Loneliness, Coping, Suicidal thoughts and Self-harm on Young People during the COVID-19 Pandemic: a Repeat Cross-sectional Study

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Background

The immediate and potential long-term impacts of the unprecedented coronavirus disease (COVID-19) on mental health, suicide and self-harm have not been widely addressed (Holmes et al., 2020; Torales et al., 2020). In relation to the extensive lockdown measures implemented, public mental health were expected to deteriorate in tandem with these dramatic changes at personal (e.g. restricted freedom), social (e.g. due to isolation and distancing) and economic level (e.g. unemployment and financial hardship), particularly for vulnerable individuals (Gunnell et al., 2020; Holmes et al., 2020).

Loneliness, the self-perceived deficiency of an individual's social relation network in quantitative or qualitative terms, has been identified as an important factor associated with suicidal thoughts and behaviours and the effect of loneliness on suicidal thoughts and behaviours is more prominent in young adults because they are experiencing periods where drastic changes in social status occur resulting in elevated loneliness (McClelland et al., 2020). Social isolation and loneliness linked to health protection measures similar to those taken in the COVID-19 pandemic resulted in a deterioration of the mental health of children and young people (Loades et al., 2020). Additionally, perceived stress and poor coping mechanisms are associated with suicidal behaviours in young people (e.g., Linda et al., 2012).

A UK-wide lockdown was announced on March 23rd 2020 which included instructions to the general population to stay at home, socially/physically distance and to self-isolate if they had symptoms. This was accompanied by guidance regarding movements outside the home for exercise and grocery shopping. These restrictions were fully in place until May 13th when they were gradually eased. Given the potential for such measures to be implemented in any further waves of COVID-19 or other pandemics, it is important to understand the effects of these measures on mental health and well-being in order to mitigate them in the future and address them currently.

This study aimed to explore the risk factors for suicidal thoughts and self-harm in response to the COVID-19 pandemic in the UK population using a repeated cross-sectional online population survey representative of the adult UK population. We assessed the effects of known amenable psychological risk factors for young adults including loneliness and coping, and other sociodemographic potential confounders.

Methods

This study was a repeated cross-sectional online population survey using a quota survey design and a sampling frame allowing recruitment of a national sample. We examined the public's mental health by assessing emotional responses, sources of social distress, coping, suicidal thoughts and self-harm in relation to the COVID-19 pandemic from individuals aged ≥18 years living in the UK.

Data collection

Data for the 'Coronavirus': Mental Health in the Pandemic' study were first collected shortly before the UK-wide lockdown was announced and repeated approximately every three to four weeks. In this study we report on the first four waves with wave 1, wave 2, wave 3 and wave 4 conducted on 17-18/03/2020, 02-03/04/2020, 24-26/04/2020 and 28-29/05/2020 respectively. Data collection is still underway although at increased intervals and all surveys were administered online by YouGov, a social market research company that recruited participants to form a panel containing over one million individuals from the UK. E-mails were sent to panellists selected at random from the base sample. The e-mail invited them to take part in a survey and provided a generic survey link. Once a panel member clicked on the link, they were sent to the survey that they were most suited for, according to the sample definition and quotas (non-probability sampling). Invitations to surveys did not expire and respondents could be sent to any available survey. In our study, quotas were based age, sex, education level, social grade and the UK's four nation population profile. The profile was derived from ONS census data and the National Readership Survey. Participants were different in each wave but taken from the same panel and representative of the UK adult population. Weighted bases, counts and percentages were reported unless otherwise specified to avoid identification of individuals in the case of small counts.

Dependent variables

Suicidal thoughts and self-harm **(available from Wave 2 to Wave 4 only)**

Self-reported experience of suicidal thoughts and self-harm behaviours were available in wave 2, wave 3 and wave 4. Participants were prompted firstly about the sensitivity of the topic and provided an option to skip the related questions. For participants who proceeded, they were prompted 'Have you done or experienced any of the following, as a result of the Coronavirus (COVID-19) pandemic in the past 2 weeks? (Please select one option on each row)' and then presented with two description with one for suicidal thoughts ('experienced suicidal thoughts/feelings') and the other for self-harm ('deliberately hurt myself'). Respondents were given three options: 'yes', 'no' and 'prefer not to say' for these two questions.

Independent variables

Loneliness **(available from Wave 1 to Wave 4)**

Participants were firstly prompted 'Which, if any, of the following emotions have you felt as a result of the Coronavirus (COVID-19) pandemic in the past 2 weeks? (Please select all that apply)' and loneliness was one of the emotions. As a result, we analysed this binary variable reflecting whether individuals felt lonely due to the pandemic.

Coping with stress **(available from Wave 2 to Wave 4 only)**

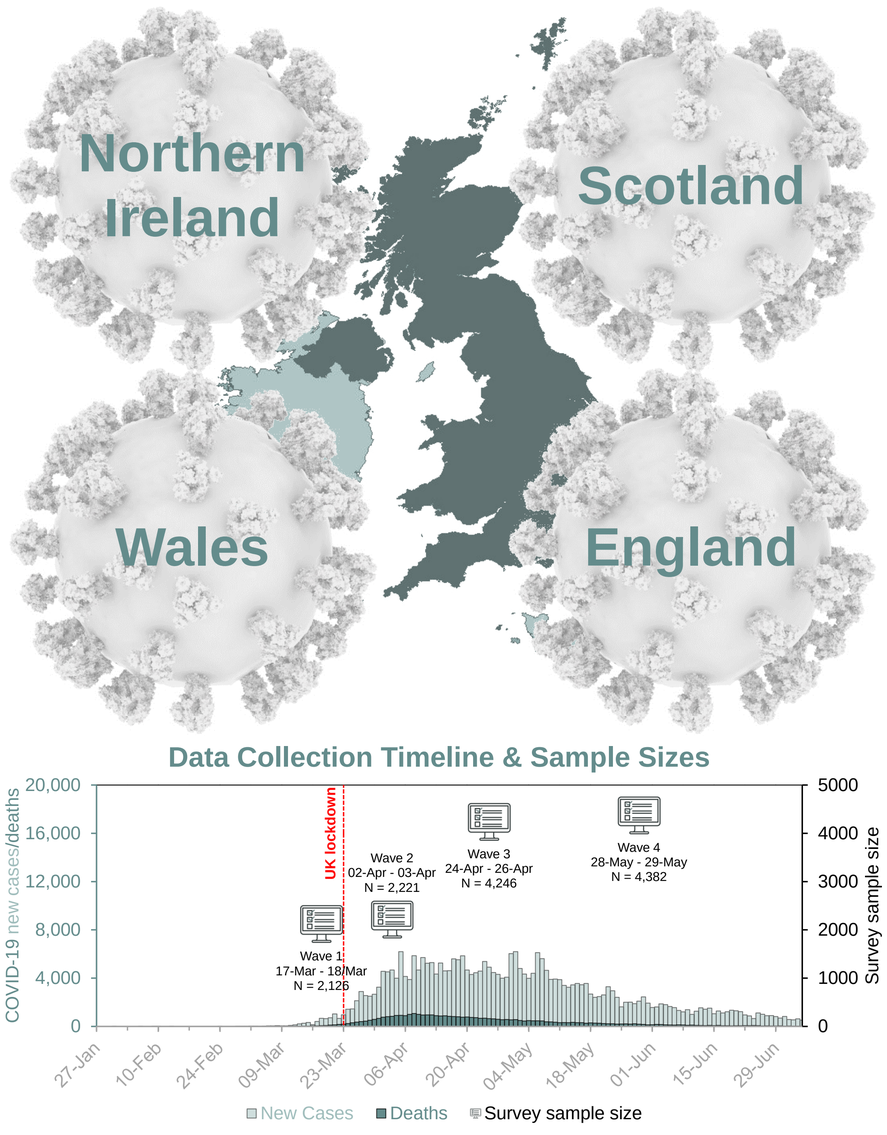
participants were asked 'For the following question, if you have not experienced any stress related to the Coronavirus pandemic, please select the 'Not applicable' option. Overall, how well do you think you are coping with stress related to the Coronavirus (COVID-19) pandemic?'. Respondents were given options of 'very well', 'fairly well', 'not very well', 'not at all well', 'don't know', 'prefer not to say' and 'not applicable I have not experienced any stress related to the Coronavirus' to answer. We combined 'very well' and 'fairly well' into 'well' category, as well as 'not very well' and 'not at all well' into a 'not well' category.

