

Spectrum Disorder was typified by VS hypoactivation to social and non-social reward, while Psychopathy was associated with VS hyperactivation in response to non-social reward anticipation. No studies were identified of social reward in Psychopathy.

**Conclusion.** The reported fMRI findings correlate with clinical observations in both conditions. Reduced reward response in ASD to a range of social and non-social stimuli would provide a parsimonious account of the social and non-social deficits that characterise the condition. Enhanced responses to the anticipation of reward in Psychopathy provides an account of the ruthless and destructive pursuit of reward-driven behaviours not inhibited by immoral or aversive signals. If, as the literature suggests, reward circuitry dysfunction plays a role in the development and manifestation of symptoms in both conditions, reward processing and its underlying neural circuitry may represent important targets for the development of novel treatment strategies.

### The utility of the Brief Edinburgh Depression Scale (BEDS) in assessing severity of depression in advanced cancer patients

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**Aims.** When using an assessment tool, brevity and validity are essential. Although brief depression inventories exist, they rely heavily on the inclusion of somatic symptoms. This can be problematic in advanced cancer populations; weight loss and sleep disturbance are for the most part ubiquitous in these patients and may not necessarily be indicative of depression.

The Brief Edinburgh Depression Scale (BEDS) is a 6-item shortened version of the Edinburgh Depression Scale which has been validated for use in patients with advanced cancer and is used internationally. The BEDS cut off threshold of 6/18 indicates that depression may be present. However, the BEDS currently provides no information regarding severity. The aim of this study is to establish severity thresholds for the BEDS by comparing it to another depression scale: the commonly used, rigorously validated, Patient Health Questionnaire (PHQ-9).

**Method.** 284 advanced cancer patients attending hospice day services in the North West of England completed both the PHQ-9 and the BEDS. Mean participant age was 66.7 (Standard Deviation = 13.2) and the sample contained both males (n = 102, 36%) and females (n = 182, 64%). BEDS severity thresholds with the highest Sensitivity (Sn) and Specificity (Sp) were selected based on their ability to predict PHQ-9 categories.

**Result.** A BEDS score of 4 to 6 was selected to indicate 'mild depression' (Sn = 81.7, Sp = 65); 7 to 8 'moderate depression' (Sn = 74.8, Sp = 78.7); 9 to 11 'moderately severe depression' (Sn = 82, Sp = 82.9) and 12 or more 'severe depression' (Sn = 63.2, Sp = 92.8). A linearly weighted kappa (with s weighting) showed a moderate level of agreement (0.47, 95% Confidence Interval: 0.40-0.54).

**Conclusion.** The BEDS is a simple and brief tool used to screen for depression in advanced cancer patients. It is administered

throughout the UK and multiple translation studies have enabled its global use (including in resource poor countries). The severity thresholds calculated here are derived from a large sample of patients with advanced cancer attending hospice services and demonstrate acceptable sensitivity and specificity in relation to the PHQ-9, a thoroughly validated reference standard. We conclude that the generated BEDS thresholds support use of the BEDS in determining the presence and severity of depression in advanced cancer populations.

### Improving facilitation of ECT treatment for patients in an acute medical hospital

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**Aims.** A Quality Improvement Project aiming to streamline facilitation of electroconvulsive therapy (ECT) treatment for psychiatric patients at a general acute hospital and reduce cancellation rates via the use of a checklist.

ECT treatment is an essential aspect of psychiatric care for patients with severe depression or treatment-resistant psychosis. Facilitation of ECT treatment is an uncommon task for liaison psychiatry and the medical and nursing teams responsible for patients' medical care. Between August-October 2019, this liaison psychiatry team had 3 patients undergoing ECT treatment a total of 13 times, with treatment being cancelled on 4 occasions. After engagement with stakeholders from the acute medical teams, the liaison team and the ECT suite team, key areas requiring intervention were identified to help reduce the rates of cancellation. Areas identified included a lack of ownership on the logistic and operational aspects of ECT amongst staff, a lack of knowledge of what the process involved and a lack of confidence in managing said patients. Difficulties in communication between teams and accurate documentation may contribute to errors and cancellation of ECT sessions, which in turn would delay treatment and impact on patient safety and clinical outcomes.

**Method.** The first author, a Foundation Year 1 doctor, developed a 10-point checklist to be referred to when arranging ECT for patients, to ensure errors were not made which could lead to missed treatment and delayed recovery. The tasks and responsibilities of each key member of the team were clearly identified. This checklist was included in all ECT patients' files and teaching was provided to staff involved. Feedback was obtained from staff involved regarding the clarity of information and their confidence in managing such cases.

**Result.** In the month following initial intervention the liaison psychiatry team organised 12 ECT sessions. The checklist was pasted into notes the day before each ECT session and 0 sessions were missed for avoidable reasons. Feedback from staff showed all teams felt more confident co-ordinating ECT treatment as a result of the checklist.

**Conclusion.** Creating a 10-point checklist for the facilitation of ECT treatment in patients at a medical hospital was beneficial in reducing avoidable errors from 16% to 0%. The liaison psychiatrists, medical doctors, and nurses involved reported greater confidence in managing patients undergoing ECT and described the checklist as enhancing the feeling of teamwork and communication within the multi-disciplinary team, and felt it had improved patient safety and clinical outcomes.