the time. In this talk we will learn about Open Dialogue and the NHS multi-centre project that is exploring its adaptation in a UK context.
**Dr Russell Razzaque** is a consultant psychiatrist and associate medical director in the NHS in east London. He is also a published author in human psychology, and an Honorary Senior Lecturer at UCL. His special interests and particular fields of research are mindfulness and Open Dialogue.

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### Parallel 12: Update on ECT
**Chair: Nicol Ferrier**

#### 13:50-14:15
**The EFFECT-Dep Trial – a randomised trial of bitemporal and high-dose unilateral ECT for depression (ISRCTN23577151)**
Declan McLoughlin

Objective: Electroconvulsive therapy (ECT) is the most effective treatment for severe depression but is limited by cognitive side-effects, to which older adult may be more vulnerable. The most common form of ECT worldwide uses bitemporal (BT) electrode placement which is more powerful than right unilateral (RUL) placement but is associated with more cognitive deficits. However, RUL-ECT at higher electrical doses may be as effective as BT-ECT but with less cognitive side-effects. The aim of this trial was to compare the effectiveness and cognitive side-effects of high-dose RUL-ECT with standard BT-ECT.

Methods: We carried out a pragmatic, two-group, parallel-design, randomised, non-inferiority trial of twice-weekly BT-ECT at 1.5 times seizure threshold versus high-dose RUL-ECT at 6 times seizure threshold for patients with a major depressive episode. Recruitment was from May 2008 till November 2012. 138 patients (69 per group) were randomised to ensure adequate power to assess non-inferiority of high-dose RUL ECT. The primary outcome was the Hamilton Rating Scale for Depression (HRSD-24) score at end-of-treatment with a non-inferiority margin of 4.0 points. Secondary outcomes included recovery of orientation after ECT sessions as well as immediate and longer-term cognitive performance after completion of the ECT course.

Results: Overall, high-dose RUL ECT was non-inferior to BT ECT with respect to the HDRS-24 at the end of ECT course (mean difference 1.2 points in favour of RUL ECT (95% CI, -1.510 to 3.995)). Recovery of orientation was quicker following RUL ECT (median 19∙1 vs 26∙4 mins, p<0∙001). RUL ECT was associated with better % recall of autobiographical information (OR=0∙66, p=0∙001) that persisted for six months.

Conclusion: Twice-weekly high-dose RUL ECT is not inferior to bitemporal ECT, and may be preferable due to a more acceptable cognitive side-effect profile.

**Declan M McLoughlin PhD MRCPI MRCPsych FTCD** is Research Professor of Psychiatry in St Patrick’s University Hospital and Trinity College Dublin, Ireland. He qualified from University College Dublin in 1986 and trained in general medicine and psychiatry in both Dublin and London. His research interests include electroconvulsive therapy and other brain stimulation techniques for neuropsychiatric disorders, treatment resistant depression, and molecular psychiatry. For more details see the [Depression Neurobiology Research Group](http://example.com) webpage.

#### 14:15-14:40
**Neurobiology of depression in relation to ECT**
Rupert McShane

Much is known about the social and personal antecedents of mood disorders but the neurobiology is only just starting to be elucidated. Scientific approaches to the neurobiology of depression have moved from the focus on a single neurotransmitter to notions of system level disruption based on deficient neuroplasticity accompanied by brain volume loss in regions critical to emotional regulation. There is also much interest in changes in network function in depression, as measured by functional brain imaging. In particular, overactivity of the ‘default mode’ network has been seen as a possible biomarker of depression. Deficient brain GABA may be implicated in overactivity of cortical networks. These formulations of depression as a network disorder based on impaired neuroplasticity provide new ways of thinking about the action of ECT. Indeed, in animals, electroconvulsive shock produce increases in markers of neuroplasticity while in depressed patients ECT decreases the increased functional connectivity that characterises the depressed state.
Dr Rupert McShane, MD FRCPsych is Consultant Lead for ECT, Oxford Health NHS Foundation Trust and Honorary Senior Clinical Lecturer in Psychiatry, University of Oxford.

14:40-15:05 Outcomes from ECT in the UK
Linda Cullen & Nicky Buley

The Scottish Electro-Convulsive Therapy Accreditation Network (SEAN) has been collecting data on all aspects of ECT since 1997. SEAN started as a paper based audit and has developed into a national clinical network and accreditation service. Since 2005 we have collected data via an electronic clinical care pathway set up in every hospital which delivers ECT in Scotland. We routinely collect data on demographics, diagnosis, treatment details, side effects and outcomes. This presentation will give an overview of ECT treatment in Scotland.

Between March 2014 and April 2015, the ECT Accreditation Service conducted a survey in England, Wales, Northern Ireland and Ireland to collect a comprehensive dataset relating to people who received ECT over a one year period. Data on patient demographics and clinical outcomes was collected, for both acute and maintenance ECT. This presentation will explore the results of the survey. It will also look at trends over time, comparing the results to the previous round of data collection in 2012 – 2013, as well as previous surveys.

Mrs Linda Cullen is RGN and RMN trained. She has worked in both district general hospitals & mental health hospitals. She has experience of working in mental health assessment for the over 65s, acute admissions for people under 65, and was lead ECT nurse at St Johns hospital in Livingston for 10 years. She is a member of the RCPsych Special Committee on ECT & Related Treatments; the Nursing Committee for the International Society for ECT and Neurostimulation (ISEN), the SANECT_Southern African Network for ECT forum; and she is the founder of the Committee for Nurses at ECT in Scotland (CONECTS).

She has been in her current position as SEAN National Clinical Co-coordinator since November 2000 and moved along with the project to Information Services Division in December 2008. Her current focus is on quality improvements in patient care, working closely with service users, carers and clinicians to ensure the optimal care and treatment for patients receiving ECT in Scotland. Linda has also recently been working with colleagues in Italy and Canada with a view to recreating a similar network to SEAN in these countries.

Miss Nicky Buley has a BA in Geography from the University of Cambridge. She currently works as a Project Worker for the ECT Accreditation Service at the Royal College of Psychiatrists’ College Centre for Quality Improvement. Nicky has worked with ECTAS for two years, and led on the most recent round of data collection and analysis for the ECT dataset survey.

Parallel Masterclasses
15:20 – 15:50

M7 Social Media for psychiatrists (‘Cultivating your online persona’)
Chris Pell

This workshop is aimed at those new to social media who want to know more of the practical aspects of building an online following; and those who are already using social media in a personal or professional capacity. We will cover the main aspects of how to curate and manage your on-line identity across the different platforms, when, what and how to share, netiquette, and how to manage difficult conversations and trolling.

Dr Chris Pell is a Consultant General Adult In-patient Psychiatrist, working at the Susan Carnegie Centre in Angus, Scotland for NHS Tayside. He has presented and written on the topic of digital professionalism and doctors' use of social media. He has an interest in how psychiatrists can best create and use online tools to improve psychiatric practice, whilst avoiding the potential pitfalls as the legal and ethical frameworks take shape around these new technologies. Other areas of interest include Mental Health Informatics, Medical Education and the History of Psychiatry. On Twitter he goes by the username @egosyntonically.
M8 Management of Alcohol-Related Brain Damage (ARBD)
Julia Lewis

This workshop will explore current concepts in relation to the pathology and clinical presentation of Alcohol Related Brain Damage (ARBD) and will bring together guidance on best practice in the management of the condition. It will seek to encourage participants to consider how the condition is managed within their own area of work and how recommendations on best practice could be taken forward at a local level. Participants will be encouraged to consider who would need to be involved in the development of a treatment pathway for ARBD and how basic education about the condition delivered to relevant frontline health and social care staff can help to prevent progression of this major cause of alcohol-related morbidity.

Dr Julia Lewis is a Consultant Addiction Psychiatrist and Clinical Director for Adult Mental Health Services in the Aneurin Bevan University Health Board. She is a member of the Gwent Area Planning Board (APB) for Substance Misuse with a remit for clinical governance and chairs both the Drug Related Deaths Review Panel and the Secondary Prevention Group on behalf of the APB. Julia has also been involved in strategy development at a national level, having been a member of the Welsh Government’s Take Home Naloxone Implementation Group and its Co-occurring Treatment Framework Steering Group.

Within her own health board Julia has developed the first dedicated Alcohol Related Brain Damage clinic in Wales and is currently a member of the Welsh Governments steering group on Alcohol Related Brain Damage. She has spoken at several conferences on the subject as well as being interviewed for the ITV programme “Newsweek”.

Julia is a director of Pulse Addictions Training Ltd.

M10 Using Attachment research and theory to inform everyday psychiatric practice
Jeremy Holmes

As a ‘masterclass’ the main focus of this session will be live discussion/supervision of cases brought by members of the seminar. However I will spend the first few minutes outlining some of the key aspects of general psychiatric work in which Attachment issues are highly relevant: the doctor-patient relationship; the psychiatrist as an Attachment figure; the importance of sensitivity as a mark of secure attachment; secure attachment as the basis for epistemic trust and therefore for compliance with treatment; the role of loss and separation in an ever-changing NHS; Disorganised attachment and its impact on the doctor patient relationship and its relevance to suicidal feelings and DSH.

For 35 years Jeremy was Consultant Psychiatrist and Psychotherapist in the NHS first at UCL and then in N Devon. He was Chair of the Psychotherapy Faculty of the Royal College of Psychiatrists 1998-2002. He set up and teaches on the Masters/Doctoral Psychoanalytic Psychotherapy Training and Research Programme at Exeter University; where he is visiting Professor; and lectures nationally and internationally.


His 2014 books are: The Therapeutic Imagination: Using Literature to Deepen Psychodynamic Understanding and Enhance Empathy, Attachments: Psychiatry, Psychotherapy, Psychoanalysis (both Routledge) and Psychiatry, Past, Present and Prospect (co-editors S. Bloch and S. Green), Oxford. He was recipient of the 2009 New York Attachment Consortium Bowlby-Ainsworth Founders Award, and the 2013 BJP Rozsika Parker Prize.
1. Use of Medication in the Management of Personality Disorder in a Community Mental Health Team in Birmingham

Ms Amy Cardwell, University of Birmingham; Mrs Maria Sagar, Birmingham and Solihull Mental Health NHS Foundation Trust; Dr Lisa Brownell, Birmingham and Solihull Mental Health NHS Foundation Trust

Aims and hypothesis: To examine how the clinical practice of a Community Mental Health Team (CMHT) in Birmingham compares to national guidelines and national practice in terms of the management of patients with personality disorders.

Background: In 2009, NICE published guidelines for the management of Borderline Personality Disorder. It was recommended that medication should generally not be used in the management of this condition. Audits undertaken through the Prescribing Observatory for Mental Health (POMH) indicate high levels of use of antipsychotics, sedatives, antidepressants and mood stabilisers in these patients. Therefore, there is a discrepancy between national guidance and clinical practice.

Methods: All 54 patients with a diagnosis of personality disorder under the care of a single CMHT were identified, and their notes reviewed to determine the management over the preceding 12 months.

Results:
Key findings include:

- Patients with a primary diagnosis of personality disorder accounted for 7.3% CMHT caseload
- Most patients (75%) had a diagnosis of emotionally unstable personality disorder
- The patients were most commonly allocated to HONOS care cluster 8 (48%) or 7 (28%)
- 56% had no comorbid mental illness. 33% had a diagnosis of a mood disorder, 29% substance misuse and 17% an anxiety disorder
- 98% patients had a crisis plan
- 96% had been treated with medication in the preceding 12 months
- 52% patients had been treated with an antipsychotic. The recorded indications for this treatment demonstrated that they were being used for a wide range of symptoms, most commonly aggression, self-harm. The most commonly prescribed antipsychotic was quetiapine (40% antipsychotic prescriptions)
- 74% patients had been treated with an antidepressant
- 13% patients had been treated with a mood stabilizer
- 23% patients had been treated with anxiolytics or hypnotics
- 92% patients who had received medication had a medication review in the previous 12 months.

Conclusion: Our results were similar to those reported by POMH, indicating that in spite of NICE guidelines, the use of medication in the management of personality disorders is common. The reasons for this are likely to be complex, and need to be explored and addressed in order to effect change.

2. What are the views and attitudes of psychiatrists towards Peer Support Workers (PSWs)? A qualitative interview-based study of 11 psychiatrists.

Ms Rachael Collins, University of East Anglia; Dr Tom Shakespeare, UEA senior lecturer; Ms Lucy Firth, Assistant Psychologist

Background

Mental health services continue to develop service user involvement, including a growth in employment of Peer support workers (PSWs). Despite the importance of the views and attitudes expressed by psychiatrists, this topic has not previously been studied.
Methods
A qualitative study based on semi-structured interviews with 11 psychiatrists in the East of England.

Results
Psychiatrists were broadly positive and supportive of service user involvement. Interviewees could foresee a range of possible benefits of employing PSWs, but also had concerns regarding their implementation and management. There was a lack of clarity and consistency between interviewees about what the exact role of a PSW might involve.

Conclusion
This study provides insights into how PSWs are perceived by psychiatrists. While broadly positive attitudes exist this paper highlights certain challenges, particularly role ambiguity.

3. Relapse rate and predictors in first-episode psychosis following antipsychotic discontinuation.
Ms Suzanne Di Capite, University of Birmingham; Dr Pavan Mallikarjun, Birmingham and Solihull Mental Health NHS Foundation Trust; Dr Rachel Upthegrove, Clinical Senior Lecturer, University of Birmingham

Aims and hypotheses:
To determine the real world relapse rate in patients with first-episode psychosis (FEP) following discontinuation of antipsychotics and identify factors associated with relapse risk.

Background:
It is common practice for patients with FEP to discontinue medication once they become well. To date controlled trials have yielded a range of one-year relapse rates (41-80%) following 12 months of treatment before discontinuation. However these relapse rates may not be representative of all patients who discontinue antipsychotic medication. It is possible relapse rates from a real world setting (i.e. representing clinical practice) may differ considerably.

Methods:
A retrospective electronic case-note review of 63 patients following recovery from a FEP who discontinued antipsychotics from 2012-2015 under the care of Birmingham Early Intervention Service. Follow-up was from the point medication was discontinued until: a relapse; end of the 12 month study period; or end of patients case-notes if 12 month data unavailable. Relapse was defined as requiring either home treatment, admission to hospital, or based on the clinician’s decision of a relapse. For relapse predictors, a pro-forma targeted socio-demographic and clinical variables. Survival analysis was performed to estimate the 12 month relapse rate after antipsychotic discontinuation and Cox regression to identify relapse predictors.

Results:
The Kaplan-Meier 12 month relapse estimate was 67% (95% confidence interval (CI); 54%-80%). Significant factors independently associated with an increased risk of relapse following antipsychotic discontinuation were: male gender (Exp B=3.72; 95% CI 1.42-9.78); not being in education, employment or training (Exp B=2.24; 95% CI 1.01-4.97); and number of previous psychiatric admissions (Exp B=1.94; 95% CI 1.31-2.88).

Conclusions:
This study’s relapse rate is in keeping with the literature and suggests relapse is common in a real world setting following antipsychotic discontinuation after recovery from a FEP. It is important for clinicians to ensure closer monitoring of patients who discontinue medication. Specific patients should be recognised as being at increased risk of relapse.

4. The prevalence of VGKC and GAD autoantibodies in psychotic disorders
Ms Rosemary Grain, King’s College London; Dr John Lally, King’s College London and National Psychosis Service; Ms Anne Lemince, National Psychosis Service; Dr Fiona Gaughran, King’s College London and National Psychosis Service

Aims and Hypothesis:
The aim of the systematic review was to assess the prevalence of voltage-gated potassium channel (VGKC) and glutamic acid decarboxylase (GAD) antibodies in psychotic disorders. In addition, we present the first case series of VGKC and GAD antibody prevalence in treatment resistant schizophrenia (TRS).

We hypothesised that VGKC and GAD antibodies may be implicated in the pathogenesis of early and chronic psychosis.

Background:
Antibodies to VGKC complex and GAD have been reported in some cases of psychosis, but their prevalence has not previously been systematically reviewed nor have they been measured in TRS.

Methods:
We searched Pubmed, Scopus and Ovid for studies providing data on VGKC or GAD antibody seropositivity in psychotic disorders. Our retrospective case series included all patients with TRS at a tertiary referral unit tested for VGKC and GAD antibodies from 2009 to 2015.

Results:
This review identified five studies on VGKC antibody positivity and seven on GAD antibody positivity in psychosis. We identified an overall prevalence of 0.5% VGKC antibody positivity (1/196) with 0% in controls (0/50) and 5.5% GAD antibody positivity (18/328), with 2.6% in controls (5/193).

In our case series, we identified a 0% prevalence of VGKC antibodies (0/24) and a 12.5% prevalence of GAD antibodies in TRS (1/8). The patient with GAD antibody seropositivity also had Type 1 diabetes (a condition itself associated with GAD antibodies).

Conclusions:
The prevalence of VGKC and GAD antibodies is low in psychosis. Case reports indicate that VGKC antibody-related limbic encephalitis presents with a broad spectrum of psychiatric symptoms. Our case series fails to support the hypothesis that VGKC or GAD antibodies are linked to treatment resistance in psychosis. The low prevalence of VGKC antibodies lessens the case for widespread screening in psychotic disorders, but screening could be considered for certain neuropsychiatric presentations.

5. Demographics of depot users: exploring profiles of long-acting injected antipsychotic users
Ms Katherine Harris, University of Birmingham; Dr Lisa Brownell, Birmingham and Solihull Mental Health Foundation Trust; Dr Rachel Upthegrove, University of Birmingham

Aims and hypothesis:
To investigate the demographic profiles of service users administered long-acting injected (LAI) antipsychotics.

Background:
LAI antipsychotics are widely used in psychiatry, administered to approximately 30% of patients with schizophrenia, also indicated in many other long-term psychiatric conditions. Knowledge of service user prescription profiles can aid tailored clinician decision-making.

Methods:
Data was collated from patient medical records for 149 participants currently administered LAI antipsychotics in five Community Mental Health Teams from a single trust.

Results:
99 (66.4%) of participants were male and 50 (33.6%) female; with 87 (58.4%) participants of white, 29 (19.5%) of black, 27 (18.1%) of Asian and six (4.0%) of other ethnic origin. Participants’ mean age was 47.4 years (SD=11.35, range 20-71 years).

The majority (96, 65.3%) had a primary diagnosis of schizophrenia; 15 (10.2%) schizoaffective disorder; 14 (9.5%) bipolar disorder; eight (5.4%) other psychoses; seven (4.8%) personality disorders; five (3.4%) had other diagnoses; and two (1.4%) had no recorded diagnosis. 44 (29.5%) participants had at least one psychiatric comorbidity.
With respect to care clusters (CCs), 60 (40.3%) participants were in CC11; 47 (31.5%) in CC12; 10 (6.7%) in CC13 (classified as ongoing or recurrent psychosis: low symptoms; high symptoms; and high symptoms/disability respectively). Furthermore, nine (6.0%) participants were in CC7 (enduring non-psychotic illnesses: high disability); eight (5.4%) in CC16 (dual diagnosis); and the remaining 15 distributed in other CCs. CC0, CC1, CC2, CC5, CC9, CC10, CC14, CC15 and CCs18-21 were not represented in this sample. In addition to the LAI antipsychotic, 93 (62.4%) participants were prescribed additional medications: 48 (32.2%) oral antipsychotics, and 60 (40.3%) medication to manage side effects of LAI antipsychotics.

Conclusions:
The majority of participants on LAI antipsychotics in this sample were male, white and with a primary diagnosis of schizophrenia. Most participants’ CCs reflected psychotic illnesses and the majority were prescribed additional medication, predominantly oral antipsychotics or medications to manage side effects.

Funding: University of Birmingham Intercalation grant.

6. **Bipolar disorder and borderline personality traits.**
   Mr Tomos Geraint Jones, University of Birmingham; Dr Katherine Gordon-Smith, University of Birmingham and Bipolar Disorder Research Network; Dr Lisa Jones, University of Birmingham and Bipolar Disorder Research Network

Aims and hypothesis:
1. To compare the frequency and severity of borderline personality traits between large UK samples of individuals with bipolar I disorder (BPI) and bipolar II disorder (BPII).
2. To explore the relationship between the severity of borderline personality traits and lifetime clinical characteristics in BPI and BPII.

Background:
Bipolar disorder and borderline personality disorder share a number of similar features and there is growing interest in their relationship. Current literature suggests that bipolar disorder with comorbid borderline personality disorder follows a different clinical course to bipolar disorder alone. However, previous studies have had small sample sizes, focused on borderline personality as a categorical disorder rather than a quantitative trait, and few have directly compared BPI and BPII.

Method:
The Borderline Evaluation of Severity over Time (BEST) questionnaire was used to compare the presence and severity of borderline personality traits between individuals with BPI (n=1008) and BPII (n=439). The relationship between the severity of borderline personality traits and lifetime clinical characteristics in both groups was examined using linear regression.

Results:
After controlling for potential confounders including current mood state, the BPII group had a significantly higher total BEST score (36v27, p

7. **The pathophysiological impact of childhood adversity in adulthood.**
   Ms Ramya Kotha, Newcastle University; Ms Natalie Seedan, Newcastle University; Ms Abigail Harrison, Newcastle University; Mr Andre Tavares da Silva, Universidade Federal do Para, Brazil; Mr Andrew Close, Newcastle University; Dr Stuart Watson, Newcastle University

Aims:
We hypothesise that epigenetically mediated alteration in HPA axis function and subsequent changes in hippocampal function mediates the relationship between early adversity and later psychiatric disorder.

Background:
Childhood adversity engenders an increased risk of psychiatric disorder, through an as yet unidentified mechanism. This could be because prolonged exposure to stress hormones leads to changes in brain anatomy.
Methods:
9,983 Newcastle University students were sent a questionnaire containing 5 emotional neglect (EN) questions from the childhood trauma questionnaire, 4 ONS wellbeing questions and asked for postcode at age 15.

1,040 questionnaires were completed. For hippocampal analysis, a stratified sub-sample of 32 was taken after cluster analysis of the summated EN score. For HPA axis function analysis, an overlapping stratified sample of 27 was used - with additional exclusion criteria regarding psychiatric disorder.

Results:
Overall, wellbeing correlated negatively with both EN ($r=-0.33$) and childhood socio-economic deprivation ($r=-0.10$).

In the hippocampal sub-sample, EN correlated negatively with Beck Depression Inventory score and State Anxiety. The tests of hippocampal function - episodic memory recollection - correlated negatively with EN ($r=-0.34$, $P=0.08$), whereas the episodic future thinking and scene construction tasks did not correlate. EN did not significantly correlate with performance on the category fluency test, DSST, forward and backward digit span or the attentional blink task, using neutral faces at T1 and neutral or fearful faces at T2 ($r=0.1$).

In the HPA axis sample, there was no relationship between EN and an ex-vivo measure of glucocorticoid receptor function but there was a non-significant reduction in cortisol awakening response area under the curve in the high EN group.

Conclusions:
We have demonstrated a relationship between reported emotional neglect, deprivation and upbringing in a large sample. There was a non-significant reduction in cortisol output in the high EN group, which may suggest mineralocorticoid receptor up-regulation in this resilient sample who have remained well despite childhood adversity. At the conference we will also display linguistic analysis and re-analysis of the hippocampal data using more robust objective measures.

8. Exploring the Link Between Traumatic Brain Injury and Violence
Ms Clare Langan, The University of Edinburgh; Dr Julie Langan-Martin, The University of Glasgow

Aims and Hypothesis: To evaluate existing literature surrounding traumatic brain injury (TBI) and its various associations with criminal and violent behaviour. We hypothesised that individuals who had sustained TBI would be more likely to display violent and aggressive behaviours. We also hypothesised that violent offenders would have higher rates of TBI relative to the general population.

Background: TBI represents a significant public health concern and constitutes a substantial source of morbidity and mortality amongst young people in the UK. TBI can have devastating sequelae in affected individuals and can predispose to a range of neuropsychiatric disturbances, including an increased tendency to display violent and aggressive behaviour. An appreciation of the association between TBI and violence and an understanding of the factors which underpin this may have significant clinical and medico-legal implications and inform potential treatment strategies for neuro-rehabilitation.

Methods: A narrative literature review was carried out using PubMed with the following search terms: Traumatic Brain Injury AND Criminal/Violent Behaviour. Abstracts were screened for relevance.

Results and Conclusions: 458 studies were identified but after screening the abstracts for relevance, only 58 studies were included. Individuals who suffered from TBI were consistently found to demonstrate higher rates of aggressive behaviour post-injury relative to controls who had suffered multiple traumas without TBI. This effect persisted even when adjusted for potentially confounding variables such as alcohol dependence. Additionally, a history of traumatic head injury was over-represented in convicted criminals. This phenomenon may be explained by a myriad of factors: head injury may deleteriously impact on an affected individuals ability to assess the world around them, predisposing to mental distress and consequent violent and aggressive behaviour. Perceptual and sensory problems which may develop as a result of TBI could also contribute to an increased tendency towards violent behaviour. An understanding of the association between TBI
and violence is of significant clinical and medico-legal importance and may potentially inform future neuro-rehabilitative strategies.