Sociodemographics **(available from Wave 1 to Wave 4)**

Sex, age, social grade (ABC1 and C2DE, generally representing individuals with higher and lower SES respectively) and working status (employed, included both full-time and part-time, unemployed, not working/others, full-time student and retired.

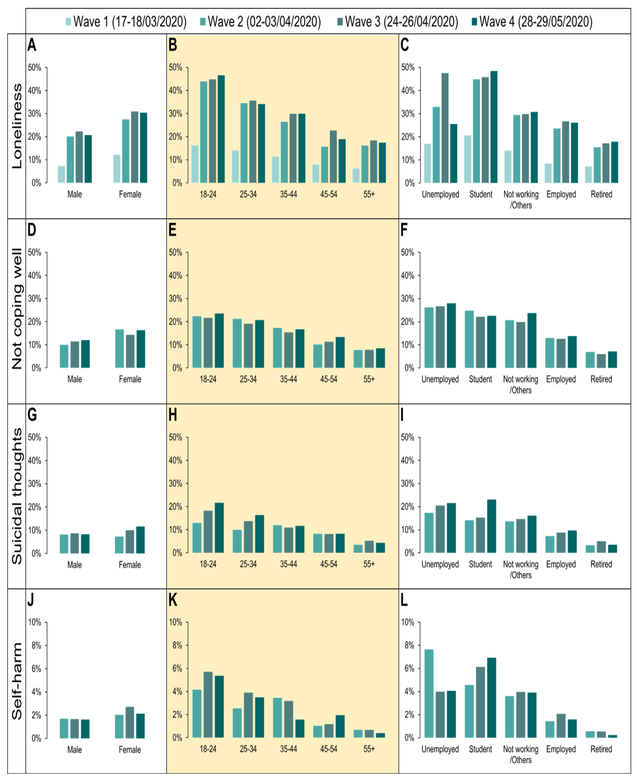
Data analysis

Cross-tabulations of variables including wave, loneliness, coping, sex, age and working status

