83% had their weight measured in the last 6 months, 76.5% had their pulse measured and 64% had their blood pressure measured.
Conclusion: This audit suggests that the rate of ID and ADHD in our clinical sample is higher than the estimated population prevalence. This will have implications for service development and training requirements, meaning that clear pathways will need to be established, with available resources and adequate monitoring in place to ensure the needs of our patient group are being met, and current NICE guidance is adhered to.

Bridging the Gap: Early Identification of Mental Health Needs in Paediatric Inpatients

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Aims: Paediatric inpatients often face both physical and mental health challenges, yet the extent of their mental health needs may not always be recognised. At the Royal London Hospital (RLH), we observed a high prevalence of mental health distress among paediatric inpatients, with many scoring above the distress threshold on the Strengths and Difficulties Questionnaire (SDQ), a validated screening tool for emotional and behavioural difficulties. We aimed to assess the prevalence of undiagnosed mental health concerns in paediatric inpatients using the SDQ, hypothesising that 80% would exhibit elevated distress scores, indicating potential unmet mental health needs.
Methods: Between 25 November and 22 December 2024, SDQs were administered to all paediatric inpatients across four wards, using parent or self-rated formats (depending on the child's age and ability). Exclusion criteria included children already receiving mental health support or those not fluent in English or Tamil. Of 62 families approached, 49 (79%) participated, with 43 included in the analysis after excluding incomplete forms. Reasons for declining participation included language barriers (5), fatigue/stress (7), and perceived irrelevance of the study (1).
Results: Of the completed SDQs, 74% of children showed elevated scores in one or more categories, with 28% having a high Total Difficulties Score. Parent-reported data identified emotional (39.3%) and peer difficulties (39.5%) as the most prevalent concerns, while self-reports revealed that 59.9% of children reported greater difficulty in prosocial behaviour. Notably, discrepancies were observed in seven children, who reported higher difficulty scores than their parents.
Conclusion: The high prevalence of elevated scores across multiple domains suggests that a significant proportion of paediatric inpatients at RLH have unmet mental health needs. Discrepancies between parent and child reports highlight the value of incorporating multiple perspectives in assessments. The proportion of families declining participation underscores barriers to engaging in mental health screening. Routine, systematic screening during admissions could help normalise assessments and improve access to timely support.

Paper in an Electronic World – the Utility of an Integrated Treatment Booklet for the Safe Provision of Electroconvulsive Therapy (ECT) in a Regional Australian Mental Health Service (MHS)

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Aims: It is incumbent upon psychiatrists to manage cognitive and physical health sequelae during a course of ECT. Monitoring post-seizure orientation and the stability of Montreal Cognitive Assessments (MoCAs) over time allows for dynamic changes to modality, frequency and energy settings in order to minimise side effects. Our service hypothesised that disparate electronic forms actually hindered this process and therefore conducted an audit.

An integrated paper-based treatment booklet for use within the ECT suite, with all forms bound together, was piloted as the quality improvement intervention. A new post-seizure orientation tool was also used.
Methods: The setting was South West Healthcare (SWH), Warrnambool, Australia. Standards were set a priori according to ECT guidelines from the Victorian Office of the Chief Psychiatrist and the Royal Australian and New Zealand College of Psychiatrists, with 80% compliance targeted. At a minimum, patients needed baseline bloods (full blood count; urea/electrolytes/creatinine), electrocardiograph, physical examination and MoCA, then physical/MoCA after every third treatment. Furthermore, a comment on orientation in the recovery suite after each treatment was required to meet standard.

Files were selected by 26/06/23 (cut-off date), capturing all ECT patients in the 6 months prior. 15 patients were identified, a combination of acute/completed and acute-continuation/maintenance ECT. Records, both paper and electronic, were audited against standards over 4 consecutive weeks by the authors. After the results were reviewed, the integrated treatment booklet (designed by the lead author) and post-ECT orientation questionnaire (licensed from the University of New South Wales) were introduced into clinical practice.

The audit cycle was completed a year later, with files selected by 30/08/24, capped at 20 patients and capturing all those who had had ECT since the pilot began.
Results: The baseline standard during the initial audit was generally met: bloods (79%), ECG (86%), physical (64%), MoCA (86%). However, the standard was not achieved once ECT commenced: physicals every 3rd treatment (60%), MoCAs (49%). Orientation status was documented in 90% of treatments.

During the post-intervention re-audit, compliance had vastly improved: baseline bloods, ECG, physical and MoCAs (100%); objective orientation scores (99%); ongoing physicals (76%)/MoCAs (72%).