



# **North West Trainee Presentations**

## **Spring 2010**

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# **Oral Presentations**

**The stability of the diagnosis of 'drug induced psychosis'**

*Dr Rob Poole, Glyndŵr University*

*Dr Robert Higgo, Merseycare NHS Trust*

**1. Background:**

Little is known about the course and outcome of psychosis attributed to cannabis and other drug use in the UK.

**2. Methods:**

Patients with no past psychiatric history who had been discharged from inpatient care between January 2002 and April 2006 with a firm diagnosis of drug induced psychosis were identified. Follow up information for at least the next two years was collected retrospectively from psychiatric records.

**3. Results:**

98 patients were identified. 78 were included in analysis. 41% were discharged to primary care follow up within two years. One person was re-referred. Nearly all of the patients who remained under psychiatric follow up experienced a change in diagnosis, most commonly to a schizophreniform disorder. The patients who were retained in follow up had experienced significantly longer index admissions than those discharged to primary care ( $p=0.05$ ). There was no evidence of a particular association between cannabis induced psychosis and a later diagnosis of schizophrenia.

**4. Conclusions:**

This study supports the suggestion that patients diagnosed as suffering from drug induced psychosis are either suffering from the effects of drug intoxication or are suffering from an ordinary functional psychosis complicated by incidental drug use. The findings do not support a special role for cannabis induced psychosis as a precursor of major psychosis.

## The Use of Antipsychotics in Dementia

*Dr Sandy Rao, Merseycare NHS Trust*

### 1. Background:

There has been increasing concern in recent years that antipsychotic medication is prescribed excessively to dementia patients. In this group of patients these drugs are poorly tolerated, have undesirable side effects and may accelerate cognitive decline.

### 2. Standards:

The main standards were based around the criteria that must be met before and while antipsychotics are prescribed, including non-pharmacological interventions, consideration of past medical history, discussion with patient and carers, care planning and dose titration. In addition, patients should not have been prescribed risperidone or olanzapine and lewy-body dementia patients should not have been prescribed antipsychotics unless cholinesterase inhibitors had been unsuccessful.

### 3. Method and Setting:

The audit looked at antipsychotic prescribing to dementia patients in in-patient, day hospital and continuing care facilities in Merseycare NHS Trust, South Liverpool. The findings were compared with standards derived from current guidelines. The initial audit was undertaken in May 2008 and the audit loop completed in November 2009.

### 4. Results:

The re-audit revealed a reduction in the percentage of patients prescribed antipsychotics, 34% compared to 48% in the initial audit. There were improvements in all areas of all standards set; most of these were significant improvements.

### 5. Lessons and Conclusions:

Antipsychotic use in dementia must be in accordance with current clinical guidelines and should be the last resort in most cases. Staff and carers should be educated about good clinical care in the management of the behavioral and psychological symptoms of dementia and the importance of thorough documentation. There should be a trial of antipsychotic dose reduction when symptoms have been under control for three months.

**Knowledge of mental health legislation in junior doctors training in psychiatry**

*Dr Aadil Jan Shah, CWP NHS Trust*

*Dr Nadarajah Jehaanandan, CWP NHS Trust*

*Professor Peter Kinderman, University of Liverpool*

**1. Background:**

Trainees in psychiatry are required to maintain and use an adequate and up to date knowledge of legislation that applies to any aspect of their professional practice. We therefore undertook a survey of psychiatric trainees to assess their knowledge of the procedures involved in involuntary admission of patients detained under section 5(2), section 2 and section 3 of the Mental Health Act 1983, as amended by the Mental Health Act 2007.

**2. Methods:**

A survey of junior doctors training in psychiatry affiliated to two training schemes in the northwest of England. Sixty trainees were interviewed by authors using a questionnaire designed specifically for the purpose.

**3. Results:**

Participants' knowledge of professionally relevant Sections of the Mental Health Act was generally low. Knowledge correlated significantly with experience in clinical practice, and with experience of using mental health legislation. Worryingly, experience of formal induction training by the employing Trusts had no significant effect on participants' knowledge, with performance actually slightly lower in the group having received induction training.

