



## WHAT ASPECTS OF AUTISM SPECTRUM DISORDER IMPACT ON PARENTAL MENTAL HEALTH AND WELLBEING?

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### BACKGROUND

Poor parental wellbeing is associated with childhood autism spectrum disorder (ASD), but it is unclear which, if any, specific symptoms of ASD have the greatest impact on parental mental health.

### AIM

We aimed to review the literature in order to identify specific aspects of ASD that have the greatest impact on parental mental health and wellbeing.

### METHOD

Relevant studies were identified by searching three bibliographic databases (MEDLINE, EMBASE and PSYCHINFO) from 1980 – July 2014 using search terms related to ASD and parental mental health.

### RESULTS

Twelve studies were included in this review and analysed. We found evidence that some demographic and clinical factors are associated with likelihood of parental stress; number of siblings of autistic children with ASD, severity of symptoms of Autistic Spectrum Disorder and the age of child with ASD. Parental distress may be more likely with the child with ASD has accompanying emotional problems, nervousness, anxiety, insecurity, social communication difficulties and difficulties relating to other people. In addition, behavioural problems especially conduct problem, self-abusive behaviour, and hyperactivity were significant predictors of parental distress. Other factors associated with caregivers' poor mental health were having a child with ASD who experienced physical pain, sleep problems and sensory over responsivity.

### CONCLUSION

Findings of this review confirmed that levels of parental distress are elevated in caregivers of children with ASD. The results also highlighted factors that may have a negative effect on parental wellbeing. Parents of children with ASD should be offered advice and support to help them in their role as carers. Further research is needed to identify how parents can best be helped to manage the emotional, social and behavioural problems that their children experience and examine the impact that support for parents has on their emotional health.

### KEYWORDS

Autism Spectrum Disorder, parental mental health, mental illness, mood, stress, distress, depression and anxiety



## PHYSICAL HEALTH MONITORING OF AOT PATIENTS IN BEXLEY BOROUGH

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### AIMS AND HYPOTHESIS

To monitor compliance with NICE guidelines and Maudsley prescribing guidelines on treatment and management of Schizophrenia and Bipolar Affective Disorder (BAD)

### BACKGROUND

People with severe mental illness have increased physical morbidity, including diabetes, cardiovascular disease, and extrapyramidal side-effects. The Bexley Assertive Outreach Team (AOT) has a weekly SHO led Physical Health Clinic to monitor physical health of patients. This audit was planned to monitor current practise, in line with NICE guidelines on Psychosis and Schizophrenia in Adults [Treatment and Management 2014] which recommends:

'Comprehensive, annual health checks focusing on physical health problems that are common in people with psychosis and schizophrenia. This should include: weight, waist circumference, pulse rate, blood pressure, blood glucose levels, lipids, prolactin levels'

### METHOD

Random selection of 20 AOT patients for the audit, and subsequent random selection of 20 patients for the re-audit after 12 months. A further full case load audit was completed as recommended by the audit cycle.

Standards were based on NICE Guidelines on annual monitoring of physical health for patients with Psychosis and Schizophrenia. Data was collected retrospectively from electronic record keeping system. Data was analysed by Quality and Audit Department.

### RESULTS

Of audit cycle:

Patient attendance increased 75% [2012] to 89% [2013]  
 100% BMI checks, ECG, Blood test, and leaflets  
 Full case load audit recommended  
 Improvement in practise after Audit Cycle  
 Patient attendance increased from 75% in 2012 to 89% in 2013.  
 Improved physical health monitoring of difficult to engage patients  
 Improved Liaison with GPs  
 Physical Health Checklist for staff

### RESULTS

Of AOT Caseload Audit:

21% did not attend  
 Abnormal Findings: raised BP 11%, Q Risk >20% 8%, ECG abnormality 5%, GAAS Score >21 3%, excessive ETOH 8%, raised Prolactin 16%.  
 Interventions offered: Smoking cessation 11%, lifestyle advice 86%, Bloods and XR Arranged 51%, leaflets offered 8%, and no advice or intervention needed 3%.

