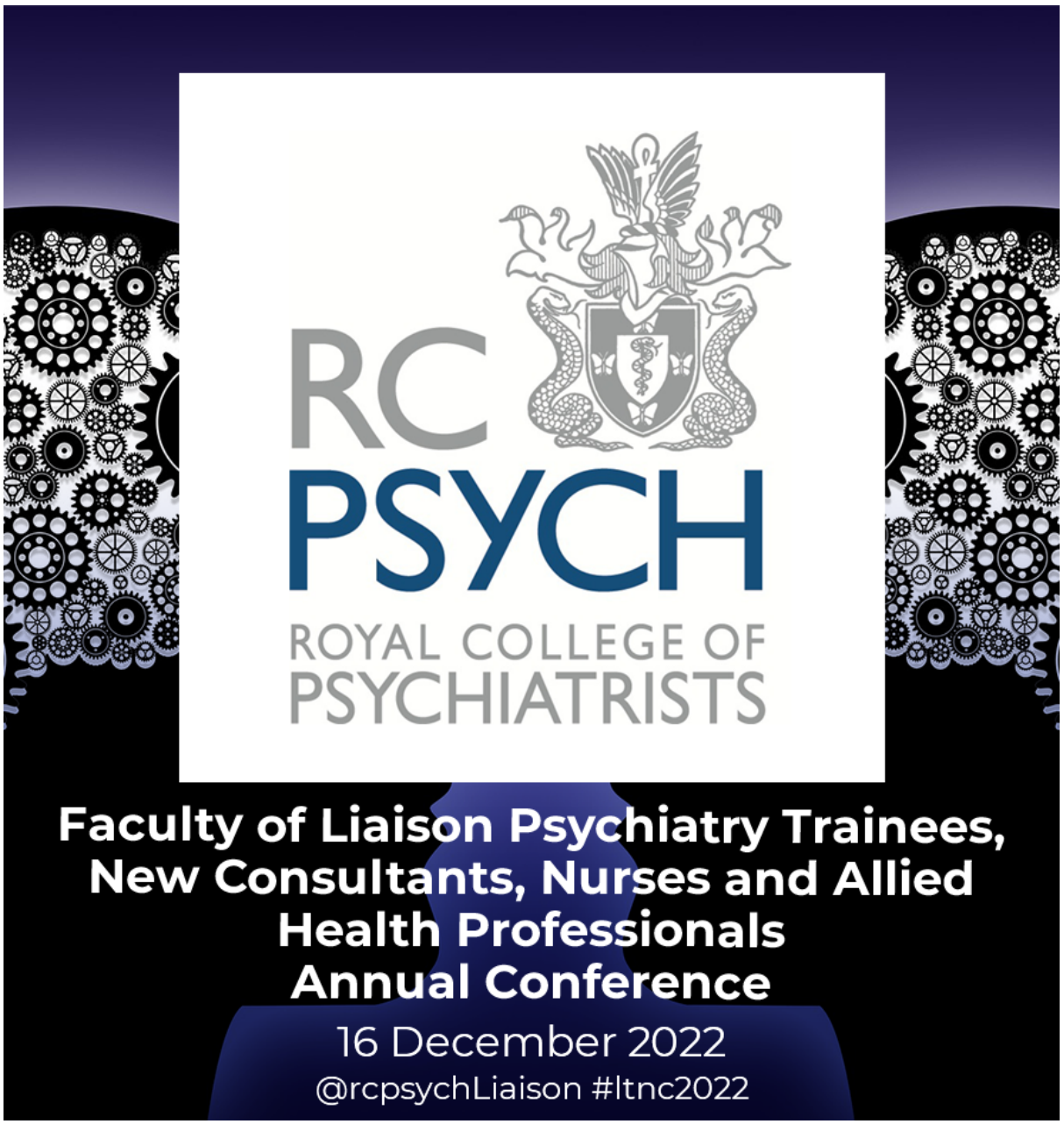

Conference Booklet

General Information

Accreditation

This conference is eligible for up to 6 CPD hours, subject to peer group approval.

Certificates

Certificates of attendance will be emailed to delegates after the conference.

Feedback

A detailed online feedback form can be found by visiting

- Friday 16 December 2022

All comments received remain confidential and are viewed in an effort to improve future meetings.

Social Media

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Programme

9:10	**Welcome** Dr Maytal Wolfe and Dr Emma Leighton **Introduction from Liaison Faculty chair** Dr Annabel Price		
9:45-10:30	**Diagnostic overshadowing in older people presenting in liaison psychiatry** Dr Matt Sheridan, lead clinician for old age liaison psychiatry NHS GGC		
10:30-11:15	**Effectively running a CAMHs liaison service in NHS GGC** Mr Martin Donnelly, CAMHs liaison nurse specialist		
11:15-11:45	Morning Break		
11:45-12:30	**Functional cognitive impairment** Dr Laura McWhirter, consultant neuropsychiatrist, NHS Lothian		
12:30-1:15	**NMDAR encephalitis and psychosis** Dr Rajeev Krishnadas, consultant psychiatrist, Esteem (First Episode Psychosis) NHS GGC		
1:15-2:15	Lunch break		
2:15-3:30	**Parallel Sessions – a choice of 3 sessions**		
	Session 1	*Session 2*	*Session 3*
	MEED Guidelines & eating disorder case presentation with discussion Dr Stephen Anderson, consultant eating disorder psychiatrist NHS GGC, and Dr Chloe Beale, consultant liaison psychiatrist & clinical lead, East London NHS	**Implementation of a GGC wide liaison psychiatry CPD session: how to maximise learning** Dr Matthew Morrison, consultant liaison psychiatrist, Dr Cathy Tran, clinical psychologist and Ms Lorraine Robertson, adult MH liaison service nurse team lead	**Discussion with the parent of a service user** Mr Martin Donnelly, CAMHs liaison nurse specialist with Hannah Roussel and Lily Roussel
3:30-:4:00	Afternoon break		
4:00-4:45	**New member elections** **Quick fire poster presentations**		
4:45	**Close of Conference**		