9. Cochrane Review of Antidepressants for Insomnia (a work in progress)
Mr Christopher Manson, Faculty of Medicine, University of Southampton; Dr Beth Stuart, Primary Care and Population Sciences, Faculty of Medicine, Aldermoor Health Centre, University of Southampton; Dr Hazel Everitt, Primary Care and Population Sciences, Faculty of Medicine, Aldermoor Health Centre, University of Southampton; Prof David Baldwin, University Department of Psychiatry, Faculty of Medicine, University of Southampton; Ms Gosia Lipinska, Clinical Neuropsychology and UCT Sleep Sciences, Department of Psychology, University of Cape Town; Dr Sue Wilson, Centre for Neuropsychopharmacology, Division of Brain Sciences, Imperial College London

Aims and hypotheses: To assess the effectiveness, safety and tolerability of antidepressants for insomnia in adults.

Background: Insomnia is common, 10-38% of the general population report sleep problems in the last year. Antidepressants are widely prescribed for insomnia despite not being licensed for this use, and limited evidence for their effectiveness in insomnia.

Selection criteria: Randomised controlled trials (RCTs) including cluster and cross-over RCTs.

Participants: Adults (aged 18 years) with a primary diagnosis of insomnia.

Types of interventions
- Any antidepressant as monotherapy including all doses.
- Antidepressants organised into classes: Selective serotonin reuptake inhibitors (SSRIs): Tricyclic antidepressants (TCAs): Heterocyclic antidepressants: MAOIs: Other antidepressants.

Comparator interventions:
- Placebo
- Other medications for insomnia (e.g. benzodiazepines).
- A different antidepressant.
- Waiting list control or treatment as usual.

Outcome measures:
Primary outcomes
1. Efficacy: any subjective improvement in sleep quality or satisfaction with sleep, total sleep duration, sleep onset latency, number of nocturnal awakenings or total nocturnal awakening time or sleep efficiency.
2. Safety.
3. Secondary outcomes
4. Objective measures of change in sleep.
5. Tolerability.
6. Effect on daytime symptoms/functioning.

Search methods: We searched the following electronic bibliographic databases: MEDLINE (1950-), EMBASE (1980-), PsycINFO (1806-) and the Cochrane Central Register of Controlled Trials between Nov 2013 and July 2015.

Results: Thus far, data has been extracted for three meta-analyses, SSRI versus other antidepressants, TCAs versus placebo, and other antidepressants versus placebo. For subjective measures of sleep quality, there was no significant difference between SSRIs and other antidepressants (standard mean difference (SMD) = 0.02, 95% confidence interval (CI) (-0.33 to 0.38) nor between other antidepressants and placebo (SMD = -0.08, 95% CI 0.67 to 1.62). However, there was a statistically significant difference between TCAs and placebo (SMD = -0.39 (95% CI 0.56, -0.2). There were no significant differences in either meta-analysis in reported adverse effects.

Conclusion: There is a paucity of data on the treatment of insomnia with antidepressants. This lack of data has meant that the possible comparisons in the meta-analysis have been limited. Further evidence would be required to substantiate the results.
10. Barriers and facilitators to providing mental health care to indigenous peoples in Colombia: the experiences and opinions of key informants.

Mr Daniel McNamara, University of Leeds; Prof Diego Rosselli, Pontificia Universidad Javeriana (Bogota, Colombia)

Introduction/background:
Though prevalence of mental disorders Colombia’s large indigenous population is not known, indigenous Colombians are particularly affected by risk factors for mental disorders including experiences of mass displacement, violence and loss of cultural identity.

Previous research has found that indigenous groups elsewhere face considerable barriers when using mental health services compared to the general population. Research on this topic in Colombia is therefore needed.

Research question/objectives:
To explore key informants’ experiences and opinions of factors affecting the utilisation of mental health services by indigenous peoples in Colombia, with a view to identifying ways in which these services can be improved.

Methods:
Fifteen qualitative semi structured interviews were conducted in May 2014. Key informants included mental health professionals, health administrators and insurance providers. Data was analysed using framework analysis.

Results:
Barriers and facilitators were identified in 14 of the interviews. Of the seven barriers identified the most frequently mentioned were differing perceptions of mental illness between patient’s and providers, lack of provider knowledge about indigenous culture and lack of mental health professionals.

Facilitating factors most frequently identified were cultural adjustment of services and outreach services.

Limitations:
Lack of data from indigenous service users themselves. Lack of generalisability to indigenous groups in Colombia not studied. Social desirability phenomenon. Sampling bias (purposive sample).

Conclusions and recommendations:
Intercultural education of mental health professionals may be a feasible way to improve standards of mental health care for these indigenous groups. Additional research quantifying the prevalence of mental disorders and rates of service use in indigenous populations is required.

11. The adverse psychiatric effects of NPS or legal highs: a systematic review

Mr Ka Ting Ng, University of Edinburgh; Prof Mark Taylor, Royal Edinburgh Hospital

Background: Novel psychoactive substance (NPS) or legal high use has increased rapidly and has been associated with adverse psychiatric effects. Objective: To systematically review the differing classes of NPS and their adverse psychological and psychiatric effects.

Data Sources: MEDLINE, EMBASE and PsychINFO databases January 2010 and May 2015. Study Selection: From 125 initial inclusions, 37 original case reports and case series were assessed, with 29 papers satisfying our inclusion criteria.

Data Extraction: Information on study design, study population, and the adverse psychiatric effects was extracted.

Results: Data were available for synthetic cathinones; cannabinoids, phenethylamines and amphetamines. Often these NPS were used in combination, and with other substances such as alcohol. Agitation and psychotic symptoms were the most common adverse effects.
Conclusion: Agitation and psychosis are a common consequence of NPS use, with synthetic cathinones appearing to be the most likely NPS class to engender these adverse effects.

12. Post-traumatic stress disorder: the origins of a condition
Mr Aaron Philip, Imperial College London

The International Classification of Diseases 10 defines post-traumatic stress disorder (PTSD) as a delayed and/or protracted response to a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. However, this condition has not always been recognised as it is now. Stress-associated disorders have over the past century gained a great deal of attention, and this has been matched by increased historical scrutiny being applied to the whole topic. Today, we might conclude that contemporaries who saw war-related syndromes as being somatic in nature were on the losing side of history. However, this view does not take into account the context in which physicians at the time perceived such conditions. The First World War saw the medical construction of shell-shock as a neuro-psychiatric disorder affecting soldiers exposed to combat. At the same time, other diseases that had traditionally been associated with the military, such as soldiers heart and nostalgia, underwent considerable changes due to new ideas surrounding their pathogenesis.

This informational poster aims to showcase a timeline of PTSD-related conditions, stretching from before WW1 to the present day, paying particular attention to one such condition known as the effort syndrome. This was a disorder described during the First World War by Thomas Lewis, an eminent cardiologist at the time, as a way of explaining the large number of soldiers who were reporting as medically unfit due to cardiac symptoms. Lewis published a thesis on his findings, in which he described combat-related disorders as being largely due to a predisposition of the patient towards nervousness rather than due to the environment in which they were placed in, and this was in fact a widely held view at the time. This perspective contrasts markedly with some of the other more visceral accounts of war-related conditions given by contemporaries such as Wilfred Owen and Siegfried Sassoon, and this poster describes some of the cultural background for this.

13. Major Depressive Disorder and Migraine
Mr Paul Ridley, College of Medical and Dental Sciences, University of Birmingham; Dr Katherine Gordon-Smith, Department of Psychiatry, Neuropharmacology and Neurobiology Section, School of Clinical and Experimental Medicine, University of Birmingham; Dr Lisa Jones, Department of Psychiatry, Neuropharmacology and Neurobiology Section, School of Clinical and Experimental Medicine, University of Birmingham

Background: Previous small-scale studies have suggested that the presence of migraine in major depressive disorder (MDD) is associated with specific clinical characteristics and may represent a bipolar spectrum trait. The aim of this research was to compare a broad range of characteristics in a large sample of individuals with MDD with and without migraine, and to explore possible similarities between those with MDD and migraine, and individuals with bipolar disorder.

Methods: Lifetime and episodic clinical characteristics, and affective temperaments of individuals with MDD with (n=134) and without (n=218) migraine were compared. Characteristics associated with the presence of migraine were then compared with a sample of individuals with bipolar I (n=364) and II (n=43) disorder.

Results: Participants with MDD and migraine were more likely to be female (76.9% vs 56.9%, p

14. The Feasibility of Routine Monitoring of Cognitive Symptoms in Patients with Schizophrenia Using a Mobile Phone
Ms Dinakshi Shah, University of Manchester; Prof Shân Lewis, University of Manchester; Prof Kathryn Abel, University of Manchester

Aims and hypothesis: The primary aim of this study was to gather evidence on the acceptability and feasibility of using a mobile phone application longitudinally to assess cognitive deficits in schizophrenia. An important potential confounder is whether cognitive impairment limits compliance with an mHealth approach. Therefore, our secondary aim was to assess whether cognitive function correlates with compliance in mHealth. Our hypothesis is that mHealth will offer a feasible and acceptable new approach to managing cognitive symptoms in schizophrenia.
Background: Cognitive deficits in schizophrenia are profound and severely affect quality of life. Strategies to improve cognitive function in schizophrenia have thus far been limited. Use of routine clinical monitoring to personalise management of cognitive symptoms may improve engagement and outcomes in schizophrenia sufferers. This study exploits the recent emphasis on mobile technology to deliver more patient accessible approaches to health intervention (mHealth) and is the first to investigate the feasibility of mHealth for routine cognitive assessment in schizophrenia.

Method: 19 participants with enduring schizophrenia were recruited from rehabilitation centers and community settings across Manchester, UK. Patients were consented to answer questions from a symptom monitoring application, ClinTouch over a period of 1 or 12 weeks. The Matrics Cognitive Battery (MCCB) is the gold standard cognitive assessment tool in schizophrenia. MCCB was administered to assess a) cognitive function of participants and b) the relationship between cognitive deficits and compliance with mHealth. Qualitative interviews explored patient views using thematic analysis.

Results: Cognitive deficits in the group were profound (T-scores = 26.2 to 40) Compliance as defined by completion of at least 33% of all possible data-points was 75% and no correlation was found between cognitive status and compliance (p =0.736) Patient interviews revealed several themes: i) Patients found using ClinTouch interesting and manageable ii) they thought the development of a cognitive application would be useful, feasible and something they would use regularly and adapt into their lives iii) their cognitive function had a notable effect on daily function.

Conclusions: Mobile applications for cognition in schizophrenia are feasible and acceptable, potentially improving patient care experiences.

15. To systematically review studies reporting stress amongst medical students in the United Kingdom
Mr Savan Shah

Background: Stress is significantly associated with burnout and mental health problems in students. Medical students in particular are thought to suffer high levels of stress due to the workload, course hours and dealing with morbidity and mortality. Systematic reviews of studies conducted in North America report medical students suffer much higher levels of stress compared to the age-matched population. However such work is difficult to transfer over to the UK as most medical students are undergraduates rather than graduates in the UK and the course is longer (5/6 years vs. 4 years). No systematic reviews have been conducted on stress in British medical students.

Methods: PubMed, Medline, Cochrane, OvidSP, Embase & PsycInfo were searched to identify peer-reviewed publications between January 1994 and June 2015. Searches used combinations of the Medical Subject Heading terms medical student AND (stress OR distress). Incidence, prevalence and any relevant statistical data were extracted.

Results: 5 papers were considered suitable for analysis. Cross-sectional studies reported between 29-45% of students were classified as having significant psychological distress on the General Health Questionnaire 12 (GHQ-12). All cross-sectional studies measured stress levels at only one time-point and used only one year group. Longitudinal studies reported conflicting results. One study showed a decrease in the percentage of students scoring a significant GHQ-12 score (36.6% to 21.9%, p

16. An Audit of the Documentation of Initial Assessments of New Referrals to Walsall Crisis Resolution & Home Treatment Team
Miss Danielle Smith, University of Birmingham, College of Medical and Dental Sciences; Dr Lilian Obakpolo, Supervisor; Miss Imogen Watkins, Medical Student Placed at hospital under Dr Obakpolo

Aims and Hypothesis; This audit aims to investigate the completeness and quality of initial assessments carried out for new referrals to the Walsall Crisis Resolution & Home Treatment (CRHT) team of Dorothy Pattison Hospital. We hypothesise that the team provides a comprehensive and high quality assessment for all new referrals, with all relevant criteria for a full psychiatric history considered.
Background; The CRHT team enables patients experiencing acute mental health crises to receive rapid assessment and access to mental health services. This service is crucial, since these patients are at high risk of self-neglect and/or harming themselves or others.

Methodology; The Camden and Islington NHS Trust developed the CRT Fidelity Review, a set of standards to which any CRHT service should adhere to provide an optimal and most beneficial service to patients. Our audit analyses and scores assessments carried out by the Dorothy Pattison Hospital CRHT team, comparing it to this audit standard for comprehensive assessment. We performed the audit retrospectively, and data collection was carried out over one day on the current CRHT case load (50 cases) at the time. We reviewed the initial assessment documentation for each case, determining whether the criteria set out by the fidelity review was met.

Results; 47 of the 50 cases (94%) received a comprehensive assessment with >=9 domains considered. Stratified by domain, 8 of the 13 domains were considered in >90% of cases. However, four domains were considered in <90% of cases. 'Physical Health', 'Medication', 'Religious Needs' and 'triangle of care' (TOC) were considered in 82%, 86%, 28% and 22% of cases respectively. Conclusions; The hospital provides a high quality CRHT service, obtaining the maximum service score possible (5). There is a clear lack of assessments documenting TOC, which facilitates collaboration between involved healthcare professionals, and religious/spiritual needs, which can be used to assist a psychiatric history. We therefore recommend that clinical staff should be educated on the importance of documenting religious needs and TOC as part of a comprehensive assessment, and regular rolling of this audit to ensure adherence.

17. Community based monitoring of psychiatric patients taking anti-psychotic medication
Ms Sarah Worne, University of Birmingham

Anti-psychotic medications are widely prescribed in conjunction with psychotherapy for conditions such as schizophrenia, affective disorders and personality disorders, for both symptomatic and prophylactic management. However, they have significant side effect profiles, depending on the generation of anti-psychotic prescribed. 1st generation anti-psychotics can cause movement disorders through their effect on the basal ganglia, and 2nd generation anti-psychotics increase the risk of metabolic syndrome. There are other notable side effects such as arrhythmia and hyperprolactinaemia common to all anti-psychotics, as well as severe drug-specific effects.

With 1% of the population developing schizophrenia during their lifetime plus anti-psychotics being prescribed for other psychiatric conditions, it is imperative that all clinicians understand the risks of anti-psychotic prescribing. People with mental illness are also at an increased risk of physical illness compared to the general population, but evidence shows that they are less likely to be offered health promotion and prevention advice. For example, the prevalence of type 2 diabetes mellitus is more than double that of the general population, independent of treatment with new generation anti-psychotics. This audit aims to assess how the practice perform up against national guidelines for anti-psychotic monitoring, and whether there is a deficit in monitoring among patients with particular diagnoses.

Recommendations for comprehensive community monitoring are outlined in national NICE guidelines CG178 for schizophrenia, supported by CG90 and CG185 for depression and bipolar affective disorder respectively. In this audit of 113 patients from a general practice in Worcestershire, 0 patients received monitoring that fully satisfies the NICE guidelines. Whilst 74.3% of patients had an overall physical health check during the assessment period, only 1.8% had a documented assessment for movement disorders. There was however little difference in monitoring between diagnoses. These results are a reflection of the targets set out in the Quality and Outcomes Frameworks, and therefore such discrepancies could be reduced by updating local guidelines in line with the national recommendations.
18. The Scale of Vitamin D Deficiency in an Inpatient Ward

Dr Ilektra Adamidou, Acute psychiatric unit- Merseycare; Dr Itoro Udo, Psychiatry Consultant

Aims and hypothesis:
We set out to determine standards that would enable the identification of persons at risk of Vitamin D deficiency in our inpatient service; the prevalence of Vitamin D deficiency in at risk patients group on a 25 bedded ward (Brunswick) and the severity of identified deficiency. Deficiencies were identified were managed according to local guidelines and care plans were updated to reflect this change.

Background:
Low Vitamin D levels has been associated with depression, psychosis, schizophrenia, suicidality, treatment resistance and poor coping. However, serum Vitamin D levels is not a routine haematological investigation on inpatient psychiatric admissions. Factors associated with inpatient Vitamin D deficiency include prolonged stay and treatments in inpatient units with limited regular exposure to ultraviolet light; eating habits of inpatients; Self-neglect and social isolation associated with mental illness.

Methods:
Using a combination of literature search; discussions at multidisciplinary team and management meetings, consultation with professionals like GP, Dietician; criteria for identifying patients who may be at increased risk was agreed.

These patients were approached, and consented to screening. Results of the investigation were discussed with patients and actioned according to need. The study period was from May to July 2015.

Results:
We were unable to identify any criteria already in use for identifying persons at increased risk in psychiatric services. The following criteria were agreed: Hospital stay for > 2 months and limited opportunities of leaving the ward such as on detention; Transfer from another unit with a total of hospital stay >2 months; Admission from the community with severe depression and history of isolation at home.

7 patients (28%) were identified to be at increased risk. Of this, 6 patients (85.7%) were deficient and another 1 (14.3 %) had insufficient level. Treatment was instituted.

Conclusions:
Clinicians ought to consider the close monitoring of Vitamin D levels during inpatient admissions and liaise with dieticians to improve diets of patients at risk. Rehabilitation, forensic and old age inpatient settings are likely sites that may experience similar challenges.

19. An Audit looking at the implementation of the search policy for new admissions to a Birmingham Psychiatric ward

Dr Alexandra Ademolu, Zinnia Centre, Birmingham; Dr Imran Waheed, The Zinnia Centre, Sparkhill, Birmingham

Aim:
To determine the degree to which staff at a Birmingham Acute Psychiatric Hospital adhere to the ‘Search Policy for new admissions’ following a serious and preventable incident.

Background:
Hospital policies aim to standardise practices to help facilitate the safety of patients and staff. Unfortunately, avoidable incidents do occur and often highlight weaknesses in the runnings of an organisation. Earlier in the year, a member of staff at the Zinnia Centre, Birmingham was stabbed by a new patient who did not meet the current search criteria. Thus questioning the robustness of the current policy and the searching practices of nursing staff.
Method:
A retrospective audit captured all new admissions to Saffron Ward at the Zinnia Centre between 1/05/2015 and 1/07/2015. New admissions were identified using Psychiatry electronic records (Rio). Rio entries made by nursing staff were reviewed for their content and detail with regards to a search on admission.

Results:
There were 18 new admissions to the ward. 13 patients met the search criteria as set out in current guidelines. Only 8 (62%) were searched. 3 of the 5 patients not searched, were noted to have had contraband removed from their possession and/or were physically aggressive during their admission. 1 was transferred to a Psychiatric intensive care unit (PICU).

Conclusions:
Adherence to the current guidelines is variable and inadequate; often depending on the personal practices of the nursing staff/grade present at the time of a new admission. It appears that the wording of the policy appears to be open to several interpretations evident in the inconsistencies in how searches are being performed and documented. Gaps in current practices may increase the risk of preventable harm to self and others which all staff, including management should take serious note of.

It is recommended that the policy is reviewed for its clarity and meanwhile all new admissions are searched ensuring the safety of services users and staff.

20. Clinical Impact of Pharmacy Documentation in Patients Notes: An Independent analysis of patients with Mental Health conditions admitted to SWBH NHS Trust
Dr Alexandra Ademolu, SWBH NHS Trust; Birmingham and Solihull Mental Health Foundation Trust; Dr Manraj Bhamra, SWBH NHS Trust, Birmingham and Solihull Mental Health Foundation Trust; Dr Mahnaz Hashmi, Birmingham and Solihull Mental Health Foundation Trust; Ms Julie Brooks, SWBH NHS Trust, Aston University

Aims and hypothesis:
To review, for quality and impact on patient outcomes, the entries made in the medical notes by pharmacy in patients with mental health conditions in our institution.

Background:
It was introduced in 2007 that all members of the multidisciplinary team should document into the patients notes so that a full and complete record of information is maintained, but limited research onto the impact of pharmacy entries is available in the literature. In relation to mental health, it was felt that pharmacy often had a significant impact on patient care by documenting key information and making clinical recommendations.

Method:
We conducted a retrospective qualitative analysis of pharmacy entries in medical notes regarding patients admitted to our institution on antipsychotics (BNF chapter 4.2) between April 2014 and April 2015. Entries were independently reviewed for the quality and detail of the information provided by two clinicians experienced in acute medicine and psychiatric practice. Data were recorded in line with national [Caldicott] ethical guidelines.

Results:
The notes of 71 patients were reviewed. Pharmacy documentation commonly included diagnosis, medication regimen, psychiatric team and contact details, details of last review/follow up and details of the patients mental health status both when well and acutely unwell. This information was used by the acute medical team to generate a management plan.

Conclusions:
Pharmacy input facilitated quicker and safer medical management of patients by alerting medical staff to diagnoses, potential contraindications; prescription errors and potential strategies should the patients behaviour become a concern during their hospital admission. Information on their usual community mental health team and contact details enabled communication lines to be maintained between care sectors. Information sharing and a multidisciplinary approach is recommended to aid the management of the vulnerable mental health patient admitted to hospital.
21. Transition of Care: An investigation into the information sharing between care sectors when patients with Mental Health conditions are admitted to an Acute General Hospital

Dr Manraj Bhamra, SWBH NHS Trust; Birmingham and Solihull Mental Health Foundation Trust
Dr Alexandra Ademolu, SWBH NHS Trust, Birmingham and Solihull Mental Health Foundation Trust; Dr Mahnaz Hashmi, Birmingham and Solihull Mental Health Foundation Trust; Ms Brooks SWBH NHS Trust, Aston University

Aims and hypothesis:
To identify the key information required, and how this can be obtained, to facilitate the review of the mental health patient in the acute care setting.

Background:
Information sharing is key to facilitating the holistic, co-ordinated and quality care of psychiatric patients admitted to hospital, as evidence suggests that physical and mental health are inextricably linked. Concern has been raised surrounding the information sharing between care sectors leaving this cohort of patients in a potentially vulnerable position.

Method:
We conducted a retrospective qualitative analysis on patients admitted to our institution on antipsychotic medications (BNF chapter 4.2) between April 2014 and April 2015. Data were recorded in line with national [Caldicott] ethical guidelines.

Results:
The notes of 71 patients were reviewed. Four key reference sources were identified:
1. Rioan electronic patient record system used by the local mental health Trust.
2. Summary Care Records (SCR). An NHS database containing key information from the GP records.
3. Clinical Data Archive (CDA). Electronic records from previous hospital admissions or clinic appointments in the Trust.

These sources allowed clarification of diagnosis, medication regimen, psychiatric team and contact details, details of last review/follow up/admissions and details of usual mental health status. No single source contained all of this information.

Conclusions:
Access to information is pivotal in the management of the vulnerable mental health patient during an admission to hospital. Only the psychiatric liaison pharmacists had access to all of the information deemed in this study to be essential for the successful inpatient management of the mental health patient in the acute trust. If the care of these patients is to be improved, government recommendations and NICE guidelines followed, this must change.

22. Inpatient Activity in General Adult Psychiatry: A Simple Interventional Study.

Dr Richard Dargie, Leverndale Hospital, NHS Greater Glasgow & Clyde; Dr Dorothy Gilkes, Leverndale Hospital, NHS Greater Glasgow & Clyde; Dr Alison Cheyne, Leverndale Hospital, NHS Greater Glasgow & Clyde

Background: There is a strong bidirectional relationship between mental ill-health and physical inactivity, with high levels of inactivity reported among psychiatric inpatients. A large body of evidence suggests that the shorter life-expectancy associated with long-term psychiatric care is largely due to increased cardiovascular disease, for which inactivity is an important and modifiable risk factor. Both structured physical exercise and higher overall physical activity have been shown to be beneficial in a range of mental illnesses.

Aims. This study obtained baseline physical activity data in our inpatient group, and investigated whether a simple intervention, allowing patients to self-monitor activity, could affect activity levels.

Methods: Standard belt pedometers were worn for 12 hours by two groups of informal psychiatric inpatients (n=14) and staff members (n=4), over 2 days. Pedometer readings were not visible on
the first day. On the second day, participants were informed of the number of steps taken the day before, and pedometer readings were visible. Participants completed a questionnaire at the end of each day.

Results: The average activity level of patients was that of a sedentary or elderly person. Only one patient achieved a recommended healthy level of activity. A 32% increase in steps taken was seen on the days when the pedometer reading was visible compared to when it was concealed. This difference was statistically significant (p=0.044), as were the increases within each patient group. Patients with no passes outwith the hospital, and those with escorted passes in the company of others, showed the greatest increases. Weather had a milder and not statistically significant effect on activity. Almost all (96%) of patients wished they were more active, and 37% felt wearing the pedometer with visible readings motivated them to be more active.

Discussion: These data demonstrate a low level of physical activity in our inpatient group, despite a widespread desire to be more active. These results correlate well with existing research. Interestingly, the simple and cheap intervention of patient self-monitoring significantly increased overall physical activity, and we feel that this trend merits more detailed investigation in further research.

