Child parent psychotherapy in the treatment of severe trauma in a 4-year-old child with co-occurring autism spectrum disorder

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Aims. This poster describes Child Parent Psychotherapy (CPP) in the treatment of severe trauma in a 4-year-old child with co-occurring Autism Spectrum Disorder (ASD).
Background. The London Infant and Family Team (LIFT) implements the New Orleans Intervention Model. It targets the mental health needs of under 5 year olds, providing evidence based assessments and interventions for infants, their parents and foster carers within the framework of the Family Court in England. The majority of children seen by LIFT have suffered severe trauma. LIFT delivers a range of interventions including CPP - a relational treatment for young children who have experienced trauma.

CPP seeks to intervene in a number of ways: provides developmental guidance, demonstrates that the child's behaviour has meaning and can be linked to past traumas, enables the child to have space to play and talk about what has happened, helps to name and contain emotions - supporting emotional regulation, and helps the dyad to understand each other. The dyadic relationship is key to the intervention - helping to establish safety for the child and strengthen the caregiver-child relationship, enabling the child to make sense of past experiences and learn new ways to express feelings. Exploration of trauma takes place through a combination of play and interpretations made by the clinician, who supports and holds in mind the experiences and history of both child and carer. There is evidence that CPP helps young traumatised children to become less anxious, more secure in their attachment relationships and more able to cue their needs. There is less evidence of the efficacy of CPP in the context of young children with a co-occurring diagnosis of ASD.
Method. The poster describes the assessment of a 4-year-old child of normal intelligence with a two year history of severe neglect, and physical and emotional abuse, who presented significant behavioural and emotional disturbance. Tools used to assess the child's behaviour, trauma symptoms and ASD are outlined. The process of CPP with the child and foster carer dyad is described. Outcome measures and symptom resolution are reported.
Conclusion. Co-occurrence of ASD did not prevent this child accessing trauma therapy. He engaged in symbolic play, made use of CPP interpretations, and achieved significant improvement in his symptoms. The differential diagnoses of trauma symptoms and ASD presenting in young children are discussed, alongside the importance of understanding and treating trauma in this context.

Physical health assessment quality improvement project

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Aims. My aim was to ensure at least 60% of clients in the Acute Day Unit have a 'physical screening tool' entry.
Background. As a GP starting training in psychiatry I am very aware of the importance of physical health and the overlap between physical health and mental health. It has been found that there is a 20 year mortality gap for men and 15 year mortality gap for women in people with mental health problems. Thorncroft described this as 'the scandal of premature mortality'.

Nice Guidelines state: 'Reducing premature mortality by improving physical healthcare for people with severe mental illness remains an NHS England priority. Funding has been made available to ensure that at least 60% of people who have severe mental illness receive NICE-recommended physical assessments and follow up from 2018/19 onwards.'

The Acute Day Unit seemed to be the ideal situation to try to address this problem as clients are with us for 6-8 weeks during which time their physical health as well as their mental health can be optimised.
Method. I emailed the whole team to invite ideas and questions regarding the QI project and discussed it further at the MDT meeting. It was important at the start to get the whole team on board. Having discussed it we decided to put six blocks of thirty minute slots weekly into the timetable for physical assessments. These were to be booked in by the client's care coordinator. I also added a column onto our team spreadsheet to input whether or not the physical assessment had been done. Frequent encouragements and reminders were sent round the team of which clients still needed a physical assessment.
Result. Before the changes were made 25% of clients were having their physical assessments done. After the changes were made 63% of clients had their physical assessment done, three of the twenty seven clients having only started at the day unit that week.
Conclusion. Having made a change to the system of scheduling six regular slots for physical assessments there has been a dramatic rise in the number of clients having their physical assessment done. As this change has been to the system and will be continued automatically on the team calendar the improvement has been more easily sustained. We are keen to keep improving on this change with an ideal level of over 75% of clients having a physical health assessment.

Staff's perspectives on physical activity in acute mental health general adult wards

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Aims. Physical activity (PA) has multiple health benefits for people with severe mental illness (SMI). Nevertheless, people with SMI engage in less exercise and more sedentary behaviour than the general population. Additionally, inpatient settings can exacerbate barriers to PA and facilitate sedentary behaviour. Staff's attitudes towards PA promotion may influence patient engagement. The aim of this study was to explore staff's views on PA for acute psychiatric inpatients, including enablers and barriers.
Method. An online anonymous survey with free text was sent to all 85 multidisciplinary team (MDT) members of two acute general adult wards, including nurses, doctors and allied health professionals. A qualitative approach was used to gain deeper understanding of the participants' perspectives. Manual thematic analysis was completed to identify discrete themes.
Result. Response rate was 64%, with 54 professionals responding. Notably, 100% agreed or strongly agreed that exercise is beneficial to physical and mental health. Nevertheless, 72% felt it was not