Presentation abstracts and speaker biographies

Introduction from Liaison Faculty chair

Dr Annabel Price

Annabel trained in medicine at the Royal Free Hospital School of Medicine, London before training in General Adult, Old Age and Liaison Psychiatry on the Maudsley Hospital Rotation London. Annabel went on to be a Clinical Lecturer in Palliative Care Psychiatry. Currently Annabel is a Consultant Liaison Psychiatrist, Older People's Team, Addenbrookes Hospital and a teaching specialist in palliative care. She is Chair of the Faculty of Liaison Psychiatry, Royal College of Psychiatrists.

Diagnostic overshadowing in older people presenting in liaison psychiatry

Dr Matt Sheridan, lead clinician for old age liaison psychiatry NHS GGC

10 years as a Consultant Psychiatrist working in Old Age Hospital Liaison. Lead Clinician of Old Age Hospital Liaison services in Glasgow. Investigator on dementia studies in Glasgow Clinical Research Facility. Research interests are dementia, delirium and lewy body diseases.

Effectively running a CAMHs liaison service in NHS GGC

Mr Martin Donnelly, CAMHs liaison nurse specialist

Functional cognitive impairment

Dr Laura McWhirter, consultant neuropsychiatrist, NHS Lothian

Laura McWhirter graduated MBChB from the University of Edinburgh in 2008, having taken an unusual route to medicine after a degree in music from the University of York in 2001. Dr McWhirter completed specialist training in General Adult and Liaison Psychiatry in South East Scotland in June 2018. Her research is primarily in the areas of Functional Neurological Disorders, cognitive disorders, and brain injury.

NMDAR encephalitis and psychosis

Dr Rajeev Krishnadas, consultant psychiatrist, Esteem (First Episode Psychosis) NHS GGC

Parallel sessions

MEED Guidelines & eating disorder case presentation with discussion

Dr Stephen Anderson, consultant eating disorder psychiatrist NHS GGC, and Dr Chloe Beale, consultant liaison psychiatrist & clinical lead, East London NHS

Stephen is a consultant psychiatrist in eating disorders in NHS Greater Glasgow and Clyde, and is Clinical Director for adult mental health services in North East Glasgow. He was joint lead of the Scottish Government national review of eating disorder services and chaired the skills and training working group of the National Implementation Group to take forward recommendations from the review. He is a Trustee of Beat, the UK eating disorder charity and is secretary of the European Chapter of the Academy for Eating Disorders.

Dr Chloe Beale is a consultant liaison psychiatrist in East London. She is a member of the RCPsych liaison faculty and eating disorder faculty executive committees. She chairs a joint faculty working group on the management of medically unwell patients with disordered eating in acute hospitals.

Implementation of a GGC wide liaison psychiatry CPD session: how to maximise learning

Dr Matthew Morrison, consultant liaison psychiatrist, Dr Cathy Tran, clinical psychologist and Ms Lorraine Robertson, adult MH liaison service nurse team lead

Discussion with the parent of a service user

Mr Martin Donnelly, CAMHs liaison nurse specialist with Hannah Roussel and Lily Roussel

Quick fire poster presentations

(pre-recorded talks)

An audit of the quality and completion of liaison psychiatry assessments at Torbay Hospital (Devon Partnership Trust) using interim measures during the Carenotes outage

Dr Francesca Harris

Reasons for referral from a specialist obesity service to liaison psychiatry and outcomes

Dr Ho Tim Timothy Leung

Psychosocial Impact of being diagnosed with Mild Cognitive Impairment; a patient and carer perspective

Dr Nina Munawar

Comorbid Anxiety and Depression in Intestinal Failure and Colorectal Patients

Dr Sophie White

Poster abstracts

1. Mental Health Manifestation in Milk-Alkaline Syndrome

Dr Suraju Adeyemo, Older Adult Specialist Trainee (ST5), 1. Dr Suraju Adeyemo, ST5 old age psychiatry, Lancashire and south Cumbria NHS Foundation Trust 2. Dr John Erfani, SAS, MHLT, Lancashire and south Cumbria NHS Foundation Trust 3. Dr Attique Shafiq, SAS, MHLT, Lancashire and south Cumbria NHS Foundation Trust 4. Dr Collins Chukwuma, CT, Lancashire and south Cumbria NHS Foundation Trust. 5. Dr Mark Worthington, OA Liaison Psychiatrist Consultant, Lancashire and south Cumbria NHS Foundation Trust.