23. Re-audit of Pharmacological Interventions in Emotionally Unstable Personality Disorder
Dr Nicole Edwards, Northumberland Tyne and Wear NHS Foundation Trust; Dr Katherine Rudd, Northumberland Tyne and Wear NHS Foundation Trust; Dr Kiran Sayyaparaju, Northumberland Tyne and Wear NHS Foundation Trust; Dr Niraj Ahuja Northumberland Tyne and Wear NHS Foundation Trust, Psychiatry Consultant

Aims and hypothesis: Given the complex and difficult presentations of Emotionally Unstable Personality Disorder (EUPD), there is a huge potential for unlicensed psychotropic medication. The objectives of this re-audit were to monitor the compliance with following NICE recommendations.

A. Drug treatment should not be used to treat individual symptoms or behaviours associated with the disorder. B. They should not be used for medium to long-term treatment. C. They may be considered in treatment of co-morbid conditions D. Development of crisis plans. E. Physical health monitoring for the first 12 months.

Background: Pharmacological interventions in Emotionally Unstable Personality Disorder (EUPD) audit was identified by the North Tyneside West CMHT, Longbenton patch with a view to ascertaining performance against NICE guidance CG78. This is a re-audit with additional criteria included. We also audited physical health monitoring as per the NICE Guidance CG178.

Methods: Service user database was searched using keywords for diagnosis of EUPD. A total of 20 patients were identified. An audit tool was designed to collect the necessary data. Compliance results of this review are graded on a traffic light system that marked good compliance rates between 90-100% to be green, partial compliance 80-89% to be amber and non-compliance 0-79% as red.

Results: Four fifth of the service users were care coordinated and had care plans and crisis plans in place. 86% of all the medicines prescribed had a documented indication for its use. There was a decrease in unlicensed antipsychotic use to 33% (previously 38%) and unlicensed antidepressant use to 5% (previously 31%). Psychological interventions offered remain at a high standard (100%). There was full compliance (100%) for relevant blood tests, adherence and monitoring of overall physical health. There was 33-50% compliance for monitoring of response to treatment, side effects, movement disorders and pulse and blood pressure. The worst performing areas were those of weight and waist circumference.

Conclusions: There were significant improvements noted in key areas i.e., decrease in unlicensed psychotropic use. Recommendations were made for use of medications forms to document indications for psychotropic drug use and to include this client group in physical health monitoring clinics.
Patients with borderline personality disorder (BPD) pose a challenge to healthcare providers. They can evoke strong negative emotions and are perceived often as manipulative help rejecters and hostile dependents. Understanding these patients and fighting the negative connotation of the diagnosis is a challenge to health care professionals, care givers and service providers. For junior doctors and trainees, film offers a unique medium through which to explore this disorder, its features and wider social impact. It offers an opportunity to appreciate nuanced elements in patient experience, treatment and therapy.

Despite being an excellent learning tool, film is flawed; it is primarily a means of entertainment. Mental illness is misrepresented in the media; film perpetuates public misunderstanding and social stigma.

As a junior training in psychiatry, with an interest in film as a learning tool, I wanted to explore how it can aid in understanding the psychopathology of BPD.

Aims and Method: To explore the portrayal of BPD in film though the character of Betty in David Lynch’s Mulholland Drive (2012). Using DSM 5 diagnostic criteria, the character was examined for symptoms of BPD. The film was reviewed for its contribution to the understanding of features beyond the diagnostic criteria and for its impact on the perception of mental illness in society.

Discussion: Using DSM 5 as a framework to diagnose the character of Betty was limiting however, her impaired personal functioning and pathological personal traits is easily demonstrable. Mulholland Drive is able to convey the complexity of delusional states, the disabling mood disorders that frequently accompany BPD and associated risk factors such as suicidality. However, the film tends to fear and extreme anxiety as its prevailing tone. It perpetuates common beliefs; that the mentally unwell are a menace and danger to society.

Conclusion: Mulholland Drive and other films depicting BPD, although flawed offer a qualitative representation of complex interpersonal interaction and the impact of BPD. It highlights the difficulties in defining something as complex as a disordered personality and the frequency of comorbid affective and other personality disorders.

25. A service evaluation of referrals to the North Tyneside West CMHT querying a diagnosis of bipolar disorder

Dr Fiona Hirst, Northumberland Tyne and Wear NHS Foundation Trust; Dr Niraj Ahuja, Northumberland Tyne and Wear NHS Foundation Trust

Background: With the increase in media attention of Bipolar Disorder over the last decade, awareness of the disorder has increased dramatically. With this there has been an increase in the number of referrals for query bipolar disorder to the North Tyneside West Community Mental Health Team even though few of these patients are given a final diagnosis of bipolar disorder. The objectives of this service evaluation were to determine what proportion of patients referred to the service for query bipolar disorder were given the diagnosis and what alternative diagnoses, if any, were given.

Method: After receiving from the Trust Audit Department, We looked at all patients referred to the Longbenton patch of North Tyneside West Community Mental Health Team between May 2014 and April 2015. Using the online patient record system Rio, we reviewed all referral letters, noted the referral source and reason for referral for each patient. We then accessed the clinic letters written after assessment by our CMHT and noted the final or working diagnosis. All patients referred for query bipolar disorder and all patients with a final diagnosis of bipolar disorder who had not been referred for that reason were recorded.

Results: Of the 41 patients referred with a query about bipolar disorder, 8 (19.5%) of those were given a diagnosis of bipolar disorder, 3 of which were a co-diagnosis of bipolar disorder with emotionally unstable personality disorder (EUPD) and another with anger/impulse control.
difficulties. Five of the 41 (12.2%) patients had a diagnosis still under review at the time of the study and 8 (19.5%) failed to attend the initial or review appointments. Only 1 of the 41 patients included in this study was given a diagnosis of bipolar disorder without having been referred for that reason. Almost half of the patients were given an alternative diagnosis (48.8%), many of which were EUPD.

Conclusion: Whilst bipolar disorder is well recognised as being under diagnosed, over-diagnosis is becoming an increasing problem. Education at the primary care level in the use of screening tools and factors which complicate diagnosis could improve accurate diagnosis and improve patient outcome.

26. Case Study: Using cognitive behavioural therapy to treat a patient who frequently presents to Accident and Emergency with seizures.
Dr George Hutchinson, West Middlesex University Hospital; Dr Giles Glass, Derriford Hospital; Dr Farhana Ahmed, West London Mental Health Trust

Aims and Hypothesis
This is a case study of Mr R, a young man who frequently attended Accident and Emergency (A&E) with seizures and anxiety. Mr R became part of a frequent attenders project which aims to reduce inappropriate A&E attendance.

The hypothesis was that additional psychiatric input and cognitive behavioural therapy (CBT) could address Mr R's psychological issues and subsequently reduce his A&E attendance.

Background
Mr R was a 22 year old who attended A&E approximately 20 times per year with seizures. His medical investigations were normal and the frequency of his seizures had not reduced with antiepileptic medication. Mr R had multiple psychological problems such as low self-esteem and generalised anxiety. He was unable to work and his independence was limited due to social anxiety and seizures.

Methods
Mr R was selected as he had a high attendance rate to A&E. Over the course of a year he was seen regularly by 2 psychiatrists, a foundation year 1 doctor, psychological therapies service and a psychotherapist. He also continued to see neurology and cardiology consultants. A&E attendance rates were calculated before, during and after Mr R's psychiatric interventions.

Results
During the year of therapy Mr R was diagnosed with generalised anxiety disorder and psychogenic seizures. After CBT and starting low dose sertraline Mr R reported a dramatic decrease in his anxiety levels, increased self-esteem, reduced seizures and greater independence. Mr R's attendance to A&E was infrequent during months when he was receiving therapy but became frequent when he had not been seen for over a month. After completing a year of therapy Mr R has attended A&E 4 times in 7 months, his lowest rate of attendance to date.

Conclusion
The case of Mr R illustrates the positive effect psychiatric and psychological intervention can have on patients with persistent seizures, particularly if they have underlying psychological issues. In this case, continued support from psychiatry alongside medical input reduced seizure frequency and A&E attendance and greatly improved Mr R's anxiety and self-esteem.

27. Delivering Better Access: Commencing NICE approved Care within two weeks for First Episode Psychosis
Dr Dean Kulendran, Mersey Care NHS; Dr Alex Till, Mersey Care NHS Trust; Dr Isabel Ellory, Mersey Care NHS Trust

Aims and hypothesis:
To identify, within the Sefton and Kirkby Early Intervention Team (Mersey Care NHS Trust) for a six month period between 01 October 2014 to 31 March 2015, the timescale between referral of a patient with first episode psychosis to when they receive NICE concordant care.
Background:
Despite early interventions being known to reduce the impact of psychosis and improve clinical outcomes, psychosis remains one of the largest public health concerns, particularly for young adults. Recognising the urgency with which the unmet needs of this population must be overcome, the government, as part of their vision to achieve better access to mental health services, have announced new standards whereby at least 50% of those experiencing a first episode of psychosis must have access to NICE concordant care within two weeks of referral.

Methods:
The cohort selected included all patients accepted by the Sefton and Kirkby Early Intervention Team (Mersey Care NHS Trust) for a six month period from 01 October 2014 to 31 March 2015. No patients were excluded. A case note review was conducted on 30 July 2015 and established key points within the patients' timeline commencing from the date first referred or presenting to Mersey Care NHS Trust services and finishing when they were commenced on a NICE approved treatment.

Results:
27 patients were identified according to the audit criteria. Whilst 89% (n=24) of patients were commenced on NICE approved treatment, only 33% (n=9) had this initiated within the 14 day target timeline, with an overall median time of 26 days.

Conclusions:
Process mapping the patients' pathway allows quantification of both known and unknown hindrances in the patients' pathway from referral to treatment and where quality improvement methodology must be targeted to deliver the timely provision of high quality care within the Early Intervention in Psychosis team.

28. Side effect monitoring of patients who are receiving antipsychotic depot injections in CMHT teams A and B in North Tyneside
Dr Katherine Rudd, Northumberland Tyne and Wear NHS Foundation Trust; Dr Nicole Edwards, Northumberland Tyne and Wear NHS Foundation Trust; Dr Niraj Ahuja, Northumberland Tyne and Wear NHS Foundation Trust; Dr Kale Northumberland Tyne and Wear NHS Foundation Trust, Psychiatry Consultant

Aims and Hypothesis
Antipsychotics can cause a range of side effects, varying from minor to potentially fatal. These side effects can also negatively impact on patients' medication adherence and thereby their mental and physical health.

Background:
This purpose of re-audit was to identify whether two CMHTs were meeting standards derived from NICE Clinical Guideline 178 regarding side-effect monitoring of patient's receiving antipsychotic depot injections, and identifying areas for service improvement. We aimed to provide data on whether or not patients receiving antipsychotic depot injections were having any side effects adequately identified and managed in order to improve medication compliance and hence mental health outcomes.

Methods:
We used depot cards and patient notes on RIO in order to establish the sample of 29 patients. We looked for a written prompt on the depot card to perform a self-rating questionnaire GASS (Glasgow Antipsychotic Side-effect Scale), which was a recommendation from the previous audit. We also used RIO and past letters to capture the data specified in our audit tool, and transferred this to an excel spreadsheet.

Results:
We found that although Team B performed well in the original audit, it continued to improve along with Team A in ensuring that all patients had performed a self-rating questionnaire ever in the past (100%), with most patients having a GASS within the previous year (86%). The patient demographic was similar to the previous year, with a slightly higher proportion of female patients than previously. The primary indication for depot injection was very similar, with schizophrenia and schizoaffective disorder being the predominant diagnoses (67%).
Conclusions:
Both teams improved in the re-audit in percentage of patients who had completed a self-rating questionnaire in the past year. There is a risk of a self-rating questionnaire becoming an arbitrary exercise to meet audit standards if we do not take note of side effects identified, and seek to address these. It has been agreed that GASS completion will be added to the annual physical health monitoring clinic targets so that all patients on antipsychotics can be routinely assessed for side effects in a structured manner.

29. Use of Long-Acting Antipsychotic Injections in a First Episode Psychosis Service
Dr Rachel Stanbrook, Leicestershire Partnership NHS Trust; Dr Debasis Das, Leicestershire Partnership NHS Trust

Aim: The aim of the study was to evaluate the use of long-acting antipsychotic injections (LAI), in patients with a first episode of psychosis. Background Compliance with antipsychotic medication can be variable. Glazer (2007) found non-compliance rates of schizophrenia patients to be as high as 50% coupled with high relapse rates; these figures highlight the importance of adherence in long term treatment. Robinson et al. (1999) concluded that non-compliance can lead to high relapse rates. The use of long-acting injections has shown to reduce rehospitalisation when compared to the oral equivalent (Tiihonen et al. 2011). NICE guidance suggests the use of LAIs, particularly where compliance has been difficult.

Methods: The population sample were patients in treatment under the Psychosis Intervention & Early Recovery (PIER) service (n=303) in Leicestershire and all patients on long acting antipsychotics (n=32), for whom data was available up to 31 July 2015, were included. PIER is an early intervention service for 14-35 year olds, with a catchment area population of 1 million. The information regarding patient demographics was extracted from RiO, the electronic patient record system. Information on medication was extracted from clinic letters and electronic prescribing data.

Results: The gender and ethnic background of patient’s on LAI’s reflected the general caseload of the PIER service; 11% of the total PIER caseload are currently on LAI’s, with 75% of those being on the newer generation antipsychotics (Paliperidone, Risperidone, Aripiprazole and Olanzapine). In addition 75% of patients on LAIs were started on them within 2 years of first contact with the service and the main reason for starting LAI’s was non-compliance (74%).

Conclusion: The study confirms the common indication for starting long-acting antipsychotic injections. However, there is a case for offering LAI’s early on and its wider use in the first episode of psychosis. Further studies will need to ascertain whether this results in any significant effect on relapse and hospitalisation rates.

Dr Kathryn Williams, Humber Foundation Trust/ Hull and east Yorkshire Hospitals; Dr Rajesh Alex, Consultant psychiatrist, Humber Foundation Trust; Mrs Jane Foster, Care, Quality and Compliance Team, Humber Foundation Trust; Mrs Jackie Stark, Principal Pharmacist, Humber Foundation Trust; Mr John Spence, Clozapine Clinic, Miranda House, Humber Foundation Trust

Background: Clozapine is a second generation antipsychotic licenced for treatment resistant schizophrenia. It is associated with rare but potentially fatal side effects such as agranulocytosis. More commonly, clozapine can cause weight gain and dyslipidaemia thus increasing risk of cardiovascular disease and diabetes. National Institute of Clinical Excellence (NICE) guideline (CG82) recommends annual monitoring of weight, waist measurement, blood pressure, blood glucose and lipid levels due to the risks of weight gain and associated glucose intolerance, diabetes mellitus and dyslipidaemia. Clozapine prescribing practise was audited in Humber Foundation Trust (HFT) in 2013.

Methods: All patients registered under RAST West community treatment team were used in the sample (N=31) for this clinical audit. Data were collected from clinical notes, CPMS database, and data from general practise (GP). Data were analysed with SurveyMonkey® web-based software, and Microsoft Excel programme.

Standards: Re-audit standards were based on NICE guideline CG82 and recommendations by CPMS used in the previous audit. Five key standards were examined looking at documentation,
Results: The key finding was poor compliance for annual monitoring of blood glucose and lipid levels (10% compliance). This highlights a potential impact of patient safety due to potentially failing to identify patients at risk of cardiovascular disease and diabetes as a result of treatment with clozapine. Target standards were achieved for aspects of physical monitoring, documentation and augmentation of clozapine. Good compliance was achieved for patient information accuracy.

Recommendations: Establish whether annual blood glucose and lipid levels are being monitored in general practise. If not, request that they are in alignment with the Severe Mental Illness Register monitoring requirements outlined by QOF.

31. Evaluating staff and service user perception of smoking legislation in inpatient psychiatry settings
Dr Christopher Wood, Foundation Doctor; Dr Hannah Arnstein; Dr Prathibha Rao

Aims and hypothesis: Evaluate staff and service users' understanding of the attitude, behaviour, health awareness and specifically, impact on mental health of a smoking ban within inpatient settings.

Background: The prevalence of tobacco use within an inpatient setting can reach 80%. These patients have increased nicotine intake, find nicotine more rewarding and experience enhanced challenges quitting. Undergoing smoking cessation at such a challenging time is associated with mixed outcomes. However, government legislation is enforcing trusts to adhere to smoke free polices.

Methods: The study design included (1) Survey of sixty-three members of staff and thirty-five inpatient service users; and (2) a semi-structured focus group of inpatients. Questionnaires covered a range of areas encompassing quantitative and qualitative data, which assessed smoking behaviour, opinions surrounding smoking ban and smoking cessation interventions.

Results: A third of staff disagreed with the ban with concerns of increased violence, agitation and negative impact on mental health. Majority of staff felt their workload and stress level would increase and smoking restrictions would contribute to increased admissions under detention. 80% of staff perceived smoking cessation interventions as an important role, but less than half felt confident providing on-going support. 52% of service users strongly opposed the smoking ban with perceptions that these were violation of human rights despite 68% reporting that nicotine addiction had a negative effect on their mental health. Many patients predicted increased violence towards staff with concerns that this would lead to covert behaviours and resumption of smoking once discharged. Despite this, they welcomed offer of medical interventions; but indicating importance of will power over interventions. Service users were largely unaware of physical health issues associated with smoking.

Conclusion: Although similar themes, staff anxieties were higher than service users. More work needs to be done in changing staff attitudes and knowledge and dedicated staff training offered for successful implementation of the ban. Inpatient programmes need to be tailored to patient preference and integrated with community programmes for longer term abstinence.

32. Audit identifying whether applications for Section 12 and Approved Clinician approval and re-approval have been processed correctly by the London Approval Office
Dr Hector Blott, Broadmoor Hospital; Dr Frederick Lewis, Broadmoor hospital; Dr Jennifer Townell, Gordon hospital; Dr Tim Lambert, CNWL; Dr Masum Khwaja, Gordon hospital

Aims and hypothesis: To assess the compliance of the London Section 12/Approved Clinician (S12/AC) approval office, as well as efficiency of the process to identify how it can be improved. The standard has been set as 100% compliance.
Background: An initial audit was conducted in 2013 of compliance with guidelines for approval for S12/AC status, and changes were made to improve the process. Following this the audit cycle was completed in March 2015; the time taken for the various stages of the approval process has now also been examined to identify where improvements to efficiency can be made.

Methods: Approximately 25% of the applications received in the six months to 6/3/15 were audited. An audit tool ensured that all of the criteria for application were met, and the time taken for each stage of application was recorded. The data were analysed using Microsoft Excel.

Results: In both cycles of audit 100% compliance with approval criteria was demonstrated. The mean time taken to approve applications increased by 21% from 48.6 in 2013 to 58.8 days in the 2015 cycle. The time taken from requesting to receiving references was identified as the rate-limiting step for most applications.

Conclusions: The London office remains 100% compliant with guidelines. The increase in mean time taken to process applications is likely due to the large increase in number of applications received in the time period assessed. This is due to the large original cohort of ACs (approved after the AC role was established) requiring renewal at that time. Efficiency of the process can be improved by making changes to the reference process, such as them being requested by the candidate prior to application, or electronically. It may be beneficial in the future to establish a national standardised AC/S12 cross-panel audit, with different regions auditing each other.

33. A Re-Audit Of The Use Of Long Acting Antipsychotic Injections In A Community Mental Health Team (CMHT).

Dr Amy Burlingham, Birmingham and Solihull Mental Health NHS Foundation Trust; Dr Padmini Anandakumar, Birmingham and Solihull Mental Health NHS Foundation Trust; Dr Lisa Brownell, Birmingham and Solihull Mental Health NHS Foundation Trust

Aims and hypothesis
Following an initial audit in 2013, which indicated some areas where there was scope to improve services for individuals receiving long acting antipsychotic injections (LAIs), several recommendations were implemented. Here, we evaluate the effectiveness of these changes.

Background
Approximately 40-60% patients with schizophrenia are at least partially non-compliant with oral medication, and approximately 30% are prescribed LAIs. These medications are not without adverse effects, and it is therefore important that patients receiving LAIs should be involved in the decision to use this treatment and should be aware of the potential side effects.

Methods
All patients receiving LAIs under the care of a single CMHT in Birmingham (n=74) were studied. Case notes were reviewed and questionnaires distributed to patients.

Results
Key findings include:

- Improvement in patients reporting that their views regarding initiating treatment were taken into account from 30% to 48% patients
- Improvement in patients reporting that their views regarding treatment are now taken into account from 72% to 86%
- Improvement in patients reporting understanding the purpose of their treatment from 73% to 86%
- Improvement in patients reporting understanding the potential side effects of medication from 45% to 62%
- Improvement in patients reporting that the medication had helped them from 66% to 86%
- Reduction in patients reporting being dissatisfied with their treatment from 8% to 5%

Conclusion
Many of our patients had their LAI initiated many years ago when there was perhaps less emphasis on sharing information. In some cases, the LAIs were commenced during a period of detention under the Mental Health Act, without the patients consent. This may explain the fact that more than half our patients still report that they were not involved in the initial decision to start these medications.
We were pleased to find that the implementation of the recommendations of the initial audit has produced significant improvements in patients current understanding, involvement in decision-making, and perceived satisfaction with their treatment.

34. Addressing physical health monitoring in Home treatment team
Dr Rowena Carter, South London and the Maudsley; Dr Charles Comley, South London and the Maudsely NHS foundation trust

Introduction
Mental illness is associated with higher levels of poor physical health. The great majority of deaths are attributable to poor physical health, particularly cardiovascular disease.

Good practice dictates baseline testing and regular monitoring. National policies have been introduced to improve the assessment of physical health in those with mental illness, and our own trust has established guidelines that apply to both community and inpatient setting.

Home Treatment Teams (HTTs) have been established in South London and the Maudsley NHS foundation trust for around 15 years. Their essential aim was to provide intensive acute psychiatric care in the community as an alternative to hospital admission; however the concept of a ward in the community is quite different to the reality and theoretical and practical considerations have dictated that Home Treatment Teams are very different operationally and structurally to the traditional inpatient ward

The question remains where HTTs fit in regards to the trusts physical health Policy. The community standard is insufficient but at the same time, the ward standard is impractical.

Our proposal is for HTTs to have their own policy, that ensures our clients receive a similar level of assessment and monitoring as could be expected from the ward policy, but which is realistic in regards the limitations faced.

Method:
Electronic records review for:
- March 2014
- September 2014
- March 2015 (following implementation of change in practice to improve our physical health monitoring within HTT)

Change of practice included requesting bloods and ECG from every new admission under HTT and documenting this. Targeted physical examination (identified by the doctor, who was tasked with screening the notes of each new admission) and actively pursuing those patients at high risk of physical complications to complete investigations.

Results:
Currently we are requesting 100% of bloods and ECGs (equivalent to ward), previously this ranged from 37% to 73% for bloods and ECGs
We have improved ECG obtainment from around 30% to 60%
We have improved blood obtainment from 67% to 76%
We have also improved physical examination but that is incidental and not secondary to interventions

35. NHS or UPS: Finding a more efficient way of getting medication to patients under Rotherham Intensive Home Treatment Team a service evaluation and improvement project.
Dr Jaazzmina Hussain, Sheffield Health and Social Care NHS Trust; Dr Sathya Vishwanath, Rotherham Doncaster and South Humber NHS Trust; Mrs Karen Crichton, Rotherham Doncaster and South Humber NHS Trust

Background:
Rotherham Intensive Home Treatment Team (IHTT) covers a geographical area of approximately 55 square miles in South Yorkshire. Patients were relied upon to inform IHTT when repeat prescriptions of their psychotropic medications were required. Frequently, this only happened when medication had run out, resulting in urgent requests for team doctors to prescribe for same day or next day delivery. A team member was required to make a non-therapeutic contact visit to deliver medication (medication drops), which in turn had a negative impact on service delivery e.g., by reducing staff availability for therapeutic contact time.
Pre-intervention:
Four weeks data collection was undertaken April -May 2015 to quantify the scale of the problem. The data was collected from the team diary requests and the fax list of prescriptions sent to the commissioned pharmacies. This showed 51.8% (55/106) of prescriptions written were for urgent repeat prescriptions; 72.7% (40/55) of these resulted in medication drops.

Intervention:
Our hypothesis was that anticipating the due date of repeat prescriptions would reduce the number of urgent requests and therefore the number of medication drops. The intervention was an Excel spreadsheet, with dates of when patients last prescriptions were done and when they were due to be renewed. The IHTT staff booking the patients next visits would consult the document to ensure the visit and medication delivery occurred together.

Post-intervention:
Another 4 weeks data collection was undertaken June -July 2015, in the same manner as the first. A reduction in the number of urgent repeats was seen, from 51.8% to 16.8% (18/107) of all the prescriptions written. Medication drops reduced from 72.7% to 33% (6/18).

Some problems and limitations identified were over-ordering of medication on 6 occasions and visits not in sync with medication due date. We aim to ameliorate these by changing the way medication requests are made and further staff meetings to discuss use of the new system. In general, this intervention has been useful in reducing the number of medication drops.