### CONCLUSION

See patients yearly (not six-monthly) – as per NICE  
 Bloods 6 monthly, and ECGs yearly – as per MPG  
 Home visits for 21% patients who DNA clinic Care coordinators to follow up clients to encourage lifestyle making changes Physical Health Clinic manual

## REMISSION OF PSYCHOSIS IN TREATMENT RESISTANT SCHIZOPHRENIA FOLLOWING A SEIZURE: A CASE REPORT

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### BACKGROUND

Schizophrenia is a serious psychiatric disorder which carries significant burden of care and disability for patients and their families. The diagnosis of treatment resistant schizophrenia (TRS) is made after failure of multiple optimum medication trials. Clozapine, a dibenzodiazepine atypical anti-psychotic is indicated as the drug of choice for TRS. However, the side-effects of clozapine, including increased risk of seizures, pose major hindrance to its use. Paradoxically, there is evidence that seizures (including electro-convulsive therapy-ECT) improve the symptoms of schizophrenia.

### OBJECTIVES:

To examine role of seizures in remitting positive symptoms in TRS.

### METHOD:

Ms U, a 22 years old lady suffered from schizophrenia for the last 1.5 year. Despite multiple trials of anti-psychotics, she did not respond to the treatment. Her symptoms as well as her functionality continued to deteriorate over time. This required further management to maintain her quality of life and it was decided to start her on clozapine. In an in-patient setting she suffered a seizure followed by tapering of clozapine dose and addition of Epival. Her symptoms remitted and functionality turned to baseline.

### RESULTS:

Ms U had TRS that did not respond well to multiple trials of antipsychotics. She was therefore started on Clozapine and paradoxically one of its side-effects improved psychotic symptoms and she continued her routine activities as before.

### CONCLUSION

Seizure is a form of natural ECT. There is extensive evidence of the beneficial effects of seizures (including those induced by ECT) in patients suffering from TRS. Our patient's symptoms remitted after she had a seizure as a side-effect of Clozapine. This case illustrates the importance of considering ECT in patients suffering from TRS.

### KEY WORDS

Treatment Resistant Schizophrenia (TRS), Electroconvulsive therapy (ECT), Clozapine, Seizure





## A STUDY OF PATIENT PROFILES AND OUTCOMES IN AN EVOLVING MODEL OF INTENSIVE COMMUNITY SERVICES FOR PEOPLE WITH LEARNING DISABILITIES.

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### AIM:

The role and function of the learning disability community intensive team following its evolution over the years. What impact, if one has occurred, have these changes had on the general LD services such as in-patient admissions, use of medication and use of the Mental Health Act- MHA.

### METHOD:

Using best practice and Local trust policies for the audit tool, 3 data samples were identified from the weekly minutes of the North Intensive Support team during the 1st 3 months of 2007, 2009 & 2011 when the team worked according to 3 different models, respectively. Results were gathered and converted into the nearest whole percentage.

### RESULTS:

This documentary analysis of data reported that with the current model, talking therapies have become readily accessible, less medication is being prescribed & the Mental Health Act Laws' are being used less, with more patients being treated in the community and less being admitted to hospital. Ensuring HONOS-LD (Health of the Nation Outcome Scales for the people with Learning Disabilities) training by all frontline workers will help in validating the accuracy of its scores. These results may also reflect on the lack of general awareness of specialized services along with assumptions of what can and cannot be provided for those over the age of 60, and those falling within the severe to profound range of Learning Disabilities.

### CONCLUSION:

This new model has evolved from its humble beginning to a recovery led service. A recovery led model combines both a cost-effective and service led approach. In the short term its impact has been fairly positive on the overall wellbeing of LD service users in Hertfordshire. Service feedback would be a useful measure to record subjective measures in line with the recovery model to assess its impact in the long term future.



## CHARLES BONNET SYNDROME: A CASE REPORT

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### INTRODUCTION

This case report documents a single case of Charles Bonnet syndrome (CBS) which is the presence of visual hallucinations usually accompanied with deterioration in visual acuity in the absence of mental illness.

There are a set of key features associated in CBS: complex visual hallucinations with a good cognition and a present insight. There is usually a decreased visual ability with an ophthalmic co-morbidity.