**4. Conclusions:**

There are potentially serious inadequacies in psychiatric trainees' knowledge of key mental health legislation. Inappropriate uses of Mental Health Act threaten patients' fundamental rights and can have important consequences for the doctors involved and their employers. Inappropriate use can lead to patient complaints or litigation. Psychiatric trainees may benefit from additional focused training in mental health law than at present and should be tested for competencies in mental health legislation.

## **Does the implementation of an investigation clinic reduce the time from referral to treatment in patients with suspected Dementia?**

*Dr Harry Allen, Manchester Mental Health Trust*

*Dr Ross Overshott, GMW NHS Trust*

### **1. Background:**

The National Dementia Strategy (2009) states dementia sufferers should have access to a pathway delivering quality early diagnosis and intervention. The majority of referrals to Old Age Psychiatry Manchester Royal Infirmary are received from GPs requesting assessment of patients with suspected dementia. In 2004 the mean time from referral to assessment in a treatment clinic was 335 days. A 'one stop shop' (OSS) was introduced where patients have all basic investigations in a day.

### **2. Standards:**

The aim of the audit was to assess where the pathway from referral to assessment for treatment fits within the 18 week rule, to assess the success of implemented change, and to monitor GP's adherence to Primary Care Trust Guidelines.

### **3. Method and Setting:**

Patients referred to the drug treatment clinic (DTC) between January 2007 - December 2008 were identified and those whose notes were available included. The delay between pathway stages was recorded as well as GP investigations.

### **4. Results:**

Implementation of the OSS has reduced overall wait time by over 100 days. All patients had hospital tests ordered together, compared to 44% before OSS. Average wait for investigation completion was 58days. Pre OSS this wait could reach 184 days if complications arose. 50% of GP referrals had blood tests included.

### **5. Lessons and Conclusions:**

The OSS has reduced overall wait time by a third. The greatest reduction is seen in wait time for investigation completion. Consideration to reduce waiting times further could be made as the pathway still takes excessive time to complete. Adherence by the GPs has deteriorated, this needs to be addressed.

# **Poster Presentations**

**High Dose and Polypharmacy Peer Reviews in a High Secure setting**

*Dr Edward Silva, Merseycare NHS Trust*

*Dr Noir Thomas, Merseycare NHS Trust*

**1. Background:**

Ashworth Hospital has taken successful measures to reduce high dose and polypharmacy antipsychotic use. One component has been regular systematic peer review of such practice followed by recommendations. We audited this practice.

**2. Standards:**

- i) Recommendations made by the peer group following RMO presentation should be implemented.
- ii) Mental state and physical health outcomes should be monitored following implementation of recommendations.
- iii) If recommendations are not implemented, clear reasons for this action should be given.

**3. Method and Setting:**

The recommendations and the outcomes in terms of implementation, recording of deviation, and clinical progress (mental state and physical health) were identified using the audit meeting minutes and discussion with consultants.

**4. Results:**

20 patients were identified, 14 of which had had the changes suggested made. Of the remaining 6, 4 had other changes made which resulted in either better prescribing practice or improved mental state. The remaining 2 had had other reasonable interventions.

Of the 14 patients, 12(86%) experienced either no change or an improvement in their mental state. 1 (7%) deteriorated and there was uncertainty with the effect on the last.

5 patients (36%) were noted to have physical effects with 2 losing weight and 3 having an adverse effect. (prolongation of QTc, diabetes, hypertension and hypercholesterolaemia.)

**5. Lessons and Conclusions:**

Peer review was successfully used and monitored regarding this practice, with most patients benefiting. Few had adverse effects on their mental or physical health. Whilst the raw data suggested some difference in the performance of some consultants when this was subject to statistical scrutiny no difference was evident.

**A quantitative and qualitative survey was conducted to explore the awareness and attitudes of Psychiatrists in Pennine Care and Greater Manchester West NHS Foundation Trusts towards assessment and management of sexual health side effects (SSE) of antipsychotic medication**

## **1. Background:**

Sexual side-effects of antipsychotics are one of the major causes of treatment dropouts and its assessment and management is important to improve quality of life. However, assessment of sexual side effects continues to be neglected. A survey of all psychiatrists in 2 major mental health trusts of Greater Manchester was conducted to ascertain the awareness and attitudes of psychiatrists towards assessment and management of sexual side effects of antipsychotics.