36. Transcultural Psychiatry: Cambodia & Mental Health
Dr Lena Jawad, West London Mental Health Trust

The 1970s represent a significant portion of Cambodia's dark and troubled past. Pol Pot, leader of the Khmer Rouge communist party, expressed his desire to create the world's first sole agrarian state in the quickest time possible and with no regard for the loss of human life. People in cities were forced to leave their homes, move to the countrysides and were obligated to work as farmers in dismal conditions. The regime adhered to extreme socialist values, removing everything that did not fit with this ethos: the so-called 'educated' (including the county's two psychiatrists) were taken to prisons, tortured, starved and killed.

Forty years and almost three million deaths later, Cambodia was left with a heavy burden of physical and psychological disabilities. Whilst efforts were made to rebuild the physical healthcare system, mental healthcare would be ignored for many years to come.

Today, only forty trained psychiatrists look after a population of fourteen million. This, in a country where 35% of the population suffer from some form of mental illness (most commonly depression, anxiety and post-traumatic stress disorder) and where the suicide rate is almost three times the worldwide average. Of the forty psychiatrists, only ten reside outside of the capital, Phnom Penh, meaning many of those in rural communities who require help cannot access it. This has led to people being tied in chains or locked in cages because their relatives do not know how else to manage them.

The overwhelming demand for mental healthcare is why Cambodia has come to rely on foreign aid. The Transcultural Psychosocial Organisation (TPO) of Cambodia is the country's leading NGO in mental health. TPO hopes to improve the mental health and quality of life of the Cambodian people through psychoeducation, ongoing research programmes, training of mental health specialists and the provision of multidisciplinary services in the community.

We aim to introduce the efforts of this NGO, as well as the Royal College's Transcultural Psychiatry Special Interest Group in facilitating the worldwide effort to deliver high quality mental health care to all corners of the globe.

37. How well psychiatrists understand Driver and Vehicle Licensing Agency guidance on driving and mental illness: a trust-wide survey
Dr Lena Jawad, West London Mental Health Trust; Dr Fiorenza Shepherd, West London Mental Health Trust
Aims and hypothesis: To investigate the proportion of doctors working in mental health that regularly assess patients' fitness to drive, and examine how well informed doctors are of the Driver and Vehicle Licensing Agency (DVLA) guidance regarding mental illness. The hypotheses state that patients are not routinely asked whether they drive but that doctors are generally aware of DVLA guidelines on mental health.

Background: The causes of road traffic accidents are multifactorial but there is evidence to suggest that the risk is increased by 1-2% in patients with mental illness and significantly more so in alcohol and substance misusers.

Methods: An online survey comprising ten questions was sent to all doctors working in mental health in both, West London Mental Health Trust (WLMHT) and Central and North West London (CNWL). The survey was open for two months. Results were collected and graphs were produced for visual representation of data.

Results: The number of participants reflected a poor overall response rate (WLMHT n=65, CNWL n=38). Of the doctors that did respond, the majority were consultants in WLMHT (44%) and core trainees in CNWL (50%). Only 48% of doctors in WLMHT enquired into whether their patient drove. This number was slightly higher in the CNWL group (53%). 75% of WLMHT and 76% of CNWL doctors were aware of DVLA guidance on mental illness, with 80% WLMHT and 76% CNWL knowing how to access it. In both trusts the proportion of doctors who asked their patients about driving was highest amongst those working in older adults (88% and 71% respectively).

Conversely, figures were demonstrably lower in CAMHS, with only 33% in both trusts asking their patients whether they drove.

Conclusions: A significant portion of doctors working in mental health do not routinely ask their patients whether they drive however the majority of doctors are aware that DVLA guidance on mental illness exists. A low overall response rate is poorly representative of practice but could highlight a general apathy with regards to driving and mental illness or a lack of knowledge, stressing the need for integration into formal training.

38. Re-audit of the Provision of Information Regarding Medications and Involvement of Patients in Choosing the Medications they Receive in a Community Mental Health Team (CMHT)

Dr Saba Mattar, Yewcroft CMHT; Dr Kate Brown, Early Intervention Services, Yewcroft Centre; Dr Lisa Brownell, Yewcroft CMHT

Aims and Hypothesis
To determine whether patients feel involved in decisions around their medications and whether they feel they have been given enough information about them. An audit completed in 2013, after introduction of the Choice and Medication website to be used as a basis for information sharing, demonstrated that patients were given sufficient information and felt involved in decision making. Here we examine whether these standards have been maintained.

Background
The no Choice, No Voice review (2007) and the National Patient Survey (2012) highlighted important principles to consider when starting patients on new medications. Choice and Medication is one tool that is available to provide information and promote decision sharing, and is used in Birmingham and Solihull Mental Health NHS Foundation Trust.

Methods
All patients under a single CMHT in Birmingham who attended a medical follow-up appointment between 1st April-31st May 2015 were given a Patient Satisfaction Questionnaire (n=98). If they had been started on any new medications in the last 12 months they were invited to answer six further questions.

Results
Key findings include:
- Of the 98 patients 83 (85%) had been commenced on new medications
- 95% reported that they had been given sufficient information, overall, about their medications
- 99% reported that they had a say in decisions around their medication
• 98% reported that they had been given information about the purpose
• 98% reported that they had been given information about the side effects
• 95% reported that they had been given written information

Conclusion
We are pleased that we have maintained the excellent results of our previous audit, indicating that sharing information about medication and sharing decision making about treatment are well embedded in our teams approach.

39. An analysis of referrals form a psychiatric liaison service to a Community Mental Health Team (CMHT)
Dr Saba Mattar, Birmingham and Solihull Mental Health NHS Foundation Trust; Ms Angela Holden, University of Birmingham; Dr Lisa Brownell, Birmingham and Solihull Mental Health NHS Foundation Trust

Aims and hypothesis
To evaluate the referrals from a Psychiatric Liaison Service to a Community Mental Health Trust (CMHT).

Background
CMHTs receive referrals from a variety of sources one of which is psychiatric liaison services in acute hospitals. In 2013, we presented an evaluation of the referrals received by one CMHT from Psychiatric Liaison Services. Here, we examine how the pattern of referrals has changed.

Methods
A retrospective electronic case note review of all referrals made by a psychiatric liaison service to a CMHT between 1 November 2014 and 31 March 2015.

Results
Key findings include:
• In 2012-13, 49 referrals were received over a 14-month period. In 2014-15, 49 referrals were received over a 5-month period. This represents a substantial increase in referral rate (approximately 300%)
• The most common stated reasons for the referral were low mood (37%) and poor coping strategies (31%)
• Of those offered an appointment with the CMHT, 45% either declined the assessment, or failed to attend a booked appointment. This is similar to the figure from 2013 (47%)
• Of those who attended the CMHT assessment, 67% were discharged without further follow-up, 19% were offered a further service but declined or failed to attend and therefore only 14% of those assessed were taken onto caseload

Overall, only 6% of those referred by psychiatric liaison service to this CMHT were taken onto caseload. This proportion is a similar to that demonstrated in our 2013 study, when 4% were taken onto CMHT caseload.

Conclusion
Individuals with psychological distress frequently present to acute hospitals, and psychiatric liaison services are important in ensuring access to appropriate assessments. Following these assessments, patients may be referred to a range of secondary care psychiatric services or may be discharged without recommendation for further input. We only examined referrals to a CMHT, but it appears that these patients frequently failed to attend appointments, and that of those who did attend, only a small proportion were felt to require CMHT services. We therefore need to explore alternative solutions to better meet the needs of this patient group.

40. Bbrain imaging studies of treatment-resistant schizophrenia: a systematic review
Dr Robert McCutcheon, Institute of Psychiatry, Psychology and Neuroscience. King's College London; Dr Elias Mouchlianitis, Institute of Psychiatry, Psychology and Neuroscience. King's College London; Dr Oliver Howes, Institute of Psychiatry, Psychology and Neuroscience. King's College London

Background
Approximately 30% of patients with schizophrenia show an inadequate response to antipsychotics, termed treatment resistance. Clozapine is the only medication licensed for resistant schizophrenia,
and for some patients this is poorly tolerated or ineffective. Furthermore, there are often long delays in identifying resistant patients. Brain imaging studies may help elucidate the underlying neurobiological reasons that certain patients show inadequate treatment response, and help identify them earlier. In addition, studies examining the effect of clozapine on the brain may help identify which aspects of clozapine make it effective in treatment resistance.

Aims
The aim of the current study was to systematically review the neuroimaging literature on treatment resistant schizophrenia with a view to informing future research.

Method
We performed a systematic search of PubMed between January 1980 and April 2015 in order to identify all neuroimaging studies that had examined treatment resistant patients, or longitudinally studied the effects of clozapine treatment.

Results
The search identified 330 papers, of which 58 met inclusion criteria. 28 compared resistant patients with healthy controls, 15 compared them with treatment responders, and 33 studies longitudinally examined the effect of clozapine. Results were often inconsistent but some common findings were found, such as reductions in gray matter in frontotemporal regions in treatment resistance, and reductions in caudate nuclei volumes following clozapine treatment.

Conclusion
The available evidence supports the possibility that some of the neurobiological changes observed in resistant schizophrenia lie along a continuum with non resistant schizophrenia; while other differences may be more categorical in nature. However, there is limited replication, and further work is required to determine neurobiological significance and potential as predictors of treatment resistance. In order for neuroimaging findings to be clinically translatable, future studies need to provide clear a priori hypotheses and test these rigorously.

41. Evaluation of smoking behaviour and cessation in non-acute inpatient psychiatric services

Dr Madhumanti Mitra, BSMHFT; Dr Samaila Bello, BSMHFT; Dr Syed Rashid, BSMHFT; Dr Leech BSMHFT, Higher Psychiatric Trainee; Esther University of Birmingham Medical student

Background: It is a well-established fact that there is a higher prevalence of smoking amongst those suffering from a mental illness. This is a great cause for concern due to the potentially harmful effects of smoking not only on physical health but also on the efficacy of antipsychotic medication.

Aims: The aim of this audit was to evaluate smoking behaviour and awareness in psychiatric patients in non-acute inpatient unit (NAIPS), following their transfer from an acute psychiatric ward.

Methods: A random sample of 12 inpatients was chosen. Data was collected from RIO software, to include patient demographics, admission details, diagnosis, medication, whether the physical health form was completed and smoking status assessed adequately during admission and following transfer. Patient interview was then conducted to understand awareness of smoking cessation interventions, knowledge about effects on antipsychotics and whether they have been successful.

Results: The data was tabulated in Microsoft Excel and analysed. On admission to the acute ward, although physical health form and assessment of smoking status was done for 67% patients, quantity and type of smoking was documented for only 42% and 33% patients respectively. Smoking was reassessed in 92% patients following NAIPS transfer. However, reassessment occurred anytime between 4 to 102 weeks into NAIPS admission. Smoking was reduced/ stopped in 33% patients. Effect of smoking on antipsychotic medication was discussed with 42% patients. In terms of intervention, the most common intervention patients were aware of was nicotine patches, and 60% patients were not offered any interventions. Patients primarily got the information from internet/media rather than health professionals. Of patients who were successful, 75% had used none of the interventions on offer.

Recommendations:
1. Complete 100% documentation on admission and transfer of patient
2. Ward doctor to discuss effects of smoking on antipsychotic medication
3. Named nurse to take initiative for educating patients regarding smoking cessation interventions
4. Re-audit

Conclusions: By implementing the recommendations above, there will be better documentation and increased patient awareness regarding smoking and cessation. This may eventually reduce smoking prevalence in this cohort.

42. Working with interpreters in mental health settings: using the results of a survey to develop local guidelines

Dr Josephine Neale, Barnet, Enfield & Haringey Mental Health NHS Trust; Dr Deniz Cerci, Camden & Islington NHS Foundation Trust

Aims and hypothesis
The aim of the project was to develop an intervention to improve communication when working with interpreters in mental health settings, based on the results of a survey issued to interpreters.

Background
Evidence-based guidelines advise clinicians to meet with interpreters before and after a patient consultation to discuss its purpose and to reflect on potential linguistic and cultural issues. A survey was designed, based on these guidelines, and sent to a group of interpreters booked by Barnet, Enfield and Haringey Mental Health NHS Trust. The participants were invited to complete an online questionnaire regarding the most recent patient consultation they were asked to interpret for.

Methods
From the time period covered, 254 interpreters were contacted and 46 responses were received. Based on the results of the survey, local guidelines were developed, appropriate to the work undertaken by trust clinicians. These guidelines were designed to provide advice particularly in areas of weakness highlighted by the survey responses, such as meeting with the interpreter before and after a consultation with a patient, discussing confidentiality and exploring relevant cultural issues and social connections.

Results
Guidelines were produced in the format of a flowchart on one A4 page, making them concise and easy to read.

Conclusions
This survey showed that there was a wide variation in practice between clinicians and indicated that guidelines would be conducive to a more uniform practice and better communication, therefore ultimately improving quality of patient care.

Difficulties in working effectively with interpreters are likely to be widespread across London, not just isolated to this trust, so the survey will be sent to other agencies providing services to London mental health trusts, with the aim of developing a pan-London guideline appropriate to mental health clinicians.

43. The Neuro-Inflammatory Association Between Diabetes Mellitus and Schizophrenia: A Systematic Review of Clinical Studies

Dr Benjamin Perry, NHS; Dr Deepali Mahajan, NHS; Prof Swaran Singh, NHS; Prof Tahir NHS, Psychiatry Consultant

1) Aims and Hypothesis
We wished to elucidate whether a fundamental association between Diabetes Mellitus and Schizophrenia, in terms of shared neuro-inflammatory pathways, may present with synchronous illness severity. Our hypothesis stated that poor glycaemic control is related to increased illness severity in Schizophrenia.

2) Background
Schizophrenia is a life-shortening illness. Life expectancy amongst sufferers is reduced by 20%, with mortality rates twice as high as the general population. Physical illnesses such as Diabetes Mellitus are the most common causes for the increased mortality rate. Recent research suggests a
direct link between Schizophrenia and Type II Diabetes independent of medication, lifestyle, health habits and access to healthcare. Recent research has also shown both conditions to have an important inflammatory, and neuroinflammatory component.

3) Methods
We conducted a systematic review employing PRISMA criteria, searching EMBASE, Ovid MEDLINE and PsychInfo to May 31st, 2015. We aimed to evaluate clinical studies with the hypothesis that poor glycaemic control is related to increased illness severity in Schizophrenia.

4) Results
Nine studies were selected for detailed analysis. Six studies reported poor glycaemic control to be related to increased illness severity in Schizophrenia, via increased symptom severity, longer inpatient stay, or cognitive impairment. Two further studies were in partial support of the hypothesis. Only one study did not support our hypothesis.

5) Conclusions
Whilst study design and analysis varied across the included studies, the authors believe that these results are promising, suggesting that further work examining the effect of glycaemia on Schizophrenia symptomatology is necessary, with more consistently designed studies.

Furthermore, to the authors knowledge, this is the first systematic review conducted examining this hypothesis.

44. DVLA guidance and how well this has been communicated to HBTT patients
Dr Andrew Porter, Greater Manchester West; Dr Ronjan Bhattacharya, GMW; Dr Ben Harris, GMW; Dr Suhaib Hafi, GMW

Aims & hypothesis;
This audit’s aim was to review if DVLA advice was given appropriately for patients of the Trafford Home Based Treatment Team (HBTT) within Greater Manchester West Mental Health Foundation Trust (GMW).

Background;
Mental health practitioners have duty of care to advise their patients of dangers of driving whilst suffering mental health issues and for certain medications. Severe mental disorder is a prescribed disability for Section 92 of the Road Traffic Act 1988. Driving must cease during acute illness due to associated risk to the driver and other road users. Patient failure to inform the DVLA about medical conditions that affect their driving can result in penalties of up to £1,000 and may lead to prosecution.

Methods;
This was a cross-sectional audit of service users of Trafford HBTT. Data was collected via the electronic patient record system - Integrated Clinical Information System (ICIS). We collated a list of patients (n=23) under Trafford HBTT on 30/03/15.

Results;
39% (n=9) of patients had been appropriately given DVLA advice and this was recorded on ICIS. 39% (n=9) had no documented evidence of DVLA advice being given on ICIS. 22% (n=5) didn’t have sufficient documentation that information of DVLA guidance was given to the patient. Therefore 61% (n=14) either weren’t informed of DVLA advice or ICIS record was inconclusive. All patients (n=23) had an indication for DVLA advice to be given.

Conclusions;
There is inadequate recording of information in patient notes relating to DVLA advice being given to patients. We are failing to meet the standard in 61% of cases.

There was unclear documentation about information that has been given to patients, including whether follow up plans were acted on. Patients referred directly to the HBTT from inpatient discharge forego HBTT triage where driving status is discussed.

In cases that met the standard, DVLA counselling was clearly and comprehensively documented.

45. Driving and Psychosis: Do we know our patients' driving status?
Aims and hypothesis
This audit aimed to assess documentation and advice around driving for patients within Kingston Early Intervention Service (KEIS). It specifically looked at recording driving status and appropriate advice regarding the Driving and Vehicle Licensing Agency (DVLA) guidelines.

Background
DVLA guidance on psychotic disorders requires drivers to cease driving during the acute episode and meet DVLA criteria for stability prior to resuming driving. KEIS supports people with a first episode of psychosis between ages 18-35. It is important to know the driving status of all service users, so they can be advised appropriately about DVLA guidelines. However, this was not routinely asked and documented.

Methods
All clients under KEIS on 23rd September 2014 were included in the audit (n=61). Their RiO Electronic Record Progress Notes were searched for the following terms: driv*, licence, DVLA. If they were current drivers and had received DVLA advice, Clinical Documentation was checked for DVLA forms as evidence of follow-up. The first re-audit was 30th December 2014 (n=60) and the second re-audit was 6th June 2015 (n=56).

Results
The initial audit showed a large deficit between compliance and standards 41% (25/61) patients had driving licence status recorded and 36% (22/61) had current driving status recorded. 72% patients with a driving licence had been given advice and 100% patients currently driving had received advice. However, only 31% were followed up. The initial action plan included an educational presentation on driving and psychosis and a patient leaflet. The first re-audit showed a modest improvement in standards. Team members were issued with a list of patients whose driving status was not documented. However, the second re-audit showed a decrease in most standards.

Conclusions
Without documentation, there is no evidence that health professionals possess knowledge of their patients driving status and are monitoring the risk. It appears that the more effective intervention was educational, resource-focused and involved a team members supervision. While the second intervention mirrored the teams usual target format, it was not backed up by quality monitoring.

46. The quality of side effect monitoring in patients on depot antipsychotic medication
Dr Natasha Rishi, Bushey Fields Hospital; Dr Amitav Narula, Bushey Fields Hospital

Aims:
To review the documentation of side-effect monitoring for patients receiving antipsychotic depot injections, in accordance with NICE guidelines.

Background:
Antipsychotic related side-effects may compromise physical health, quality of life and lead to non-adherence, a likely determinant of relapse. The longer elimination half-life of a depot injection means there is less flexibility should side-effects arise, hence the need for prompt intervention. Regular patient contact also provides an ideal opportunity for monitoring. In 2009, a national audit by the Prescribing Observatory for Mental Health reported that over one-third of patients were not assessed for side-effects in the previous year.

Methods:
Electronic records of 35 randomly selected patients on depot medication were audited. A pro-forma was designed to collect basic demographic data, diagnoses and details of psychotropic medication. The documentation of side-effects was noted, specifically: the presence of documentation within the past year; whether documentation had been by nursing staff, medical staff or both; and whether appropriate action had been taken in cases of reported side-effects.

Results:
The sample was 69% male with a mean age of 56. Schizophrenia was the principal diagnosis and typical antipsychotic injections were most frequently prescribed. Over the past year, every patient
had side-effect related documentation. In 63% of cases, this had been recorded by both nurses and doctors. The following side-effects were reported: 45% no side-effects; 28% extra-pyramidal side-effects; 14% injection site complaints; 10% sedation; and 3% weight gain. In 16 of 19 cases of side-effects, appropriate action was taken.

Conclusions:
There is regular enquiry into side-effects in accordance with national guidelines, however, mostly in the form of generic statements. Side-effects were not always elicited in encounters with doctors. Implementing recommendations including, systemic enquiry through annual physical health checks and six monthly use of the Glasgow Antipsychotic Side-effect Scale, would enable a formal review into the presence and severity of specific side-effects. Quality improvement in monitoring, may offer further opportunities for managing antipsychotic related side-effects. The audit cycle will be completed in September 2015.

47. Steps taken to reduce Did-Not-Attend rates at Christchurch & Southbourne Adult CMHT
Dr Abhishek Shastri, Dorset HealthCare University NHS Foundation Trust; Dr Domenico Scala, Dorset HealthCare University NHS Foundation Trust

Aims and hypothesis:
Following the merger of Christchurch and Southbourne CMHTs there was an anecdotal sense that the Did-not-attend (DNA) rate at the CMHT had risen. This posed the following questions:
What are the DNA rates?
What can be done to reduce DNA rates?
Has there been a reduction in DNA rates following interventions?

Background:
Failed appointments cost the NHS over £160 million per year. They also have an adverse impact on patients leading to missing vital medications, delay in identifying possible relapse of health problems and increasing waiting times.

Methods:
A patient DNA was counted as anyone not attending; who had given less than a days notice. Hence phoning before 1700 hrs the day before the appointment was not a DNA; while calling at 0900 hrs on the day of appointment or not informing CMHT was counted as DNA. Using RiO electronic system, data was collected regarding DNA rates for new (first) and follow-up appointments. DNA rates were collected and then repeated after interventions were made. Patients/service users offered appointments at Christchurch & Southbourne CMHT were identified from 01.12.2012 and 28.02.2013 and then from 01.12.2014 to 28.02.2015.

In between the data collection cycles, the following interventions were carried out:
1. Text reminder to service user regarding date of appointment.
2. Telephone call to new appointment service user a day before the appointment.
3. Leaflet & a poster were created to raise awareness about implications of DNA rates in terms of quality of care.
4. Screening of GP referrals at CMHT were done by clinicians along with Consultants.

Results: Number of patients that DNA in first cycle of data collection was 232. This reduced to 110 following the interventions started in 2014.

Conclusions:
By putting in place interventions, reduction in the DNA numbers were observed and its potential benefits include:

1. Reduction of illness symptoms.
3. Enhancement of therapeutic relationship
4. Improved quality of life by engaging with services
5. Enhancing patient safety by regular interaction with healthcare professionals

48. A literature review looking at Attention Deficit/Hyperactivity Disorder in adults and associated psychiatric co-morbidity

47
Aims and hypothesis:
To review, compile and interpret the literature about Attention deficit/hyperactivity disorder (ADHD) in adults and associated psychiatric co-morbidity in order highlight the importance of the consideration of diagnosis in the general adult psychiatry setting.

Background:
Attention deficit/hyperactivity disorder is characterised by inattention, hyperactivity, impulse control and emotional dysregulation. It was previously thought to be a disorder of childhood and adolescence however research clearly shows that the disorder persists into adulthood. Studies also show that between 65 and 89% of adults with have one or more other psychiatric disorders during their lifetime.

Methods:
A literature search was conducted via the trust library, the articles identified were then analysed to identify common themes and areas for future research.

Results:
Most studies concluded that not only is there a greater risk for comorbid psychopathology in adult ADHD but there is also an impairment of educational, occupational and social functioning which leads to poorer outcomes and greater resistance to treatment as well as a higher cost of illness. The disorders commonly associated are major depressive episodes, substance misuse, anxiety disorders and anti-social personality disorder. The significant lifetime psychiatric comorbidity associated with ADHD is not explained by clinical referral bias.

Conclusions:
A high rate of psychiatric comorbidity in the estimated 4% of adults with ADHD is a major public health concern. The outcome in patients with a sole diagnosis of ADHD is better than those with comorbid psychiatric disorders. In daily clinical practice comorbid psychiatric disorders in adults with ADHD need to be recognised and treated in a hierarchical manner. Further research is required to establish whether comorbid psychopathology emerges as a developmental consequence of ADHD and if continuous treatment of ADHD reduces adult comorbidity.

49. Mental Healthcare: Stigma and Discrimination Clinical Audit on Medical Handover in a Mental Health Unit (MHU)
Ms sana sohail, Lakeside Ward Leigh infirmary Leigh

Aims and hypothesis
1. To identify whether a handover has been sent while referring a patient from MHU by the Psychiatry team to the Medical team.
2. To identify whether a handover/discharge letter has been received from the Medical team.
3. To look at the quality of referral/discharge letters and identify any discrepancies.

Background
Patients from the MHU at Leigh have had to go for physical health problems to AnE, other medical wards and outpatient clinics. As per GMC (good medical practice guideline) there should be a handover to the referring team detailing the reasons for admission/transfer and any interventions or changes to medications performed. We had 3 serious untoward incidents in the last 6 months due to lack of poor communication between both teams.

Methods
One auditor surveyed 32 patients in the MHU that were sent either to A n E or outpatient clinics over a period of 5 months from March 2015 to July 2015.

Results
Of a total of 32 inpatients, 23 outpatient referrals and 33 referrals to AnE were identified. For outpatient appointments, 100% patients had referral letters from psychiatry juniors including the reasons and suspected outcome. From the medical team, 48% had clinic letters while 48% did not and 4% had handover via phone call without any clinic letter. For AnE referrals, 76% had
referral/handover letters from psychiatry juniors, 21% had no handover and for 3% no record was found although the doctors assessment mentioned that a letter has been sent to AnE. From the Medical team 59% had discharge letters, 38% had no discharge letters and 3% received discharge plan via phone call but no letter was received.

