therefore essential that clinicians review resuscitation status as part of their routine practice. However, we are aware that advanced decision-making – to resuscitate or not to resuscitate – is not routine practice across older adult psychiatric wards in the UK. Our 2017 audit reflected this, demonstrating a very low rate of resuscitation decisions at NELFT.

This re-audit aimed to measure the frequency and quality of resuscitation decisions on an older adult psychiatric ward. We expected improvements in these areas, subsequent to changes implemented from the initial audit. We also sought to identify which patient factors influenced clinicians' decision-making on resuscitation.

Please note, this audit was completed prior to the COVID-19 pandemic.

Method. In June 2017, an audit of 25 patients admitted to two older adult psychiatric acute wards was completed. In December 2019, a retrospective analysis of the last 25 admissions to one older adult ward was undertaken. Electronic patient notes and DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) orders were examined. The audit measured frequency of resuscitation decisions and quality of documentation against current standards. DNACPR orders were analysed and clinicians were interviewed to identify the reasons for such decisions.

Result. There was an increase in the number of patients for which resuscitation decisions were made, from 4% in 2017 to 40% (n = 10) in 2019. The majority of patients with a DNACPR decision (n = 8) had a diagnosis of dementia. Prospective quality of life, with this diagnosis, was the most frequent determinant of DNACPR decisions (n = 7). Qualitative analysis indicated that clinicians were more likely to consider a resuscitation decision for patients with an organic disorder rather than functional disorder.

Adequate completion of DNACPR orders was seen in each case. Either the patient, a family member or carer was involved in every decision. The standard for recording decisions on the electronic patient record was not met.

Conclusion. It is good practice to consider resuscitation decisions for patients admitted to older adult psychiatric wards. This re-audit found an improvement in frequency of resuscitation decisions and also revealed differences in decision-making for patients with organic and functional disorders. Implementation of further change is indicated; decision-making can be improved through reflection, teaching, changes to practice, and technologies.

Maternal stress in pregnancy and child autism spectrum disorder: evaluating putative causal associations using a genetically informed design

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Aims. Prenatal adversity is hypothesized to increase risk of Autism Spectrum Disorder (ASD) via epigenetic changes. Maternal stress in late pregnancy may alter offspring neurodevelopmental outcomes by disrupting a unique period of rapid neurogenesis. Observational studies reporting an environmentally mediated programming pathway face challenges in drawing causal inferences including passive gene-environment correlation. This project aims to use a quasi-experimental genetically informed design to assess if reported correlations between maternal prenatal stress and offspring ASD traits were due to maternally inherited factors or consistent with a potentially causal prenatal exposure effect. No previous cross-fostering studies have assessed the effects of prenatal stress on childhood ASD.

Method. This study used an in-vitro fertilization cross-fostering sample with pregnant mothers related (n = 365) or unrelated (n = 111) to their offspring (mean age = 9.84 years). Prenatal stress was assessed using a subjective Likert scale during pregnancy. Questionnaires examined maternally rated offspring ASD traits using the Social and Communication Disorders Checklist. Birth weight and gestational age from medical records were used as comparison outcomes to validate the measure of stress as evidence suggests they are influenced by environmental factors. Correlations from multiple regression models were examined in relation to magnitude of effect size as well as significance. This is partly due to small sample size and that cross-fostering designs rely on comparing magnitudes of associations between related and unrelated groups. An interaction term was used to test the difference in the strength of association between related and unrelated mother-child groups.

Result. Subjective assessment of prenatal maternal stress showed construct validity as it was associated with low birth weight ($\beta = -0.297$, $p = 0.005$) and reduced gestational age ($\beta = -0.320$, $p = 0.001$). Subjective late pregnancy stress was associated with increased offspring ASD traits in the whole sample ($\beta = 0.089$, $p = 0.073$) and in the related ($\beta = 0.045$, $p = 0.424$) and unrelated mother-child ($\beta = 0.233$, $p = 0.029$) subgroups. Non-significant interaction terms demonstrated that the mechanisms underlying the association between maternal stress and ASD and birth outcomes are likely to be similar and environmentally driven in the different conception groups.

Conclusion. Findings demonstrate the utility of genetically informed designs in disentangling inherited factors from environmental influences in the study of prenatal risk factors. Correlations between maternal prenatal stress and offspring ASD being present in both related and unrelated mother-child groups indicate an environmental link that is consistent with a potential causal effect. Associations detected are of imperative use for clinicians and policymakers, as they can guide the implementation of early psychosocial care for families at high liability.

A different perspective: using interactive virtual reality (IVR) for psychiatry training

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Aims. To evaluate the potential of interactive virtual reality in teaching and training Postgraduate Psychiatry Trainees in the Keele Cluster

Background. Face to face supervised clinical experience will always be the best way to train and learn, followed by using simulated patients in practice scenarios allowing a safe environment in which to practice and train without risk. However, the practicalities of a busy NHS often mean that the expense and time required for both of these are not possible and often PowerPoints and handouts in induction are used to prepare new starters in Psychiatry, which is clearly suboptimal.

