

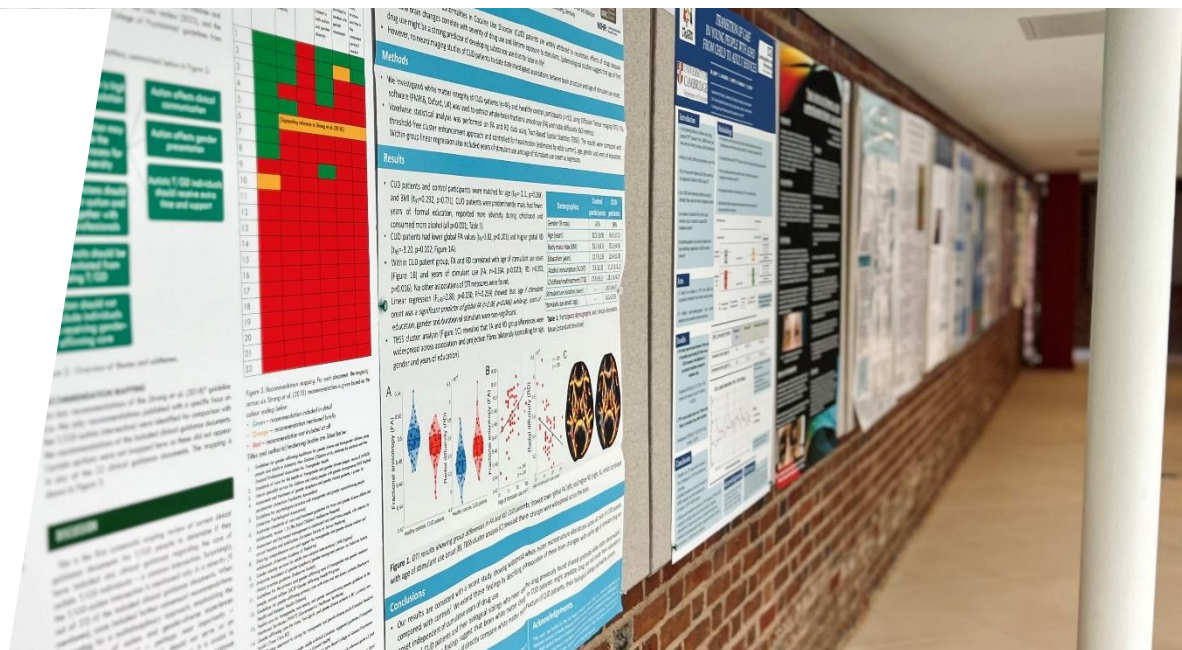
Poster Abstracts

RCPsych | Eastern Division

Spring Conference 2025

“Recent Developments in Psychiatric Practice:
Updates on clinical conditions and the MHA”

Wednesday 30 April | 9:00am – 4:30pm



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Medical Student Category

MSFY 1 – Mental Health Burden among National Health Service Staff: A Comparative Analysis

Madeline Coode (Medical Student), Dr Muzaffer Kaser (Consultant),
Dr Danielle Lamb (Senior Research Fellow), Professor Peter Jones (Honorary Consultant).

Aims: The significant mental health difficulties experienced by NHS staff are becoming more widely recognised, yet there remains a lack of evidence to guide decisions on how best to support healthcare workers. In this study, we aimed to investigate mental health symptoms among NHS staff using two samples: 1) NHS CHECK study, a national epidemiological study of healthcare workers, and 2) NHS staff presenting to a bespoke clinic in Cambridgeshire, the Staff Mental Health Service (SMHS).

Methods: Participants were NHS staff who either accessed the Staff Mental health Service (SMHS) (n=1,176) or were enrolled in NHS CHECK (n=23,661). Data were collected between April 2020 and December 2024 using the following measures: Generalised Anxiety Disorder-7 (GAD-7), Patient Health Questionnaire-9 (PHQ-9), Post Traumatic Stress Disorder Checklist – Civilian Version (PCL-C) and Warwick-Edinburgh Mental Wellbeing Scale (WEBWEMS). Additionally, NHS CHECK staff completed the Community Assessment of Psychic Experience (CAPE) questionnaire. Longitudinal changes in SMHS scores were assessed using the Kruskal-Wallis test, while the Friedman and Cochran's Q test were used for NHS CHECK. The distribution of scores by job role and demographics were examined using the Kruskal-Wallis and Mann-Whitney U tests. Bonferroni correction was applied for pairwise comparisons. One-tailed Spearman's rank correlation was used for both age and CAPE analyses. VARIMAX rotation was used to generate a common psychopathological factor.