Conclusions
We conclude that often patients are referred between Psychiatry and Medical teams without referral letters. We recommend that the information regarding a letter should be passed on to the receiving team to make sure that it is sent and received along with the patient. Junior doctors induction should include this discussion and wards should also have posters to remind them. Re-audit post implementation of the policy should be performed.

50. Retrospective Audit of the management of Per-Anal insertion of Foreign bodies (IFB): a mental health perspective.
Dr Ahmed Saeed Yahya, Chase Farm Hospital; Dr Chukwuma Jude, Chase Farm Hospital; Dr Lekkos Petros, Camden and Islington NHS trust; Mr David Westbroek; Mr Dhiren Nehra

Aims and Hypothesis:
To establish the current practice in the management of per-anal IFB and update a framework for the initial work-up, surgical intervention and appropriate mental health intervention.

Background: Most patients with per-anal IFB present to the Emergency department and are then largely managed by the surgical team. Per-anal IFB can be a type of self-harm; the factors leading to self-harm and per-anal IFB mandates risk assessment and appropriate mental health interventions. Timely Psychiatric assessment is of Paramount importance. (Unruh BT et al, 2012)

Methods:
A literature search of electronic databases (Medline, Embase, PubMed and PsychInfo) was undertaken to identify relevant publications from January 2005 to September 2013. Further searches were done on google search engine and by hand-searching relevant journal bibliographies. Using local audit guidelines, we retrospectively reviewed operative logged interventions and clinically coded procedures for per-anal IFBs between May 2009 and September 2013.

Results:
Our literature search yielded one systematic review, twenty one multiple case series reviews, two clinical practice guidelines and seven case reports. Our retrospective review yielded 10 patients, aged 14 - 70 years (mean 26.2 years) who underwent emergency surgery following IFB. The male to female ratio was 5:1 respectively. Of these 40% resulted from a misadventure with a sex-toy. One in four patients had recurrent presentations and a psychiatric history. There were no records of psychiatric assessments, intervention or follow up with these patients. No records were found of involvement of or referrals to mental health services.

Conclusions:
The majority of patients presenting with per-anal IFB do not have a mental disorder. However, 25% were people with a mental disorder. Those with a mental disorder were more likely to have repeated presentations. We found no evidence to suggest that those with mental disorder had any form of specific Psychiatric input.

A multi-disciplinary and holistic approach to the management of per-anal IFB including the involvement of mental health services may reduce the potential for recurrence.

51. Getting to the heart of the matter: can we improve physical health on inpatient psychiatric wards?
Dr Charlotte Allan, University of Oxford; Dr Mark Toynbee, Oxford Health NHS Foundation Trust; Dr Nicholas Dobson, Oxford Health NHS Foundation Trust; Mr Isaac Lioggia, Oxford Health NHS Foundation Trust; Mr Stephen Browne, Oxford Health NHS Foundation Trust; Dr Barrera Oxford Health NHS Foundation Trust, ; Allan Higher Psychiatric Trainee

Aims
To improve physical health monitoring and interventions for patients on a general adult inpatient unit.

Background
Severe mental illness is associated with increased cardiometabolic risk and premature mortality. This is recognised by the Physical Health CQUIN 2014/2015 and 2015/2016, which outlines national standards for screening and intervention for cardiometabolic disorders in patients with severe mental illness.

On an 18-bed acute male inpatient unit in Oxford, audit in November 2014 demonstrated shortfalls in documentation of physical health parameters on admission. Following the introduction of new admission documentation, a re-audit in March 2015 showed improvements on most parameters, however, significant omissions still remained.

Methods
To promote integrated physical and mental health care, and to increase engagement with patients, we developed a weekly well-being clinic on an acute inpatient unit. The clinic screened for cardiometabolic risk factors (body mass index, blood pressure, glucose regulation, lipids and smoking status) and offered interventions. All new patients admitted over the preceding week were invited to attend the clinic, and bookable appointments were available for patients with concerns about their physical health. The clinic was staffed by a nurse and a junior doctor.

Results
Five well-being clinics were held in June and July 2015 and 18 patients were seen. Compared to previous data collection (November 2014 (n=29) and March 2015 (n=19)), re-audit in July 2015 showed improvements in the following parameters: weight, height, urine drug screen and dipstick, health questionnaire, ECG and bloods. Interventions were offered to five patients (smoking cessation, diet, exercise).

Conclusions
The introduction of a weekly wellbeing clinic on an inpatient unit has improved screening and interventions related to physical health care and management of cardiometabolic risk factors. The challenge now is to ensure this is a sustainable intervention, maintaining momentum despite staff changes and the pressures of a busy ward environment. Reflecting on progress and ongoing data collection will help monitor its effectiveness and drive further improvements.

52. A three month follow-up study evaluating changes in clinical profile and attitudes towards involuntary admission
Dr Emma Bainbridge, Mid western mental health services, Ennis Day Hospital, Ennis, Co Clare; Dr Brian Hallahan, National University of Ireland, Galway; Mr David McGuinness, National University of Ireland, Galway; Prof Agnes Higgins, Trinity College Dublin; Prof Kathy Murphy, National University of Ireland Galway; Prof Colm McDonald, National University of Ireland, Galway

Objective/Aims
In individuals detained involuntarily in three acute psychiatric inpatient units, levels of insight, perceived coercion, attitudes towards involuntary admission, treatment and fairness of involuntary admission were assessed on admission and three months following revocation of their involuntary admission order.

Methods
Three hundred and ninety one consecutively involuntarily detained patients over a 30 month period were invited to participate. Demographic and clinical data collected included Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-1), Brief Psychiatric Rating Scale (BPRS), Scale for Assessment of Insight in Psychosis (SAI-E), Client Assessment of Treatment (CAT), Global Assessment of Functioning (GAF), Hogan Drug Attitude Inventory (HDAI), MacArthur Admission Interview, Heinrichs Quality of Life (QOL).

Results
Of the two hundred and sixty three individuals who participated at baseline, one-hundred and fifty six (59%) completed follow-up. The most common Axis I diagnoses was schizophrenia (n=47, 30%) followed by bipolar affective disorder (n=46, 29.5%). Significant improvements in BPRS (p
53. "Breaking down the Barriers" A pilot study of mental health crisis care teaching for emergency medicine and psychiatry doctors

Dr Lindsay Banham, North East London NHS Foundation Trust; Dr Tom Stockmann, North East London NHS Foundation Trust; Dr Matthew Slinger, North East London NHS Foundation Trust; Dr Flavia Napoletano, North East London NHS Foundation Trust; Dr Agnieszka Strzelczak, North East London NHS Foundation Trust

Aims and Hypothesis
This pilot aimed to increase the confidence of Emergency Medicine (EM) and psychiatric doctors in treating patients in mental health crisis. It was hypothesised that training would improve confidence for both groups.

Background
This pilot was part of the University College London Partners (UCLP) Breaking down the Barriers (BDTB) project, which aims to improve mental health crisis care by encouraging multidisciplinary working and enhancing knowledge in front-line clinicians.

Methods
Eight psychiatry and eleven EM doctors took part in the pilot session which included one 45 minute simulation (using a trained actor) and two 22.5 minute case-based discussions (CBDs). Topics covered were self-harm, risk assessment, psychosis, personality difficulties and differentiating physical and mental disorder. Participants were divided into two mixed-specialty groups. Each group was facilitated by two consultant psychiatrists and completed both simulation and CBDs.

Pre and post-session surveys allowed participants to rate their confidence in each subject area; comment on scenario difficulty, realism and relevance; and reflect on any change in attitude towards people with mental health problems and on whether the session might change the way they work with other disciplines.

Participants confidence ratings were assigned a numerical value (poor=1, moderate=2, good=3, excellent=4). Mean scores before and after training and mean change in scores were calculated.

Results
Pre-training, psychiatry doctors were more confident across all competences (mean score 2.42 vs 2.22). Mean confidence improved for both groups, though EM doctors gained more (0.84 vs 0.57). After training, psychiatric trainees remained slightly more confident (3.00 vs 2.93). Free-text feedback revealed perceived benefit, improved understanding of the other teams role and improved attitude to patients with mental health problems.

Conclusion
An improvement in confidence was seen across competences for both groups. Multidisciplinary training using case-based discussion and simulation may be useful and effective for teaching crisis mental healthcare.

Financial Sponsorship
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54. Psyched Up for Medical School- a work experience scheme

Dr Sophie Behrman, Oxford Health NHS Foundation Trust

Aims:
- To provide work experience in Psychiatry for students applying to medical school
- To promote careers in psychiatry
- To address stigma towards mental illness amongst 16-19 yr olds
- To provide novel management and mentoring opportunities for junior doctors
- To evaluate the efficacy of the scheme in meeting the above aims.

Background:
Students applying to medical school complain of a lack of opportunities for relevant and interesting work experience. Mental Health Trusts offer very few work experience placements. Stigma towards mental illness is particularly rife amongst 16-19yr olds.
Methods:
We offer a week of work experience in psychiatry to 17+yr olds applying to medical school. Doctors (from F1 to Consultant) supervise and mentor the students in a variety of placements. The students also have opportunities to present cases, reflect, and learning about research. We have run 3 iterations of the scheme, supporting 51 students across two counties. Students are encouraged to become Mental Health Ambassadors following the scheme by involving themselves in local mental health initiatives, with support from the scheme providers.

Qualitative and quantitative feedback is collected at the end of each scheme evaluating changes in attitudes towards psychiatry and mental health and perceived pros and cons of careers in psychiatry.

Results:
Of the last cohort (13 students), 100% report they are more likely to consider a career in psychiatry following the programme. 100% feel they better understand mental illness. Themes in feedback from students include mental health conditions not being as scary as they expected, positive experiences of psychiatrists working in teams and an enthusiasm for the complexity and breadth of patients presenting to Mental Health Services. Doctors report generally positive experiences with the students and, in particular the more junior doctors relish the opportunity to develop mentoring and supervision skills.

Conclusion:
Preliminary results suggest the scheme is successful locally and we are keen to support others across the country running similar schemes.

55. Survey on development of Ageless (Age Inclusive or Age Blind) Mental Health Services in Wales
Dr Patrick Briggs, Cefn Coed Hospital, Swansea; Dr Sajitha Koratala, Royal Glamorgan Hospital, Llantrisant. Cwm Taff UHB;

Background
In recent years, the Department of Health has called health providers across the country to commit to providing an Ageless mental health service. The Royal college of Psychiatrist opposed this proposal citing concerns about the compromise to the quality of care provided to older people and the degradation of mental health services.

Aims
To explore the views of psychiatrist in relation to implementation of Ageless mental health services in Wales

Methods
We carried out a cross sectional survey using an Online structured questionnaire format. This was sent to Psychiatrists working in NHS Wales (Consultants, Associate specialist/ Speciality doctors and ST4- 6). Responses were analysed using quantitative and qualitative approach.

Results
Majority of the respondents were consultant psychiatrists who felt the most appropriate criteria for transition of patients from general adult to old age services should be presence of mental disorder and frailty or people with psychological and social difficulties relating to the aging process. More than 80% of responders agreed that old age psychiatry services are specifically designed, trained and skilled, hence should be the vehicle for provision of age appropriate services for older population. Majority of responders felt that there will be an increase in the work load on General Adult services.

Common emerging themes includes lack of clarity of criteria for acceptance into old age services, and the necessity for designing services to be needs led. Respondents raised concerns about the possible delays of clients receiving appropriate care and Primary Mental Health Support Services are under resourced to meet the needs of the aging population.

Conclusion
This survey highlights that implementation of Ageless mental health services are likely to pose a significant challenge on service provision across the Wales. This supports the Needs led criteria as put forward by the Old Age Faculty of the Royal College and in favour of Royal College decision to halt ageless services.

56. Repeated Ketamine Infusions in Treatment-Resistant Depression: A Case-Series of Patients from the Newcastle Regional Affective Disorders Service (RADS)

Dr Mahathir Chan, Crisis Resolution Team, West Park Hospital, Darlington; Dr Stuart Watson, Wolfson Research Centre, Campus for Ageing and Vitality; Dr Hamish McAllister-Williams, Regional Affective Disorders Service, Newcastle

Aims
We aim to provide a narrative of our first two patients who received ketamine treatment. We considered challenges faced in implementing and delivering this service, and to identify barriers and facilitators to change.

Background
Research studies have shown that a sustained period of mood response and remission can be achieved with serialised ketamine treatment. With growing evidence, there is interest in incorporating ketamine treatment into clinical practice. The RADS in Newcastle is collaborating with the secondary NHS Physical Treatment Centre (PTC) in delivering intravenous ketamine to patients with treatment-resistant depression.

Methods/ Service Set-up
Ketamine treatment was deemed appropriate for capacitous patients of 18 years and above with a diagnosis of treatment-resistant depression. We elected to administer intravenous ketamine at a dose of 0.5mg/kg over 40 minutes. We anticipated that, barring significant side effects, patients would initially receive three infusions and a subsequent review allowed ongoing infusion with scope for treatment adjustment. PTC provided the necessary facilities and treatment was given the same day as twice weekly ECT.

Results
Patient A experienced side-effects during her initial three infusions which included dissociative symptoms, numbness to face and legs, and transient abdominal discomfort. Her infusion duration was increased to 60 minutes and resulted in her better tolerating subsequent infusions. She reported improvement to mood symptoms lasting up to 36 hours after each treatment. Patient B tolerated all his infusions and denied significant side-effects. He reported both subjective and objective mood improvement lasting up to a 48-hour period following each of his infusions.

Conclusions
There is difference in patient tolerability to ketamine, with identified scope to tailor dosing, infusion rates and treatment frequency. We looked at the role of dissociative effects and whether this is necessary for mood response. The period following treatment response provides a window of opportunity to utilise other interventions, i.e. psychological or social-based interventions. We addressed translational issues from research-based evidence into routine clinical practice. It is proposed that ketamine treatment would become a core service alongside ECT with identified need for further role development and training.

57. Paliperidone palmitate, risperidone long-acting injection and zuclopenthixol decanoate in clinical practice: an 18 month comparison.

Dr Matthew Cordiner, NHS Lanarkshire; Dr Matthew Cordiner, NHS Lanarkshire; Dr Polash Shajahan, NHS Lanarkshire; Dr Sarah McAvoy, NHS Lanarkshire; Dr Muhammad Bashir; Dr Mark Taylor NHS Lothian, Psychiatry Consultant

Aims and hypothesis;
To measure clinical effectiveness of Long-Acting Antipsychotics (LAIs) by determining discontinuation rates and Clinical Global Impression (CGI) outcomes. Hypothesis of no difference between LAIs. Secondly, to determine effects of antipsychotic polypharmacy, hypothesis being polypharmacy would be associated with poorer outcomes.

Background;
Increasing number of LAIs available for prescription, few guidelines or head-to-head trials available. Antipsychotic polypharmacy is common, controversial and potentially dangerous, we sought to discern differences in outcomes for patients exposed to polypharmacy.

Methods;
Retrospective, naturalistic, observational study. Electronic document system for our health board, NHS Lanarkshire, searched for patients prescribed one of three commonly used LAIs (paliperidone palmitate (PP), risperidone long-acting injection (RLAI) and zuclopenthixol decanoate(ZD)). Permission granted from Caldicott Guardian and study registered with local Clinical Quality Department. Only LAI naive patients included. Records with insufficient information excluded. Demographic and clinical details included Clinical Global Impression (CGI)(severity and improvement) at start and end of treatment (either 18 months or drug discontinuation). As markers of clinical effectiveness, discontinuation rates, reasons, and hospitalisation examined using Kaplan-Meier and Hazard-Ratio statistics.

Results;
238 patients eligible: PP (n=31), RLAI (n=102), ZD (n=105). ZD patients associated with being significantly older, having lower rates of alcohol and substance misuse and higher co-prescription of oral antipsychotics. Most patients showed CGI improvement, PP=61%, RLAI=72%, ZD=76%. PP showed significantly poorer outcomes for time to all cause discontinuation, discontinuation due to inefficacy and hospitalisation. LAIs with antipsychotic polypharmacy showed lower any cause discontinuation rates, most notable for zuclopenthixol for any cause discontinuation and adverse effect discontinuation.

Conclusions;
Discontinuation due to any cause, inefficacy and psychiatric hospitalisation highest for paliperidone - also associated with smallest proportion of patients assigned desirable CGI improvement scores. LAIs prescribed with additional antipsychotics had a generally favourable discontinuation outcome.

Funding: Nil

58. A Trust-wide Audit of Rapid Tranquilisation procedures in adult inpatient wards at Lancashire Care NHS Foundation Trust (LCFT)

Dr Vaishali Damle, at Lancashire Care NHS Foundation Trust (LCFT); Dr Ranji Thomas, Lancashire Care NHS Foundation Trust (LCFT); Dr Mrithyunjay Kumar, Lancashire Care NHS Foundation Trust (LCFT)

Aim: To establish if the trust standard operating procedure (SOP) for rapid tranquilisation (RT) was followed in adult inpatient wards.

Background: The trust SOP for RT recommends recording physical examination, vital signs, ECG and effective use of de-escalation techniques before administering RT and robust monitoring of vitals after RT. Patient should be offered a debrief after RT. The audit was undertaken as few instances of non-adherence to SOP were reported to authors.

Methods: Data was collected from 49 patients admitted to 4 wards at one inpatient site in 2014. Data was collected over a 2 week period using the prescription charts and electronic records. In 2015, we re-audited the practice across all adult inpatient wards in the trust including the original site and a total of 180 patients were included.

Results: The physical examination, vitals and ECG before administration of RT were recorded in more than 90% patients in both audits.

In the initial audit (2014) 14% of the patients had clear documentation of de-escalation methods before RT, 8% were offered debrief and 10% had monitoring of vitals following RT. Majority (96%) had oral Lorazepam. The results were disseminated to all nursing and medical staff. The re-audit (2015) showed slight improvement in documentation of de-escalation (35% vs 14%). Only 3% were offered debrief and 7% had vitals monitored after RT. 86% had oral Lorazepam. All 13 patients who received intramuscular RT had vitals monitored after RT.

Conclusion: Our practice in terms of documentation required prior to RT is excellent. A positive change in service delivery in terms of using non-pharmacological interventions before RT was noted during re-audit. Monitoring after intramuscular RT is excellent but remains poor with oral
It is possible that oral lorazepam may have been used in some cases as an anxiolytic rather than RT. A re-audit with emphasis on exploration of the reasons for oral lorazepam administration is recommended following trust-wide dissemination of results.

59. Development of Peer Mentoring Scheme for Core Trainees in Psychiatry in Mersey Deanery.
Dr Isabelle Eardley, 5 Boroughs NHS Foundation Partnership; Dr Manoj Agarwal, Head of School of Psychiatry Mersey Deanery

Aims
Appraisal of the development of the peer mentoring scheme
The aim of the scheme was for C1s in psychiatry to be able to learn from more experienced colleagues who have recently experienced similar hurdles as the Ct1.
For more experienced core trainees to acquire experience in mentoring and supporting junior colleagues.

Background
There is an issue with recruitment and retention to psychiatric training posts nationally but also within the Mersey deanery.
Psychiatry trainees are often quite isolated in their work place and therefore the opportunities for informal peer mentoring which often happens in bigger specialities is lost. This can leave the trainee feeling isolated and struggling to know what they need to do. Potentially this is contributing to some of the retention problems.

There was a similar scheme pairing core trainees in Mersey Deanery with Liverpool and Lancaster medical undergraduate students who are interested in perusing a career in psychiatry which proved very successful.

Methods.
A peer mentoring scheme pairing Ct2/3 trainees with Ct1 trainees was implemented and a survey was completed of trainees pre and post implementation of scheme to evaluate benefits and scope for improvement.

Results.
20 Mentorship pairs in the first 2 years of the programme.
The survey results show that on average the mentors rated the scheme as 6.4 out of 10 and the mentees on average rated the scheme as 7 out of 10 (with 10 being most useful). The survey revealed many positive comments and suggestions for improvements.

Conclusions.
Several Ct1 mentees have gone on to become mentors.
Feedback from the survey re the scheme is generally positive.
Scheme is now in its 3rd year.
As the scheme is relatively unique in psychiatry we hope that other deaneries can learn from our results and promote it locally.

60. Case Report: Overlap between Acute Porphyria and Paranoid Schizophrenia
Dr Natasha Gupta, Surrey & Borders Partnership NHS Foundation trust; Dr Ayo Sangokunle, Surrey & Borders Partnership NHS Foundation trust; Dr Jeremy Mudunkotuwe, Surrey & Borders Partnership NHS Foundation trust

Aim: To present a case with a diagnosis of paranoid schizophrenia and variegate porphyria as acute porphyria can present with neuropsychiatry symptoms in 19% to 58% patients. Due to rare presentation of this illness these symptoms may be diagnosed as primary presentation of paranoid schizophrenia and other mental illnesses.

Background: Acute porphyria comprise a group of four disorders of autosomal dominant inheritance of which acute intermittent porphyria (AIP) is the commonest type. The prevalence is reported to be as high as 210 in 100,000 in the psychiatric population. They are classically described as a triad of abdominal pain (seen in 90%), peripheral neuropathy, and neuropsychiatric disturbance which can range from depression, anxiety, delusions and hallucinations.
Methods: Case discussion of our patient who is 49 years old lady known to psychiatry for 21 years. She was admitted recently following paranoid and persecutory delusions and had no insight into her mental illness. She was first diagnosed with variegate porphyria at the age of 25 after she presented with abdominal symptoms and skin eruptions. Three years later she presented with paranoid thoughts. Her porphyrin levels were noted to be high so she was treated for porphyria and psychosis. She had repeated admissions to psychiatry units following this psychotic episode and was treated with different anti-psychotics. We managed her on Haloperidol depot which is considered safe in porphyria.

Results: Porphyria is diagnosed by appearance of abnormal porphyrin related chemicals in the blood and urine. In some of these admissions her porphyrin levels were raised.

Conclusion: AIP is a rare but important metabolic disease with psychosomatic components, the diagnosis of which is often delayed or missed due to its rarity and the variable nature of its presentation. So a clinician needs to have high index of suspicion especially in patients presenting with above clinical symptoms and precipitating factors in order to exclude this diagnosis.

61. An evaluation of the standard of completion of an initial assessment proforma for new patient referrals to the Assessment and Immediate Care Service in Mersey Care NHS Trust

Dr Declan Hyland, Clock View Hospital, Liverpool, Mersey Care NHS Trust; Dr Hannah Ruth, Clock View Hospital, Liverpool, Mersey Care NHS Trust

AIMS AND HYPOTHESIS
To establish how thoroughly the initial assessment proforma used for patients referred to the Assessment and Immediate Care Service is being completed and whether there were any sections that are recurrently not being completed.

BACKGROUND
The Assessment and Immediate Care Service was established in December 2014 to centralise all referrals to mental health services in Sefton, Kirkby and North Liverpool. Most assessments are conducted by Mental Health Practitioners and Trainee Advanced Nurse Practitioners under medical supervision. More complex assessments are conducted by a medic.

METHODS
All new patient assessments conducted from 1st of December 2014 to 31st of January 2015 were identified. 50 assessments were then randomly selected from this sample. The assessment proforma for each patient was scrutinised to establish whether each section was completed and, for those sections being qualitatively assessed, the quality of completion was identified as inadequate, adequate or comprehensive. All of the assessments were analysed by the same investigator.

RESULTS
21 of the 50 patients were male, 29 were female. The age of patients ranged from 18 to 70-years-old. 33 of the 50 assessments were conducted by Mental Health Practitioners, 15 by Trainee Advanced Nurse Practitioners and 2 by a Consultant Psychiatrist. The rate of completion was at least 80% for the following sections of the assessment proforma: reason for referral, presenting complaint, activities of daily living, past medical history, current medications, family history, forensic history and premorbid personality. The quality of documentation of: history of presenting complaint, past psychiatric history, personal history, social history, substance use history, mental state examination, diagnosis / formulation, management plan, risk assessment and risk management plan was variable.

CONCLUSIONS
Evaluation of this sample of initial assessment proformas highlighted the need for the Mental Health Practitioners to be provided with teaching on history taking, mental state examination and formulation. Following this evaluation, all Practitioners were provided with a template to use when performing an initial assessment of any patient referred to the service. Use of this template, the delivery of appropriate training and closer medical supervision should improve the quality of assessments completed in the future.

62. Complete Audit Cycle : Prescribing for people with Personality Disorder
Aims:
The Prescribing Observatory for Mental Health-UK (POMH-UK) has commissioned national audits into the prescribing practice for people with Personality Disorder. The data presented in this poster is from a re-audit prescribing for people with a personality disorder which was actioned by POMH. The audit was conducted in 2012 followed by re-audit in July 2014 completing the audit cycle.

Method:
A total of 51 mental health trusts participated in the re-audit, one of which was Southwest London and St George's NHS Mental Health Trust.

11 teams (In-patient, CMHT, Home Treatment Team, Eating Disorders Team) from SWLSTG participated by collecting data for 177 patients. Most participants were White British Females with age range of 26-35y, majority were from General Adult Out-patient with diagnosis of EUPD and most co-morbid illness was Mood Disorders.

