

Psychiatric comorbidity was high (49%), of which generalised anxiety disorder was the most common (59%).

Referrals were typically from primary care (77%). Approximately half (51%) had reported suicidal thoughts according to the referral.

A quarter of patients (26%) were seen by CMHT within 8 weeks of referral; 20% of referrals however waited over 12 months before being assessed.

Risk assessments were out of date for 71% of patients.

100% of patients had a crisis plan noted within their most recent clinic letter; however, none of these met the required standards.

Polypharmacy was common (60%), with 34% prescribed two antidepressants. Use of lithium augmentation was uncommon, with only one patient prescribed this. 43% were prescribed an antipsychotic; of which, 29% had appropriate physical health monitoring completed.

Over half of patients (60%) had been referred to psychology services; of these, 38% had either completed or were in ongoing treatment at the time of review.

**Conclusion.** CMHTs manage the care of individuals with depression who have high levels of active symptoms and disability, psychiatric comorbidity, care requirements, and complex treatment plans. Pharmacological management was broadly in line with guidelines, and rates of referral to psychology were satisfactory. Risk assessment and crisis planning are clear areas in need of urgent attention in order to comply with guidelines and ensure patient safety.

### Epidemiology and current treatment patterns of treatment-resistant depression in Scotland: a CPRD study

Timothy Ming<sup>2\*</sup>, Tom Denee<sup>1</sup>, Gemma Scott<sup>1</sup>, Joachim Morrens<sup>2</sup> and Christopher Weatherburn<sup>3</sup>

<sup>1</sup>Janssen-Cilag Ltd; <sup>2</sup>Janssen Cilag and <sup>3</sup>Dundee Health and Social Care Partnership

\*Corresponding author.

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**Aims.** To assess the incidence and treatments currently used in clinical practice for the treatment of treatment-resistant depression (TRD) in Scotland.

**Background.** Patients with major depressive disorder (MDD) who have not responded to at least two successive antidepressant (AD) treatments in a single episode are described as having Treatment-Resistant Depression (TRD). Epidemiological data on TRD in Scotland is lacking. Furthermore, there is no data to our knowledge on therapies prescribed in Scottish clinical practice to treat TRD.

**Method.** A retrospective, longitudinal cohort study was conducted using Clinical Practice Research Datalink (CPRD) medical records. Adult patients were indexed on AD prescription, requiring MDD diagnosis within 90 days, from Jan 2011-May 2018 with 360-day baseline and 180-day minimum follow-up periods. Failure of  $\geq 2$  adequate oral AD regimens following indexing constituted TRD classification. Incidence rates of MDD and TRD (within the MDD cohort) and treatment lines following TRD classification were derived.

**Result.** The analysis included 20,059 patients with MDD (mean age 44 years, 63% female, median follow-up 59 months); 1,374 (6.8%) were classified as TRD. Median time-to-TRD classification was 25 months. The incidence rate of MDD was 15.9 per 1,000 patient-years and for TRD was 14.7 per 1,000 MDD-patient-years. For all first four post-TRD treatment lines, SSRI monotherapy was the most commonly prescribed therapy, followed by

combination (dual/triple) therapy and augmentation therapy (at least one oral AD supplemented with lithium, an antipsychotic or an anticonvulsant therapy). At first-line of TRD treatment, 1,050 (76.4%) patients received monotherapy AD, 212 (15.4%) received combination AD therapy and 112 (8.2%) received augmentation therapy. The most common monotherapy treatments at first-line TRD were sertraline (15.6%), mirtazapine (13.8%), fluoxetine (12.2%) and venlafaxine (11.6%). Among combination therapies, mirtazapine, venlafaxine, sertraline and amitriptyline were frequently used. Among the TRD and MDD cohort, no somatic treatments were coded in CPRD, although the use of these treatments was likely underestimated.

**Conclusion.** Monotherapy AD treatment was the most common therapy type for all four post-TRD treatment lines. These data support the need for new treatments that can achieve and maintain therapeutic response, and avoid continuous cycling through similar AD therapies.

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### COVID-19 and young people with intellectual disability: a service review

Omer Minhas<sup>1\*</sup>, Pippa Mundy<sup>2</sup> and Jessica Stewart<sup>2</sup>

<sup>1</sup>Cwm Taf Morgannwg University Health Board and <sup>2</sup>Cardiff and Vale University Health Board

\*Corresponding author.

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**Aims.** A service review of specialist child and adolescent intellectual disability provision in South Wales was conducted between March and May 2020. The purpose was to explore the impact of the first COVID-19 pandemic lockdown on children with intellectual disability and their families. The review aimed to explore if the disruption to the systems involved in their care would impact their wellbeing and behavioural presentations. We also measured if there had been an increase in the use of medication. Our focus was on the distress calls, which are requests for urgent clinical review to prevent a crisis. A service review of specialist child and adolescent intellectual disability provision in South Wales was conducted between March and May 2020. The purpose was to explore the impact of the first COVID-19 pandemic lockdown on children with intellectual disability and their families. The review aimed to explore if the disruption to the systems involved in their care would impact their wellbeing and behavioural presentations. We also measured if there had been an increase in the use of medication. Our focus was on the distress calls, which are requests for urgent clinical review to prevent a crisis.

**Method.** Six clinical areas across three Welsh health boards under the same specialist team were surveyed. Case notes and email correspondence were reviewed to obtain the number and content of crisis calls made to specialist CAMHS across an eight week period during the first UK COVID-19 lockdown. Data were gathered on frequency, purpose, and outcome of calls. Comparison data were also collected for the period October 2019 to March 2020.

**Result.** Pre-COVID-19: Two crisis calls were identified in two different areas during the pre-COVID period surveyed. Increases in medication and increases in respite care packages were made as a result.

During COVID-19 restrictions: 20 different initial distress calls made (children age 9 and 17 years old (M = 13.2); 75% were boys) across five of the six clinical areas. Of these 20 calls, 17 were active cases and 3 were new referrals. 95% of calls resulted in medication increases and there were few other interventions used due to COVID-19 constraints. Changes to the child's support system were discussed across all cases and return to school was highlighted as