Results: Depression, anxiety and wellbeing scores were stable over time in both samples. At six months in NHS CHECK, there was a significant increase in PTSD symptoms. Women reported higher depression and PTSD symptoms in both samples. Ethnic minority staff in both samples reported lower depressive symptoms and higher wellbeing scores compared to white counterparts. Younger NHS CHECK staff reported lower wellbeing, and higher depression, PTSD and anxiety symptoms. Medical staff consistently reported lower symptoms in all measures in both samples. Administrative and Clerical staff reported lower wellbeing in both samples. SMHS staff referred via Occupational Health or Other Mental Health Services reported higher anxiety and PTSD symptoms. NHS CHECK participants with above cut-off scores for psychotic experiences reported higher anxiety, depression and PTSD scores, and lower wellbeing scores.

Conclusions: The SMHS sample represents more severe cases and the overlap with NHS CHECK sample was small. NHS CHECK data helps contextualise the findings from a general staff population perspective. Certain job roles and demographics were associated with increased mental health burden in both samples. Further granulation of the SMHS sample will support the development of targeted staff support. Longitudinal assessment of both epidemiological and clinical samples develops our understanding of the mental health burden of NHS workers and inform strategic intervention.

MSFY 2 – ReSPECT Forms: Are they being respected? A clinical audit and re-audit

Dr Kavya Francis (FY1), Dr Shankari Gnanakumar (FY1), Dr Mohamed Elkoshiery (SAS),
Dr Ruhi Shamim (Consultant psychiatrist - supervisor)

Introduction: Documentation of a 'Recommended Summary Plan for Emergency Care and Treatment' (ReSPECT) allows individuals to vocalise their preferences for medical treatment, providing clear communication in emergency situations. This is particularly important in an old-age psychiatry ward where many patients have multiple co-morbidities and are at risk of sudden deterioration.

Aims: Our aim was to evaluate the adherence to ReSPECT policy set by Norfolk and Suffolk NHS Foundation Trust (NSFT). Secondary aims included assessing the quality of form completion and involvement of legal welfare proxy and/or family members if the patient lacked capacity.

Methods: Retrospective analysis of prospectively collected data. Inclusion criteria for analysis set to all patients admitted to Willows Ward, Woodlands, between 28.01.25 to 04.02.25 (N=17). We reviewed both patients' clinical notes and LORENZO entries to locate a ReSPECT form. If present, we assessed how well each section was completed (9 in total) measured against standards set by Resuscitation council UK. Re-audit was done in 8 weeks post intervention as follows: a teaching session for staff members, posters in doctors' office and ensuring handover in MDT meeting indicated if ReSPECT form was present.

Results: The main audit highlighted that only 29% of patients had a ReSPECT form (5/17). Of those, completion of individual sections was variable with the highest being 100% (5/5) having Sections 1, 4 and 6 completed whereas only 40% (2/5) having Sections 3 and 8 completed. Furthermore only 20% (1/5) of pre-existing forms were re-reviewed on admission to Willows (Section 9). Re-evaluation after interventions showed 61.1% of total patients had a ReSPECT form (11/18), an increase of 32% from previously. Furthermore, 100% completion (11/11) of all sections noted apart from Section 4 (81% completion).

Discussion: Sections 1, 4 and 6 were completed well which encompassed key information including patient details, CPR decision and ceiling of care during escalation and patient involvement in decision-making respectively. However, sections requiring more detailed patient conversations (Section 3 – 'what matters to me...') had poor completion rates. Furthermore, conversations with NOK/family members were inadequate when patients lacked capacity hence subsequent sections were not completed (Section 8). After interventions, the total completion of forms increased to 61.1% with most sub-sections being completed – this could be explained by greater awareness of individual component requirement and confidence in filling this out. Overall, this completed audit cycle demonstrated a positive change to clinical practice.

Conclusion: Open conversations around ReSPECT empowers patients to make informed decision about their future care. It is vital to involve family members if not capacitous to understand what their preferences would be to ensure patient dignity and respect. We recommend trusts to incorporate teaching sessions during induction for healthcare staff on how to adequately fill out ReSPECT forms and to incorporate mandatory forms as part of admission clerking.