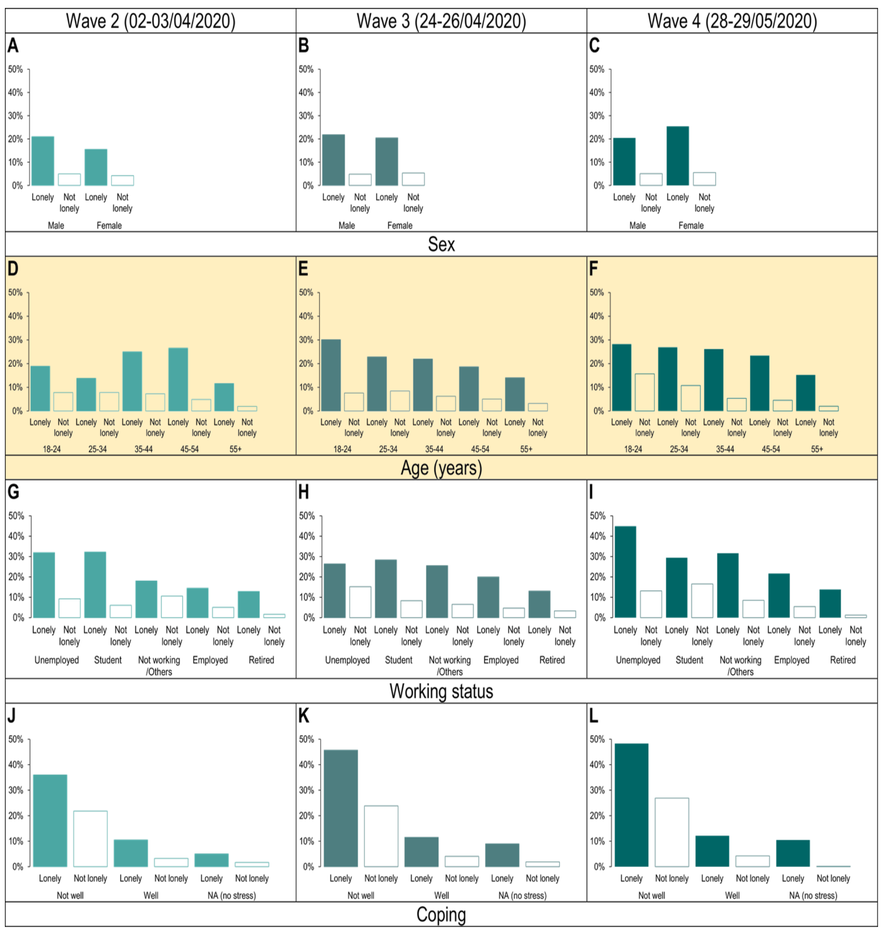


Results & Discussion

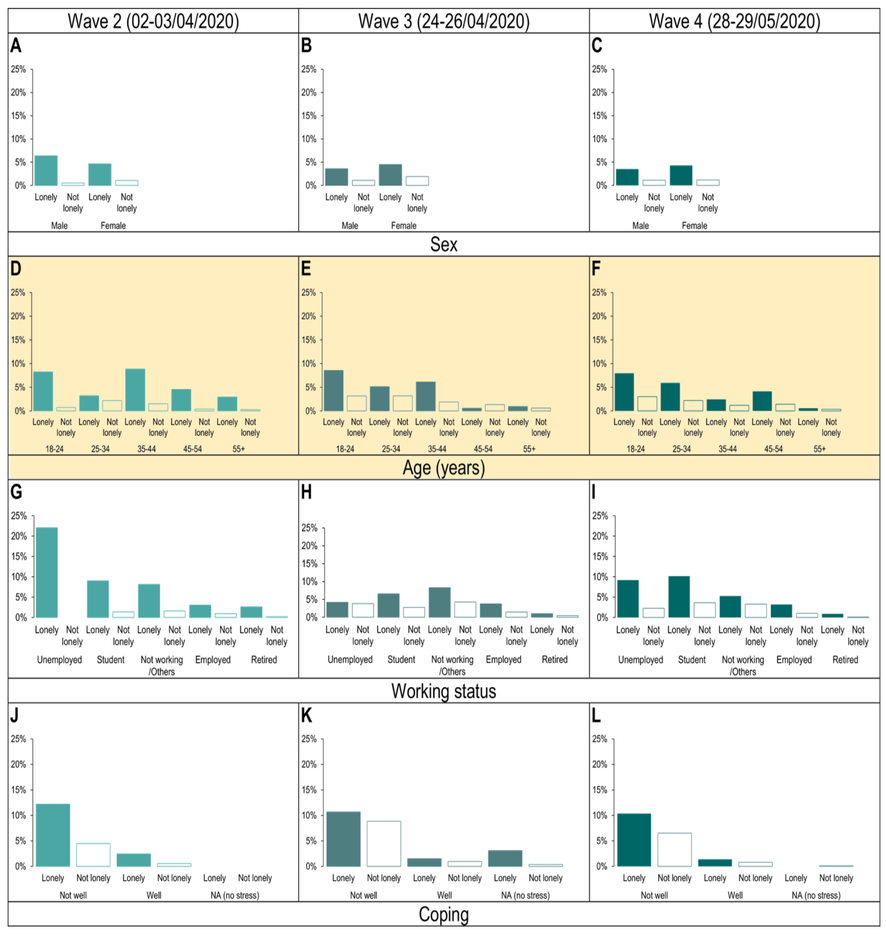
Loneliness, not coping well, suicidal thoughts and self-harm by sex, age and working status



Association of suicidal thoughts and loneliness by sex, age, working status and coping



Association of self-harm and loneliness by sex, age, working status and coping



We observed a sharp increase in loneliness among the UK population between wave 1 and wave 2 (later March 2020) when lockdown measures were implemented. Young adults aged 18-24 years were particularly affected by loneliness during COVID-19 (16.3% to 46.6%) and they were not coping well (21.6% to 23.5%) in response to the pandemic. This age group was also more likely to have suicidal thoughts (13.0% to 21.6%) and self-harm (4.2% to 5.7%) groups.

Our findings on loneliness, coping and young age being risk factors for suicidal thoughts and self-harm during COVID-19 can better inform policies and intervention strategies for vulnerable individuals and the general population.

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For more about the survey:
https://www.mentalhealth.org.uk/our-work/research/coronavirus-mental-health-pandemic

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Swansea University Medical School
Ysgol Feddygaeth Prifysgol Abertawe

Mental Health Foundation

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Adolescent Mental Health DATA PLATFORM

Swansea University Prifysgol Abertawe

QUALITY IMPROVEMENT PROJECT ON RAPID TRANQUILISATION

Are we adhering to the NICE Guidelines in patients who are agitated/ aggressive???

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INTRODUCTION:

Violence, agitation and aggressive behaviour refer to behaviours that can cause harm to others or to the person with those behaviours, regardless of whether it is verbal, physical and intentional. These behaviours are common in health care settings.

From 2013 – 2014, 68,683 assaults were reported against NHS staff in England, 69% of these were within mental health and learning disability unit. [1]

Rapid tranquilisation is to be used in situations where psychological and behavioural approaches, such as 'de-escalation', have failed. It is a treatment of last resort.
It is a restrictive treatment and therefore needs to be monitored closely to ensure its correct use, and to ensure patient safety.[1]

Rapid tranquilisation is defined as**, "use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed".[**1]

There was a national audit on rapid tranquilisation in 2007 which made several recommendations; including **the importance of monitoring following rapid tranquilisation, which was found to be one of the areas of poorer performance and this audit/QIP aims to find out if their recommendations have been followed.**[3]

AIMS & METHODOLOGY:

Aim

- To explore whether the NICE guidelines for rapid tranquilisation are adhered to on the psychiatric inpatient unit (PICU/ Tryweryn).
- Hence Audit was first done in 2018
- Re-Audit in 2019-2020
- QIP followed the Audit

Objectives

1. To discover if more conservative steps, such as de-escalation and oral medications are being used and given chance to work before giving IM medications.
2. To find out if safe doses are being prescribed with appropriate medications
3. To discover if patients receive appropriate aftercare following rapid tranquilisation

Standards were taken from NICE guidelines NG10

1. Conservative de-escalation to be utilised before medication offered
2. Oral and IM medications should be written up separately on the medication chart
3. Oral medication should be offered before IM
4. Enough time should be given for oral medication to work before going to IM
5. Only 1 drug of each class is to be used, unless rationale documented otherwise
6. To not exceed BNF doses
7. Documentation of rationale for use of Acuphase (Zuclopenthixol acetate) is clear
8. Patient to be monitored appropriately after rapid tranquilisation (i.e. vital signs – see appendix A)
9. To give the opportunity for the patient to discuss the event afterwards

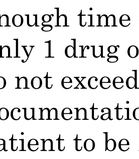
Sample - All patients who had received rapid tranquilisation, that were in PICU from August 2019 to February 2020. Unlike the previous audit which was retrospective, this audit is a prospective one. Over a period of 6 months, we collected data from those patients who had received rapid tranquilisation.

RESULTS: PDSA 1

Plan: Plan the test, including a plan for collecting data.

- State the question you want to answer and make a prediction about what you think will happen.
- Develop a plan to test the change. (Who? What? When? Where?)
- Identify what data you will need to collect.

- **QUESTION**: Are the rapid tranquilisation NICE guidelines adhered to, in patients with agitated/aggressive behaviour?
- **WHAT IF IT DOES NOT WORK?** We will continue to share the importance of the protocol adherence.
- **PREDICTIONS:** Following the discussion with the ward manager in PICU and the staff, especially after seeing the Audit results from 2018, we believe that we will adhere to the NICE guidelines
- **W**[4] : Trainee doctors (Asha and Sathyan) along with the staff in Psychiatric intensive care unit will be involved in this project and data collection for 6 months from August 2019-Feb 2020
- Prospective data collection based on standards from NICE NG10 guideline. This included 10 questions



Study: Analyze the results and compare them to your predictions.

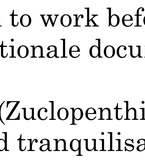
- Complete, as a team, if possible, your analysis of the data.
- Compare the data to your prediction.
- Summarize and reflect on what you learned.