easy to do PA with patients during their shift, while many reported they were able to encourage exercise but were unable to accompany patients to sessions. Specifically, participants reported lack of time (40%), high level of clinical activity (32%), lack of staff (30%), lack of PA resources inside the wards (20%) and conflicting priorities (18%), stopping them from helping patients to do more exercise. However, they felt more staff (28%), time dedicated to PA (26%), on-ward resources (18%), access to the gym and gardens (18%), staff dedicated to PA (16%) and staff trained in facilitating PA (10%), would help participants promote PA on the ward. Other suggestions to enable PA included a change in ward culture, valuing and promoting PA, daily patient encouragement by all MDT members instead of only occupational therapists, and PA promotion as part of mental health treatment and as physical health strategy. Finally, 70% of participants said they exercised regularly, although some reported lack of time or motivation, work commitments and workload-related exhaustion reducing their ability to exercise.
Conclusion. Participants acknowledged the importance of PA for physical and mental health. Furthermore, they described multiple enablers and barriers. Prioritising PA during admission, providing on-ward activities, educating/training staff, reiterating that PA promotion is within all MDT members' job roles, and offering organisational support can contribute to improved PA provision and regular involvement of patients.An integrative approach to mental health and well-being, promoting PA in inpatient psychiatric settings is required.

Improving accessebility to psychiatry in NHS Tayside

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Aims. Our aim is to improve the accessibility of Psychiatry to other specialties when being contacted for review and advice, both in hours and out of hours.
Background. From clinical contact and informal conversations, other specialties sometimes have difficulties contacting psychiatry for advice/review. The aim of this is quality improvement project is to determine how accessible we are to other specialties and work on improving how we communicate with the general hospital.
Method. We created a questionnaire for colleagues from other specialties to fill in from 26/9/19 for 6 weeks. We gathered information regarding their grade, work site, previous contact with psychiatry, whether they knew where to find our contact information and if they could identify the correct method to ask for advice from general adult psychiatry (GAP), Psychiatry of old age (POA) , and out of hours psychiatry (OOH). We also asked colleagues to put in free text comments regarding their experience in contacting psychiatry. We also asked if our colleagues were aware of how to perform an Emergency Detention Certificate as this is advice we sometimes give which does not always need our input immediately.
Result. There was a total of 39 responses, 29 from Ninewells Hospital (NW) and 10 from Perth Royal Infirmary (PRI). There was a mixture of staff grades from Foundation Doctors to Consultants. 23/39 colleagues knew where to find contact information for Psychiatry, 14/39 colleagues correctly answered how to contact GAP (Phone), 15/39 colleagues correctly answered how to contact POA (Email), 15/39 colleagues correctly identified who to contact OOH, and 16/34 colleagues who could do emergency detentions (FY2+) knew how to do one. Free text comments often referred back to the difficulty of finding the right grade of staff first try, Feedback from PRI where there was no dedicated Liaison Service and relies on a duty doctor system was less positive, with terms 'tricky', 'difficulty', 'awkward' used in majority of responses.
Conclusion. From our results we can conclude that contacting Psychiatry in NHS Tayside can be confusing for other specialties. Taking this forward, we will utilize the 'referral finder' system in NHS Tayside and review the existing information available, and to update the contact information for our subspecialties to make contact ourselves more streamlined and accessible. We will also review appropriate clinical protocols that we can link to our page on referral finder to help save time for our colleagues as well.

Improving the physical healthcare of COVID-19 patients in inpatient psychiatric settings

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Aims. COVID-19 can spread rapidly in psychiatric inpatient settings. Previous studies have found that patients have a higher risk of hospitalisation and death than adults in the community. The aim of this project was to improve the care of patients with COVID-19 in psychiatric inpatient settings.
Method. A baseline audit was conducted of care COVID-19 patients received in wards that experienced outbreaks in January 2021 in a London Mental Health Trust. Clinical notes were reviewed for management plans, including clear documentation of risk of serious illness, frequency of vitals monitoring, and thresholds for escalation to medical teams.

A new protocol was subsequently developed and implemented at one inpatient unit: "COVID-19: Early Identification of Risk and Management". This included an adjusted 4C mortality score to determine risk of deterioration, and schedules for observation monitoring based on this outcome. Each schedule specified separate frequencies of monitoring of critical observations (oxygen saturations, respiratory rate) and routine observations, thus minimising unnecessary staff exposure. It prompted venous thromboembolism (VTE) assessment and documentation of escalation criteria.
Result. 44 patients were identified across three working age (WAA, n = 29) and two older age (OA, n = 15) adult wards. 7.5% of WAA and 33.3% of OA patients were hospitalised. 20% of OA patients died following a positive test. 58% of patients had a documented management plan for COVID-19, but only 56% mentioned observation frequency, 19% escalation criteria, and 9% risk of serious disease. No patient received a repeat VTE assessment following diagnosis. The audit identified inconsistent approaches to COVID-19 management between wards, and found no relationship between risk of deterioration and frequency of observation monitoring. Following implementation of this protocol, 100% (n = 4) of patients had a robust plan for COVID-19 management, and 100% received a VTE assessment.
Conclusion. The audit supported previous findings that psychiatric inpatients are at risk of serious COVID-19 infection. This highlights an urgent clinical and ethical need to optimise COVID-19 care in psychiatric inpatient settings. The results of this audit suggest that risk factors for severe infection and elements of routine care are not widely understood or implemented by clinical staff. Introducing evidence-based protocols to support clinicians in managing the physical healthcare of these patients