MSFY 3 – Addressing Treatment-Resistant Depression: A Review of (2R,6R)-hydroxynorketamine as an Emerging Therapeutic

Nathaniel Leung Yiu Ka (Medical Student), Marcus Owen Tsang (Medical Student)

Keywords: RR-HNK, (2R,6R)-hydroxynorketamine, Depressive disorder, Depression, Treatment-resistant depression

Aim: To explore the efficacy and safety of (2R,6R)-hydroxynorketamine (RR-HNK) in patients with Treatment-Resistant Depression as a safer and more efficacious alternative to ketamine

Methodology: A literature search was conducted on the PubMed database with the following selected terms used: ((RRHNK)OR ((2R,6R)-hydroxynorketamine)) AND ((Depressive disorder) OR (Depression) OR (Resistant depression)).

Results: Preclinical Efficacy RR-HNK demonstrated promising efficacy for treatment-resistant depression across proteomic studies and preclinical models, particularly in promoting long-term potentiation (LTP) and rapid symptomatic resolution. In terms of long-term sustained effects, RR-HNK enhances glutamatergic neurotransmission by inhibiting presynaptic metabotropic glutamate receptor 2, thereby increasing brain-derived neurotrophic factor (BDNF) release. Subsequent BDNF–TrkB autocrine signalling enhancement of synaptogenesis is closely linked to the induction of LTP, a core mechanism of synaptic plasticity and circuit-level recovery in depression, enabling long-term sustained effects of RR-HNK.

In terms of the rapid resolution effect, BDNF–TrkB autocrine signalling in RR-HNK also contributes by exerting effects within 24 hours. Moreover, an in-vivo study on RR-HNK concluded that it achieved rapid antidepressant effects by rapidly potentiating glutamate release through adenylyl cyclase activation and cAMP-dependent protein kinase activation processes but independent of TrkB activation via BDNF. The glutamergic effects of RR-HNK affect multiple brain regions, including the hippocampus, prefrontal cortex, periaqueductal gray and basolateral amygdala, allowing for a widespread antidepressant effect.

Clinical Safety: Building on the promising in vivo efficacy of RR-HNK in depression models, recent Phase 1 trials have evaluated its safety, tolerability, and pharmacokinetics in healthy individuals. The trial replicated the ketamine infusion protocol used in depression treatment and exhibited a favourable safety profile. across all dosing cohorts, with no serious adverse events reported or discontinuation due to tolerability issues. Mild adverse effects were observed but resolved spontaneously.

Notably, RR-HNK was not associated with dissociative, psychotomimetic, or anaesthetic effects – adverse outcomes commonly observed with ketamine that may limit its clinical utility. This is contributed by the minimal involvement of NMDA receptor antagonism in the mechanism of RR-HNK, which leads to adverse neuropsychiatric effects of ketamine. The absence of acute neuropsychiatric adverse effects suggests lower abuse potential and improved suitability for routine therapeutic use.

Pharmacokinetic data demonstrated dose-proportional increases in drug exposure, supporting the development of precise dosing strategies. Additionally, cerebrospinal fluid sampling confirmed central nervous system penetration, with detectable levels sustained several hours post-administration. Furthermore, minimal drug accumulation was observed in repeated dosing, reducing long-term toxicity risks.

Conclusion: This review shows RR-HNK as a promising novel, well-tolerated, rapid-acting antidepressant with sustained effects. Current findings in the field support the progression into Phase 2 trials to investigate the efficacy, long-term safety and dosing optimization in the clinical population. Further, exploring the use of RR-HNK in other neuropsychiatric disorders.

General Medical

GM 1 – Relapse rates following electroconvulsive therapy and factors affecting the maintenance of electroconvulsive therapy effects

Dr Trish Phiri (CT3)

Aims and hypothesis: The main aim of this study is to investigate relapse rates after electroconvulsive therapy (ECT) following treatment over 2-year follow-up period. Also, to identify key demographic and clinical factors associated with sustained ECT effects in patients.

Background: ECT is an important treatment option for major depressive disorders, acute mania, mood disorders with psychotic features, and catatonia.¹ A study carried out in 2013, showed that up to half of all patients who respond to ECT relapse within the first year, the period of highest risk being the first 6 months.² In gaining consent for this treatment, clinicians discuss side effects with the patients which inevitably leads to discussions around effects of ECT on cognition. Having local data showing how ECT has affected people's memory not only does it bring confidence amongst clinicians but increases the likelihood of patients being receptive to this treatment.

Methods: Data was collected in the period from May 2021 to August 2022 from the electronic patient records. All patients who attended the clinic during this period were included in this study. Patients who were lost to follow-up after having received treatment were excluded from accounting for relapse rates.