BACKGROUND Milk-alkali syndrome is a medical condition, which could present with psychiatric manifestations. Caused by hypercalcemia resulting from ingestion of large amounts of calcium and absorbable alkali. The core symptoms include hypercalcemia, metabolic alkalosis, and renal failure. Diagnosing this syndrome requires a high index of suspicion. AIMS: In this paper, we describe the case of Mrs C who had psychotic symptoms because of Milk-Alkaline syndrome. METHODOLOGY: Mrs C was a 75-year-old white British female with previous history of anorexia nervosa who has been clinically stable for more than 15years. She was discharged by the community mental health services about 11 years ago but has been on repeated dose of gaviscon for about 8 years. She presented to the accident and emergency (A and E) unit with history of confusion, unsteadiness, paranoid beliefs, low mood, and reduced rate of speech. No history of infection or other physical health concern. Routine blood showed increased calcium, bicarbonate and sodium, with reduced potassium level. CT head scan did not show any acute changes. She was stabilised and transferred to the ward for further management. Result: While on the ward, she had diagnosis of Milk-Alkaline syndrome with psychiatric manifestation. Gaviscon was discontinued because medic felt this was responsible for the electrolyte imbalance. She was also referred to the mental health liaison team (MHLT). At the time of psychiatry review, electrolyte had been corrected. Impression following review of Mrs C mental state was that she had no acute mental disorder. She was subsequently discharged from MHLT and referred to the GP for follow up. Conclusion: Diagnosis of Milk-Alkaline Syndrome requires a high index of suspicion, missing this could lead to inappropriate use of medication. As psychiatrist, this case has shown the importance of adequate investigation before making a definitive diagnosis especially in a psychiatric liaison setting

2. Patient Perspective of the Quality of Assessments

Dr Oluwatoyin Aliu, Core Psychiatric Trainee, Dr Zahra Patel, ST5, Dr Fiona Shaw CT3, Dr Toyin Aliu CT2

Aims: This Quality Improvement (QI) Project was established to 1) evaluate the quality of the assessments for patients referred to PMPC 2) improve the quality of the assessments in order to improve patient care and the support offered to patients. Background: The Psychological Medicines in Primary Care (PMPC) Service in Stockport works with patients in the Stockport borough with complex mental health needs including persistent physical symptoms and

personality difficulties with a high use of health services. Prior to being accepted by the service, PMPC offers an assessment which can span between 2-5 sessions. The service views assessment as a therapeutic intervention in its own right. Method: In June-July 2020, 32 telephonic semi-structured interviews were collected from post-assessment service-users. Following this, the three authors of this poster, conducted a thematic analysis of the interviews, using an inductive approach to derive themes from the data relating to how service-users perceived the quality of their assessment with PMPC. Results: Five key themes were identified, the most significant being feedback on what service-users viewed as therapeutic elements of the assessment process and how specific skills and methods utilised by the assessors related to this as well as the perception of the strength of the therapeutic alliance. Significantly, patients also fed back on ruptures in the relationship, which related to what they experienced was missing in the relationship with the assessor(s). Conclusion: The results from this QI Project clearly demonstrate that the process of assessment can be a therapeutic intervention, including the specific ways in which this can be done, which patients can benefit from even if not accepted for ongoing input from PMPC and by extension, other services. Based on the results of this project, the authors have made recommendations to PMPC on how the assessment process can be further improved.

3. An audit of the quality and completion of liaison psychiatry assessments at Torbay Hospital (Devon Partnership Trust) using interim measures during the Carenotes outage

Dr Francesca Harris, Trust Grade Doctor, Dr Francesca Harris, Trust Grade Doctor, Torbay Liaison Psychiatry, Devon Partnership Trust

Aims and Hypothesis To identify areas of inconsistency in interim note keeping methods during the Carenotes outage and improve this. Even in exceptional circumstances, all patient information and notes should be thorough, complete and accessible. Background The Carenotes outage since 4th August 2022 has meant affected trusts have been unable to access patient data and have needed to develop alternative systems for recording patient notes. This has led to inconsistencies in the way notes are recorded, and omissions of information which, at times, could have had a potentially detrimental impact on ongoing patient care. Methods An audit was completed looking at initial and risk assessments conducted by liaison psychiatry at Torbay Hospital over a 2 week period between 31/08/22 and 14/09/22. In this time 91 referrals were received. Assessments were audited for 12 domains chosen in line with Psychiatric Liaison Accreditation Network standards, including patient identification factors, medications, drug and alcohol use and care planning. After highlighting the importance of accurate recording and team education in person and via email, a further 80 assessments were audited between 09/10/22 and 23/10/22 to assess improvement. Results There was improvement in all domains measured on repeat audit. The most significant improvement was recording of alcohol use and smoking, increasing by 40% and 41% respectively. There was 100% completion rate in 6/12 domains on repeat audit, compared with 0/12 in the first audit. Conclusions Simple education and frequent reminders significantly improved documentation. The repeat audit highlighted certain areas of

assessments which continued to be more frequently missed by assessors. These included prescription medications, smoking, and recreational drug use, demonstrating a need for ongoing education and building confidence in these areas.

4. Liaison Psychiatry Referrals in a Large Teaching Hospital: A Quality Improvement Project

Dr Lyam Hutchinson, FY Doctor, Dr Lyam Hutchinson, FY1, GSTT NHS Trust. Dr Donia Amdouni, FY1, GSTT NHS Trust. Dr Perera Bentarage Nethmi Dulanga, FY2, GSTT NHS Trust. Dr Anna Borissova, CT3, GSTT NHS Trust. Dr Oliver Tamblyn, FY2, GSTT NHS Trust. Dr Areeb Zar, FY2, GSTT NHS Trust. Dr Kirsten Howson, ST4, GSTT NHS Trust. Dr Cormac Fenton, Consultant, GSTT NHS Trust. Dr Ranjith Gopinath, Consultant, GSTT NHS Trust.