- Over the first 2 months, 12 patients received Rapid Tranquilisation. Out of these 12, we randomly selected 4 patients to find the NICE guidelines adherence to be a 100 percent. (Overall adherence for 12/12 patients was 100%)
- The predictions regarding the adherence to protocol shows that the PDSA was successful.

Do: Run the test on a small scale.

- Carry out the test.
- Document problems and unexpected observations.
- Collect and begin to analyze the data.

- Following discussion with ward manager during February 2019 and following showing the presentation from 2018 with regard to the audit, we discussed with the staff in the ward regarding the protocol.
- Prior to actually starting the second audit, the adherence was noted to be low.
- However following persistence and having created a protocol jointly with the ward manager, we could see the difference.



Act: Based on what you learned from the test, make a plan for your next step.

- Adapt (make modifications and run another test), adopt (test the change on a larger scale), or abandon (don't do another test on this change idea).
- Prepare a plan for the next PDSA.

- Following the first PDSA, the plan was to continue the same.
- **The staff were appreciated for their efforts in maintaining 100% adherence a success.**
- The same will be continued with some positive reinforcement from ward manager and myself

PDSA 2

PDSA 2 – Step 1 /2: PLAN/ DO

- We continued with the same protocol. The staff have been consistent in monitoring the data effectively while following to the protocol strictly.

PDSA 2 – Step 4: ACT

- The PDSA done second time showed that the adherence was 100% again.
- The adherence to the protocol has been followed for not just the sample that was selected, but for the entire set of patients who received the Rapid Tranquilisation

PDSA 2

The table below demonstrates levels of achieving the various standards 1-9 and compares them to each other. Blue being achieved, red representing not achieving the targets.

Table of standards from 1-9 (standards listed above) from old Audit (2018)

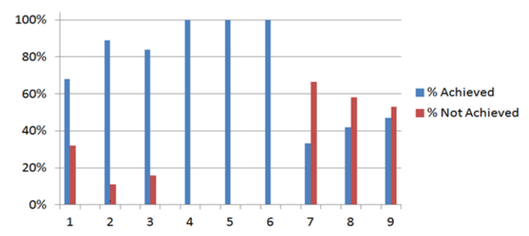
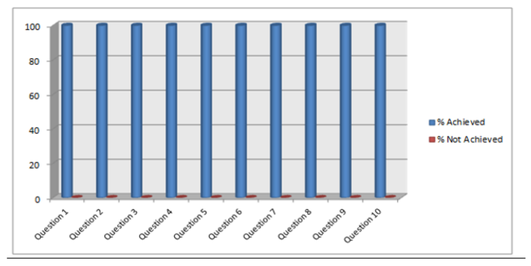


Table of standards from 1-10 (standards listed above) from this Audit (2019-2020)



PDSA 2 – Step 3: STUDY

- Over the next 2 months, 8 patients received Rapid Tranquilisation.
- **Out of these 8, we randomly selected 4 patients to find the NICE guidelines adherence to be a 100 percent. (Overall adherence for 8/8 patients was 100%)**
- The predictions regarding the adherence to protocol shows that the PDSA was successful.

Graph and Tables

Assessment – compliance achieved against standard:

No.	Comparison with the previous Audit	% Achieved 2018	% Not Achieved 2018	% Achieved 2020	% Not Achieved 2020
1.	Conservative de-escalation to be used before medication	68%	32%	100%	0%
2.	Oral and IM medications written up separately on the chart	89%	11%	100%	0%
3.	Oral medication offered before IM	84%	16%	100%	0%
4.	Enough time to be given for oral medication to work before going to IM	100%	0%	100%	0%
5.	Only 1 drug of each class to be used, unless rationale states otherwise	100%	0%	100%	0%
6.	To not exceed BNF doses	100%	0%	100%	0%
7.	Documentation of rationale for use of Acuphase (Zuclopenthixol acetate) is clear	33.3%	66.6%	100%	0%
8.	Patient to be monitored appropriately after rapid tranquilisation	42%	58%	100%	0%
9.	To give the opportunity for the patient to discuss the event afterwards	47%	53%	100%	0%
10.	Datix	Not checked	Not checked	100%	0%
11.	Overall number of patients	19		21	

DISCUSSION:

Following the previous Audit and a detailed discussion with the ward manager in Tryweryn in 2019 February regarding the results obtained, we then further took it forward with the TODAY WE TALKED INITIATIVE.

This was the first part of QIP,→ here in restraints and enforced Rapid tranquilisation was looked into. This initiative reduced the coercive measures in dealing with aggression.

The utilisation of de-escalation techniques and behavioural support plans that was person centred in turn brought down the rate of Rapid Tranquilisation successfully. Thus placing our PICU as having least restraints in UK in 2019 (Second least 3/ month) → PICU was awarded the prestigious *Nursing Times* Team of the Year Award for their pioneering work transforming the Tryweryn psychiatric intensive care ward at Betsi Cadwaladr.

Following this QIP, we then formatted the proforma for Rapid Tranquilisation which included the services to be provided/ actions to be taken, Post Rapid Tranquilisation physical health monitoring and patients response to medication.

The PICU will continue to maintain this 100% standard and we would then consider extending the Audit to both Open wards and PICU in entire North Wales.

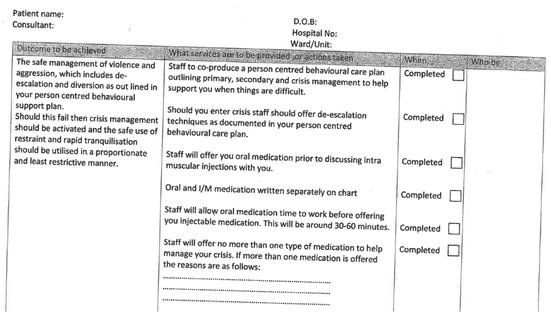
What have we achieved?

With the co-operation from the team in PICU, the results showed that:

- ✓ all the patients only receive rapid tranquilisation when truly necessary and
- ✓ this is done in the safest manner possible;
- ✓ with appropriate monitoring afterwards
- ✓ and a discussion with the patient about the event.

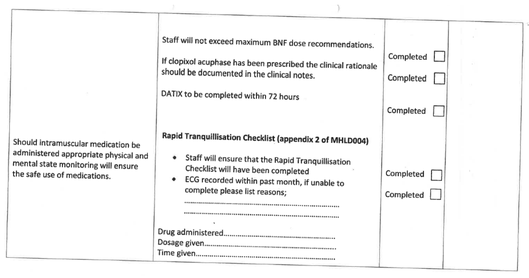
This adherence ensures that rapid tranquilisation is done as safely as possible, with risks as low as possible.

With the restraints reduced due to TODAY WE TALKED INITIATIVE, the number of Rapid tranquilisations have reduced as well. On an average over 6 months it was 21 patients who were rapid tranquilled. This is less than the national rate.