Results: 41 patients with a median age of 64 (71% women), found that more than half had a primary diagnosis of unipolar depression. Following an average of 10 treatments, all patients achieved remission based on Clinical Global Impression (CGI) scores. Relapse rates were highest at 12 months, with rates of 15.4%. Among those who relapsed, 83% had chronic physical health comorbidities such as endocrine, vascular, or pain-related conditions. Of 17 patients offered memory assessments post-treatment, one declined. Five scored below the expected range, but all improved from baseline except one, whose treatment ended early due to worsening memory. Follow-up testing varied, with only three patients assessed after ECT.

Conclusions: ECT remains a highly effective treatment for severe and refractory mental health conditions, but the findings stress the need for policies to address gaps in cognitive assessments, long-term follow-ups and integrated care approaches to sustain positive outcomes and reduce relapse risks.

1 (Silvia Hoirisch-Clapauch, 2014)

2 (Ana Jelovac, 2013)

GM 2 – Audit of the assessment and prevention of risk of osteoporotic fragility fractures by General Practitioners in at risk old age female patients admitted on Blickling ward

Dr Samuel Diduyemi (Specialty Doctor), Dr Amina Jaji (Specialty Doctor); Dr Roseline Samuel (CT3)

Aims: Osteoporotic fractures are a major cause of morbidity in older adults, often leading to long-term disability and reduced quality of life. The National Institute for Health and Care Excellence (NICE) guidelines (2012) recommends that women aged ≥ 65 years and men aged ≥ 75 years be assessed for fracture risk using tools such as FRAX and QFracture. This audit aims to assess compliance of General Practitioners (GPs) with the NICE guideline and determine whether high-risk patients in our inpatient ward received appropriate preventive assessment /management in the community.

Methods: Retrospective audit was conducted using electronic patient records from Lorenzo, WebICE, and EPMA. The sample included 20 patients admitted to **Blickling ward, Julian hospital** between 01/12/2024 and 31/12/2024. The audit focused on determining whether fracture risk assessments were performed using FRAX or QFracture for service users(women) aged 65 years and older. Additionally, the audit examined whether high-risk patients received appropriate management, including bone density scans (DEXA), lifestyle changes, and pharmacological treatments. Secondary risk factors such as chronic kidney disease, diabetes, and smoking were also evaluated for their impact on fracture risk.

Results:

- None of the 20 patients (0%) had documented FRAX/QFracture assessments or evidence of a DEXA scan.
- Over 90% of the audited patients were classified as having intermediate or high risk for major osteoporotic or hip fractures within 10 years.
- Despite the high fracture risk, only 19% of patients were actively treated with bone-protecting medications, and none had documented assessments for fragility fracture risk prior to admission.
- 60% (12 out of 20) of the patients had secondary risk factors, such as chronic kidney disease, diabetes mellitus, rheumatoid arthritis, glucocorticoid use, smoking, or low BMI, which further increased their fracture risk.
- Approximately 70% (14 out of 20) had a history of falls, and 57% (8 out of 14) had a history of previous fractures. However, none had undergone orthopaedic surgeries.
- Internal barriers to initiating bone-protecting medications, largely due to the mental health-focused nature of the care team, were noted, with responsibility for prescribing remaining with GPs.

Conclusion: The audit revealed significant gaps in the implementation of NICE guidelines, with none of the patients receiving documented fracture risk assessments or appropriate interventions. Addressing internal barriers and improving follow-up care is critical to ensuring better adherence to guidelines and preventing fragility fractures in high-risk patients.

GM 3 – Assessing the Quality of Discharge Summary Letters for Patients Discharged from the Mother and Baby Unit, Hellesdon Hospital

Dr James Rand (CT1), Dr Okorie (ST5), Dr Rand (CT1), Dr Chullikattil (GPST1), Dr Hontanosas (FY2)

Aims: To reevaluate the recommendations from the previous audit done in 2023 and assess the implementation of recommendations in the last six months.

Methods: A re-audit was conducted of discharge summaries uploaded to Lorenzo for service users discharged from the Mother and Baby Unit (MBU) at Hellesdon Hospital between February 2024 and August 2024. A total of 27 discharge letters were reviewed. Compliance with established criteria was assessed and compared to results from the previous audit. Lorenzo records were also analysed to verify the completion of post-discharge follow-up arrangements.

Results: Compliance with all criteria either remained at 100% or showed improvement. The most notable improvement was in the category of "clearly written follow-up arrangements," where compliance increased from 74% (28/38 letters) to 96% (23/27 letters), representing a 22% improvement. The category with the lowest compliance was "sending the discharge summary to the GP within seven days," which improved from 74% (28/38 letters) to 85% (23/27 letters), indicating further room for progress. The total number of criteria fully adhered to rose from two to five. Post-discharge follow-up arrangements were successfully executed in 25 out of 25 cases, achieving a 100% success rate, an 18% increase from the previous audit (82%, 31/38 cases). Two cases classified as "N/A" were excluded as the patients were admitted directly to acute wards from the MBU.