Aims & Hypotheses Our aim of this project was to improve hospital staff understanding of the referral process, with a long term aim to improve referrals. We hypothesised that we could improve the referral process by: 1. Understanding what difficulties referrers have 2. Addressing identified difficulties, such as needing access to information or guidance 3. Providing a Referrals Guide Background Liaison psychiatry bridges the gap between physical and mental health. This requires adequate communication, aided by an effective referral. We identified limitations in this process. Referrals contained limited information, were more appropriate for other sub-specialities, and did not have risk information. Methods PLAN: Survey 1: We surveyed a random sample of nursing and medical staff about their confidence/knowledge when making referrals; measured on a 1-10 scale. We recorded awareness of sub-specialty teams with a 3 point scale. Suggestions were collected. DO: Based on responses, we created and distributed a referral guide as hard copies, on the hospital intranet and through junior doctor groups. STUDY: Survey 2: We repeated the survey. We calculated mean scores on confidence and knowledge, with an unpaired t-test comparison of pre-post scores, significance level of <0.05. ACT: Target specific wards to raise awareness and identify what support with referrals the wards would like. Results Following introduction of the guide, the mean difference in confidence/knowledge between Survey 1 and Survey 2 was 0.04 – 0.62 ($p=0.21$-0.93). Awareness of available sub-specialty teams also did not change. Conclusions We found no improvement in staff confidence and knowledge referring to liaison psychiatry following implementation of a referral guide. We considered the following reasons: were people given enough time to utilise the guide, do staff need teaching on the guide. We are now taking a targeted approach, identifying a small number of wards and providing teaching about the referral process.

5. Prevalence of Excessive Internet Use in a Clinical Sample of Adolescents Attending a Child and Adolescent Mental Health Service in Sligo/Leitrim/West Cavan Ireland

Dr Nneka Kalu, Consultant Psychiatrist, Dr Nneka Kalu, Consultant Child and Adolescent Psychiatrist, CAMHS in Sligo/Leitrim/West Cavan Ireland - Dr Alameen Salih, Registrar CAMHS, CAMHS in Sligo/Leitrim/West Cavan Ireland - Dr Surriaya Jabeen, Registrar CAMHS, CAMHS in Sligo/Leitrim/West Cavan Ireland

Aims To assess the prevalence of excessive internet use in a clinical sample of adolescents attending CAMHS Sligo/Leitrim/West Cavan Ireland. To determine the relationship between the level of internet use and their psychiatric diagnosis. To identify prevailing online habits and its relationship to their diagnosis. Background Multiple review of research papers have identified that excessive internet use can have an impact on the emotional, social and psychological wellbeing of adolescents with presentations ranging from aggressive behaviours, disturbed sleep, social withdrawal, depressed mood, suicidal ideation, poor family relations, etc. Methodology Cross sectional survey of adolescents aged 13-17 over 3 months using a self-rated 20-item internet addiction test questionnaire developed by Dr Kimberly Young. Scores were calculated with scores ranging from 0-30 classed as normal use, 30-49 as mild, 50-79 as moderate and 80-100 as severe of use. A brief questionnaire inquiring about internet use habits was also used. Results Excel and SPSS version 20 used for analysis. Results were evaluated at a 5% significance level. Total patients were 46. 40% (n=19) males, 60% (n=27) females. 7% reported normal levels of internet use, 42% reported mild levels, 46% reported moderate levels and 5% reported severe levels of excessive use. The commonest reasons were entertainment 93%, messaging 83%, social media 90%, information gathering 58% and games 52%. Neither there was a significant association between the level of internet usage and diagnosis nor between gender and level of internet addiction. Conclusion Findings show a prevalence rate of 42% for mild levels of excessive internet use, 46% for moderate and 5% for excessive. Results are to be interpreted with caution given the population sampled and their underlying diagnoses. Entertainment purposes, messaging and social media were the most common habits for the adolescents. Further research is needed to enhance our understanding this area.

6. Reasons for referral from a specialist obesity service to liaison psychiatry and outcomes

Dr Ho Tim Timothy Leung, Other Psychiatric Trainee, Dr Ho Tim Timothy Leung, ST6, South London and Maudsley NHS Foundation Trust Dr Tasnim Alam, FY1, Guy's and St Thomas' NHS Foundation Trust Dr Gavin Urban, CT3, South London and Maudsley NHS Foundation Trust Dr Giulia Ferrari, CT2, South London and Maudsley NHS Foundation Trust Dr Dan Poulter, ST6, South London and Maudsley NHS Foundation Trust Dr Polyxeni Christodoulou, Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust

Aims and hypothesis The aim was to describe the reasons for patients to be referred from a specialist obesity service to liaison psychiatry and the outcomes of their assessments to examine our role. We hypothesised that most patients were referred for medication review. Background The Guy's and St Thomas' Centre for obesity is a Tier 4 severe and complex obesity service consisting of obesity surgery and medicine multidisciplinary teams, including liaison psychiatry. The aims of bariatric psychiatry have been conceptualised as determining psychiatric contraindications to surgery and diagnosis and treatment of pre-surgery and post-surgery psychiatric conditions affecting weight loss or quality of life. Methods Referrals from the obesity service to liaison psychiatry service from 1/1/2022 to 1/10/2022 were reviewed to identify their stage in the bariatric pathway and reasons for referral. Our first assessment letter was

reviewed to record actions, follow-up and diagnoses. Results 23 referrals were received. 47.8% were for patients pre-surgery, 26.1% post-gastric bypass and 21.7% post-sleeve gastrectomy. Reasons for referral were general psychiatric assessment (52.2%), review of medications in preparation for surgery (47.8%) or following surgery (30.4%), and assessment of readiness for surgery (21.7%). 17 patients had been reviewed. Changes in psychotropic medications were recommended in 58.8%, including initiation (17.6%), dose reduction (11.8%), switch (11.8%), formulation change (11.8%) and dose increase (5.9%). Referral to community mental health services was recommended in 35.3%. Follow-up in our service was arranged for 70.6%. The commonest ICD-10 diagnoses following review were F60.3 emotionally unstable personality disorder (17.6%) and F31.7 bipolar affective disorder, currently in remission (17.6%). Conclusions Most referrals were for review of psychotropic medications in the context of bariatric surgery and changes in medications were recommended for most patients. This highlights the important role of psychiatry (as distinct from psychology) and specialist pharmacy input in the care of this group.

7. Characteristics of patients referred from a specialist obesity service to liaison psychiatry

Dr Ho Tim Timothy Leung, Other Psychiatric Trainee, Dr Ho Tim Timothy Leung, ST6, South London and Maudsley NHS Foundation Trust Dr Gavin Urban, CT3, South London and Maudsley NHS Foundation Trust Dr Giulia Ferrari, CT2, South London and Maudsley NHS Foundation Trust Dr Tasnim Alam, FY1, Guy's and St Thomas' NHS Foundation Trust Dr Dan Poulter, ST6, South London and Maudsley NHS Foundation Trust Dr Polyxeni Christodoulou, Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust

Aims and hypothesis The aim was to describe the characteristics of patients referred from a specialist obesity service to liaison psychiatry to understand the needs of this cohort. We hypothesised that most patients had diagnoses of depression or anxiety, were prescribed psychotropic medications and had contact with mental health (MH) services. Background The Guy's and St Thomas' Centre for obesity is a Tier 4 severe and complex obesity service consisting of obesity surgery and medicine multidisciplinary teams, which includes liaison psychiatry. Although bariatric psychiatry has been proposed as a new subspecialty, the literature lacks description of the characteristics of bariatric patients referred to psychiatry. Methods Referrals from the obesity service to liaison psychiatry from 1/1/2022 to 1/10/2022 were reviewed to identify each patient's age, gender, MH diagnoses, psychotropic medications and contact with MH services. Results 23 referrals were received. The mean age of patients referred was 42.4 years. 91.3% were female. In the 18 patients where MH diagnoses were documented, 77.8% had depression, 55.6% anxiety disorder and 27.8% emotionally unstable personality disorder. In the 21 patients where current medications were documented, 85.7% were prescribed psychotropic medications. 52.4% were prescribed more than one psychotropic. 76.1% were prescribed antidepressant, 19.0% anxiolytic and 19.0% antipsychotic. In the 22 patients where MH input was documented, 77.3% had previous or current contact with either primary care talking therapies or secondary care MH services. 9.1% had previous and 9.1% current input from primary care talking therapies. 31.9% had previous input from secondary care MH services, while 13.6% had

been referred and were awaiting input. Conclusions Most patients referred have existing MH diagnoses, are prescribed more than one psychotropic medication and have had previous or current contact with MH services beyond their GP. This highlights the complexity of this cohort and need for specialist psychiatry input.

8. Psychosocial Impact of being diagnosed with Mild Cognitive Impairment; a patient and carer perspective

Dr Nida Munawar, Psychiatric Trainee, Dr. Nida Munawar, ST4, NHS GGC Dr. Liam Kennedy, Senior Registrar Psychiatry, HSE Ireland Dr. Memoona Usman, Senior Registrar Psychiatry, HSE Ireland Diana Burgui, Senior Social Worker, St. James Hospital, Dublin Irene Bruce, Clinical Nurse Manger, St. James Hospital, Dublin Prof. David Robinson, Consultant Geriatrician, St. James Hospital, Dublin Prof. Elaine Greene, Consultant Psychiatrist, St. James Hospital, Dublin

Aims & Hypothesis A cross-sectional, cohort study was conducted at St. James Hospital Memory Clinic, Dublin with the following aims: • To examine the perspectives of persons with Mild Cognitive Impairment (PwMCI) and their family member/friend (FwMCI) of their experience of receiving the results of their Memory Clinic assessment; their recall and understanding of the diagnosis • To explore emotional wellbeing and changes in attitude to health and lifestyle following the diagnosis • To explore and understand the needs of the PwMCI and their family members. Background Mild cognitive Impairment (MCI) may represent an intermediate, prodromal phase of dementia. The Lancet Commission 2020 Report highlighted that early interventions and modifying risk factors can prevent or delay up to 40% dementias. Methods The study was completed with patients and their nominated family member/friend, using questionnaires formulated by iterative design, who attended the Memory Clinic for an assessment from 1st January 2020 to 30th April 2021 and received the diagnosis of MCI. Results Ninety-five patients received the diagnosis of MCI during this time period and forty-seven participated in the study. 36 nominated family member/friend completed the FwMCI questionnaire. In our cohort of PwMCI, most of the participants were not aware of their diagnosis, only 21% used the term MCI. Only 25% attributed their problems to a pathological cause. The majority of participants had no recollection of any discussion around the likelihood of progression. One third of participants expressed relief that they did not have dementia. Most PwMCI reported positive psychological wellbeing and did not endorse symptoms of depression or anxiety. There was slight discordance of Illness perception among the PwMCI-FwMCI dyads. Participants from both cohorts in our study had a limited understanding of the potentially modifiable risk factors for dementia. Conclusions There is a clear gap between what we tell patients and their loved ones about MCI, and what they hear and retain.