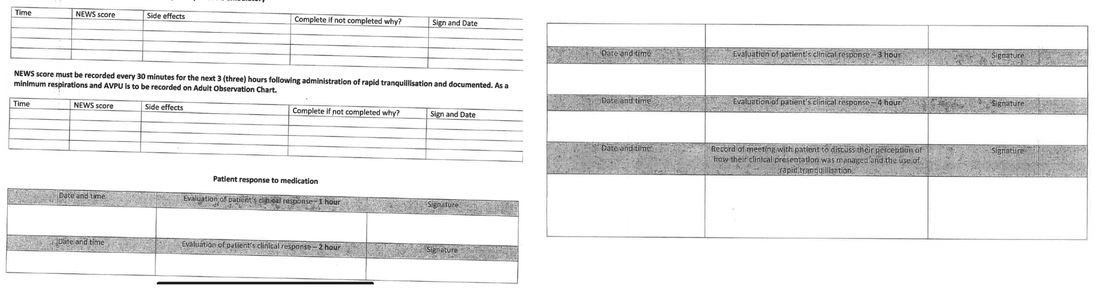


Patient name:
Consultant:
D.O.B:
Hospital No:
Ward/Unit:

Outcome to be achieved	What services are to be provided / actions taken	When	Who by
The safe management of violence and aggression, which includes de-escalation and diversion as out lined in your person centred behavioural support plan. Should this fail then crisis management should be activated and the safe use of restraint and rapid tranquillisation should be utilised in a proportionate and least restrictive manner.	Staff to co-produce a person centred behavioural care plan outlining primary, secondary and crisis management to help support you when things are difficult.	Completed ☐	
	Should you enter crisis staff should offer de-escalation techniques as documented in your person centred behavioural care plan.	Completed ☐	
	Staff will offer you oral medication prior to discussing intra muscular injections with you.	Completed ☐	
	Oral and I/M medication written separately on chart	Completed ☐	
	Staff will allow oral medication time to work before offering you injectable medication. This will be around 30-60 minutes.	Completed ☐	
	Staff will offer no more than one type of medication to help manage your crisis. If more than one medication is offered the reasons are as follows:	Completed ☐	



Should intramuscular medication be administered appropriate physical and mental state monitoring will ensure the safe use of medications.	Staff will not exceed maximum BNF dose recommendations.	Completed ☐
	If clopixol acuphase has been prescribed the clinical rationale should be documented in the clinical notes.	Completed ☐
	DATIX to be completed within 72 hours	Completed ☐
	Rapid Tranquillisation Checklist (appendix 2 of MHLD004) • Staff will ensure that the Rapid Tranquillisation Checklist will have been completed • ECG recorded within past month, if unable to complete please list reasons;	Completed ☐ Completed ☐
	Drug administered..... Dosage given..... Time given.....	



Post rapid tranquillisation physical health monitoring

NEWS score and side effects must be recorded every 15minutes for minimum of 1 hour following administration of rapid tranquillisation and documented and should include pulse oximetry until patient is ambulatory

Time	NEWS score	Side effects	Complete if not completed why?	Sign and Date

NEWS score must be recorded every 30 minutes for the next 3 (three) hours following administration of rapid tranquillisation and documented. As a minimum respirations and AVPU is to be recorded on Adult Observation Chart.

Time	NEWS score	Side effects	Complete if not completed why?	Sign and Date

Patient response to medication

Date and time	Evaluation of patient's clinical response – 1 hour	Signature
Date and time	Evaluation of patient's clinical response – 2 hour	Signature

Date and time	Evaluation of patient's clinical response – 3 hour	Signature
Date and time	Evaluation of patient's clinical response – 4 hour	Signature
Date and time	Record of meeting with patient to discuss their perception of how their clinical presentation was managed and the use of rapid tranquillisation	Signature

References:

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Video Consultations in Mental Health Services in Wales: A Mixed Methods Evaluation Using a Quality Improvement Approach.

BACKGROUND

Covid-19 put the physical and psychological health and well-being of the nation at risk. **Technology Enabled Care (TEC) Cymru** designed and implemented a new **National Video Consulting (VC)** Service in Wales as an emergency response. The VC service was offered to all primary, secondary and community care services, with a large uptake among mental health and psychiatry specialties (11%). Emerging research suggests that symptoms of depression, anxiety and stress are common reactions to the Covid-19 outbreak. It is therefore important that the use and acceptability of innovations such as VC are robustly evaluated so that they can be confidently utilised within mental health services.

METHOD

Using a mixed methods quality improvement approach, measuring the use and acceptability of video consultations (VC). Over **24,000 participants**, from **40 specialties** have participated to date.

The evaluation is in two phases, with regular **PDSA cycles**. The current analysis includes data from phase 1 (March-Sept 2020) of the first 10K participants (20% response rate of VC users)

There was a total of **1028 survey responses** specific to Psychiatry, Psychology or Mental Health Counselling, with 640 clinicians and 388 patients.

RESULTS

Respondents rated VC positively (n=1019), with **82.5%** rating VC **excellent, very good,** and **good**.

Face-to-face (FTF) was prevented for 87.7% of respondents (n= 977).

A significant difference between patients and clinicians on quality rating for VC U = 102849.0, $p < .001$ with patients rating VC more positively.

Further analysis begins to explore this difference, revealing clinicians placed more emphasis on technological restraints associated with VC. Nonetheless, there remained a **high level of acceptability** despite technological limitations.

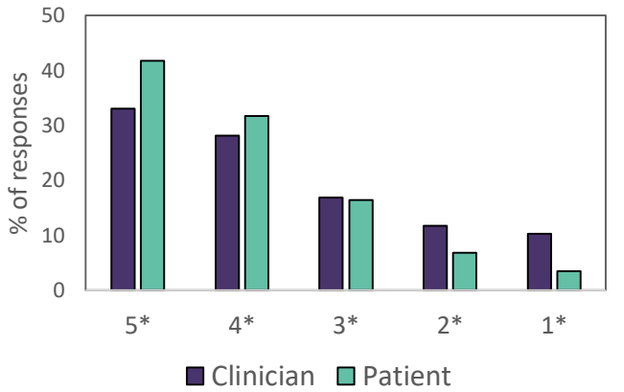

Figure 1. The difference between clinician and patient VC quality rating.

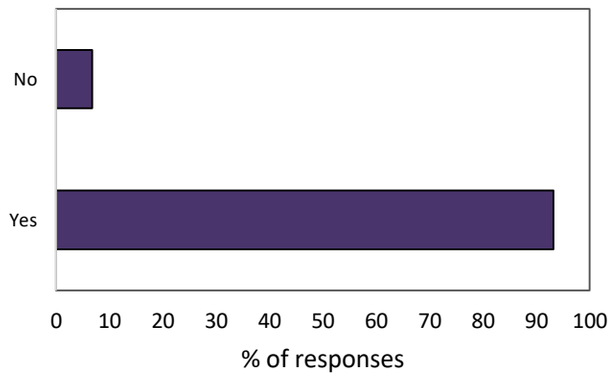

Figure 2. The prevention of FTF across the sample.