Conclusions: The findings demonstrate significant improvements in the quality of discharge summaries and adherence to audit criteria. The 100% compliance achieved in several criteria highlights successful implementation of prior recommendations. However, further efforts are required to improve timely completion of discharge summaries within the seven-day deadline. Implementing reminders and systematic tracking of deadlines is recommended to achieve full compliance in this area. Continued adherence to high standards and regular re-audits will ensure sustained improvements in patient care.

GM 4 – Re-audit of prolactin monitoring in patients receiving long-acting injectables of antipsychotic medication

Dr Kalina Milochova (CT3), Dr Joel Philip (ST6)

Aims:

1. Ensure that the practice of monitoring of prolactin levels in patients receiving long-acting injectables of antipsychotic medication is consistent with current national standards
2. Ensure that the necessary remediation is undertaken for those patients found to develop high prolactin levels following the initiation of depot medication

Methods: Retrospective review of serum prolactin levels (information on ICE test results system) and depot clinic 'out-patient clinic notes' (information on Mobius) of 100 patients above 18 years of age receiving regular depot injections of LAI preparations of antipsychotic medication at the depot clinic at the Taylor Centre and presenting to the depot clinic between 15th November 2024 and 15th December 2024.

The re-audit looked at whether baseline prolactin levels were checked prior to starting the LAI and the monitoring of hyperprolactinemia symptoms and prolactin levels in the year preceding the date of presentation to the depot clinic in the month of November 15th to December 15th 2024.

Results:

- 41 out of 85 patients who were finally included in the sample did not have a prolactin level (baseline or follow-up) checked and recorded.
- 9 out of 85 patients who were finally included in the sample had baseline prolactin levels checked.
- 38 out of 85 patients who were finally included in the sample had a check of prolactin level in the preceding year (excluding baseline check).
- Symptoms of hyperprolactinemia were specifically asked for and documented in 8 patients.
- 1 patient had their antipsychotic medication changed to oral form with less propensity to cause elevation of prolactin levels. 1 patient had the dose of their LAI reduced due to symptoms of hyperprolactinemia.
- Compliance with checking of baseline prolactin levels was 10.58%.
- Compliance with yearly checks of prolactin levels was 44.7%.
- Compliance with specifically checking for symptoms of raised prolactin was 9.4%.

Conclusions:

- Following the implementation of the action plan from the original audit, there was improvement in the compliance of yearly checks of prolactin levels from 10.58% to 44.7%.
- There was improvement of compliance of baseline prolactin levels from 5.88% to 10.58%.
- There was improvement of specifically checking for symptoms of raised prolactin from 1.17% to 9.4%.
- There was inadequate monitoring of prolactin levels 3-6 months following commencement of LAI, with 0% of patient's having prolactin repeated at this time.

GM 5 – Audit of Transfer of Care between Under 14 CAMHS and 14+ Youth Team

Dr Tosin Daropale (CT3), Dr Bolanle Mojibola (CT3), Dr Samuel Diduyemi (SAS Doctor)

Aims: To assess compliance with NICE guidelines regarding the transfer of care between Under 14 CAMHS and 14+ Youth Team, ensuring patient safety and continuity of care.

Methods: A retrospective audit of **56 service users** who transitioned from Under 14 CAMHS to the 14+ Youth Team was conducted. Data was extracted from **Service User's records**, including transfer-outcome reports and case notes. NICE guidelines (QS140) were used as the benchmark. Key criteria assessed:

1. **Caseworker Allocation Before Transfer**
2. **Caseworker Allocation After Transfer**
3. **Frequency of Transition Planning Meetings**
4. **Average Duration of Transfer Completion**
5. **Reasons for Transfer Delays**

Results: Caseworker Allocation Before Transfer: 11% compliance, Caseworker Allocation After Transfer: 9% compliance, Annual Transition Planning Meeting Compliance: 85%, but declining, Average Duration of Transfer: 2-3 months, Documented Reasons for Delay: Only 9% of cases recorded reasons.

Findings: A structured transfer process exists, but inconsistencies in caseworker allocation compromise continuity of care. A lack of standardization across teams leads to delays and rejection of transfers due to differing referral criteria. Declining interface meetings indicate a weakening transition process over time.