9. Risk factors and outcomes of delirium in hospitalised older adults with covid-19: a systematic review and meta-analysis

Dr Nida Munawar, Psychiatric Trainee, 1. Dr. Nida Munawar, ST4, NHS GGC 2.Dr. Maria Costello, Clinical Fellow, St. James Hospital, Dublin. 3. Rubab Syed, Data Analyst, Finja

(Lahore, Pakistan) 4. Prof. David Robinson, Consultant Geriatrician, St. James Hospital, Dublin & Trinity College Dublin 5. Prof. Colm Bergin, Consultant Physician,St. James Hospital, Dublin & Trinity College Dublin 6. Prof. Elaine Greene, Consultant Psychiatrist, St. James Hospital, Dublin & Trinity College Dublin

Aims & Hypothesis To identify the risk factors for delirium and outcomes of delirium in hospitalised older adults (65yrs or above) with COVID-19. Background Older adults with COVID-19 are more likely to present with atypical symptoms, notably delirium. Such atypical presentations may delay recognition of COVID-19 leading to poorer outcomes in this cohort. Few studies have focused exclusively on hospitalised older adults. Methods The protocol for this study is registered in the International Prospective Register of Systematic Reviews (PROSPERO) under the ID number CDR42021277723. The study adheres to the preferred reporting items for systematic reviews and meta-analysis (PRISMA) reporting guidelines. Comprehensive literature search of Embase, CINAHIL, Medline and Web of Science was performed for published literature until 31st August 2021. Two independent reviewers evaluated study eligibility and assessed study quality using the Newcastle Ottawa Scale (NOS) for cohort studies and Joanna Briggs Institute (JBI) critical appraisal tools for case series. The association of various predisposing factors with delirium in this cohort was reported as odds ratio and its 95% confidence interval. Results A total of 31 studies from 11 countries were included in this review. Most of the included studies investigated patients from non-ICU settings (n=24; 77.4%). The median age of the participants ranged from 76.2 to 86 years. Frailty (OR 3.52 [1.96, 6.31], p<0.0001,I2=71.63%), cognitive impairment including dementia (OR 5.76 [3.05,10.86], p<0.00001, I2=85.83%) and being nursing home residents (OR 1.72 [1.31, 2.24], p<0.0001) were significantly associated with increased likelihood of developing delirium in older adults with COVID-19. The presence of delirium also significantly increases mortality risk in hospitalised older adults with COVID-19 (OR 2.39 [1.42-4.04], p<0.001, I2=89.84%). Conclusions The prevalence of delirium in hospitalised older adults with COVID-19 in the studies included ranged from 11% to 87%. Preventive measures should be instituted early during admission in older adults with risk factors to improve outcomes.

10. DNA and Disengagement Audit

Dr Rosy Purakayastha, Core Psychiatric Trainee, Dr. Rosy Purakayastha, CT2, Kent and Medway NHS and Social Care Partnership Trust. Dr. Anirban Bhowmick, Consultant and Supervisor, Essex Partnership University NHS Foundation Trust

Aims and hypothesis: Non-attendances are costly waste of resource within NHS. So it is important for service providers to have focused plan of action to proactively manage them. Hence we aimed this study to see if trust policy of DNA and disengagement is being followed. Background: Though people may choose to discontinue contact with the services we provide, there will be occasions where patient's non-attendance is an indicator that: they may be at risk to themselves or others through deterioration in their mental health, or other issues preventing them from attending. Therefore, any failure of planned contact should be regarded as potentially serious matter and should lead to assessment of potential risk. Methods: Data was collected for

51 patients who missed their scheduled appointment between February - August 2021, using a predesigned questionnaire tool. Results: Out of 51 patients, 37 Did not attend the initial assessment. 14 of them missed follow-up appointments. 18 patients had diagnosis of depression, 9 had anxiety and 8 had the diagnosis of personality disorder. 98.1% patients were notified adequately. Letter was sent to the patient and GP for all of them. In 50.9% cases Risk Assessment was completed. For 25% risk assessment was updated. Review of Contingency plan was done for 26 patients. Out of 51 patients, family was contacted for 3 patients. 3 patients were referred for home visits or AHMP, welfare check was done for 4 of them. Remaining 31 patients were discharged from the services after no response to multiple correspondences. Conclusions: Though trust policy is being followed to a good extent in regards to adequately notifying and contacting service user, offer another appointment and informing GP, we are failing to adhere to trust policy in regards to updating risk assessments, review crisis plans or doing welfare checks.