### CASE HISTORY

69 year old female with relevant diagnosis of medication controlled bipolar disease and retinal vessel thrombosis presented with low mood, anhedonia, fatigue, suicidal ideation and visual hallucinations. These manifested as cartoon figures with big teeth and bright dresses that were seen in the shower but vanished after 4 days.

### INVESTIGATIONS

A typical set of investigations would include a classic history, cognition assessment, blood tests and various imaging. An MMSE would rule out cognitive decline. Simple bloods to exclude infections and metabolic disturbances are required. Radiology starts with a CT brain scan which would rule out organic pathology. More complex diagnostics could involve an MRI or SPECT.

### TREATMENT

There is no universally accepted treatment: there needs to be management of the co-existing eye disease and some conservative therapy. The latter focuses on patient reassurance, improved ambient lighting, prescription glasses, diversionary tactics and rapid blinking or eye movements.

### DISCUSSION

CBS highlights the importance of a careful psychiatric history and relevant medical history: this is particularly relevant in the elderly population. It requires a multidisciplinary approach which involves mental health services, neurology and ophthalmology.



## PREVALENCE AND FORMS OF SEXUAL DYSFUNCTIONS AMONG MALE EPILEPTIC PATIENTS ATTENDING AL-CHWADER OUT PATIENTS PSYCHIATRIC UNIT

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### BACKGROUND

Epilepsy is a chronic neurological condition and many men with epilepsy suffer from loss of sexual desire, reduced sexual activity, anorgasmia and erectile dysfunction.

### AIMS OF STUDY

- 1 To identify the most important socio-economic variables that may affect or are associated with mental disorders among male epileptic patients.
- 2 To recognize which antiepileptic drugs are more likely to cause sexual dysfunctions.
- 3- To study prevalence and types of sexual dysfunctions among epileptic patients.

### PATIENTS AND METHODS

A case series of 193 male epileptic patients in Al-Chwader Psychiatric Unit in Baghdad was conducted within two years. Arizona sexual experience scale was used as a tool for diagnosis of sexual dysfunctions while diagnosis and type of epilepsy were confirmed by neurologists.

### RESULTS

45.6% of patients suffered from arousal disorders followed by desire disorder in 45%, orgasm disorders (delayed type 17%, premature type 16,6%) and dyspareunia in only 4.7% of the male epileptic patients

### CONCLUSION

Sexual disorders are common, relevant, distressing among epileptic patients. Both epilepsy itself and antiepileptic medications are possibly implicated in sexual dysfunction making it difficult to determine which factor is causative.

### KEY WORDS

Sexual disorders Arizona sexual experience scale, male epileptic patients



## AUDIT ON SAFE PRESCRIBING OF DEPOTS AND PHYSICAL HEALTH MONITORING IN THE COMMUNITY

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### AIMS

To look at the adherence of the nursing homes to MMHSCT Guideline SOP 23 with regards to; Prescribing of depot antipsychotics correctly and record of administration on the depot card

To look at the adherence of the services to NICE guideline 178 (last updated March 2014) which states; routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report.

### METHOD

The audit was carried out in the east community mental health team. We examined the records between January 2014 and January 2015. We looked at depot cards and the prescription charts in the nursing homes. The Amigos (Electronic) records were checked for each of these patients and GPs contacted for information on concurrent medication and physical health tests

### RESULTS

From this small sample it is difficult to draw firm conclusions but depot was not administered on the due date in 3 patients. Depot card was not reviewed in the last six months in 1 patient, and it is unclear whether it was reviewed in 3 patients. ECGs were not done in the last twelve months in 9 patients. Bloods were not done in the last twelve months in 3 patients. Physical examination was not done in the last twelve months in 4 patients. Allergies were not recorded in 2 patients. There was no record of administration of depot in 1 patient on the electronic records system. Physical observations were not recorded in the last twelve months in 4 patients. No data was provided by one GP.

### CONCLUSION

There should be a mechanism of monitoring depot prescribing in the nursing homes. As GPs do most of the prescribing, the information about prescribing and monitoring should be shared with the primary care services. A tick box checklist should be attached with every depot prescription.





## IMPROVING CARER KNOWLEDGE OF DEMENTIA USING STRUCTURED MANUAL BASED TRAINING PROGRAMME

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### AIMS

Currently in the UK there are 800,000 people living with dementia, of which two thirds are looked after in the community by over 670,000 family carers, and the demands on individuals and families are set to increase (Alzheimer's Society, 2012).