Discussion: The audit highlights significant gaps in the transfer of care, particularly in caseworker allocation and standardized criteria for referrals. The absence of a Trust-wide policy results in inconsistent practices across teams, impacting patient outcomes.

Conclusion & Recommendations: To improve the transition process:

1. **Develop a Standardized Trust-wide Policy** for uniform transfer procedures.
2. **Enhance Caseworker Allocation** to support service users throughout the transition.
3. **Harmonize Transfer Criteria** between teams to prevent unnecessary delays.
4. **Improve Documentation & Tracking** with real-time systems to monitor transfer processes.
5. **Conduct a Re-Audit** to assess improvements, ensuring CPA/non-CPA distinctions are considered.

Next Steps: Initiate policy discussions with leadership, pilot a live tracking system for realtime oversight, Establish a task force to resolve referral discrepancies, Schedule a follow-up audit to evaluate the impact of these interventions. This audit underscores the urgent need for structured reforms to enhance continuity of care and patient safety during service transitions.

GM 6 – Audit: Identification and Monitoring of Delirium on Old Age Wards

Dr Tugba Kavasoglu (ST4), Dr Fiona McDowall (Consultant)

Background: Delirium is a serious and often underdiagnosed neuropsychiatric condition linked to increased morbidity, mortality, longer admissions, higher institutionalization rates, and substantial healthcare costs. According to NICE guidelines, patients aged 65 or older, with cognitive impairment or dementia, current hip fracture, severe illness, are considered at higher risk and need to be observed for recent changes or fluctuations in usual behavior. Early identification is essential for diagnosis, initiating timely treatment and preventing complications. Structured assessments such as the Confusion Assessment Method (CAM) play a vital role in improving recognition. The first cycle of this audit revealed a low rate of delirium assessment, prompting local teaching sessions and staff training to raise awareness and improve practice.

Aim: This re-audit aimed to evaluate whether the implementation of staff education and awareness initiatives improved the identification and diagnosis of delirium in old age psychiatry wards. The goal was to increase the usage of assessment tools on admission and during inpatient stay

Methods: The methodology mirrored that of the first cycle. A total of 40 patients from four wards (two organic and two functional old age psychiatry) in the North-East and South EPUT areas were included. Ten patients per ward, admitted from 01.06.2023 onwards, were randomly selected. Patient records were reviewed to determine delirium risk factors, the use of CAM at admission, and evidence of delirium symptoms during the admission. Where indicators of delirium were present, we checked whether any formal diagnostic assessments were conducted (CAM, 4A, ICD-10, DSM-5). Data on baseline characteristics, admission length, referrals to acute hospitals were also collected and analyzed.

Results: Of the 40 patients, 19 (47.5%) had a CAM assessment completed on admission. Seventeen patients (42.5%) had cognitive impairment at admission, yet only 4 underwent CAM assessment. Delirium indicators were noted on 31 occasions (77.5%), but only 4 of these (12.9%) had a formal diagnostic assessment. Overall, 10% of patients received a formal delirium diagnosis during their stay. Twelve patients were referred to general hospitals for physical health concerns, 10 of whom showed signs of delirium; however, only two had a formal assessment. One patient (2.5%) with multiple delirium indicators died during their admission.

Discussion: While the CAM completion rate improved compared to the first cycle, it remains suboptimal. The gap between recognizing delirium indicators and initiating formal assessment persists, highlighting the need for further staff engagement and system-level changes

Conclusions: The audit highlights the need for continued awareness and enhanced training on delirium recognition. Exploring a simple and practical yet effective alternative diagnostic tool like 4A and ensuring access to them could improve practice. Integrating CAM/4A into electronic records would also enhance accessibility and support better delirium recognition.

GM 7 – Physical Health Monitoring In Young People (18-25 Years) On Mood Stabiliser And Antipsychotics In Central Youth Service May 2023-April 2024

Dr Amina Jaji (Specialty Doctor), Dr Srijeeta Mukherjee (ST4), Dr Prajita Neupane (Specialty Doctor)

The audit focused on the necessity of physical health monitoring for young people aged 18 - 25 taking psychotropic medication. Given the Long-term physical health risks associated with psychotropic medication and mood stabilisers, monitoring is essential to prevent metabolic complications ensure early intervention in line with NICE guidelines.

Aim:

- Assess the extent of physical health monitoring in young individuals prescribed mood stabilizers and /or antipsychotics and evaluate the adherence to guidelines.
- Identify gaps in compliance with monitoring guidelines.
- Improve awareness and intervention strategies amongst professionals.