## **2. Methods:**

An online questionnaire was designed and sent to all psychiatrists working in Pennine Care and Greater Manchester West NHS Foundation Trusts. All responses were analysed using Microsoft Excel.

## **3. Results:**

All the SAS, Consultants and ST4-6 (but only 1/4<sup>th</sup> of ST 1-3) psychiatrists were aware of the SSE.  
Only 23% of the respondents felt that assessment of SSE was very important.  
54% of the respondents did not regularly assess SSE of which 40% were consultants.  
None of the respondents used a validated scale to assess SSE.  
34% of the respondents were not aware of the medications that can be used to manage SSE of whom 59% were ST1-3.  
Prominent barriers to assessing SSE included lack of training and limited understanding of symptoms.

## **4. Conclusions:**

There is a clear lack of awareness amongst core trainees which needs to be addressed through MRCPsych curriculum and clinical supervision. Senior psychiatrists need to be proactive in assessment of SSE and regular training sessions are required to update their knowledge and skills. In addition, mental health trusts should have separate/dedicated policies for management of SSE.

**Evaluation of an Adult ADHD Service**

*Dr Peter Mason, CWP NHS Trust*

**1. Background:**

To evaluate functional and symptomatic outcomes in 55 patients who have completed 6 months or more treatment with the Adult ADHD Service of the Cheshire & Wirral Partnership NHS Foundation Trust

Despite a prevalence of 2% in the population the needs of adults with ADHD are largely unmet. NICE clinical guideline 72 published in September 2008 recommended the need to set up multidisciplinary teams to meet this need. The developing Adult ADHD Service of CWP offers assessment and treatment for adults with a possible diagnosis of ADHD.

**2. Methods:**

All patients who were given a diagnosis of ADHD and who had completed more than 6 months of treatment with the Adult ADHD Service were evaluated using the Global Assessment of Functioning Scale (GAF) and Health of the Nation Outcome Scale. These scales had been completed at onset of treatment and at follow-up (N = 55). Treatment consisted of either Methylphenidate or Atomoxetine. Scores for risk and substance misuse were taken from the subsections of HoNOS

**3. Results:**

GAF Scores and HoNOS scores { (GAF  $p < 0.0001$  ( $t = 6.614$ ) HoNOS  $p < 0.0001$  ( $t = 6.8517$ ) } both improved over the course of treatment and this improvement was statistically significant. A statistically significant reduction in risk score (Risk  $p < 0.0001$  ( $t = 5.6936$ ,) was also demonstrated and there was a reduction in substance misuse (0.0949 ( $t = 1.6997$ ) as well.

**4. Conclusions:**

Investment in Adult ADHD services by CWP has produced positive outcomes in functioning, symptoms, risk and substance misuse despite treatment being limited to pharmacotherapy only. Better outcomes are expected as the service expands to include psychological therapies

## Locked doors on psychiatry wards- Do they serve any purpose?

Dr Sudip Sikdar, Merseycare NHS Trust

### 1. Background:

A retrospective study was carried out that aimed at evaluating the safety and security measures of a locked (coded) door system in adult mental health inpatient units before and after they were introduced at University Hospital Aintree site, Mersey Care NHS Trust in Liverpool. The study also investigated whether the locked door system reduced the number of adverse incidents, 1:1 observation levels and number of Sec5 (2) applications

### 2. Standards:

Many mental health units in the late 1990s introduced the facility to lock their inpatient wards either using a key lock system or a digital code to prevent in-patients from leaving the ward without staff permission. This seemed to be reasoned and planned in order to reduce incidents. A number of studies however revealed that the disadvantages outweighed the advantages of such a policy. Moreover locked doors were thought to be responsible for reduced self confidence in some involuntary patients while voluntary clients felt the policy to be unfair as they too were 'locked in'

### 3. Method and Setting:

The following incidents which were considered to be common in a unit with open doors and were compared between the two study periods: *Absconding, substance misuse, false fire alarms, security breaches, theft, C&R incidents, Sec 5(2) MHA applications and close observation(1:1,1:2)levels*

### 4. Results:

Results revealed that there were no significant differences either in the number of section 5 (2) ( $\chi^2 = 3.545, p=0.06$ ) applications or in adverse incidents and observation levels with the locked (coded) door system This highlights the expenses involved in using bank staff and those incurred in changing the door codes. Patients rather felt unsafe and described the locked wards as prisons.