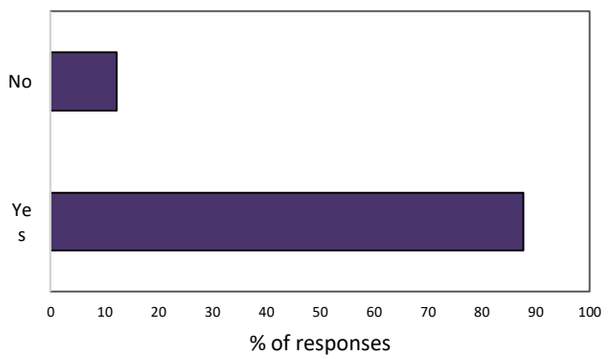

Figure 3. The proportion of responses for whether patients would use VC again.

PATIENT

"This type of consultation was beneficial for my son as it removed the need for my son to travel to the hospital and therefore reduced his anxiety."

"Overall ...worked very well with just a small amount of intermittent lagging. Much better than a telephone consultation as you have a human connection by seeing each other"

"It was very good to be able to see the other person and actually feel that it was a therapy session. I found it extremely helpful and certainly see it as a way forward for times when people are unable to physically get to places."

TRAVEL SAVINGS

28,652 (478 hours)

13,970 miles

CLINICIAN

"A bit blurred at times but brilliant overall."

"Everything worked well today."

""It was very easy to set up this initial call with a client who had agreed to a trial/test call before her appointment tomorrow. She was able to test out the screen share option also and was happy that she could minimise the thumbnail of herself as she doesn't like to see herself when she is upset. Overall it worked well."

CONCLUSIONS & NEXT STEPS:

VC is **highly satisfactory** within mental health in Wales, despite a discrepancy between patient and clinician **acceptability**. Phase 2 of the evaluation will aim to understand this difference beyond unavoidable technical problems.

Find out more at:
www.digitalhealth.wales/tec-cymru/vc-service

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Children and Young People Contacts with healthcare services prior to suicide

Case–control study using electronic health records from Wales, UK, 2000–2017

Marcos DelPozo-Banos, Ann John, David Gunnell, Michael Dennis Jonathan Scourfield, David V Ford, Keith Lloyd

Background:

Among young people, suicide is one of the leading cause of death wolrdwide.

Suicide rates of .4 and 1.5 per 100,000 population for 5-14 years-old are reported by the WHO.

In the last **50 years**, suicide research has seen **slow progress** and innovation, and a scarcity of longitudinal studies [Franklin2017].

What we know:

In the UK, 14% of young people who die by suicide are in contact with mental health services [Windfuhr2008].

At the same time, there seems to be high psychiatric morbidity among young people who die by suicide [Gould2003].

Longitudinal studies of patterns of healthcare contacts in under 25 year-olds who die by suicide are scarce.

Existing studies do not simultaneously explore healthcare routinely collected data across all settings.

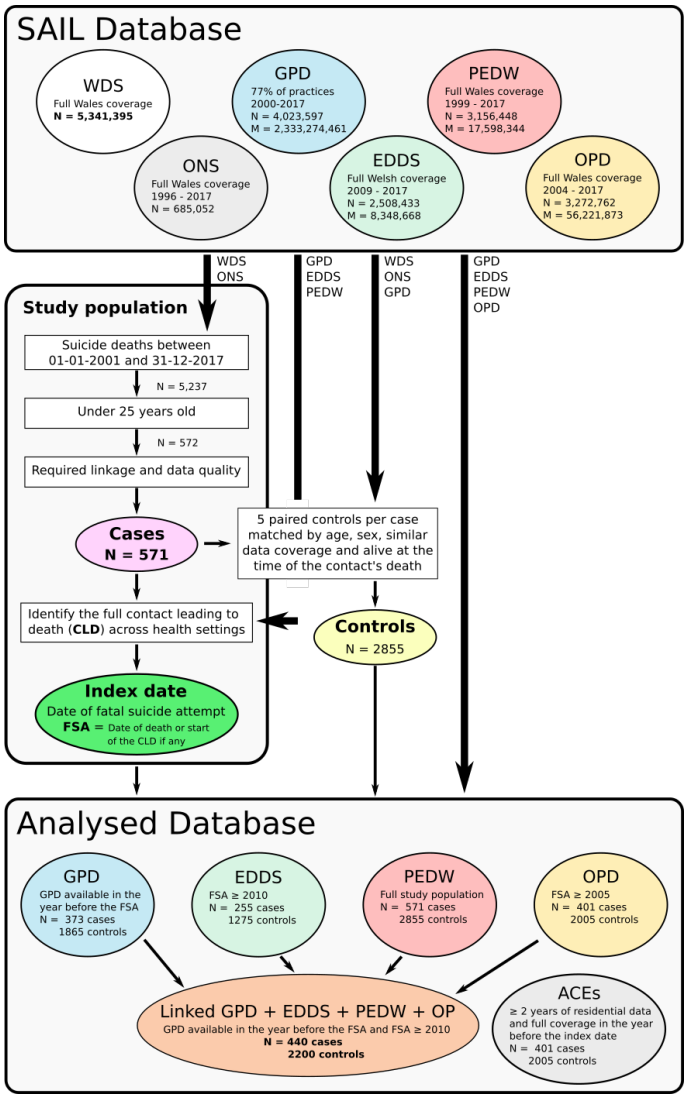
Aim:

To explore the **type** and **time** of health care services contacted by under 25 years old who die by suicide in the year before their death in order to identify potential opportunities for prevention.

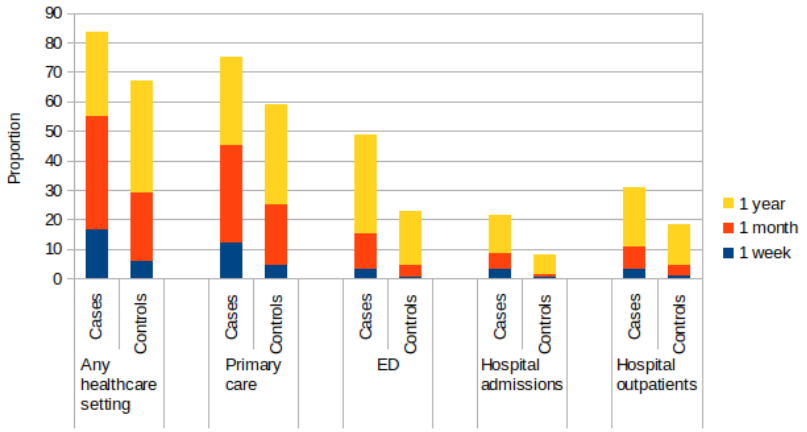
Study characteristics:

Combines all of the following characteristics:

+ A population-based dataset
+ Case-control design with controls drawn from the general population
+ A study period of 17 years
+ Linkage of administrative, primary and secondary care data at a person level
+ Continuous longitudinal analysis over the last 12 months of life.