Methods: Retrospective audit of records from 2023- April 2024 in a sample size of 50 service users within the ages 18-25, under the care of the youth team prescribed regular psychotropic medication. Evaluated key health parameters include weight, BMI, blood pressure, glucose levels, lipid profile, prolactin, thyroid function, ECG.

Compared findings with national guidelines for monitoring.

Results: Physical observations were recorded in 66-88% of cases. Monitoring compliance for various investigations as follows LFT (68%), UandE (66%), FBC (64%), HbA1c (60%), TFT and Lipid profile (50%), Glucose and ECG (26%), Prolactin (12%). Many cases had incomplete monitoring or tests conducted at irregular intervals. Lithium only users did not receive appropriate Prolactin tests.

Discussion: The Audit found that the service did not meet the NICE guidelines for physical health monitoring. Contributing factors included patient dis engagement, difficulty contacting service users, unclear communication between prescribers and GP, Disruption from staff turnovers. Missing or irregular monitoring of key health indicators could lead to undetected physical issues and poorer long-term outcomes.

Proposed solutions include staff training, structured checklist and automated reminders, more clear communication between professionals.

Conclusions: There is a need for improved adherence to monitoring physical health monitoring guidelines. Enhancing awareness, introducing systemic monitoring approaches, better communication, and team wide engagement are essential to meet standards and ensure physical wellbeing of service users. Also, integrating lifestyle interventions will help improve outcome for young people on psychotropic medications.

Multidisciplinary

MD 1 - Amenorrhea in Anorexia Nervosa. Role of Hormonal Replacement Therapy?

Dr Olga Nikolaienko (GPwER)

Pathophysiology: Anorexia is associated with hypothalamic dysfunction; Energy deficit due to weight loss, exercises, loss of body fat, starvation results in misbalance of GnRH in hypothalamus; reduced secretion of LH and FSH in pituitary gland; reduced oestrogen secretion by ovaries reduced resulting in amenorrhea.

Subsequently this leads to increased risk of osteoporotic fractures, affecting bone health; infertility; negative effects on cardiovascular and mental health systems.

Low leptin levels may also contribute to abnormal GnRH secretion and loss of menstrual cycle.

Amenorrhea is no longer a diagnostic criterion for anorexia nervosa (DSM-5); however, it remains an important clinical indicator of the severity of anorexia. Weight loss dependant dysregulation (IGF-1-GH (reduced) and in cortisol hormones (increased)) osteoclast activity and bone resorption increases, bone formation reduces and bone health deteriorates due to low intake of protein, vitamin D and Calcium.

Use of HRT in anorexia nervosa: A systematic review of literature was conducted using databases including PubMed, Cochrane Library, and PsycINFO. Studies included were those examining the effects of HRT on patients with AN and amenorrhea, focusing on hormonal, psychological, and nutritional outcomes.

The review identified 15 relevant studies, most of which indicate that HRT can help alleviate some physiological symptoms associated with amenorrhea, such as bone density loss and metabolic disturbances. However, varied responses were noted, with some patients experiencing improvements in psychological well-being, while others showed negligible effects. There are no research findings which convincingly show a reduction in fracture risk of any intervention. Addressing the underlying cause of low fat and muscle mass are critical. Little changes in fracture risk if disease continues. Some HRT (topical oestrogen) rather than COCP can change bone mineral density in Adolescents.

Spinal imaging is important to check for vertebral fractures. Since AN-associated osteoporosis is characterized by low bone formation, teriparatide (a portion of human parathyroid hormone; effective anabolic agent which promotes bone formation) may be a useful treatment option. Multidisciplinary input including ED team, rheumatologists, endocrinologists is important considering combination of psychiatric, metabolic and hormonal abnormalities.

Management Strategies for Amenorrhea in Anorexia Nervosa:

- Requires comprehensive and multidisciplinary approach.
- Includes medical, nutritional and psychological interventions.
- Restoring healthy weight and food rehabilitation;
- Psychological therapy (CBT, FBT)
- Regular medical monitoring of vital signs and biochemical markers, assessment of bone mineral density;
- Use of Hormone replacement therapy;
- Physical activity education and balanced exercise plan;
- Holistic approach, family and social support, involvement and education;
- Regular follow up and monitoring of progress.

MD 2 - Formulation Based Health Assessments (FBHA): Moving away from protocol based medical monitoring in eating disorders

Dr James Leaver (GP), Dr Charlotte Marks (GP), Dr Conway Morris (Consultant Psychiatrist), Minimol Sajith (Clinical Nurse Specialist), Dr Fraser Arends (Consultant Psychiatrist)

Aim: To compare the impact of moving from a protocol based medical monitoring to an FBHA approach within an adult community eating disorder service.