The following data were collected:
- Demographic, diagnosis, type of service
- Antipsychotic(s), z-hypnotics and benzodiazepine prescribed, and their duration
- Clinical indications
- Other medicines prescribed
- Information about medication review
- Collaborative crisis planning

Results:
Our Trust performed very well achieving above average results on Clinical and Treatment Standards set for the audit.

1. In less than 80% of the patients on antipsychotics the clinical reasons for prescribing the most recently initiated antipsychotic were documented in the trust sample (fully or partially). The results were slightly better than TNS.
2. 90% of patients had crisis plan where 58% showed evidence of collaborative work with the patient in comparison to TNS where the total figure was 80%.
3. 40% patients with a diagnosis of personality disorder under our trust were on antipsychotic medication. The figure was slightly better when compared to TNS which was around 48%.
4. Z-Hypnotics were prescribed in less than 20% cases by out trust which matched TNS results.
5. Proportion of patients with a PD diagnosis prescribed benzodiazepines was less than 20% whereby in the TNS it was slightly above 20%.
6. Review of medication prescribed for more than four weeks was around 70% mark at the Trust and National level.

Recommendations:
An Action plan was formulated following discussions with clinicians.

63. Telepsychiatry in Perinatal Mental health - A Re-audit
Dr Qurat Khurram, Melbury Lodge, Winchester; Dr Foluke Odeyale, St Marys Hospital Campus, Solent NHS Trust; Dr Eleanor Clark, Melbury Lodge, Winchester

Aims:
To compare current practice in the Telephone clinic to guidelines set out for the clinic in 2004 and further recommendations made in previous audit in 2011.

Background: This re-audit was carried out in community perinatal mental health team, Melbury Lodge, Winchester. It’s is a small team, covering a wide geographical area and as such has to prioritise its time. Telephone clinics were introduced in 2004 as a means of cutting waiting times and increasing team productivity. This entailed brief specialised telephone assessment and advice, with short summary letter.

Methods: Reaudit was carried out between June 21st to July 21st. 50 patients referred to the telephone clinic in March- April 2014 were randomly selected. Electronic records were checked for
information from referral to point of discharge. Standards from 2010 used. Using designed questionnaires, current practice were compared against guidelines and recommendations from previous audits. Survey questionnaires were sent out to referring professionals and patients from the clinic to investigate their overall satisfaction with the clinic.

Results: Standards were not being met in number of calls to make contact, time from allocation to assessment, patient contactability, sending of summary letters to patients. 22% of patients were requiring face to face after telephone. Time from allocation to contact < 3 weeks in 85% of cases. 24% patients were un-contactable. Rates of re-referrals have gone up 10 times in the last 4 years (from 2% in 2011 to 20% in 2014). Referrals to the clinic were appropriate in 92% of referrals.

Recommendations/Conclusion: Identified reasons for non compliance were increased referrals to the clinic with no concordance increase in staff; contact information might not be up to date. Suggestions made for team to review existing standards to improve achievable compliance. Amendments in referral templates for the telephone clinic was developed.

64. Audit of leave procedures (informal V detained patients)
Dr Swapna Kongara

Aims:
- To audit the leave procedures for inpatients
- Identify (if there is any) difference in practice between informal and detained patients
- Make recommendations to improve practice
- Re-audit to identify if practice improved

Background: In the case of Rabone v Pennine Care Trust (2012), the Supreme Court judgment outlined the duty of NHS to protect mental health patients against the risk of suicide and that there is no practical or legal distinction between informal and detained patients. This responsibility to take adequate steps to protect the lives of patients whether informal or detained, has implications for planning and implementing leave

Method: A retrospective case note review was done to evaluate the leave procedures for patients who went on home-leave during a 2-month period. Standards outlined in Trust policy for section-17 leave and standards agreed in liaison with the ward manager for informal patients leave were used.

Aspects audited included; planning /granting leave as Multi-Disciplinary Team (MDT) decision, considering family/carers views regarding leave, thorough documentation of risk assessment, obtaining feedback from patient/family following leave etc

8 patients had home leave during initial audit (4 informal and 4 detained); 5 patients had home leave during re-audit (3 informal, 2 detained)

Results: In the initial audit, leave was planned as MDT decision and risk assessment was well documented in 6 out of 8 patients; family was not consulted prior to leave in any of the 8 patients; family feedback following leave was obtained for only 1 patient. The failure of adherence was noted more in informal patients. Brief staff survey outlined their disinclination towards informal patients leave procedures as they were perceived to be in contention with the Human Rights of informal patients. Audit recommendations included staff education regarding above Supreme Court Judgment.

Re-audit showed improvement in all areas; 80% adherence noted in risk assessment, 60% adherence noted in involving family/carers in leave process

Conclusion: It is important for professionals to be aware of the implications of the above Supreme Court Judgment when planning and implementing leave for patients

65. Audit of the quality of medical recommendations for compulsory hospital admissions (Section 2 and 3 of Mental Health Act)
Dr Sajitha Koratala, Cwm Taf University Health Board; Dr Adarsh Shetty, Cwm Taf University Health Board; Dr Bhushan Vaidya, Cwm Taf University Health Board
Background
Mental Health Act 1983 (as amended) prescribes roles, duties and powers that allow hospital detention. Usually two Doctors (one section 12 approved) are required to satisfy that a patient meets legal criteria, and give reasons in their recommendations.

Aim
Audit the quality of medical recommendations for detention under Section 2 and Section 3 using the gold standard statutory criteria as set out in the Mental Health Act.

Methods
Section 2 and 3 recommendations between November 2014 to January 2015 in Cwm Taf health board were reviewed by three section 12 approved clinicians. In total 113 recommendations were studied, of which 108 were single recommendations.

Results
The description of the presence of a mental disorder was explicit in 76% of the recommendations and implied in 16%. There was no documentation in 8% of cases. The description of the nature and/or degree of the mental disorder was explicit in 85% and implied in 15% of recommendations. Reasoning substantiating that detention was in the interest of the patients health, safety, or for the protection of others was explicit in 70% and implied in 20%. No reasoning was provided in 10%. Documentation of reasoning for 24-hour hospital detention was missing in 43%, with only 36% providing explicit reasons and implied in 21%. Justification of why not informal admission was explicit in 45%, Implied in 36%, none was given in 19%.

Conclusions
Results are comparable to other studies, in this area. Overall the written recommendations were consistent in documenting the mental disorder, its nature and/or degree. However, there is significant room for improvement in documentation supporting the rest of the statutory criteria.

In order to improve our practise, we disseminated these results and worked on improving doctors understanding and documentation of statutory criteria. We devised and recommended the use of an aide-memoire, suggested scrutinisers to return forms for amendment and encouraged doctors to discuss relevant issues in local forum. We intend to re-audit in September 2015.

66. PROMOTING POSITIVE ATTITUDES TOWARDS PATIENTS WITH MENTAL HEALTH NEEDS USING INTERPROFESSIONAL SIMULATION
Dr Christopher Kowalski, Maudsley Simulation, South London and Maudsley NHS Foundation Trust; Dr Angharad Piette, South London and Maudsley NHS Foundation Trust; Dr Catherine Wilson, South London and Maudsley NHS Foundation Trust; Dr Rosemary A Humphreys, South London and Maudsley NHS Foundation Trust; Dr Fernando South London and Maudsley NHS Foundation Trust, Higher Psychiatric Trainee

Aims
To assess the ability of interprofessional simulation (IPS) to alter healthcare professionals attitudes towards patients with mental health needs, and establish the educational mechanisms for achieving this.

Background
We have developed a number of IPS courses for staff from mental health, acute, primary and social care settings. The primary aim of these is to improve skills, knowledge and confidence in assessing and managing patients with mental health needs. After initial pilots, and a review of the literature, it became apparent that it was necessary to address stigma and negative attitudes in participants at the time of course delivery. We examined the mechanisms by which attitudinal change might be achieved and assessed our courses ability to achieve this outcome.

Methods
Through observation and critical reflection, we modified our scenarios and debrief techniques in order to deliberately effect positive attitudinal change. We adopted a mixed methods approach to measuring this. This included: qualitative data from live debriefs, focus groups and questionnaires; and pre- and post-course Likert scales. Data was analysed using statistical methods and content analysis.
Results
We have achieved statistically significant shifts towards more positive attitudes in relation to patients with mental health needs (n=143). Qualitative data demonstrates greater understanding of and compassion for this group. Participants also demonstrated better recognition of their professional roles and responsibilities towards them.

From the data collected, important mediators in promoting attitudinal change appear to be: affective activation, enhancing participants mentalising ability, making links between patients past history and current presentation, and challenging the use of stigmatizing language.

Conclusion
Our findings show that IPS can be used to achieve positive attitudinal change towards patients with mental health needs. Certain elements of scenario design and debrief methods are important in achieving this goal. These need further exploration.

Measuring attitudinal change comes with particular difficulties. Any change achieved via simulation may not translate into the clinical arena. Analysis of participants subsequent behaviours is required. Encouragingly, our findings suggest that participants intend to adopt a more caring and compassionate stance in the future.

67. Audit of Implementation of Nicotine Management and Replacement Therapy in Ribble ward (GA female Acute Psychiatric Ward)
Dr Maryam Manzoor; Dr Anand Pillai; Dr Ranji Thomas

Aims:
To find out whether Ribble ward was complying with the Trusts Nicotine Management and Replacement Policy as our crude observation was contrary to above. We wanted to identify the areas and reasons of poor compliance to improve our clinical practice and patient care.

Background Information:
The policy came into effect on 05/01/15 and according to policy statement, it came into effect to comply with the law and follow the NICE guidance. It also has significant health benefits to the service users and the Trusts staff as smoking is largest single cause of premature deaths and preventable ill-health in England.

Method:
All admissions in the month of June 2015 were identified and data was collected prospectively by reviewing the electronic records and by random staff questionnaires.

Results:
Random staff questionnaires identified significant breaches to the expectation of the policy as only 50% of the staff had read the Trusts Nicotine management policy, only 44% had completed the online face to face mandatory training, 39% were not aware of the designated smoking champion in their locality, 85% were not filling any Datix forms if they witnessed a patient smoking in Trusts premises and patients concerns were largely ignored.

Audit of patients records also identified significant breaches from the policy statement. 50% of the records did not have any information about the tobacco use. Only 15% of the gate keeping assessments made a comment about service users smoking status. Only in 9% of the cases, discussion took place about no smoking status of trust. Unfortunately 0% records indicate patients views about smoking cessation. Overall, very poor results highlighted in terms of offering the patient nicotine replacement and increased number of incidence recorded.

Conclusions:
Lack of clarity on practical issues, increases the overall hopelessness and helplessness amongst staff on how to deal with such situations, leading to less frequent reports, records and Datix which is again a breach of GMC guidance on good medical practice.

There is also an overall increase in the passive smoking by professionals working within the ward.
68. Audit of Adult Safeguarding Documentation
Dr Rachel McKie, Bradford District Care NHS Foundation Trust/ Leeds and York Partnership NHS Foundation Trust

Safeguarding adults is a key responsibility of healthcare staff and this is emphasized in the Care Act 2014. All clinicians should receive Safeguarding training and be aware of their duties. After Safeguarding issues have been identified, communicating salient information to relevant professionals is an essential aspect of good quality care. This communication is often via documentation in case notes.

In December 2014 an audit was completed at Leeds and York Partnership NHS Foundation Trust; the audit considered the quality of documentation of adult safeguarding information in clinical records.

The aim was to ascertain if not only local policies and procedures, but also national standards for good quality documentation, were being adhered to. This was the first audit of this nature at the Trust.

Electronic clinical case records were used as the source of data. Sequential case records were scrutinised for the quality of documentation with regard to the following: accessibility, completeness, timeliness, and risk management. A comprehensive safeguarding database is held by a dedicated adult safeguarding team; this was regarded as the reference point for each of the areas under consideration.

Results showed that in 63% cases, and entry was made into the records at the time an adult safeguarding referral was made, and a risk management tool was completed on 84% occasions. The most significant problem areas were the accessibility of information and the accuracy of documentation of protection plans. Safeguarding information was being entered in a variety of different sections of the notes making it time-consuming to locate. In 50% cases, the protection plans were only partially concordant between the case records and the safeguarding database. Recommendations were made to implement a policy of documenting adult safeguarding information in a specifically created box on the electronic records system, and to grant access to the electronic records system to designated Safeguarding Co-ordinators, to enable comprehensive documentation of protection plans. Additionally, the findings of the audit were widely distributed and the importance of good quality documentation highlighted. We plan to repeat the audit in April 2016.

69. Counting the pennies: Prescribing For Sustainability, a A2i Experience.
Dr Foluke Odeyale, St Mary’s Hospital Slent NHS Trust; Dr Ian, St Marys Hospital Campus, Solent NHS Trust

Aims-To investigate whether there is any cost implications associated with medical interventions received by referrals to Access Team in Solent Health NHS Trust.

Methods: Referrals to the service were selected for review by medical members of the service based on appropriateness of referrals; medication information on letters of referral; Patients difficulties/reason for referrals. Interventions offered by medics included medication review /advice; outpatient reviews. Using the British National Formulary, the cost of prescribed medications before and after medical interventions was calculated to determine if costs had changed.

Results: Between 1st April to 30th April 2015, 126 referrals were received. 50 of which were males and females 76. From the referrals, medication information was available for 110 patients; 91 patients were on antidepressants, 20 on antipsychotics, 10 were on other medications while 8 were on no medications. Medication reviews were provided to 64 patients. For these, 6 patients (9%) incurred an increase in cost on discharge; 3 (5%) had decreased costs and 55 (86%) had no changes in costs. Overall, no increased costs incurred for 58 patients (91%) who were referred.

Conclusions: Utilising available resources within the patient, team and the mental health service wisely has potential to lead to a sustainable health service. Giving careful thought and care to prescribing, 91% of medical interventions did not result in increased costs. Within a health service that needs to make efficiency savings, medics can make useful contributions to this goal through prescribing for sustainability.
SIMULATION TRAINING FOR COMMUNITY MENTAL HEALTH TEAMS
Dr Angharad Piette, Maudsley Simulation, South London and Maudsley NHS Foundation Trust; 
Dr Christopher Kowalski, South London and Maudsley NHS Foundation Trust; Dr Rosemary A Humphreys, South London and Maudsley NHS Foundation Trust

Aims
To design, implement and evaluate three different interprofessional simulation courses for community mental health teams (CMHTs).

Background
Simulation training has been widely used in acute medical specialties. More recently, it has been used in mental health particularly in the context of interprofessional education. There is evidence that simulation is effective in improving knowledge, skills and team-working. This is of particular relevance for CMHTs. By evoking situations close to clinical practice, but without exposing staff to real patients or services to disruption, simulation is well placed to tackle issues arising from service reconfigurations, as well as everyday clinical matters.

Methods
Three one-day interprofessional simulation courses were developed for CMHTs. Each focused on a unique area: mental state examination, working with families and networks, and triage and assessment skills.

A primary learning objective was to enhance participants understanding of human factors, with the aim of improving communication and team-working both within the multiprofessional team and with other agencies.

A mixed methods approach to evaluation was used. This included pre- and post-course questionnaires and written feedback. 9 participants were purposively selected to take part in semi-structured interviews 12 weeks after each course. Transcripts were independently reviewed and thematic analysis used to generate salient themes.

Results
All courses demonstrated statistically significant increases in knowledge and confidence with large effect sizes. Qualitative feedback was positive overall with participants particularly valuing the engaging and learner-led nature of simulation.

Qualitative themes from the interviews were: valuing the opportunity to reflect on clinical practice and to learn clinical skills from colleagues, enhanced appreciation of the patient perspective, improved awareness of the perspective of other professionals, and the importance of reflective space to improve staff well-being and morale. All three courses were integrated as mandatory training after successful pilots.

Conclusion
Simulation offers a unique opportunity to promote team-working and interprofessional collaboration in CMHTs. Participants also demonstrate improved knowledge and confidence in their clinical skills. Embedding this way of learning into existing educational strategies may be key in supporting teams under strain or undergoing service change.

71. Comparing short-term risk of repeat self-harm after psychosocial assessment of self-harm patients by psychiatrists or psychiatric nurses in emergency departments:
Dr Alexandra Pitman, UCL Division of Psychiatry; Ms Deborah Casey, University of Oxford; Dr Galit Geulayov, University of Oxford; Ms Fiona Brand, John Radcliffe Hospital; Dr Holmes University of Oxford, Psychiatry Consultant; Hawton Psychiatry Consultant Researcher

Aims and hypothesis: We aimed to test the hypothesis that short-term risk of self-harm repetition among those receiving a psychosocial assessment for self-harm would be lower in patients assessed by a psychiatric nurse than in those assessed by a psychiatrist, and that any difference would be only partly explained by a reduced tendency of psychiatrists to utilise community resources.
Background: There is mixed evidence for the therapeutic effect of psychosocial assessment in relation to risk of repeat self-harm. One explanation not yet explored is the impact of the professional background of the assessor. NICE guidelines provide little guidance on the therapeutic components of a psychosocial assessment. Differences in training and professional orientation of assessors are likely to give rise to heterogeneity in outcomes due to variability in therapist style.

Methods: Using data from the Oxford Monitoring System for Self-harm for the period 2000-2011, we compared repetition of self-harm in patients who were assessed by a psychiatrist at their first emergency department presentation for self-harm with those assessed by a psychiatric nurse. During the study period there were 10,290 patients, and 21,035 self-harm presentations. We used Cox regression for our primary outcome: time to repeat self-harm within 12 months. We used zero-inflated Poisson regression for our three secondary outcomes: number of repeat presentations within 3, 6, and 12 months of the index presentation. Models were adjusted for age, gender, method, past psychiatric history, recent use of alcohol, resulting admission (as a marker of severity), previous presentation to another hospital, and year of presentation.

Results: We found no difference in short-term risk of self-harm repetition between patients who were initially assessed by a psychiatrist or by a psychiatric nurse.

Conclusion: The short-term risk of repeat self-harm after psychosocial assessment for an index presentation of self-harm did not differ by professional background of the assessor. Further research into variables describing the content of assessments, and of the role of the professional in the process and outcome of treatment (therapeutic alliance, adherence, and competence) will help delineate aspects of the psychosocial assessment with a therapeutic effect.

72. Service user integrated teaching groups- A novel approach to medical education
Dr Gaelle Slater, Sheffield health and social care trust; Dr Helen Crimlisk, Sheffield health and social care trust

The University of Sheffield offers all third year medical students an integrated learning activity masterclass. Topics include a variety of options that are outside of the usual scope of the undergraduate medical curriculum. These experiences give students a chance to broaden their knowledge and explore areas of medicine that would not otherwise be available to them. This year we have introduced a new psychiatry based ILA to improve student interest and understanding of the field of psychiatry by exploration of the recovery model through storying. Students learn how the past histories of service users can be used as a tool in recovery and the therapeutic importance of developing a narrative story to voice an individual's experiences of mental illness.

The teaching was designed and facilitated by 2 service users (experienced in leading therapeutic groups) and a higher psychiatry trainee. The project was overseen by a consultant psychiatrist.

Unlike existing medical student teaching the storying masterclass integrated service users at different stages in their own recovery into the group as active participants. 5 service users and 8 students worked together to complete a 6 week therapeutic course involving group work, interactive activities, home work tasks and expert speakers. The groups worked towards presenting individual creative projects about their own stories.

This approach to medical education gave students a unique insight into the process of a recovery storying group and allowed them to explore the real life stories of mental health service users. It also gave service users an opportunity to better understand the training of doctors and closely work with them as group members rather than as patients which they found empowering. Feedback from all group members was positive and it is hoped that the continued use of integrated groups could help to reduce the stigma surrounding patients with mental health problems and improve medical student attitudes to psychiatry as a speciality leading to longer term improvements in recruitment.

73. Audit of Capacity documentation in Acute Assessment Ward
Dr John Sterling, Barnet Early Intervention and Complex Care Team

Aims and hypothesis: To work out how well capacity was documented in regards to informal admission and treatment and to see if interventions could improve this. It was hypothesised that
capacity documentation would be poor, that patients admitted informally would get detained at a later date and that further education to staff was necessary to improve this.

Background: Informal patients being admitted to hospital should have capacity to consent to admission and treatment and if not they should be admitted under the MHA or DOLS. It is important this is clearly documented.

Method: Between 2nd December 2014 and 25th January 2015, 37 patient records of informal admissions to an acute assessment ward were examined. It was noted what risks were identified on admission, whether capacity was specifically documented about admission and treatment and whether their informal status changed during admission.

Results: 29 (78.4%) were noted to have clear risks to self, 9 (24.3%) to others, 18 (48.6%) of self-neglect, six (16.2%) of vulnerability and 2 (5.4%) admitted for declining mental state as main risk. 27 (73.0%) did not have clear capacity specific to admission documented; 15 (40.5%) had agreed or consents to admission documented and capacity may have been implied and two were documented as having capacity but not specified in regards to what. 27 (73.0%) did not have clear capacity specific to treatment documented; 5 (13.5%) had consents to treatment documented. Two patients were documented as having concerns about their capacity and 5 patients were specifically noted to have significant impairment in insight. 5 (13.5%) patients informal status changed within 7 days; two were documented as having deteriorated, 2 because they wanted to leave and 1 as they lacked capacity.

Conclusions: Specific capacity was poorly documented with 27.0% specific to admission and 27.0% to treatment. 13.5% of patients legal status changed after informal admission. Further education to staff was to be given and the audit cycle repeated in September 2015 to check for improvement which results should be available for the time of the conference.

74. A prospective 8 week pilot study assessing the delivery of urgent care via crisis resolution home treatment
Dr Jaspal Singh Swalli, Birmingham & Solihull Mental Health NHS Foundation Trust; Dr Vinod Singh, Birmingham & Solihull Mental Health NHS Foundation Trust

AIMS & HYPOTHESES: To assess the impact of an urgent care response team, within crisis resolution home treatment (CRHT) on: 1. Time of response to initial crisis, 2. Appropriate intervention/signposting, 3. Home treatment/inpatient services and 4. Patient and referrer satisfaction. Our null hypothesis is that there will be no difference on how CRHT currently assesses, signposts and provides intervention to patients being referred.

BACKGROUND: CRHT provides care for patients presenting with acute psychiatric crisis in the community as an alternative to hospitalisation. Although the workload of assessing new referrals and providing intensive psychiatric input for those under CRHT is being managed adequately, a more streamlined approach, in providing intensive urgent care via crisis resolution together with promoting quality home treatment has been identified.

METHODS: A prospective study covering an 8 week period from 11th May 2015. All new referrals will be received and triaged, by a senior nurse, by telephone contact with the referrer/patient/carer to obtain further collateral information. Subsequently, the patient will be assessed by a dedicated urgent care response team, consisting of a senior medic and psychiatric nurse. If deemed suitable for crisis intervention patients will be taken on for an initial period of up to 72-hours with the aim to resolve the crisis, signposting thereafter if required.

RESULTS: 74 patients referred to urgent care 6 were not applicable for assessment. 53% (36/68) were seen within 4-hours with the remainder seen within 24-hours as pre-arranged. Following the 72-hour assessment 28% (19/68) were referred back to the GP, 16% (11/68) were referred to the Community Mental Health Teams, 56% (38/68) were taken onto home treatment. Only 2 patients were admitted to hospital. Patients/carers/GP feedback recommends this pathway to continue 24-hours.

CONCLUSIONS: This study has demonstrated a need to integrate urgent care response teams within CRHT to allow more prompt and effective patient care with better communication and interface with primary care and other secondary care teams.
75. An audit of physical health measures in a community psychosis team
Dr Sophie Tomlin, South London & Maudsley NHS Foundation Trust

Background:
There is 2-3 times the prevalence of metabolic syndrome in people with severe mental illness (SMI) compared to the general population. It is thought that reduced access to medical care and side effects from psychotropic medication can contribute towards this. Currently those with SMI lose 25-30 years of potential life due to cardiovascular risks.

Standards:
There are two main sources of guidelines on physical monitoring: The Maudsley Guidelines, and NICE, which were combined in order to audit against. Patients should have annual weight, BMI, waist circumference, blood pressure, pulse, U+Es, LFTs, prolactin, lipids, fasting glucose, HbA1c and ECGs. Patients on clozapine only do not need prolactin, but instead need 6-monthly fasting glucose and HbA1c.

Method:
A patient list was obtained from ePJS. Patient records were searched for recent correspondence from the GP (either a physical health proforma or GP summary), medication, and all the measures mentioned under Standards. The result of these measures, as well as the date they were last documented, was recorded.

Results:
A total of 184 patients records were included in the audit. 53% had a completed physical health form completed and returned by their GP in the last 12 months. The average BMI was 30.2 (35: 9.2%). 4.3% had a waist circumference measurement in the last year, 47.3% blood pressure, 23.4% pulse, and 13.6% an ECG. It was an average of 2.52 years since the patients last documented ECG, 1.55 years since the last weight, and 1.35 years since the last documented BMI. Of the blood tests, 13% had abnormal U+Es, 17.9% had abnormal LFTs, 52.2% abnormal lipids, 11.4% abnormal fasting glucose, and 17.9% had abnormal prolactin.

Conclusions and Recommendations:
The most striking results were of the low numbers of patients who had documented ECGs and waist circumference. A new, improved GP physical health proforma has been designed and is being sent to all GPs prior to CPA review.