Cases and controls healthcare contacts before their FSA index date



Results:

- Primary health care was the most common point of contact.
- Primary health care was the most common last point of contact (for 60.4% of cases).
- The difference between cases and controls was larger in times closer to the FSA index date.
- **1 year before the FSA index date**:
  - 83.6% of cases vs 66.9% of controls had a contact with health services (OR 2.7 [2.1, 3.6]).
  - 75.0% of cases vs 59.0% of controls had a contact with primary care (OR 2.2 [1.8, 2.8]).
  - 48.8% of cases vs 23.0% of controls had an ED visit (ORs 3.0 [2.4, 3.8]).
  - 21.4% of cases vs 8.1% of controls had a hospital admission (ORs 3.5 [2.5, 4.8]).
  - 31.1% of cases vs 18.3% of controls had a hospital outpatient contact (ORs 2.1 [1.7, 2.8]).

Conclusions:

- The great majority of children and young people who died by suicide contacted health services in the year before their FSA index date.
- Almost half of children and young people who died by suicide were seen in ED at least once in the year before their FSA index date.
- As close as 1 week before the FSA, 1 in 6 cases had a contact with health services, almost three times as high as the rate observed for controls.
- Frankling's et. al. meta-analysis [Franklin2017] has shown that, despite the efforts, traditional epidemiological techniques have not advanced much our practical knowledge of suicide prevention.
- We believe that more effort should be put in applying advance machine learning techniques, such as deep learning, to this problem. Our early results seem to indicated that these tools are better place to identify the many and complex relationships between factors and risk [DelPozo-Banos2018].

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The Impact of Non-Clinical Patient Factors on Clinical Decision-Making: Uncovering The Impact on Mental Health

Burns, L., Sergio Da Silva, A., & John, A

Introduction

Patient factors such as demographics, socioeconomic status, and education can unintentionally impact mental health-related clinical decisions[1]. Understanding the extent to which these non-clinical patient factors (NCpF) influence clinical decision-making is imperative to minimising errors in diagnosis or treatment caused from internal biases.

Aim:

- To use a mixed-methods design to understand the impact of NCpF on mental-health related diagnostic, treatment and referral decisions.

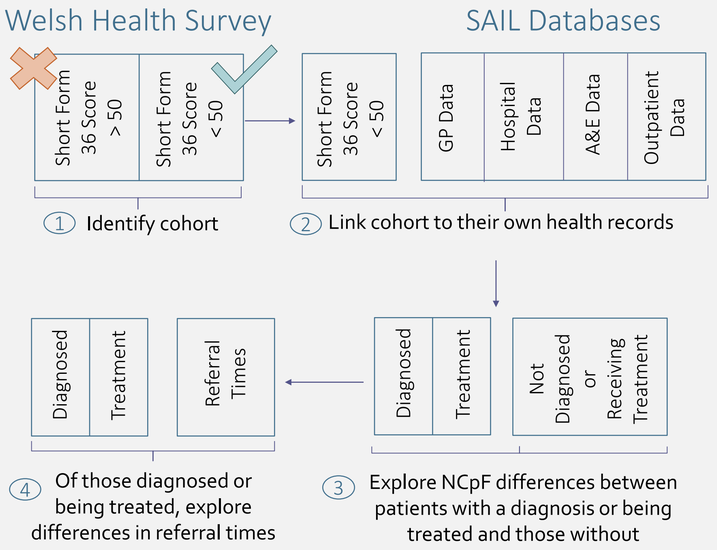
Methods

Focus Groups

Two focus groups involving patients with mental ill-health were conducted to gain a better understanding of their mental health journey and identify any NCpF not previously identified in the literature. The NCpF to be observed in the data linkage were:

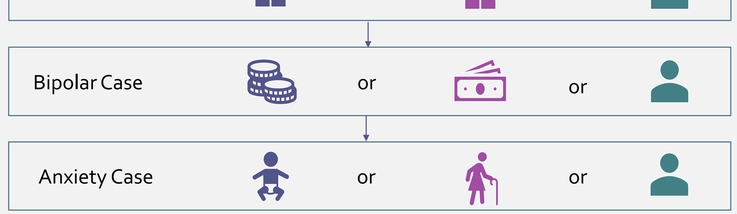
- Age
- Sex
- Education
- Socioeconomic Status
- Number of GP events

Data Linkage



Clinical Vignettes

Three fictitious clinical cases were coproduced to see whether the presence of a NCpF influenced the mental health treatment, referral or diagnostic decision of general practitioners (GPs). Each GP was presented with one Bulimia case, one Bipolar case and one Anxiety case, but a different NCpF.



Results

Data Linkage

Increased likelihood of diagnosis and treatment was associated with: being female, permanently unable to work, more GP events. Decreased likelihood of diagnosis or treatment was associated with: age of over 66 years, working in a lower supervisory role. Those who hold a higher degree were also less likely to receive treatment.

Clinical Vignettes

The results of the vignette study show there were differences between cases with NCpF included versus the control, such as Anxiety being better identified in young people than in the control or older person case.

Conclusion

NCpF can influence mental health diagnostic, treatment and referral decisions. This research uses a combination of research designs in order to gain a complete view of the impact of NCPF on mental health clinical decisions. This study will be used to ; identify where inconsistencies between decisions lie and assist clinicians to make better informed mental health-related decisions. By gaining a better understanding of the influence of NCpF on clinical decisions, it is possible to transform practice and prevent inequity in mental health care.

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An Innovative CASC Training Redesign

'Experience of Virtual Mock CASC Exam'

Dr Jessica Foster ST4, Dr Jennifer Rankin ST5,

Introduction

Cardiff CASC Training (CCT) provides structured and formal training for the CASC exam for Wales trainees, in conjunction with the Wales Deanery.
First established in 2012, CCT has delivered face-to-face mock CASC exams for the past 8 years. Feedback from candidates and examiners has been excellent, with extremely positive outcomes in terms of improvement in CASC pass rate for candidates.

COVID-19

As with many aspects of medicine in the current COVID-19 pandemic, delivery of the most recent mock CASC examination had to be adapted in order to run safely and in accordance with government guidelines.
The aim was to run the mock exam remotely via an online platform, ensuring candidates did not miss out on vital exam practice.