There is a need for multicomponent training programme for carers of people with early dementia as part of routine post-diagnostic support.

### METHOD

We have developed a group-based problem-solving 'Dementia First Aid' (DFA) course for carers looking after family member with dementia. It covers basic knowledge of dementia including behavioural and psychological symptoms of dementia and impact on person and carers.

The course is delivered by a pair of professionals who had training in delivering the course. The course was delivered to the carers using a Power point presentation and a course manual.

A 30-item Alzheimer's disease Knowledge Scale (ADKS) was used to assess carers' knowledge of dementia before and after the course.

### RESULTS

Altogether 39 family carers attended the course - 24 in 8-hour and 15 in 4-hour course.

26 caregivers attended the 8-hour course on day one, of which 24 completed the ADKS pre-test questionnaire. Only 13 carers attended the second session, whereas all 15 participants of 4-hour course completed both pre- and post-course ADKS questionnaire.

Compared to pre-test score of correct answers, the overall post-test mean score increased from 17.3 (58%) to 21.4 (74%), and from 14 (47%) to 24.3 (81%) for participants of 8-hour and 4-hour course respectively.

### CONCLUSION

Feedback from the participants was very positive.

The level of dementia knowledge improved after attending the course (both 8 hours & 4 hours version). There was a significant difference between the scores of all seven ADKS domains.

As there was no dropout in the 4 hour course, the shorter version of course is more acceptable and effective.

We will now be rolling out this course to other sites in our trust.





## ONE STOP SHOP CLINIC – PROJECT TO REDUCE DNA RATE AT PSYCHIATRIC FOLLOW UP CLINIC

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### AIMS

DNA(Non-attendance) is a common problem observed in outpatient clinics in both general and psychiatric hospitals. It has been noticed that NHS has to bear huge cost for missed appointments.

It was observed lately that in our CMHT the DNA rate of patients on depot antipsychotics attending follow up clinic was around 28%. However on the other hand it was also noticed that most of these patients have regularly been attending depot clinics for administration of depot medication. From this observation it appears that patients were keen to have depot antipsychotics however they were not very punctual in coming back to see the psychiatrist at CMHT due to some reason.

The aim of this project is to establish why patients fail to attend appointment and to implement robust changes to reduce the DNA rate.

### METHOD:

We conducted an initial survey which showed that DNA rate between January 2014 and October 2014 was 28%. There are total of 21 patients who attend the depot clinic. Out of these, 15 patients DNA'd at some point. Remaining 6 patients had 100 % attendance. A telephone survey was conducted to check reason for missed appointments. Five patients were not contactable. Out of remaining 10 patients, five patients didn't receive an appointment letter, two of the patients were unwell and remaining patients forgot to attend the appointment.

Further to this survey we managed to organise the follow up clinic on the same day and just after patient has attended the depot clinic.

### RESULTS:

After a period of 3 months another study was conducted which showed that DNA rate at follow up clinic was greatly reduced and out of 21 patients only 1 patient missed the appointment.

### CONCLUSION

The results clearly indicate a significant drop in DNA rate since the introduction of 'one stop shop clinic'.

We will now be rolling out this project to other sites in trust.



## EARLY ONSET SCHIZOPHRENIA

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Early onset of schizophrenia usually indicates a higher genetic loading, poor response to treatment and worse prognosis than if onset is in adulthood. Schizophrenia affects approximately 1.9 per 100,000 in child population. Its prevalence rate increases rapidly from age 14.

Early onset schizophrenia usually presents with atypical symptoms and despite comprehensive assessment the clinicians have to face diagnostic uncertainty. In young patients developmental disorders such as autism spectrum disorders often pose significant diagnostic challenges.

This talk would provide clinicians a framework for accurate assessment including differential diagnosis, and management, of this complex disorder, associated with significant psychosocial, educational, cognitive decline and shorter life expectancy than the general population.

Evidence base for treatment options including, pharmacological and psychosocial treatment will be presented. Treatment of acute onset and relapse prevention will be considered.

The role of NICE Guidelines and importance of smooth transition from CAMHS to adult psychiatric services will be highlighted.