### 5. Lessons and Conclusions:

This may question the very justification of having locked doors on psychiatry wards. Results of this study echoes that of a previous studies and the need for hospital managers to reflect on the wider implications of locking ward doors and preserving the rights of informal patients.

**Patient choice, satisfaction and involvement at St. Helen's North  
CMHT- time for change?**

*Dr Debakanta Behera, 5BP NHS Trust*

**1. Background:**

Promoting choice in mental health acts as a platform for psychiatrist's to empower their patients and promote their independence. The exciting recent development of the Royal College of Psychiatrist's working group on Choice in Mental Health has set out a "choice agenda" that calls for wider patient choice and participation to be at the centre of future college policy.

**2. Methods:**

We designed and piloted a comprehensive patient questionnaire that focused on 3 key 'choice areas'- access, medication and information sharing. The survey was distributed to all CPA patients who attended St. Helen's North CMHT base for CPA review with their psychiatrist during September-December 2009.

**3. Results:**

Out of the 113 community mental health team patient's who returned completed or partly completed questionnaires: 62% of patients were female, and 2% were employed. 65% of respondents were either "completely" or "very" satisfied overall. Historically the majority of patients (63-92%) had *not* had choice on matters such as: choice of psychiatrist, care-coordinator, time of appointment, and venue of review. 63% of respondents considered involvement in choice of medication as either "essential" or "very important" and 42% want to be more involved in this matter in the future. 41% of respondents wanted the psychiatrist alone to make the final decision on choice of medication. 62% of patients want to have copies of their care plans/clinic letters in the future.

**4. Conclusions**

Historically patient choice in this CMHT has been lacking. Patients do want more choice regarding their future psychiatric care especially on access, information sharing and medication.

**Impact of a new approach 'Acute Care Model' on detained patients in Adult Psychiatric wards**

*Dr Sowmya Krishna, Merseycare NHS Trust*

*Dr Qaiser Javed, CWP NHS Trust*

**1. Background:**

Acute Care Model introduced in 2003 in UK has revolutionised the way Adult inpatient services are provided. The impact of this model on detained patients has not yet been reported. This might serve as a service evaluation tool for this new model.

**2. Methods:**

Data on Section 2 (for assessment) and Section 3 (for treatment) were collected retrospectively from the Mental Health Act (MHA) Register at the hospital MHA Office. This was supplemented by information from the electronic records where clarifications required. As the Acute Care Model was implemented on 6<sup>th</sup> June 2007, the data were collected from 6<sup>th</sup> March 2006 to 5<sup>th</sup> Oct 2008. The information collected included the date of implementation of detention, date of discharge and outcomes on discharge. From these data, the number and duration of stay of detained patients were calculated.

**3. Results:**

The number of people who were detained in hospital before and after the introduction of acute care did not change (n=122). However, the average duration of detention under Section 3 reduced significantly from 81.44 days to 46.25 days (43.21% reduction). There had also been a 55% decrease in the utilisation of tribunal hearings after the implementation of the new model (45 tribunals before vs 18 tribunals after).

**4. Conclusions:**

The Acute Care Model in Adult Psychiatry seems to have had a significant positive impact on detained patients in reducing their in-patient stay and the need for tribunal hearings. This in turn has substantial financial implications.

## **Brief Intervention and Referral for Smoking Cessation in Liverpool Community Rehabilitation Service**

*Dr Selvaraj Malarvizhi, Merseycare NHS Trust*

*Dr Robert Brown, Merseycare NHS Trust*

*Mrs Patricia Parker, Merseycare NHS Trust*

*Mr Jim Meehan, Merseycare NHS Trust*

### **1. Background:**

Brief Intervention and Referral for Smoking Cessation (BIRSC) is embedded in the Care Programme Approach for Liverpool Rehabilitation Service. Our literature review reported no studies that examined the impact of BIRSC on community rehabilitation service users (SUs). This study is the first of its kind that aims to do so.