76. The Trainee and Advocate led Inpatient Christmas Service Evaluation 2014
Dr Jennifer Townell, Central and North West London NHS Foundation Trust; Dr Chloe Pickup, Central and North West London NHS Foundation Trust; Dr Estelle Laughton, Central and North West London NHS Foundation Trust; Dr Masum Khwaja, Central and North West London NHS Foundation Trust

Aim:
The aim of this service evaluation project was to look at understanding patients views and recommendations for improvements on their in-patient experience of Christmas and the festive period in the Gordon Hospital in Central London.

Background:
The psychiatric inpatient experience of Christmas and the festive period is an area not widely researched. The studies that have been done have shown an increase in depression, loneliness, alcohol related poisoning and suicide around the festive period.

Methods:
A 32 point questionnaire was devised in collaboration with the local service user involvement group. The questionnaire covered demographic information, personal views and recommendations for improving the experience of Christmas and the festive period (defined as 24th December 2nd January). The Advocacy Project distributed the questionnaire to all 60 patients over the 3 wards between the 19th January and 30th March 2015, with a response rate of 18 patients.

Results:
The results showed that patients find Christmas is important, rating it 7 out of 10. Only 1 of the 18 had received any advice from mental health professionals about how to look after their mental health on Christmas day and the festive period. Patients most commonly described Christmas as
depressing, joyful, enjoyable and stressful and the festive period as depressing and nice. The positive factors over the festive period included the food; entertainment; staff, receipt of xmas cards and presents and faith outings from one ward. The commonest recommendations were increased section 17 leave, quiet space extended visiting hours entertainment visit to church and group walk.

Conclusions and Recommendations:
Several changes are being made to improve the patient experience of Christmas and the festive period. Specifically re-evaluating care plans prior to the period, creating information leaflets on services available and wards to review their access to visiting hours, entertainment and faith representatives. This service with the improvements will be re-evaluated in the Christmas and festive period 2015/16.

77. Audit of Hyperprolactinaemia Monitoring in South Worcestershire Early Intervention Service.
Dr Jessica Two, Black Country Partnership Foundation Trust; Mr Thomas Dunne, Birmingham University; Ms Alina Phoolchund, Birmingham University; Ms Zita Okeke, Birmingham University;

Aims:
To assess the quality of prolactin level monitoring in the South Worcestershire Early Intervention Service (EIS), as compared to national and trust standards.

Background:
Hyperprolactinaemia is a well-known side effect of several frequently prescribed antipsychotics. Patients are often embarrassed and reluctant to discuss hyperprolactinaemia side effects, particularly those related to sexual dysfunction. As a result they are a significant contributing factor in discontinuation of medication. It is therefore vital to ensure that monitoring of prolactin is not overlooked and is in line with appropriate standards.

Methods:
Worcestershire Health and Care NHS Trust (HACW) suggests that for patients on antipsychotics monitoring should be carried out at 3 months and then at 6 monthly intervals. Data was collected using a tool designed to facilitate comparison with the above standards. The information required was obtained using an online pathology results database and the current volume of patient notes. The first data collection included 52 patients under the care of the EIS. A re-audit of 46 patients was completed 4 months later.

Results:
81% of patients had their prolactin checked at least once during their time in the service. However only 23% were checked at baseline, 22% repeated at 3 months and 33% repeated at 6 months. 18 patients experienced mildly raised prolactin during their time under the care of the EIS, whilst 8 patients had moderately to severely raised prolactin levels. 3 patients reported significant side effects. Unfortunately no improvements were identified in any standards during the re-audit. Further recommendations have been made and the audit will subsequently be repeated.

Conclusion:
Greater attention needs to be given to regular prolactin monitoring. We have therefore designed a hyperprolactinaemia flowchart to guide clinical staff about the appropriate frequency of prolactin monitoring and to advise them on the management of hyperprolactinaemia. This flowchart is currently undergoing approval by the Medicines Management Sub-Committee for trust-wide use. The audit cycle will be repeated once this flowchart has been implemented across HACW.

78. Quality Improvement Project Improving safety for individuals detained in Places of Safety
Dr Aurielle Goddard, Cardiff and Vale University Health Board; Dr Josie Mouko, Avon and Wiltshire Mental Health Partnership Trust; Dr Victoria Nimmo-Smith, Avon and Wiltshire Partnership NHS trust

Background
In Bristol a 4-bedded Place of Safety (PoS) was opened in 2014. Patients are taken here after detention under Section 136 of the Mental Health Act (MHA) by police. Patients can legally be held up to 72 hours, during which time physical health issues or disturbed behaviour may develop.
Such patients are detained under the MHA awaiting assessment, but cannot be treated against their will under the MHA.

Problem
A trainee survey identified: lack of clarity about whose role it is to provide medical cover; uncertainty about what interventions were safe and legal; and ambiguity about prescribing for alcohol withdrawal and sedation. There was no guidance for trainees on managing physical health problems, alcohol withdrawal or disturbed behaviour in the PoS.

Intervention
Guided by survey results, we took a number of approaches to improve patient safety: production of a guidance document for managing common scenarios, specific guidance on the safe management of alcohol withdrawal, and defining whose role it was to provide medical cover in the first instance senior trainees. These interventions were cascaded to trainees, staff on the PoS and the local switchboard.

Results
We re-surveyed the trainees after these interventions and found 100% clarity on the point of contact and a clear understanding of how to get senior support. We found a distinction between the confidence and understanding of junior and senior trainees, providing support for our protocol that only senior trainees should be called upon to provide medical cover. We predict further improvement in trainees working understanding of the MHA and confidence managing alcohol withdrawal after face-to-face training in August.

Conclusion
The issues arising on the PoS are complex and should only be dealt with by doctors with previous experience in psychiatry. The current climate for mental health services bed shortages, delays in transfer, and prevalence of alcohol intoxication indicates that there is increasing need for the delivery of a well-provisioned PoS with adequate medical cover. A clear guideline document could be useful in other parts of the country with similar service challenges.

79. Promoting Physical Health in Early Intervention in Psychosis: A Service Evaluation
Dr Stephanie Durant, South West London and St George's Mental Health NHS Trust; Ms Elif Huseyin, South West London and St George's Mental Health NHS Trust; Dr David Li, South West London and St George's Mental Health NHS Trust

Aims and hypothesis
The aim of the service evaluation was to examine the effectiveness of a physical health programme on service users physical health and overall wellbeing. The hypothesis was that by improving service users knowledge about physical health and increasing self-esteem, physical health would in turn improve.

Background
One major focus of research in mental health is the overall poor health of people with serious mental illness compared with the general population. The Richmond Early Intervention Services (REIS) Wellbeing Group, targeted for patients suffering from a first episode of psychosis, included topics such as physical exercise, healthy eating, cardiovascular health, cannabis and substance misuse, smoking and self-esteem.

Methods
Four service users under the care programme approach of the REIS caseload consistently attended the programme (n=4). The programme ran over six weeks, with each 90-minute session focusing on particular health related topics. Measurements taken pre and post intervention included the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), General Practice Physical Activity Questionnaire (GPPAQ) and physical measurements (weight, height, Body Mass Index (BMI), waist circumference, blood pressure and smoking status). Data analysis included calculating descriptive statistics, inferential statistics (paired t-test) and clinically reliable change.

Results
There was an overall slight improvement in weight, BMI and waist circumference observed at a ten week follow up. Physical activity index scores (GPPAQ) generally remained the same with minimal
improvement. Qualitative feedback demonstrated that service users felt better informed about maintaining good physical health. Furthermore, wellbeing scores increased at follow up but demonstrated no clinically reliable change.

Conclusions
Overall, physical health parameters improved post intervention. Wellbeing scores and user satisfaction were also positive. However, statistical significance was difficult to ascertain owing to the small sample size. Additionally, medication changes had an effect on service users weight and mental health, thus affecting the results. Nevertheless, it would be beneficial to run the REIS Wellbeing Group again in the future.

80. Reducing Prescribing Risk around Discharge from Acute Psychiatric Settings: A Collaborative Approach
Dr Rebecca Osborne, Health Education South West (General Practice); Dr Celice McDermott, Cornwall Partnership NHS Foundation Trust; Dr Ellen Wilkinson, Cornwall Partnership NHS Foundation Trust; Dr Mary Ryan, Service User Consultant

Aims: To assess whether potentially harmful quantities of prescribed medications are frequently obtained around discharge from inpatient settings, and consider ways to reduce access to this means of suicide.

Background: The 2015 National Confidential Inquiry into Suicide and Homicide found the first 3 months after discharge remain a time of particularly high suicide risk, particularly the first 2 weeks. 20% of all patient suicides between 2003-13 were post-discharge. The South West Zero Suicide Collaborative brings together those with lived experience alongside statutory and voluntary sector organisations whose work involves suicide prevention, to share good practice and identify areas for improvement.

Within a workshop discussing access to means of suicide, service users shared experiences of often being given sufficient quantities of medicine to act as a means of suicide around discharge.

Method: 10 cases admitted with suicidality were selected. Each patients GP was interviewed and discharge documentation was reviewed.

Results: 1 patient was not on medication and was excluded from further study. All received 7-days of medication at discharge. Only 2 patients verbalising ongoing suicidal thoughts at discharge were highlighted to the GP within the discharge letter as being at risk of suicide and advised regarding limited prescribing.

The remaining 7 cases were not described as being at ongoing risk of suicide, and no advice was given regarding limited prescribing. All 7 patients received 28-day supplies of medication, several through routine repeat prescribing mechanisms.

Conclusion: Although a small sample, the cases reviewed suggest that GPs do act on specific discharge advice to limit prescribing, but if no advice is given, 28-day prescribing is likely to continue, both due to perceived lack of risk of suicide and unintentionally through common administrative procedures.

Following this work, recommendations have been made to primary and secondary care teams to help develop safer prescribing practices around this high risk period, including changes to discharge advice, and IT solutions to ensure clinician-only issuing of prescriptions in General Practice.

81. Re-Audit of Physical Health Monitoring for Adult Inpatients On a Psychiatric Intensive Care Unit (PICU)
Dr Giri Madhavan, Health and Care Worcester; Dr Catherine Cooper, Coventry and Warwick; Dr Steve Choong, Health and Care Worcester

Aims and hypothesis;
To investigate possible improvements in physical examination of inpatients since introduction of a standardised form, to identify difficulties using the form and changes that might improve it.

Background;
Psychiatric patients are at high risk of physical illness. Inpatient admission provides opportunities to assess physical health and initiate appropriate management. An audit of physical health monitoring was done retrospectively for all 20 patients admitted to our 9-bedded PICU from 01/01/14 - 31/03/14 using case notes. Examinations had been documented in patients notes but were often difficult to find and of variable quality. Following this, we introduced an Inpatient Physical Health Assessment Form in June 2014 to standardise examinations, documentation and improve thoroughness of examinations.

Methods;
A structured proforma, designed around the Trust physical health policy, was used to retrospectively review case notes. Records of all 20 patients admitted between 01/07/14 30/09/14 were audited. Data were gathered on items in the history, physical examination and investigations, whether this was done in the first 24 hours of admission and, if not, a reason documented. We also gathered data on ongoing monitoring of several physical health parameters.

Results;
In both audit and re-audit, 95% of patients had their physical within 24 hours or a reason documented why not. On History and Health Screening, there were improvements in 9/13 areas, no change in 1/13 and decline in 3/13 areas. On Examination, there were improvements in 17/22 areas, no change in 0/22 and decline in 5/22 areas. On Investigations, there were improvements in 6/11 areas, no change in 1/11 and decline in 4/11 areas.

Conclusions;
Areas of good practice included improvements in history and examination, and testing of lipids. However more patients need to have thyroid examination, waist measurement and BMI. We recommended continued use of the Inpatient Physical Health Assessment Form, incorporating some alterations suggested by Junior Doctors using the form. Further work is necessary to develop a system to track changes in physical health during admission.

82. The Wellbeing Clinic - Addressing physical health in a mental health setting
Dr Joanne Perera, Surrey & Borders Partnership NHS Trust; Dr Jeremy Mudunkotuwe, Surrey & Borders Partnership NHS Trust

Aims
To set up a Wellbeing Clinic for our service users; enabling them to have access to a physical health check and access to healthy living advice.

Background
Increased rates of physical health problems and reduced life expectancy in patients with severe mental illnesses have been noted. Long-term psychiatric medications further exacerbate the physical health problems. The Royal College of Psychiatrists and the National Institute for Health and Care Excellence (NICE) have issued guidelines for the physical monitoring in patients with mental health illness. This is held in high regard within our trust. Using these guidelines we have set up a Wellbeing Clinic.

Methods
The Wellbeing Clinic was set up to give advice and carry out health checks to our patients presenting for their monthly depot injections and those under an enhanced Care Programme Approach (CPA).

The clinics are run by experienced mental health nurses, in a friendly and safe environment on a weekly basis. Advice is given on lifestyle including smoking cessation and exercise, sleep hygiene, medication side effects and other general healthy living advice. A doctor from the team is also on duty and assigned to cover the clinic each week for medical advice.

The Wellbeing check includes the following: Blood Pressure Check, Body Mass Index (BMI), pulse check, blood glucose test, cholesterol checks and blood testing. Results are interpreted to the patient and we liaise and correspond with the patients GP. The data is also used by the patients care coordinator for future plan and advice within the CPA.
Results
In June 2015, a total of 23 patients used this service. At present, basic health checks have indicated over half of the patients were hypertensive. In addition, a large proportion of patients had a BMI over the recommended; including being overweight, obese and morbidly obese. This further substantiates a need for monitoring physical health within our patient cohort.

Conclusions
Taken together, our team has taken the steps to aid in the identification, at the earliest opportunity, to address physical health problems or monitor known physical health problems in patients with severe mental health illness.

83. NICE guidelines for Self-harm: Longer-term management, closing the audit loop
Dr Joanne Perera, Surrey & Borders Partnership NHS Trust; Dr Prem Pal, Surrey & Borders Partnership NHS Trust; Dr Jeremy Mudunkotuwe, Surrey & Borders Partnership NHS Trust

Aims and hypothesis
Our aim was to re-audit the National Institute for Health and Care Excellence (NICE) guidelines for the management of longer term care of patients who self-harm, specifically the psychosocial assessment. It was hypothesised following clinical education; an improvement of the different elements of the 'assessment of needs' would be seen.

Background
According to NICE guidelines the term self-harm refers to any act of self-poisoning or self-injury. Following self-harm, NICE guidelines recommend implementation of a thorough psychosocial assessment to be made in a setting such as the Community Mental Health Recovery Services (CMHRS); as part of the longer-term management. This is implemented after short-term physical and psychological management guidelines are followed.

In 2013, our team carried out an audit on the psychosocial assessments of 13 patients having self-harmed in a six month period. A shortfall was seen in recording of skills, strategies and assets (38%) and coping skills (54%). All other areas were carried out satisfactorily (100%). It was identified that clinical education of these NICE guidelines was required. A re-audit of these criteria has therefore been conducted.

Methods
46 records for patients who had self-harmed from June 2013 to May 2015 were identified on the RIO patient management system. Inclusion criteria involved a patient's assessment of needs carried out in the first 6 weeks of seeing a clinician. A case note review was conducted. In addition, demographics were also investigated. Mental health conditions linked to self-harm were also recorded.

Results
All patient records showed satisfactory documentation (100%) in all areas of the assessment of needs. A large proportion of patients were aged 40-55 years, with more cases in females. EUPD was the most common associated mental health illness.

Conclusions
Improvement in documentation of the assessment of needs was observed. Relevant and specific questions have been addressed with this cohort of patients; current practice should therefore be continued. Taken together, great importance lies in a full and thorough assessment to increase competence and confidence in the management of this anxiety-provoking disorder; self-harm.

Specialist Registrar

84. Aripiprazole Augmentation in profound, Sri-Refractory Obsessive-Compulsive Disorder
Dr Maha Khan, Southwest London and St George’s NHS Mental Health Trust; Dr Ilenia Pampaloni, Southwest London and St George’s NHS Mental Health Trust; Dr Himanshu Tyagi, Southwest London and St George’s NHS Mental Health Trust; Dr Lynne Drummond, Southwest London and St George’s NHS Mental Health Trust
Aim and hypothesis: The aim of this study was to look at the use of Aripiprazole as an augmentation strategy in the management of Treatment Resistant Refractory Obsessive Compulsive Disorder (OCD); compared to other antipsychotics. Null hypothesis: Aripiprazole shows results no better or worse than any other typical or atypical anti-psychotic when used as augmentation strategy for patients with Treatment Resistant Refractory OCD.

Background: The National Inpatient service for Obsessive-Compulsive Disorder (OCD) And Body Dysmorphic Disorders (BDD) is the only 24-hour inpatient facility in the UK. OCD is a disabling condition which often responds well to treatment with either Cognitive Behavioural Therapy or Serotonin Reuptake Inhibitors (SRI). Pharmacological strategies utilized in SRI non-responders include, amongst the others, the use of first or second-generation antipsychotics. David Veale et al (2014) highlighted in a recent Meta-analysis that two studies have found Aripiprazole to be effective in the short term which led us to conduct this research study.

Method: Data was gathered from a total of 89 patients (March 2006 to September 2011) using their case records, electronic record system called RIO and direct observation. Information was gathered focusing on changes in Yale Brown Obsessive-Compulsive Rating Scale (YBOCS).

Results: Our sample consisted of 45 male and 44 female patients with an initial YBOCS average score of 23.5± 2.9 SD, indicating profound OCD. Overall, the highest number of patients (n=30) were treated with Aripiprazole when discharged from the National Service. Research showed that in patients whose treatment was augmented with Aripiprazole, there was an average YBOCS reduction of 14 (highest amongst the sample) followed by quetiapine.

Conclusions: Aripiprazole was widely used in our population of inpatients with profound, treatment-refractory OCD, producing a significant reduction in the YBOCS scores. Conflict of interest: None to disclose. No financial sponsor.

Specialist Training Registrar (StR) in Special Care Dentistry

85. Beliefs about Oral Health Promotion (OHP) amongst the mental health team a pilot study
Ms Camilla Boynton, The Browning Centre, Boscombe, Dorset (Somerset Partnership NHS Foundation Trust); Dr Blánaid Daly, Academic Lead/Senior Lecturer in Special Care Dentistry, King's College London Dental Institute; Dr Koula Asimakopoulou, Senior Lecturer in Health Psychology, King's College London Dental Institute; Dr Sasha Scambler, Lecturer in Sociology, King's College London Dental Institute

AIM
This pilot study aimed to describe the behavioural, normative and control beliefs of mental health staff in relation to engaging in four oral health promotion (OHP) behaviours with people living with severe mental illness (SMI), so that factors influencing staff capability, opportunity and motivation to change clinical practice were understood.

BACKGROUND
The oral health of people with SMI is poorer than the general population. As many of the risk factors for physical illness and dental disease are common, it would be logical to integrate oral health promotion into general health promotion for people with SMI. Interventions to improve the oral health of people with severe mental illness (SMI) by the mental health team are few and research is required to understand how oral health promotion (OHP) could be introduced into existing health promotion practice.

METHODS
A mixed methods approach was used to study staff (n=28) from a mental health team in South London. A quantitative online questionnaire (Part 1), following Ajzens Theory of Planned Behaviour (TPB), elicited beliefs around four OHP behaviours: asking about a regular source of dental care, accessing dental care, advice on mouth care/side-effects of anti-psychotic medications and recording this conversation in the clinical notes. Data from qualitative interviews and one focus group (Part 2) were organised into themes around existing health promotion (HP) practice and the four proposed OHP behaviours.
RESULTS
Mental health professionals held appropriate and requisite behavioural, normative and control beliefs to engage in OHP, if interventions were correctly designed. The organisational context was equally positive. The most significant barriers were factors that would reduce respondents control beliefs: patients mental state, patient refusal to engage, lack of time, computer facilities and, for some, no suitable local dental service.

CONCLUSION
The mental health team has the potential to engage in oral health promotion behaviours, and oral health promotion could be readily integrated into interventions designed to promote physical health in people with SMI.

86. Altered salivary flow and risk to dental health in patients taking antipsychotic medication - a pilot study.
Dr Emily Sherwin, Oxford Health NHS Foundation Trust; Dr Blanaid Daly, King's College London; Dr Tom Stevens, South London and Maudsley NHS Foundation Trust

Aims
To report on perception of altered salivary flow, management of associated symptoms and relationship with salivary flow rates in adults taking antipsychotic medication; to report on the risks posed to dental health by the management strategies used.

Background
Studies have shown that the oral health of people with mental illness is poorer compared to the general population. Risk factors identified include poor oral hygiene, infrequent dental attendance and side effects of antipsychotic medication such as xerostomia. There is limited research into patients’ perception and management of altered salivary flow and the risks to dental health posed by how altered salivary flow is managed.

Methods
Participants (N=23) were recruited from an outpatient clinic in London. An objective measure of saliva flow rate was recorded followed by a structured interview, which assessed perception of xerostomia and drooling, management of altered salivary flow and oral health behaviours.

Results
While the majority of participants (74%) had a normal saliva flow rate, 39% perceived they had too much saliva in their mouth and 13% reported they had too little saliva. Participants reported using a number of strategies to manage these symptoms, 39% of participants drink carbonated drinks or fruit juice to manage dry mouth. Participants who self identified as droolers had higher mean flow rates (p=0.01). Participants taking clozapine had a statistically higher mean Drooling Frequency Score (p=0.009) and Drooling Severity Score (p=0.032) compared to the group taking other antipsychotic medications and reported symptoms were worse at night. Risk behaviours for dental disease including smoking, adding sugar to hot drinks and drinking sugar-containing drinks was more prevalent compared to the general population.

Conclusions
Over half of participants perceived an altered salivary flow. Participants management of these symptoms, tobacco use and pattern of sugar consumption placed their dental health at risk and highlights a need for dental health education. Mental health teams can discuss salivary flow and raise awareness regarding risk behaviours to dental health.

87. The clinical review checklist a tool for delivering safe and effective care
Dr Laurine Hanna, Camden and Islington NHS Foundation Trust; Dr Judith Livingston, Camden and Islington NHS Foundation Trust; Dr Alexandra Pitman, Camden and Islington NHS Foundation Trust; Dr Laurine Hanna, Camden and Islington NHS Foundation Trust
Aim
Our aim was to develop and evaluate a clinical review checklist. We designed this checklist to ensure that safety critical information was systematically discussed and documented at every clinical review meeting.

Background
This work was conducted on the North Camden Acute Day Unit (ADU), which forms a key part of the adult crisis care pathway within Camden & Islington NHS Foundation Trust. The ADU provides a non-residential alternative to hospital admission for adults with acute mental health difficulties. It comprises a multidisciplinary team of nurses, occupational/music/art therapists, psychologists, assistant practitioners, and psychiatrists. The standard length of admission is eight weeks.

Methods
An initial checklist was designed to capture key information on:
- date of admission
- psychiatric diagnosis
- physical health co-morbidities
- medications
- progress since admission
- plan for follow-up care on discharge

We carried out a retrospective audit of electronic patient notes, measuring the percentage documentation of each item on the checklist, comparing 30 casenotes pre- and 30 post-implementation of the checklist.

We envisaged use of the PSDA tool, to make iterative changes to the checklist following each evaluation.

Results
A striking improvement was recorded in systematic documentation of each of the safety critical domains pre and post implementation of the checklist. Variation in proportions documented in each safety critical domain pre-implementation ranged from 0-85%, whilst post-implementation these ranged from 85-100%.

Conclusions
The clinical review checklist is an effective and pragmatic means of improving systematic documentation of safety critical aspects of care.

The success of the checklist approach has led to the development of a safety vignette that ensures important clinical and risk information is reliably shared between the multidisciplinary team at all team discussions and handover meetings.

Ethical approval for the project was granted by the Camden & Islington NHS Foundation Trust Audit and Quality Improvement Committee.

88. A Novel Stimulus Dosing Protocol: A completed audit cycle
Dr Harsh Jhingan, Bradgate Mental Health Unit, Leicester; Dr Waqgas Khokhar, Bradgate Mental Health Unit, Leicester; Dr Naz Omar, Bradgate Mental Health Unit, Leicester

Introduction
We introduced a new stimulus dosing protocol (SDP) for delivering ECT at Leicester in December, 2008. A year later we conducted this audit. Based on the audit findings, interventions were made and then a re-audit was conducted in 2011.

Standards:
1. 90 % patients should have ECT using SDP.
2. If SDP was not used, reason should be documented for 100 % patients.
3. A seizure threshold (ST) should be determined in the first two sessions for 90 % patients.

Methods:
Case notes of all the patients (61) who started receiving course of ECTs during 2009 were checked for the standards of the audit with audit tool. Re-audit was conducted for all the patients (67) who started receiving course of ECTs during 2011 with the same methodology.

Results:
In the first audit, 51% of the patients received ECT using SDP and seizure threshold was determined within two sessions for 97% of patients. Another 15% were administered ECT without following the SDP but reason for not following the protocol was documented. For the rest (34%), reason for not following the protocol was not recorded.

Following the audit, recommendations were made including strengthening the training of junior doctors and a prompt was added in the ECT booklet Was the protocol followed, if not why.

In the re-audit, SDP was correctly used for 70% of patients and for another 15%, the reason for not following the SDP was documented. In 100% of patients for whom the protocol was followed, seizure threshold was determined by the end of second session.