## SYSTEMATIC OVERVIEW OF NON-PHARMACOLOGICAL INTERVENTIONS IN DELIBERATE SELF HARM

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### INTRODUCTION

The lifetime prevalence of deliberate self-harm is about 3% to 5% of the population in Europe and the USA, and has been increasing. Familial, biological, and psychosocial factors may contribute. We conducted a systematic overview of efficacy and safety of non-pharmacological treatments in deliberate self harm using methods similar to Cochrane and BMJ Clinical Evidence.

### METHODS

We aimed to answer this question: What are the effects of non-pharmacological treatments for deliberate self-harm? The 'PICO' was as follows: Population was of people age 15 or over with recent deliberate self harm as the main selection criteria; Interventions were

non-pharmacological; Comparison was 'usual care'; and Outcome was reduction in subsequent deliberate self harm as primary outcome. We carried out comprehensive searches of the following: Medline, Embase, The Cochrane Library and other sources up to August 2013. We selected only those articles which were systematic reviews (SR) of randomized controlled trials (RCTs) and those RCTs which were not included in the SRs selected. The information on interventions was 'GRADE' evaluated (including for quality) for reaching conclusions; we did not carry out our own meta-analysis.

## RESULTS

We found 1 systematic review and 10 RCTs that met the criteria. The quality of evidence for most interventions was not good with overall GRADE mostly being very low to moderate. We found that cognitive behavior therapy and psychodynamic interpersonal therapy may reduce self harm. Paradoxically we found that continuity of care worsened self harm. We also found that emergency card, hospital admission, intensive outpatient follow up and outreach, nurse lead case management, problem-solving therapy and telephone contact may not reduce self harm. However all these findings were based mostly on low quality evidence leading us to conclude that all interventions were of unknown effectiveness. We found no RCTs of DBT in which primary selection criteria was recent self harm.

## CONCLUSION

There is lack of enough evidence for effectiveness of all 10 non-pharmacological interventions reviewed.

## ABSTRACT



### RE-AUDIT ON SCREENING FOR DEPRESSION IN PATIENTS WITH COGNITIVE IMPAIRMENT

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## AIMS

Depression is highly prevalent in cognitive impairment. NICE Dementia Guidelines [2006] recommend: "at the time of diagnosis, and regularly afterwards, assess for medical and psychiatric co-morbidities, including depression and psychosis to ensure optimal management of associated conditions"

This re-audit was carried out as follow up to the initial audit that evaluated the adherence to NICE Dementia guidelines by Memory Services in Older Peoples Directorate, Oxleas NHSFT.

## METHOD

1280 new referrals were received by the memory service during February 2014 to July 2014 and was the Re-Audit cohort. Every 4th referral was randomly selected and included in the Re-Audit. Data was collected retrospectively from electronic record keeping system.

## AUDIT TOOL WAS AMENDED TO INCLUDE

Screening for core and biological symptoms of depression  
Use of standardised screening tools i.e. CDS, BDI [not only GDS]  
Treatment for depression, medical or psychological offered to patients.  
Documentation of discussion on diagnosis, treatment, and progress.



Data was collected by B-AN in line with Data Protection Act 1998.

## RESULTS

Audit Nov 2013	Re-Audit Feb 2015
N=210	N=302
Mixed Dementia 25% Dementia in Alzheimer's Disease 25%	Mixed Dementia 17% Dementia in Alzheimer's disease 15% Multi Infarct 12%
Pre-existing diagnosis of depression: 15% 87% assessment of 'mood' 6% assessed using standardised tools	9% 93% assessment of 'mood' 25% assessed using standardised tools
No previous diagnosis of depression: 87% assessment of 'mood' 4% assessed using standardised tools	88% assessment of 'mood' 19% assessed using standardised tools.
Not included	69% assessment of core and biological symptoms
16% on treatment	17% on treatment 96% medication 4% psychotherapy
47% discussion on diagnosis, treatment and progress.	64% discussion on diagnosis, treatment and progress.

## CONCLUSION

Improvement in screening for depression in patients presenting with cognitive impairment.

## FURTHER RECOMMENDATIONS

Teaching session for memory services on 'Depression and Treatment of Depression' [B-AN]

Include core and biological symptoms when screening for depression.