Limitations

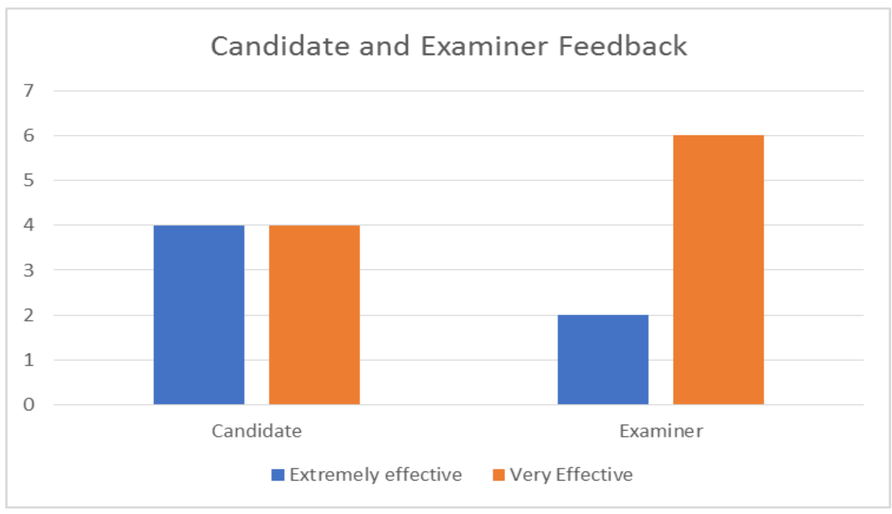
A few technical difficulties were experienced. Hospital computer internet browsers did not support Zoom and it was not possible for candidates to view instructions throughout the station due to inability to simultaneously view candidates and screen share.
The logistical workload for the lead exam coordinator on the day was high and involved coordinating at least 24 people at any one time.

Method

The online platform chosen was Zoom. This was due to it's accessibility and ease of use including ability to screen share candidate instructions and assign participants in to break out rooms. With the actors and examiners remaining in the same breakout room throughout the exam, one lead exam coordinator manually rotated candidates around the circuit of 16 stations.The stations utilised remained in keeping with the blueprint provided by the Royal College of Psychiatrists. At the end of the exam all candidates were rotated around the circuit for a second time in order to receive verbal feedback from examiners.

Outcome

Overall this first online mock CASC examination was a success. A total of 8 candidates sat the exam. Written feedback was obtained from candidates and examiners and ranged from 'very effective' to 'extremely effective' as shown in the graph.



Conclusion

Although online learning may feel very different to the face-to-face interactions we are all used to we are in an era where adaption is necessary. This initial online mock CASC examination was a success and is also in keeping with how the actual CASC examination is currently being run by the Royal College of Psychiatrists. CCT are running a further online mock examination in December to support the next cohort of candidates through their CASC exam in this particularly challenging time.

Enhanced Care Home Liaison Project

Dr Deni Mohan , ST6 Care Home Liaison team , Cardiff UHB , Dr Arpita Chakrabarti , Consultant Care Home Liaison , Cardiff UHB, Craig Walters Team Leader Care Home Liaison team , Amy Smith Care Home Liaison nurse and Team Coordinator

Introduction

The COVID-19 pandemic raises challenges for care home residents, their families and the staff that look after them. Discharge from inpatient units to long-term care can be particularly challenging given the current circumstances. As we all know care home residents are regarded as shielding and are therefore the most vulnerable to the effects of COVID-19. In order to safeguard resident's health it is essential that robust controls are in place to mitigate the risk of transfer and spread of infection within the closed setting.

Aims

Hospital in patients who are fit for discharge to a care home setting are expected to have a negative swab result 72 hours before discharge and are required to isolate in their bedroom for 14 days after transfer. This has meant that patients who are mobile or who are unable to isolate for 14 days remain in hospital The requirement for inpatients (many of whom have Dementia) to isolate in a bedroom for 14 days has caused significant distress to the individual patients (who often lack understanding for the reason behind this), when discharged to care homes. The patients with dementia that are mobile will naturally attempt to leave their room, only to be assisted back inside much to their frustration.

This has led to many of the patients with Dementia becoming agitated and aggressive on discharge to care homes. Subsequently, the care homes have had difficulty managing these behaviours. This has made it very hard to place these patents in care homes as the care homes are now either not accepting them or requesting costly 1:1 observations for the entire isolation period.

Methods

A step down facility that will allow patients to comfortably isolate for 14 days in line with Welsh Government isolation guidance before transitioning to their identified care home placement. To facilitate this, an Enhanced Care Homes Liaison (ECHL) Team within MHSOP have been identified to support patients in their transition to residential and nursing care homes during the Covid-19 pandemic.

Specific aims of the project include:

To reduce the length of stay in hospital for individuals by 20%.

To ensure that individual patient goals and functional ability is maintained once in a care home setting. This will be measured at discharge from the service if the care and treatment plan and personalised goals have been achieved.

Reduce the readmission rate from a care home environment to an acute hospital location.

To identify and support training for care home staff in specific areas.

To ensure the safe transfer of patients into isolation pods/individual bedrooms within care homes that are unable to self-isolate thereby protecting the care home population from the risk of COVID 19.

To help improve patient's experience of the isolation period.

Implementation and Measures

Implementation strategies will include:

1. Regular team meetings for the ECHL team and include the care home staff where possible through the use of technology
2. Ensuring that personalized care booklets have been developed and supporting and training care home staff in the interventions identified for that individual, with the flexibility of the team being available to monitor, assess and evaluate any changes due to the change of environment
3. Linking with MHSOP d/c liaison team and General Hospital medicine d/c team, who can also champion the service.
4. Linking with the local authority, Response Enhanced Assessment Crisis Treatment, carer support agencies, third sector, educational providers and Community Resource Team .

Baseline measures:

- This will include length of stay in hospital and length of DTOC.
- Behaviour Rating Scale to be used at the start and end of intervention to monitor progress of individual Patients' mental state/behavior throughout ECHL involvement.
- Outcome measures:
- Number of patients successfully transferred to main stream care home beds/discharged home.
- Monitoring of readmission rates of patients involved in the project.
- Monitor rate of changes to medication
- Qualitative measure:
- Feedback from patients and carers on their experience.
- Feedback on training received by care home staff in respect to approaches and role modeling .

Team

Consists of Psychiatry Speciality Doctor (St6), Band 8a nurse, Band 6 RMN Nurse, Physiotherapist, Dietician, SALT and three Multi-Professional Rehab Assistants. There are two identified care homes with capacity to take 5 patients. These care homes have been identified as they have isolation units that are separate from the main care home in order that patients are able to isolate in smaller cohorts. This separate space will enable patients to move around more freely, work with the MDT on recovery outcomes, enable the care home staff to implement and carry out care plans with the ongoing support of a dynamic and flexible ECHL workforce. This team will be providing clinical interventions in addition to the care home input that will be provided by the home itself.

Conclusion

Improvement in quality is the way forward to making the health system in Wales fit for the future. Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable health care in the context of a learning culture.

The ECHL team is built on the principles of the Welsh Government plan for health and social care. Our aim is to create a new model of seamless care integrating health and social care with particular focus on delivering care in the community and support the smooth transition from hospital to care home. The model is built on a foundation of local innovation including private health care providers. The ECHL team is underpinned by a strong shared philosophy and continuous engagement.

Funding

Funded by Cardiff and Vale University Health Board