11. DNACPR Status in Older Adult Psychiatry and Communicating these Decisions with Primary Care

Dr Haseeb Qureshi, FY Doctor, Dr Haseeb Qureshi (FY1), Surrey and Borders Partnership NHS Foundation Trust (SABP) Dr Geo Edgerley Harris (ST4), Surrey and Borders Partnership NHS Foundation Trust (SABP) Project Supervisor: Dr Giles Townsend (Consultant Psychiatrist), Surrey and Borders Partnership NHS Foundation Trust Acknowledgements: Victoria DiPlacito (RN, Advanced Practitioner – Lead Resuscitation Officer, SABP), Maria Cappelletto (Assistant Resuscitation Officer and Instructor, SABP)

Aims/Hypothesis: The Meadows Unit is an inpatient psychiatry unit that cares for older people with complex functional and organic mental health disorders. Given the demographic of our patients, it is important to ensure we are reviewing the suitability for Do Not Attempt CPR (DNACPR) forms as part of standard procedure. Our Trust Guidance states that decisions around resuscitation status should be considered during admission review and MDT meetings. The Resus Council outline that any decision regarding CPR should be clearly communicated between healthcare professions. We proposed that 100% of patients should have a discussion around CPR suitability and 100% of patients should have this communicated to GP's upon discharge. Background: Cardiopulmonary resuscitation can be an invasive intervention and therefore due care and consideration has to be given to the harm versus benefit. The proportion of people who survive CPR following an arrest is relatively low. Survival rates in acute hospitals are reported to be on average 15-20% and 5-10% in the community setting. Methods: We audited 38 patients. As per guidance set out in our trust policy and by the Resus Council, we audited: 1) Has there been documentation of discussion around DNACPR status with the patient and/or family during admission review or during initial care planning meeting (CPA). 2) Has the DNACPR status been communicated to the GP on discharge. Results: Less than 35% of patients had a DNACPR discussion at initial CPA and less than 10% at admission review. 55% of patients had their DNACPR status communicated to the GP on discharge. Conclusions: The Audit highlights we are not meeting the 100% targets set out by the Trust and Resus Council. One improvement includes

collaboration with the Trust's Resuscitation Team who are designing an easy-read flow chart for DNACPR decision making for doctors.

12. Diagnostic Mirroring and Medical Incoherence

Dr Laurence Reed, Consultant Psychiatrist, Dr Laurence J Reed PhD MRCPsych, GMC: 4116237 RCPsych: 12980 Lead Consultant Liaison Psychiatry Psychiatric Liaison Team, West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk IP332QZ NSFT & WSH NHS Trust

Aims and hypothesis: Diagnostic mirroring is the process by which the physiological disturbance of long-term physical illness manifests itself in a person's subjective experience – a mirroring between physical and mental experience – AND attracts a separate 'mirror' psychiatric diagnosis. Medical incoherence arises when such 'mirror diagnoses' are treated as if they are of independent existence, amenable to conventional psychiatric management. This paper hypothesises not only that such mirror diagnoses do not meaningfully exist, but that their treatment as independent entities is unhelpful and harmful. Background: A major group of referrals to a liaison psychiatry service is that of suspected psychiatric disorder amongst medical admissions. Such referrals pose a significant diagnostic challenge, especially given overlap with delirium, wide variation in diagnostic practice, imperative pressures to assertively treat prima facie mental illness, inception effects (physical recovery coincident with diagnosis), all of which inflate the risk of mirror diagnoses, inadvertent labelling, diagnostic overshadowing and inappropriate medication without meaningful oversight. Methods: A review of comprehensive meta-analyses of comorbidity of physiological and psychiatric illness in the major illness groups of cardiac failure, chronic obstructive airways disease, chronic renal failure, and stroke were conducted. These examined: criteria for psychiatric diagnosis, control of confounders, response to treatment, and prognosis. Results: The majority of studies assert 'psychiatric comorbidity is under-diagnosed and under-treated', that psychiatric comorbidity was associated with a 'mortality gap' of adverse outcomes including death, and that psychopharmacological treatment was associated with 'disappointing outcomes and high rates of side-effects'. Control of confounding was largely absent. Conclusions: Diagnostic mirroring is a significant factor obscuring the consideration of physical/psychiatric comorbidity, leading to incoherence - diagnostic error and practical mismanagement with adverse outcome. There is a pressing need to radically re-evaluate the relationship between physical and psychiatric disorder atheoretically, to discount categorical diagnostic approaches and to practice caution in psychopharmacological prescribing.

13. Clozapine use in Treatment resistant Schizophrenia with co- morbid Acute Myeloid Leukemia in an acute hospital setting

Dr Nittu Sidhu, Specialty Doctor, Nittu Sidhu, Speciality Doctor, Greater Manchester Mental health NHS trust

Aims- There have been few case reports on Clozapine use in Treatment resistant Schizophrenia with co-morbid AML. Side effect profile of Clozapine includes myelosuppressive effect leading to Neutropenia and agranulocytosis. This case report highlights the complex decision making in

terms of dose and blood testing in such cases. Background A 50 year old female was admitted to hematology ward with a diagnosis of AML and was undergoing Cycle 1 chemotherapy. She had a diagnosis of treatment resistant Schizophrenia and was stable in the community for more than 8 years. She was on 250 mg of Clozapine along with 15 mg of Aripiprazole. She was referred to Mental health liaison team regarding advice on clozapine dose and further management. Methods After discussion with all the professionals involved in her care including medical colleagues, decision was made to continue with same dose of clozapine considering risks vs benefits. Clozapine levels were done and blood tests were done everyday to monitor neutropenia. Results Clozapine levels came back high and neutrophil levels were declining, hence decision was made to reduce clozapine dose. The ward team and patient were educated about the side effects of clozapine. WBC and neutrophils started coming back to normal towards the end of the admission. Conclusions Careful consideration and multidisciplinary team involvement is important to weigh the benefits vs risks of continuing Clozapine in this patient population.