Offer psychological treatment Make standardised tools for depression more accessible to memory services

## ABSTRACT



## PREVALENCE OF FAMILY BURDEN AMONG CAREGIVERS OF PATIENTS WITH SCHIZOPHRENIA

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## BACKGROUND

The life time prevalence of Schizophrenia is 1.3%. Studies have shown that schizophrenia causes family burden among caregivers (14%) leading to unhealthy family functioning and in addition to, the caregivers reported family burden due to emotional distress (31.3%) and stigmatization (33.3%).



## STUDY DESIGN:

Cross Sectional study

## SETTINGS

Department of Psychiatry and Behavioral Sciences (Mowadat Hussain Rana), Sheikh Zayed Medical College/Hospital, Rahim Yar Khan, Pakistan.

## DATA COLLECTION PROCEDURE

The caregivers of patients having Schizophrenia (n=130) were included in the study from March 2014 till May 2015. The data was collected using a structured Proforma. The participants were assessed with a comprehensive battery of using Zarit burden interview scale which explores negative physical, mental, social and economic impacts of care giving on the life of caregivers.

## RESULTS

There were 130 caregivers of which 65 male (50%) and female (50%). The mean age of the care givers were  $34.03 \pm 11.59$  years ranged between 16 to 70 years 47 (36.15%), 63 (48.46%) and 20 (15.39%) care givers were caring their patient for the last 2-3 years, 4-5 years and 6-7 years respectively. Mean ZARIT score was  $62.60 \pm 6.88$  ranged between 33 and 80 (Table-3). 01 (0.8%), 42 (32.3%) and 87(66.9%) care givers had mild to moderate, moderate to severe and severe burden among the caregivers respectively. A statistically significant association present between severity of family burden among the care givers and the duration of care giving. i.e. (p-value=0.012) 01 caregiver had mild to moderate burden was in the age range of 31-45 years and among the 42 caregivers had moderate to severe burden; 20, 14, 07, 01 were in the age range of 15-30 years, 31-45 years, 46-60 years and above 60 years respectively. Among the 87 caregivers had severe burden; 44, 26, 17 were in the age range of 15-30 years, 15-30, 31-45 years and 46-60 years respectively. The p-value did not show statistically significant association between severity of burden and age of care givers. i.e. (p-value=0.602). 1 male caregiver had mild to moderate burden, 20 male and 22 female caregivers had moderate to severe burden, 44 male and 43 female caregivers had severe burden. The p-value did not show statistically significant association between gender of care givers and severity of burden.

## CONCLUSION

Relatives of patients with schizophrenia face enormous burdens, with financial, stigma and negative patient behavior being more prominent.

## KEY WORDS

Family burden, Care givers, Schizophrenia

## QUALITY OF LIFE AMONG TWO GROUPS OF PSYCHIATRIC PATIENTS IN BAGHDAD

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### OBJECTIVES

To assess and compare the subjective rating of quality of life (QOL) in psychiatric patients who attended two psychiatric outpatient clinics in Baghdad city [Al-Rashad Psychiatric Teaching Hospital and Baghdad Teaching Hospital]. In addition, it also aims at studying the effect of socio-demographic and clinical characteristics on the patients' life qualities.

### METHOD

A sample of one hundred patients divided equally into two groups (fifty patient) from each hospital were interviewed and diagnosed in accordance with the DSM-IV diagnostic criteria, for the period (from the 1st of March to the 1st of September 2011).The Arabic modified version of WHOQOL-BREF questionnaire (modified by WHO) was applied on each patient. Data collected was submitted to statistical analysis by using SPSS program version 10.

### RESULTS

Data gathered from completed hundred forms showed that 50% of patients from Baghdad Teaching Hospital responded and scored (fair, acceptable) to describe their satisfaction in overall QOL ,while (38)% of patients from Al-Rashad Psychiatric Teaching Hospital scored (bad ) and (16%) scored (very bad).There was no significant difference in the four domains of QOL between the two studied groups. The findings were discussed accordingly

### CONCLUSIONS

This study showed that although the overall satisfaction of the patients' life quality was higher in patients from Baghdad Teaching hospital than those of Al-Rashad Psychiatric Teaching Hospital, a non-significant difference in the four domains between the two hospitals was found. The socio-demographic and clinical characteristics were not significantly correlated to the QOL domains except for the educational level which was significantly correlated with the physical health domain in patients from Al-Rashad Psychiatric Teaching Hospital.





