

- Telephone appointments seem less satisfactory - less likely to meet the emotional need of patient/carer

#### Memory Service:

- Generally positive feedback from carers and patients in all areas - able to take a meaningful history over telephone

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## Optimising and Future-Proofing Dementia Care With Amnestic Mild Cognitive Impairment (aMCI) Clinics

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doi: 10.1192/bjo.2023.385

**Aims.** Amnestic Mild Cognitive Impairment (aMCI) is considered a pre-dementia (prodromal) phase of Alzheimer's disease (AD), with a higher probability in patients with positive biomarkers (temporo-parietal region, atrophy on CT/MRI imaging and hypometabolism on FDG-PET scan). We developed a pilot service development project in the North Sector of Gloucestershire Health and Care (GHC) Trust. Its' main aim was to ease some of the pressures on the Memory Assessment Service (MAS) nurses and the medical memory clinics. The main objectives were: 1. To develop and run an aMCI Clinic service for eight months between March and November 2022 at GHC with North Sector patients to reduce waiting times compared to the preceding years. 2. In patients with aMCI and a positive biomarker, continue annual cognitive testing with early identification of conversion to dementia, thereby starting anti-dementia medication, and continue through the post-diagnosis pathway. Future plans include creating a business case for the Care Commission Group to consider commissioning a countywide aMCI service.

**Methods.** Patients (n=23) with the diagnosis of aMCI and a positive biomarker were selected. Data included the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) to assess patients' daily functioning, clinical history and service satisfaction questionnaires. Different initial objective tests, including Addenbrookes Cognitive Examination (ACE-III), Repeatable Battery for the Assessment of Neuropsychological Status (R-BANS), Telephone Interview for Cognitive Status (TICS), and Rowland Universal Dementia Assessment Scale (RUDAS) were used. Data for waiting times from referral to first assessment were collected and statistically analysed using a repeated measures design across years 2020,2021,2022 (March-November) and a one-way repeated measure ANOVA was performed.

**Results.** Analysis of waiting time indicated a non-significant decrease in waiting times from referral to first assessment. A decrease in the waiting times from September 2022-November 2022 was noted, pointing towards a possible time lag effect. Within six to twelve months of repeat testing, 62% of patients remained with an aMCI diagnosis whereas 32% of patients progressed to dementia (Alzheimer's or Vascular). From the post-

appointment patient feedback received (65%), all patients reported to be very satisfied (57%) or satisfied (9%).

**Conclusion.** It is prudent to assess the time lag effect on the results produced in subsequent months. A repeat review with a larger sample size to increase the sensitivity and specificity of the results obtained is recommended.

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## High Lithium Levels: Dead, Alive or Doing Well? a Service Evaluation Looking at Outcomes Over Subsequent 2 Years

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doi: 10.1192/bjo.2023.386

**Aims.** Lithium is an effective mood stabiliser in the management of Bipolar affective Disorder. Timing and decision to restart lithium after an episode of toxicity can be challenging. National guidelines offer advice on management of acute toxicity but little information on restarting lithium. Abrupt withdrawal of lithium can provoke relapse. Clinical experience of the authors was that patients who had Lithium stopped following toxicity often relapsed, leading to poor mental health, frequent admissions to acute and psychiatric hospitals and sometimes death. Restarting of lithium in hospital or after discharge was often variable. The aim of the evaluation was to review the outcomes of patients admitted to the University Hospitals Birmingham NHS Foundation Trust (UHB) with a lithium level over 1.2 mmol/L.

**Methods.** Patients were selected if recorded lithium level was over 1.2mmol/L on admission to UHB. Case note review of electronic patient records was carried out to identify demographic factors of participants alongside medical and psychiatric outcomes over the following 2 years.

**Results.** 84 patients were identified as having lithium levels over 1.2mmol/L. 76% Female. Mean age 61 years (range 20-95 years). 77% of patients had been prescribed lithium for more than 6 years. Mean lithium level was 1.68 mmol/L (range 1.2-3.44 mmol/L). Around 2/3 of patients admitted with lithium above therapeutic range were referred to the liaison psychiatry team. 12% of the patients died during that admission. Just over 2/3 (69%) of those discharged from hospital had been restarted on lithium. When lithium was not restarted during the acute admission, only 13% were restarted in the community within the next 2 months. Two year mortality of patients admitted with elevated lithium levels was 31%. 10% of patients were admitted to a psychiatric hospital within 1 year. The mean number of admissions to the acute hospital (UHB) within one year was 1.6 (range 0-26).

**Conclusion.** Admission to hospital with high lithium levels appears to be associated with a number of negative outcomes. These data cannot attribute causality. Conditions predisposing to lithium toxicity such as frailty could contribute to negative outcomes. Given these high mortality figures for this group, discussions on restarting lithium following high levels may need to focus more on the priorities for the patient. Further studies looking at the outcomes of restarting and discontinuing lithium and comparing with those who have not experienced elevated levels would be helpful.