14. Mental Health Input on Trauma and Orthopaedic wards at a major trauma centre: A quality improvement project

Dr Labib Syed, FY Doctor, Dr Labib Syed, FY2, University Hospitals Sussex NHS Trust Dr Alice Bennett, Consultant Psychiatrist, Sussex Partnership NHS Foundation Trust

Background: Orthopaedic patients can present in a various way with some mechanism of injuries being sustained from deliberate self-harm or attempted suicide. Early mental health input for such patients is vital to ensure they achieve optimum recovery and outcomes following their treatment. The aim of this project was to evaluate the confidence of orthopaedic multidisciplinary team members in managing patients with mental health conditions Method: A survey was disseminated to the orthopaedic multidisciplinary team (MDT) to establish their confidence in managing mental health patients who require their care. Survey consisted of 10 questions using a 5-point likert scale ranging from strongly disagree to strongly agree. Results: 15 members of the team completed the survey. Most members of the MDT team reported not often being aware of the mental health background for their patients. On average, members did not feel adequately prepared to identify suicide risk factors or a deterioration of their patient's mental health. Conclusion: Mental health conditions can present in all specialities and requires a multi- disciplinary approach in appropriately treating patients both physically and mentally. Following the results, a series of interventions were developed. A clear ward plan was developed from the mental health team in which they will update to keep ward staff informed of patient's mental health background and presenting risks. Short teaching sessions will be provided to give MDT members on ways on identifying new risks and warning signs that their patient's mental health is declining and to instigate a mental health review. 12 months following this intervention a re-audit will be done establish if there is improvement in staff confidence.

15. Comorbid Anxiety and Depression in Intestinal Failure and Colorectal Patients

Dr Sophie White, Core Psychiatric Trainee, Dr Sophie White; Psychiatry CT1; Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. Ms Sally Watts; Intestinal Failure Specialist Nurse; Newcastle Upon Tyne Hospitals NHS Foundation Trust. Ms Lisa Gemmell; Lead Specialist Dietitian; Newcastle Upon Tyne Hospitals NHS Foundation Trust. Dr Adam Jan, Foundation Year 2 Doctor, Newcastle Upon Tyne Hospitals NHS Foundation Trust. Mr Fintan Bergin; Consultant Colorectal Surgeon; Newcastle Upon Tyne Hospitals NHS Foundation Trust.
Aims and hypothesis: Newcastle Hospitals' Intestinal Failure (IF) team often observe anxiety and low mood amongst patients. A previous evaluation demonstrated unmet need in this area. We aimed to re-quantify this by: • Identifying cases of anxiety disorders and depression. • Assessing symptom severity. • Comparing with other surgical patients and the previous cycle. Background: Significant anxiety and depression are common amongst IF patients with a significant impact upon quality of life. We previously conducted a service evaluation where patients completed a Hospital Anxiety and Depression Scale (HADS) to inform service development. Results confirmed comorbid anxiety disorders and depression were a problem amongst IF patients. Newcastle has since been designated a national IF centre and practice has changed, including appointment of an IF Specialist Nurse who helps to ensure patients receive more holistic care. This repeat cycle aimed to assess the impact of this. Methods: We asked inpatients and outpatients with Type 2 IF (defined as requiring parenteral nutrition for at least 28 days) to complete a HADS. We also extended this to patients undergoing other colorectal surgical procedures not requiring parenteral nutrition. Results: The mean anxiety and depression scores for IF patients were both 7.9 (previously 9.8 and 9.1), compared with 4.3 and 4.7 for Colorectal patients (previously 6.5 and 5.8). Although scores had reduced overall, there was still a statistically significant difference in symptomatology scoring between the groups ($p = 0.0086$ and $p = 0.0256$ respectively). There were also more cases of anxiety and depression in the IF group than the Colorectal group. Conclusions: Anxiety and depression appeared reduced amongst patients in both groups, possibly due to improved recognition and management along with the changes to the IF service. However, anxiety and depression remain a problem amongst IF patients. We have now appointed an IF Psychologist and will repeat the cycle.

16. An Audit of Waiting Times & Outcomes in Patients Presenting to Walsall A&E With a Mental Health Crisis

Dr Shalini Sundararamen, Consultant Psychiatrist,

Background – from 1st April 2021 to 31st March 2022, there were 119, 875 psychiatric A&E attendances for mental health crisis. The Core24 guidance states that patients presenting to A&E with an acute mental health crisis should be seen by the MHLS within 1 hour of referral. This study aims to use a sample of patients presenting to Walsall A&E with a mental health crisis to determine adherence to this guideline.

Methods – the inclusion criteria for participants in the audit was defined as: adults (>18 years old) presenting to Walsall Manor A&E with a referral to MHLS due to an acute mental health crisis between 1st July 2022 and 31st July 2022. The data will be collected retrospectively and data

categories include: reason for admission, time of referral, time seen by mental health liaison team, and the outcome. The time waited will be determined by the difference between the time that patient was referred to the MHLS, and the time they were seen by the liaison team.

Conclusions – This audit is therefore a starting point to investigating how quickly patients are assessed by mental health professionals on presentation to A&E for a mental health crisis, more research needs to be done to determine the cause of delayed assessments, and to determine if all patients are leaving the department with sufficient support systems in place.

Forthcoming Events

Faculty of Liaison Psychiatry Annual Conference

10 – 12 May 2023, In person (London)/Live-stream