## DIOGENES SYNDROME – 2 CASE STUDIES

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### INTRODUCTION

Diogenes Syndrome is a term first suggested by Clarke et al (1975) and is characterised by extreme self neglect, domestic squalor, hoarding, and social withdrawal. Synonymous terms include senile squalor syndrome, senile breakdown, Haversham's syndrome and Plyuskin's syndrome. It is named after Diogenes of Sinope who was a Greek philosopher in the 4th century BC, who lived in a barrel to express his contempt for the material world

### EPIDEMIOLOGY

The annual incidence is 5 per 10,000 in over 60-year olds, with up to 50% suffering from dementia or other psychiatric illness.

### CASES

One case examines a lady with a history of self neglect who was living in an unsafe cluttered house. She was very unkempt with dried faeces on her legs. She was diagnosed with mixed Alzheimer's and vascular dementia and the probability of Diogenes was noted. Another case looks at a lady who had not left her house for years and had become bedridden. She was in soiled clothes with faeces all around her. After assessment she was diagnosed with Senile Squalor Syndrome and Alzheimer's dementia, she returned to her living conditions and eventually moved to a nursing home.

### DISCUSSION

Risk factors for Diogenes include dementia, depression and frontal lobe changes. It has been suggested to be the end stage of a paranoid personality disorder.

### CONCLUSION

Diogenes encompasses a variety of psychiatric, physical and social disorders. Behaviour exhibited by these patients should make us assess more closely for an underlying treatable mental illness. Home assessments are important in helping decisions regarding hospitalisation. Persistent refusal of help raises complex legal and ethical issues. The management of the condition is a challenge and the prognosis is poor.



## AN AUDIT CYCLE ON USE OF HYPNOTICS FOR THE SHORT TERM MANAGEMENT OF INSOMNIA IN PATIENTS UNDER THE CARE OF CRISIS RESOLUTION TREATMENT TEAM

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## AIM:

To ensure that Crisis team is adhering to the following guidelines for the use of hypnotic for the management of insomnia:

1. Non-pharmacological measures are considered before the prescription of medication for the insomnia
2. The hypnotic with the lowest purchase cost is prescribed and adverse effects are documented
3. Hypnotics are prescribed for a short period of time only, in strict accordance within the licensed indications

## METHODOLOGY:

Data was collected retrospectively from the electronic case notes of 30 patients on Hypnotics while under the care of the crisis team prior to 15.01.2014.

## RESULTS:

1. Advice on non-pharmacological measures before prescribing hypnotics was given to 45% of patients
2. Lowest cost hypnotic (zopiclone) prescribed in 96%. Evidence of documentation of explaining adverse effects of hypnotics particularly driving 0%
3. Hypnotics were prescribed within licensed indication in 100% cases. Management plans for discontinuation of hypnotics after patient's discharge advised to GP in 47% cases only.

## REFERENCE GUIDELINES:

NICE (2004)  
NHFT  
BNF

***Aim of the Re- Audit (September 2014) was to ensure the Crisis team had implemented the following changes recommended after the initial Audit in February 2014 in addition to the original Audit aims***

1. To advise and provide leaflets to clients on non-pharmacological measures before prescribing hypnotic, and to document this in their case notes.
2. To advise clients on side effects of hypnotic including driving and to document this in their case notes.
3. To ensure a management plan is in place for GP when clients on hypnotics are discharged back to care.

### ***Re-audit revealed following improvements***

1. 8% improvement on advice and providing leaflets to the patients on information about non-Pharmacological measures to improve the sleep hygiene and documentation of these in the case notes.
2. 23% improvement on advice and documentation of adverse effects including driving while on hypnotic.
3. 39% improvement in formulating clear management plan for GP when patients on hypnotics were discharged back to care.

## CONCLUSION:

Crisis team to advise and document the following warning in their case notes: "Hypnotics may cause drowsiness, if affected do not drive or operate machinery"