Comments:
Our new stimulus dosing protocol was found to be good for the purpose. Interventions made after the first audit brought about marked improvement in the findings of the re-audit. The second intervention of adding a prompt in the ECT booklet was made half way through the year and so its full effect was not visible in the re-audit. The new SDP and the interventions made after the first audit have led to improved efficacy of ECT and minimal the side-effects.

89. What happens when 55% of acute psychiatric beds are closed in 6 days: an unexpected study
Dr Richard Laugharne, Cornwall Partnership NHS Foundation Trust; Mr Matt Branch, Cornwall Partnership NHS Foundation Trust; Ms Anji Mitchell, Cornwall Partnership NHS Foundation Trust; Ms Lindsay Parkin, Cornwall Partnership NHS Foundation Trust

Aims to evaluate the consequences of a sudden closure on an acute NHS psychiatric ward. Background: the sudden closure of 30 out of 54 acute psychiatric beds in Cornwall presented a stressful challenge to staff but also a natural experiment on how a service dealt with this situation. We aimed to evaluate the outcomes of patients needing to leave the closed ward, how bed occupancy rates were affected and the impact on admission rates.

Method: a service evaluation of the impact of the ward closure. Setting: a comprehensive secondary NHS mental health service in Cornwall serving 550,000 population. Main outcome measures: the destination of the patients needing to leave the acute unit, the effect of the closure on bed occupancy, admission rates and serious untoward incidents.

Results: of 26 patients needing to be moved from the acute ward, only 10 needed an acute psychiatric bed. None of the 7 patients who had been on the ward longer than 9 weeks needed an acute unit. Admission rates fell over the subsequent 3 months. There was no increase in serious incidents due to the closure.

Conclusions: this naturalistic event suggests that many patients on acute units could be cared for elsewhere, especially recovery/rehabilitation care environments, if political and financial urgency is present. Admission rates are responsive to the pressure on beds.

90. Three cycle audit study for Lithium Monitoring in a Community Mental Health Recovery Service
Dr Jeremy Mudunkotowe, Epsom, Ewell and Banstead CMHRS; Dr Zafrina Majid, Epsom, Ewell and Banstead CMHRS; Dr Natalie Whitehead, Epsom, Ewell and Banstead CMHRS;

Aims:
In order to improve the physical health monitoring of patients receiving lithium therapy under our care the authors present a three-cycle audit study of lithium monitoring compliance based on NICE guidance and endorsed by our trust.

Background:
Lithium is used for treatment of Bipolar Affective Disorder. It has a narrow therapeutic range, toxic side effects and interacts with other medications. Therefore it is important to highlight the
importance of Lithium monitoring practices in community teams and establish if improvements in our current practice are necessary.

Method:
Case-load of three clinicians were analysed and patients on lithium were identified by reviewing GP letter and electronic notes. We assessed if care plans, blood test results for serum Lithium Levels, TFTs, U&Es, Weight were recorded for each patient. Additionally, GP surgeries were contacted if blood test results and weight were not recorded on electronic notes.

Initial audit was completed in January 2013. The intervention brought forward by initial were implemented and second cycle of audit was performed in January 2014. Results of re-audit showed that there was an improvement in all areas except for recording of lithium levels. Recording weight of patients showed significant improvement and completion of lithium plan remained low. Therefore, we performed a third cycle of audit after reinforcing interventions. 27 patients were identified in November 2014 for third cycle of audit.

Result:
In third audit cycle there was a noticeable improvement in recording of lithium levels, TSH and U&Es which were all >90% compared to second audit cycle. However, annual weight recording, implementation of lithium care plan and booklet were 90% compliance in recorded lithium levels and biochemical markers for those on lithium therapy. However, recording and implementation of other important parameters such as weight, care plan and lithium booklet are low. We therefore recommend following changes and further re-audit:

- Adapting IT systems and establishing an online lithium booklet
- Further education for staff involved and therefore improving links for collaborative work with primary care
- Wellbeing clinic for weight monitoring.

91. A Randomised Controlled Trial of Cognitive Behaviour Therapy or a waiting list for treating a Specific Phobia of Vomiting (Emetophobia)
Dr David Veale, South London and Maudsley NHS Foundation Trust; Ms Lori Riddle, University of California;

Aims and hypothesis
A Specific Phobia of Vomiting (SPOV) (or emetophobia) has been an under-researched topic with no randomised controlled trials (RCT). This is the first RCT to evaluate a protocol for cognitive behaviour therapy (CBT) compared with a waiting list and to use assessment scales that are specific for a SPOV.

Methods
24 participants (23 women; 1 man) were randomly allocated to either 12 sessions of CBT or a wait list. The primary outcome measure was the Specific Phobia of Vomiting Inventory (SPOVI). Three different clinicians at different centres delivered the CBT.

Results
At the end of treatment, CBT was significantly more efficacious than the wait list with a large effect size (Hedges g = 1.48) on the SPOVI between the two groups after 12 sessions. 50% of participants receiving CBT achieved clinically significant change on the SPOVI compared to 16% in the wait list group. 58.3% receiving CBT achieved reliable improvement compared to 16% in the wait list group.

Conclusions
Our conclusion is that a SPOV is a treatable condition using CBT but not everyone responds. In such cases, the treatment may need to be stepped up to a more intensive programme (e.g. at a residential unit or by a longer treatment with more therapy assisted exposure). To date, this trial is the best available evidence for the treatment of a SPOV, however further developments in the treatment protocol are required to increase efficacy in the numbers who achieve clinically significant change.

92. Outcome of Intensive Cognitive Behaviour Therapy in a Residential Setting for People with Severe Obsessive Compulsive Disorder: A Large Open Case Series
Aims and hypothesis
There is little data to inform the treatment of severe obsessive compulsive disorder (OCD) in an inpatient or residential setting. This paper aimed to: a) describe treatment outcomes at a residential unit over 11 years; b) investigate whether treatment was successful for a subset of severe treatment refractory residents; c) compare an intensive treatment program to a standard treatment program; and d) find predictors of self or early discharge from the unit.

Methods
We compared treatment outcomes for (i) a minimum 12-week treatment (hereafter standard) program versus a 2-week intensive program and (ii) for severe treatment refractory cases on the standard program. We identified 472 residents (250 female, 222 male) with OCD admitted to the Anxiety Disorders Residential Unit at the Bethlem Royal Hospital between 2001 and 2012. 418 were admitted to the standard program, and the remaining 54 to a 2-week intensive program. Outcomes were measured with the Yale- Brown Obsessive-Compulsive Scale (Y-BOCS), Obsessive Compulsive Inventory (OCI), Beck Anxiety Inventory (BAI) and Beck Depression Inventory (BDI) obtained throughout treatment and up to one year after discharge.

Results
Although residents had very severe OCD on admission, sequential assessment with the Y-BOCS, OCI, BAI and BDI demonstrated that scores on all outcome measures significantly decreased from pre- to post-treatment and were generally maintained at follow-up. There was no significant difference between those on the standard or the 2-week intensive program. 69% of residents with OCD made significant improvements, with at least a 25% reduction on the Y-BOCS. There were predictors of self or early discharge but (alcohol misuse, depression) but none for outcome on the Y-BOCS.

Conclusions
The data support the principle of stepped care for severe OCD.

93. Use of novel psychoactive substances by inpatients on general adult psychiatric wards
Mr Jack Stanley, University of Edinburgh; Dr Daniel Mogford, NHS Lothian; Dr Rebecca Lawrence, NHS Lothian; Prof Stephen Lawrie, Head of Psychiatry and Professor of Psychiatry and Neuro-imaging, University of Edinburgh.

Purpose
Non-illicit alternatives to controlled drugs, known as Novel Psychoactive Substances (NPS) have recently risen to prominence. They are readily available with uncertain pharmacology and no widely available assay. Given that psychiatric patients are at risk of comorbid substance abuse, we hypothesized that NPS use would be present in the psychiatric population, and sought to determine its prevalence and investigate the characteristics of those who use these drugs.

Design
Retrospective review of 388 available discharge letters, calculating prevalence of recorded NPS use and comparing demographics and characteristics of patients who had, and had not, used these substances.

Setting
General adult inpatient wards of a psychiatric hospital in a Scottish city.

Participants
Adult inpatients (18-65) discharged from general psychiatric wards between 1/7/14 and 31/12/14. 483 admissions identified, 46 were admissions for maintenance ECT and were excluded. Of the remaining 437 admissions, 49 discharge letters were unobtainable, leaving 388 admissions to analyze (88.7%).
Results
NPS use was identified in 22.2% of admissions, contributing to psychiatric symptoms in 59.3%. In comparison to non-users, NPS users are younger ($p$ 

94. Risk of incident cardiovascular events amongst individuals with depression and anxiety in east London
Dr Luis Ayerbe Garcia-Morzon, Centre for Primary Care and Public Health, Queen Mary, University of London; Dr Rohini Mathur, Centre for Public Health and Primary Care; Dr Maria Perez-Pinar, The Westborough Road Heath Centre Westcliff-on-Sea; Dr Quinti Foguet-Boreu, Institut Universitari d’Investigacion en Atencia Primaria Jordi Gol Universitat Autonoma de Barcelona, Spain; Dr Salma Ayis, Division of Health and Social Care Research King’s College London; Dr Ayerbe Garcia-Morzon Centre for Primary Care and Public Health, Queen Mary, University of London

Aims and Hypothesis
To quantify differences the risk of stroke or myocardial infarction (MI) among patients with depression or anxiety. We hypothesize that risk will be increased in patients with these psychiatric conditions compared to those without and that risk can be further explained by sociodemographic and cardiovascular risk factors.

Background
Patients with anxiety and depression have an increased incidence of cardiovascular disease. It is unknown how the age of onset and risk of MI and stroke differs for patients with depression and anxiety and whether risk varies by gender, ethnicity, deprivation, medication use and morbidity.

Methods
524,952 patients aged 30 and over were identified from the east London primary care database. Cox proportional-hazards regression models adjusting for anxiety or depression, demographic characteristics, diabetes, hypertension, hyperlipidemia, smoking and antidepressant use prior to 2005 were used to examine the risk of incident MI and stroke between March 2005 and March 2015.

Results
21,811 (4.1%) individuals had a diagnosis of depression and 22,128 (4.2%) had a diagnosis of anxiety prior to March 2005. Anxiety was associated with a younger age at first MI and depression was associated with a younger age of first stroke. The adjusted risk of incident MI, but not stroke was increased in patients with depression (HR 1.25 CI95% 1.08-1.44). After adjustment for all confounders, no association between anxiety and either MI or stroke was evident. South Asian ethnicity, deprivation, smoking, the presence of clinical co-morbidities and antidepressant use were independent predictors of stroke and MI in all models.

Conclusions:
Patients with depression have more MI than others while patients with anxiety have equivalent cardiovascular risk to that of the general population, which may suggest equitable care for this patient group. Some, but not all associations between mental health conditions and cardiovascular events can be explained by common cardiovascular risk factors. The different risk profiles for individuals with depression or anxiety are a novel finding and should be taken into consideration when targeting primary care services for these populations.

95. Mental Capacity Survey
Dr Daniel Francis, Derbyshire Healthcare NHS Foundation Trust; Dr Subodh Dave, Derbyshire Healthcare NHS Foundation Trust

Aims and Hypothesis
To determine whether mental capacity is being formally documented on all inpatient psychiatric wards on the Radbourne Unit, Derby whether on admission, on ward rounds, on expiry of section 3, for example and at other decision points. The hypothesis is that we are not routinely assessing and recording capacity. This survey is to determine how compliant we are.

Background
The Bournewood and West Cheshire judgments illustrate that that detaining patients in their best interests or based on assumption of capacity may be insufficient and lead to deprivation of patient liberty and moreover leave the trust open to legal action.

Methods
On 6/05/2015 all 85 in-patient psychiatric case notes were reviewed to determine whether capacity was recorded on admission, or later for example on ward round documentations or at other decision points.

Results
Of the 85 inpatients only 19 (22%) had a capacity assessment on admission, 12(14%) had capacity recorded at a point after admission and 1 at 28 day review after being assessed on admission. Only on one of the wards was capacity 9/17 (60%) recorded on admission at anything like a consistent basis and monitored thereafter.

Conclusions
The hypothesis that capacity is not being routinely and formally documented especially on admission and on ward rounds was demonstrated by the results of the audit. Only one ward demonstrated that they monitor patients mental capacity on a manual whiteboard.

To avoid depriving patients of their liberty and minimise potential law suits recommendations have been made and implementation begun which include mandatory recording of capacity on admission enabled by amending Mental Health Act admission template and ward round sheets coupled with a training package for staff and repeat audit in October 2015. In the meantime another ward has conducted their own re-audit with the result that 60% of patients were assessed within 72 hours and 70% at their last review.

Other recommendations include improving management information to provide a patient admission breakdown of patients under the Mental Health Act, informally or under the Mental Capacity Act.

96. Two-week Wait for Cancer comes to Psychosis
Dr Fatima Ghazi, Thorpe Coombe Hospital Early Intervention in Psychosis (EIP) Department; Dr Peter Carter, Thorpe Coombe Hospital Early Intervention in Psychosis (EIP) Department; Dr Rebecca White, Thorpe Coombe Hospital Early Intervention in Psychosis (EIP) Department; Mr Kirit Singh, Thorpe Coombe Hospital Early Intervention in Psychosis (EIP) Department

For decades psychiatry has been treated as the poor cousin of medical specialties in the UK. Timely access to services and then for treatment is one of the most obvious imbalances. For example, whilst patients suspected of cancer are to be seen within 2 weeks by secondary-care, there is no such deadline in psychiatry. The government is finally aiming to reverse this historical trend and achieve parity of esteem between mental and physical illness. One of the targets that is being rolled out is treatment within 2 weeks for more than 50% of people experiencing a first episode psychosis in 2015, increasing to 95% by 2020.

We were interested to know how long it took EIP to see patients and commence treatment from point of referral, and thereafter carry out interventions and undertake a re-audit. The initial audit collected all consecutive referrals between September to November 2014, amounting to 29 patients. A number of internal and external interventions were implemented before the re-audit in February-April 2015 which looked at 33 consecutive referrals. Some of these interventions included:
- 14 day limit discussed with internal teams
- Changing the EIP team structure
- Senior management review pathway to EIP, including revamping the EIP checklist referral form
- Better documentation by EIP staff members e.g. why a referral is rejected, timely entries, dates of referral noted
• More structured guidance for EIP staff e.g. how long we should keep a non-responding patient
• Improving links with referring teams and educating them about EIPs remit

Attendance at NHS England Workshops
In the first audit, only 20% of accepted referrals were seen within 2 weeks, whilst in the second cycle this almost doubled to 43% of accepted referrals being seen within 2 weeks. There was an overall improvement in the appropriateness of referrals: for example, of GP referrals 0% were accepted in audit 1 compared to 75% accepted in audit 2.

A third audit cycle will take place between August to October 2015. We also aim to evaluate the longer term morbidity and mortality benefits that these changes will have on patients'.

97. Takotsubo Cardiomyopathy following suicidal hanging: A case report and literature review
Dr Alice Sherwood, Epsom & St Helier University Hospitals NHS Trust; Dr Martin Schmidt, Surrey and Borders Partnership NHS Foundation Trust

Background: Takotsubo Cardiomyopathy is a form of acute reversible heart failure frequently triggered by acute physical and/or emotional stress. Several cases have been described in psychiatric patients experiencing relapses

Aim: To present a case report of Takotsubo Cardiomyopathy following attempted hanging and raise awareness about this serious condition which is relevant to all psychiatrists especially in acute settings

Case report: A 42 year old male with no history of mental illness was found by his wife hanging from the ceiling by a belt in an apparent suicide attempt. He was intubated at the scene and transported to hospital via HEMS. On admission he had a GCS of 6, normal CT head with no bony injury to the c-spine and was successfully extubated after 3 days. An initial echo showed severely impaired left ventricular dysfunction with extensive regional wall motion abnormalities and estimated ejection fraction of 20-30%. He underwent a coronary angiogram which showed unobstructed coronary arteries and was diagnosed with Takotsubo cardiomyopathy. He was started on Eplerenone, Bisoprolol and Ramipril. A follow up echo showed a marked improvement in left ventricular function with an estimated ejection fraction of 55%. He was admitted to an inpatient ward for a period of observation where he displayed no signs of depression or psychosis and denied any further suicidal thoughts. He was discharged after a week with Home Treatment Team follow up and referred to the Community Mental Health Recovery Service

Review: A literature review found 15 other cases of Takotsubo Cardiomyopathy following hanging, of which 13 cases were female. Our case is only the third case of a male diagnosed with Takotsubo Cardiomyopathy following hanging worldwide and the first such case in Europe. All cases made a full recovery

Conclusion: Although Takotsubo is uncommon it is a potentially serious condition which is probably underdiagnosed, due to its varying presentation. Any increased sympathetic activity such as during severe anxiety or panic attacks has the potential to initiate Takotsubo Cardiomyopathy.

Psychiatrists need to be aware of this condition especially in patients following attempted hanging as Takotsubo symptoms can present several hours later

Senior Mental Health Nurse

98. Systematic reviews of psychological therapies: has the gold standard become a lead brick?
Ms Rhiannon Buick, Advanced Interventions Service, NHS Tayside; Mrs Karen Walker, Advanced Interventions Service, NHS Tayside; Dr David Christmas, Advanced Interventions Service, NHS Tayside

Background: The gold standard for evidence-based practice is considered to be a systematic review and meta-analysis of randomised-controlled trials. Whilst there are scales for assessing the
methods and reporting of meta-analyses, the quality of the underlying evidence (and suitability for inclusion) is often not detailed. It is uncertain how generalizable the included studies are to the clinical populations seen in secondary care.

Aims & Hypothesis: We wished to determine if all of the studies would meet criteria relevant to a general adult population (e.g. age 18-65; treatment not prevention; diagnosis of OCD; controlled study; outcome data reported).

Methods: We took a recent meta-analysis of CBT for OCD that included 37 studies published between 1993 and 2014 (Ost, 2015). Each study was assessed by two raters using the CONSORT 2010 guidelines and the Cochrane Collaboration ratings of bias. Differences were resolved by discussion. We also extracted information on the population characteristics from each study along with baseline illness characteristics.

Results: The 37 studies included 2,037 participants. Whilst almost two-thirds of the total sample were outpatients, 25% were recruited from community samples and the population was unspecified in 11%. One study was a relapse-prevention (rather than treatment) trial. No inpatients were included in the studies. Only 75% of studies fulfilled all of our criteria. One study reported duplicate data from another included study. 10% of studies didn't report pre- and post-scores. Ratings of bias revealed high risk of bias estimates in: random sequence generation (3%); allocation concealment (6%); blinding of outcome assessment (30%); incomplete outcome data (51%); selective reporting (14%). The mean ± SD baseline Y-BOCS score in the sample was 25.0 ± 4.1. Only 50% of participants had had previous/current medication. One third of participants in studies (when reported) were treatment naive.

Conclusions: We urge clinicians to be cautious about assuming that they can generalise findings from every meta-analyses to their patients. Ratings of bias may be underestimated and participants typically have much lower levels of severity and treatment resistance than patients seen in secondary care.

99. How to get a good night's sleep in a psychiatric ward: ask staff to rate it

Mrs Anne Mather, Advanced Interventions Service, NHS Tayside; Ms Cara Cockburn, NHS Tayside; Dr David Christmas, Advanced Interventions Service, NHS Tayside

Background: Sleep problems are common in mental disorders and are part of diagnostic criteria for most mood and anxiety disorders. Sleep quality/duration can be a useful marker of illness severity among inpatients and impaired sleep is an independent risk factor for suicide. Traditionally, inpatient staff assess sleep by observing patient activity; often through a window and/or in a darkened environment. These may be suboptimal conditions.

Aims & Hypothesis: We aimed to assess whether staff assessments of sleep quality correlated with self-report assessments.

Methods: Over two separate two-week periods, patients in two inpatient wards (in different hospitals) completed self-report measures of sleep using the Athens Insomnia Scale. Staff were asked to complete concurrent (but independent) ratings of sleep quality using the same scale which permits use by clinicians and patients. Higher scores on the scale indicate worse sleep. Scores between the two groups were then compared and correlations between ratings were reported.

Results: At the end of two periods of assessment, there were 735 ratings from 87 unique patients. The most common diagnoses were: depressive illness (25.3%); schizophrenia (19.5%); personality disorder (8.1%); and drug-induced psychosis (6.9%). 71% of patients were taking an antipsychotic; 42% were on a hypnotic; and 54% were on an antidepressant. Sleep quality varied by diagnosis. Mean scores on the Athens Insomnia scale were: 4.5 for depression; 2.2 for personality disorder; and 3.1 for schizophrenia. Correlations between staff report and patient self-report were poor (R-squared = 0.1), with staff consistently reporting better sleep than patients themselves. Correlations didn't differ significantly by hospital/ward. Attempts to support staff to complete ratings were limited by complex pressures on inpatients staff and other demands on their time.

Conclusions: There is minimal correlation between self-report of sleep quality and staff ratings. We recommend that all assessments of sleep quality and duration in inpatient environments should include information obtained by self-report and should be corroborated with disorder-specific
symptom ratings. Traditional approaches to assessing sleep quality in inpatients are likely to have low reliability.

**Emergency Medicine Trainee**

100. Improving the Journey for Adult Mental Health Patients in the Emergency Department Developing the Adult Mental Health Pathway

Dr Sarah Edwards, Ysbyty Gwynedd, Bangor. Betsi Cadwaladr University Health Board; Dr Phyllida Roe, Devon Partnership Trust, Torbay.; Dr Leesa Parkinson, Ysbyty Gwynedd, Bangor. Betsi Cadwaladr University Health Board

Aims

Our aim was to fully understand the mental health patient journey, the impact on the Emergency Department (ED) and identify potential areas for improvement.

Background

In England during 2011 there were more than 114000 in-patient admissions for intentional self-harm alone. This was a 7% increase on the previous year. The Royal College of Psychiatrists requires all patients presenting with mental health (MH) issues to be assessed by a member of their team. All patients must be seen, treated and discharged or admitted within 4 hours in the ED. We conducted a review of mental health attendances to a South West England general Hospitals ED.

Methods

All patient records presenting between October to December 2013 with a primary MH complaint were reviewed. Data collected included time of arrival, time to first assessment, time to psychiatry assessment and disposition. Following this period and discussion with the Liaison Psychiatry Team. A MH patient pathway was developed. This aimed to fast track these MH patients through triage if medical fit, liaise earlier with the on-call psychiatric team and educate the staff. We re-audited in May 2014 comparing results to the original cohort.

Results

From October-December 2013, 2.7% (215 of 7858) of patients attending the ED had a primary mental health complaint. 45% (98 of 215) of these patients were eligible for psychiatric assessment in the ED for potential direct discharge. Average time to referral was 1 hour 32 minutes by ED staff, with a further average wait of 1 hour 41 minutes for psychiatry review. 42% (41 of 98) of patients spent greater than 4 hours in the department. In May 2014 the average time to referral was 1 hour 6 minutes, with the average time to see psychiatry 1 hour 2 minutes with 13% of patients waiting more than 4 hours.

Conclusion

The introduction of this MH pathway has seen a 40-minute reduction in waiting to see Psychiatry and improved collaboration with our Liaison Psychiatry Team. There has been a 30% reduction in patients breaching the 4 hour target awaiting psychiatry.

**Trust Grade Junior Doctor**

101. No smoking no way! Views of staff and patients on a no smoking policy on psychiatric wards.

Dr Mrityunjai Kumar, Lancashire Care NHS Foundation Trust; Dr Rahul Malhotra, Lancashire Care NHS Foundation Trust; Dr Gurpal Gosall, Lancashire Care NHS Foundation Trust

Aims: We aimed to understand the views of staff and patients on the introduction of a no-smoking policy within a mental health trust.

Background: In January 2015 Lancashire Care NHS Foundation Trust implemented a Nicotine Management Policy (NMP) which prohibited smoking (including e-cigarette use) on the
organisations buildings and grounds. The policy applied to staff and patients, including detained patients.

Methods: We carried out a qualitative study on staff and inpatients using semi-structured interviews. Responses were anonymised, directly transcribed, coded and grouped into themes. Results: Data saturation was achieved after 19 respondents were interviewed. Key themes that emerged in patient interviews (n=10) included that most did not want to quit smoking, that smoking was a coping strategy, that smoking cessation should not be part of their treatment package, a perception that the policy infringed on their right to smoke and that the policy implementation lacked compassion. Some patients expressed a reluctance to stay in hospital because of the policy.

All the staff respondents (n=9) believed that policy should not exist. Concerns were raised that the policy was at odds with least-restrictive practice, that it impeded a collaborative approach with patients, that detained patients had not chosen to be admitted to a no-smoking organisation and that some absences without permission were caused by the policy. Staff reported increased episodes of patient aggression.

Conclusions: Challenges remain in persuading staff and patients of the merits of a no-smoking policy. Despite clear evidence of the adverse health consequences of smoking and the provision of nicotine replacement, many found it difficult to accept the policy. The conflict between adopting a least-restrictive approach and forcing patients to quit smoking presents a dilemma to staff, with many of them siding with patients who want to smoke. A more flexible and collaborative approach may allow for a smoother implementation in smoking patients.