Background: Our medical monitoring (MM) service was commissioned in 2019 to improve patient safety and reduce hospital admissions. In 2021 a local protocol was created. It used patient BMI, presence of purging symptoms and any electrolyte disturbance to determine the frequency of monitoring. Due to patient safety concerns and caseload increase we reviewed our practice in November 2023.

Comparing August 2022 with August 2023 we saw an increase of 90 patients being monitored, 82 additional appointments in one month, annual acute hospital attendance rise of 353% from 17 in 2021 to 60 in 2023. We identified a number of problems with our current approach:

- Frequent monitoring enabling eating disorder behaviours and/or encourage care seeking
- Clinician centred monitoring – driven by staff anxiety rather than individual patient's needs
- Endless monitoring of stable patients
- Unsafe caseload
- Risk of disengagement from primary care
- The term “medical monitoring” disempowers patients

Implementation: Adopting a more holistic, psychological formulation approach, the following changes to practice were adopted:

- Considered reducing FBHA frequency if “stable”.
- Increase in MDT working facilitating formulation-based decision making
- Individualised approach, encouraging patient responsibility and respecting autonomy
- Home visits stopped
- Subjective data interpreted in the context of formulation and current symptoms (which may not correlate with objective data)
- Consultant psychiatrist led supervision for FBHA team
- Consultant led triage ensuring the right patient for the right service at the right time
- Complex discharge planning and collaboration with primary care, taking positive risks
- Rebranding the team to FBHA team

Results: After 1 year of adopting the FBHA approach monthly medical appointments dropped 66%, monthly number of patients being monitored fell by 69% and there was a reduction in acute hospital attendances of 60%. 76% of the 21 patients who attended the acute hospital in 2022-23 reduced their frequency of presentation to A&E in 2024.

Conclusions: Protocol based medical monitoring should not be considered benign assessments as it has potential to enable injurious behaviours and create dependency. We suggest that FBHAs should be considered the gold standard approach to physical health monitoring in eating disorders as it gives experienced clinicians the flexibility to interpret data in the context of a patient's formulation. However, the complexity of decision making requires senior leadership, psychiatric oversight and experienced medical colleagues to work closely with the wider multi-disciplinary team. We understand this is not a model easily replicated across services nationwide.

MD 3 – Quality of care of young people presenting with self-harm at the Norfolk and Norwich University Hospital Emergency department

Dr Bolane Mojibola (ST4), Dr Ayomipo Amiola (ST5), Dr Tosin Daropale (CT3)

Aims: To determine the quality of care received by young people (16-25 years) presenting with self-harm at the Norfolk and Norwich University Hospital Emergency department using NICE guidelines QS34.

Methods:

- Retrospective data collection from electronic patient records
- These patients referred via the emergency department of the Norfolk and Norwich University Hospital were assessed as a one off.
- 271 patients presented with self-harm behaviour to the Accident and Emergency of the Norfolk and Norwich University Hospital in July and August 2024. They were all referred for assessment to the Mental Health Liaison Service. 85 of these patients were of ages 16 to 25. We have audited all the 85. The youngest patient was 16 years old while the oldest patient was 24.9 years old.

Results:

- 84.7% of patients had a record of risk assessment to reflect if there were any immediate concerns about their safety while 11.8% did not have a record of risk assessment. 3% left before assessment.
- 81.2% had mental state examination done, 15.3% did not have a mental state examination. 3% left before assessment.
- 78.8% had an initial assessment of safeguarding concerns, 17.6% did not, and 3% left before the assessment.
- 82.3% had a collaboratively developed care plan, 11.8% did not and 5% of them either left before the assessment or did not engage with care planning.
- 80% had initial assessment of social circumstances, 12% did not and 5% either did not engage or left before the assessment.
- More than 80% compliance was achieved with in the areas of assessment except for safeguarding concerns which was only 78.8%.

Conclusions:

- There is a template on electronic patient record for Liaison assessment with all the necessary headings as a guide. This template is NICE guideline compliant, if followed, the guidelines will be adhered to. Assessments that did not meet the guidelines did not use the template on the electronic patient record (EPR). This template can be created in other trusts to ensure compliance
- It is useful to familiarize new/locum staff about the importance of the different aspects of assessment and to follow the guide of the template provided on EPR.
- The content of these assessments varied, some had comprehensive assessment while others were less detailed. This should be investigated in the future to determine the definition of an adequate assessment across board.