### **2. Standards:**

Brief interventions and referral for smoking cessation in primary care and other settings. Public Health Intervention Guidance No.1. London: NICE; 2006.

### **3. Method and Setting:**

A questionnaire was revised based on criteria recommended by NICE. Data was obtained from clinical notes and interviews with community SUs and staff. Data was stored and analyzed using SPSS-16. Descriptive and non-parametric statistics were used. The audit was completed in August-September 2009.

### **4. Results:**

The whole case-load of 102 SUs was included; male: female ratio was 2.3. Mean age was 51 years. 76(75%) of SUs were smokers. Median number of smoked cigarettes per day was 30. 70(90%) of the smokers received BIRSC, 34(44%) attended NHS Stop Smoking Service, 16(21%) received nicotine replacement therapy. 10(13%) reported benefiting from BIRSC by reducing the median number of smoked cigarettes from 35 to 13 per day ( $T=45$ ,  $n=10$ ,  $p<0.01$ , 95% CI=0-0.03). Of these 10 people, 9 were males (16% of male smokers) compared with 1 female (4% of female smokers).

### **5. Lessons and Conclusions:**

BIRSC is a cost effective intervention in reducing smoking level. Benefits will be audited annually with aim of increasing quitting rate. The findings should encourage healthcare professionals to incorporate BIRSC into their practice as the study findings are generalisable to other mental health settings.

## The Use of Neuro-imaging Techniques in Dementia patients - A Study in the Memory Clinic

### 1. Background:

There are currently 700,000 people in the UK with dementia. The diagnosis of dementia is made clinically using structured history taking and mental state examination.

### 2. Standards:

The NICE guidelines state that 'structural imaging should be used in the assessment of people with suspected dementia to exclude other cerebral pathologies and to help establish the subtype of dementia.'

### 3. Method and Setting:

The study was carried out retrospectively on case notes of patients who visited the memory clinic at the Hesketh Centre for the first time between 1 July 2008 and 31 December 2008 (6 months' period). Only patients who visited the memory clinic for the first time were included.

### 4. Results:

75 patients met the eligibility criteria to enter the study (first visit to the memory clinic). These included 22 males (29%) and 53 females (71%)  
75% of the patients received a head scan, the majority of whom received a CT scan.

A single provisional clinical diagnosis following the initial assessment was documented in 47 patients (62.5%).

The diagnosis of dementia subtype was NOT changed following the head scan in 55% of patients.

### 5. Lessons and Conclusions:

This study emphasises the importance of history taking and mental state examination as the main tool for making the diagnosis of dementia, and that neuro-imaging should be used to assist the diagnosis and exclude other cerebral pathologies.

## **Impact of the smoking ban on the incidence of adverse events in adult psychiatry wards on the Wirral**

### **1. Background:**

This research was conducted to investigate the impact of the smoking ban on the incidence of adverse events in adult psychiatry wards on the Wirral. This study was prompted by concerns that the smoking ban may cause an increase in adverse events on the wards. In 2008 there were 587 admissions, 115 violent incidents and 34 emergency detentions (section 5.2 and 5.4 of the mental health act).

### **2. Methods:**

We compared the number of violent incidents reported in the 6 months before and after the smoking ban. We also compared the number of emergency detentions implemented in the 6 months before and after the smoking ban.

### **3. Results:**

There was a 36% reduction in violent incidents in the 6 months after the smoking ban compared to the 6 months before the ban (70 in the 6 months before and 45 in the 6 months after). There was a 64% reduction in emergency detentions in the 6 months after the smoking ban compared to the 6 months before the ban (25 in the 6 months before and 9 in the 6 months after). The number of admissions during each 6 month period that we looked at were very similar (288 in the first 6 months and 299 in the second 6 months).

### **4. Conclusions:**

Prior to the smoking ban there were concerns that it may cause an increase in the number of violent events and patients who required emergency detention. This study shows that there was a reduction in the incidence of adverse events following the smoking ban.