Interactive Virtual Reality (IVR) allows trainees to not only be immersed in a simulation but take control, choosing the direction of questioning for example. It also allows the training to be easily repeated and scaled to any number of students, anytime and anywhere there is an internet connection.
Method. Following successful funding from the RCPsych General Adult Faculty we chose three common scenarios that a new started in Psychiatry would face. These included acute agitation/rapid tranquilisation, a patient wishing to leave/section 5(2) and a patient with tachycardia following clozapine initiation. Using established guidelines and literature, in conjunction with feedback from subject matter experts and practicing clinicians, scenarios were written. We then researched the best hardware and software to make this possible, ensuring that the resources required were realistic to allow accessibility to as many trainees as possible.
Result. Creating IVR is challenging but an engaging medium. Achieving consensus on the training material is time consuming yet paramount to a good training session. Producing high quality videos is extremely resource intensive requiring large amounts of computing power and storage. However, the outcome is an engaging and practical alternative to face to face training.
Conclusion. The possibilities for IVR for are vast. For example, trainees can practice different methods of asking questions (e.g. open vs closed) and how this affects the outcome. Training could be produced centrally and then shared, allowing best practice to be disseminated. It could improve and standardise induction, especially considering the expanding workforce. It could also improve recruitment, allowing an immersive experience of Psychiatry to those who would otherwise be unable to obtain shadowing. It also has a role in patient safety – demonstrating common scenarios that the trainee may face allowing them to practice in a safe environment.

Patterns of antipsychotic prescribing in first episode psychosis – differences between acute and early intervention services

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Aims. This study aimed to evaluate the patterns of antipsychotic prescribing in patients with first episode psychosis (FEP) at the time of their initial treatment and over the first year with the Early Intervention Service (EIS). It was hypothesised that different care teams would have a preference for certain antipsychotic medications and that initial medication choice would be continued through the first year.
Background. Research indicates that with the exception of clozapine, all antipsychotics are equally as effective. However, anecdotally it has been observed that inpatient and crisis teams and EIS have differing initial medication choices.
Method. An analysis of the North West Sussex EIS caseload (n = 67) was conducted. The first antipsychotic prescribed and initiating team was recorded. Prescribed medication for those that had completed 12 months (n = 43) with EIS after initial prescription was recorded. An analysis was performed of prescribing choice by initial care team (acute vs EIS vs other community services) with the frequency with which medication was changed during treatment.
Result. 97% (n = 65) of patients were started on an antipsychotic. Initial medication choice was olanzapine (44.8%, n = 30), aripiprazole (22.4%, n = 15), risperidone (20.9%, n = 14), quetiapine (6%, n = 4) and zuclopenthixol were least common (1.5%, n = 2). At the 12 month point 51.2% (n = 22 of 43) had switched and 16.3% (n = 7 of 43) had discontinued.

The most common medication started by acute services was olanzapine (56.0%, n = 28 of 50), though of those who completed 12 months this had been switched in 53% of cases (n = 9 of 17). EIS most commonly initiated aripiprazole or risperidone (37.5% each n = 4). At 6 and 12 month follow-up by EIS, the most commonly prescribed antipsychotic was aripiprazole (24 patients 40.7%, and 14 patients 32.6% respectively).
Conclusion. There was a clear preference for olanzapine as initial treatment of First Episode of Psychosis in the region. On breakdown it was apparent that there was a split in prescribing choices between more sedating medication in acute services and less sedating medication in EIS. Given that most patients changed to less sedating and less metabolic active medications over their first year it is not clear why alternative options are not used at the start of treatment. Future research will focus on clinician's rationale for initial prescribing choice. This will look for any underlying bias toward specific medications.

Eating disorders and psychosis: a case report and review of the literature

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Aims. Despite evidence from case series, the comorbidity of eating disorders (ED) with psychosis is a challenging field to which little attention has been paid. There is no consistent sequence in the co-occurrence of the two conditions-eating disorders sometimes precede, and sometimes follow the onset of psychosis. In this case report, we present a 25-year-old female patient suffering from recurrent episodes of binge eating and inappropriate compensatory purging behaviours with psychotic components to discuss the co-occurrence of these conditions in the light of the literature.
Method. Our patient suffered from sleep disturbances, homicidal thoughts, self-induced vomiting worsened in one year. Psychiatric examination revealed psychotic symptoms such as blunted affect, persecutory delusions, and delusions of appeal and justification. In our inpatient psychiatry clinic, she was treated with olanzapine 20 milligrams(mg) and quetiapine 500 mg per day.
Result. Psychotic episodes occur in 10–15% of eating disorder patients. The prevalence of primary psychotic diseases like schizophrenia and schizoaffective disorders in eating disorder patients appears to be comparable to that in the general population. An ED can be the early sign of an impending psychosis, or psychotic symptoms can signal the beginning of an ED. The advent of the psychosis, and sometimes the treatment of the psychosis can cure the eating disorder, but it can sometimes aggravate it. The case presented illustrates the difficulties in managing a patient with a comorbid eating disorder and psychosis. To ensure a rigorous assessment of both psychotic and