Methods. A cross-sectional survey was done in three first-generation universities in southwest Nigeria. A sample size of 550 participants per institution was estimated with a margin of error of 2.5%, a 95% confidence level. This gave a total sample size of 1650 respondents participants for the study. In each university, Students and staff were categorized by faculties into 3 clusters: science, social science, and arts. A proportionate sampling technique was used. Participants were assessed for SH, age, sexual orientation, gender, motivation for dressing, depressive symptoms, and suicidality. Associations were tested using Pearson correlations.
Results. SH was higher with age, among females, among lesbian, gay, and bisexual (LGB), participants with sexual motivation for dressing, high sexual desire, high suicidality, and low perception of campus safety. In terms of gender differences, correlation with age was slightly higher in females while correlations with lesbian/gay status was higher in males. In terms of sexual orientation, correlation with age was largest in LGB, association with dressing motivation, sexual desire, and depressive symptoms scores was greatest in heterosexual participants, association with suicidality scores was greatest with lesbian/gay status; and correlation with perception of campus as safe lowest among bisexual participants. Generally, the associations were weakest among staff compared to students.
Conclusion. There are certain demographics (heterosexual and bisexual females and gay men) that appear to be more vulnerable to SH in tertiary institutions. The correlates of SH also vary in the different sample groups. These should be considered when programming for prevention and response to SH in Nigerian tertiary institutions.

Association of Various Factors With Deliberate Self-Harm Among Patients of Bipolar Disorder

Dr Yasir Mateen[1]*, Dr Usama Bin Zubair[2], Dr Hirra Hussain[3] and Dr Sumira Qambar Bokhari[3]

[1]South West Yorkshire Partnership NHS Foundation Trust, Huddersfield, United Kingdom; [2]Fauji Foundation Hospital, Rawalpindi, Pakistan and [3]Services Institute of Medical Sciences, Lahore, Pakistan
*Corresponding author.

doi: 10.1192/bjo.2023.211

Aims. Deliberate self-harm is one of the common psychiatric emergencies in medical practice, and bipolar disorder carries one of the highest risks for self-harm among various other psychiatric and physical disorders. The relationship between self-harm and bipolar disorder and its risk factors has not been sufficiently studied in Pakistan and remains an area of investigation elsewhere. The objective of our study was to determine the frequency and factors associated with deliberate self-harm in patients with bipolar disorder.
Methods. This cross-sectional study was conducted in the outpatient department of psychiatry of a tertiary care hospital in Lahore, Pakistan, from May 2020 to April 2021. A total of 165 patients living with bipolar disorder, between the ages of 15 and 65 years, were included in our study. The diagnosis was in accordance with the criteria in International Classification of Diseases 11th Revision (ICD-11). Deliberate self-harm was defined as a non-fatal act in which an individual deliberately causes self-injury or ingests a substance in excess of any prescribed or generally recognized dosage. This was assessed through history (during last 6 months) and physical examination performed by the psychiatrist.

Sociodemographic variables like age, gender, educational status, marital status and employment status, and the clinical variable of treatment compliance, were documented. The data were recorded and analysed using Statistical Package for the Social Sciences (SPSS) version 20. The association of above factors with the presence of self-harm in our study participants was then explored with Pearson Chi-Square test. The p-value of less than 0.05 was considered as significant.
Results. Out of 165 cases included in the study, 62.42% (n = 103) were male and 37.58% (n = 62) were females. The frequency of deliberate self-harm in bipolar disorder was 35.15%. In terms of association, only female gender was found to have a statistically significant relationship (p-value <0.001) with the presence of self-harm in our study.
Conclusion. We concluded that deliberate self-harm is a common finding in cases of bipolar disorder in Pakistan. Additionally, vulnerable subgroups, such as female patients in this study, should receive more clinical attention and safeguarding support.

A Systematic Review of Clinical Practice Guidelines on the Use of Deep Brain Stimulation for Obsessive-Compulsive Disorder

Miss Adele Mazzoleni[1]*, Miss Shreya Bhatia[2], Miss Maria Anna Bantounou[3,4], Mr Niraj S. Kumar[5,4], Miss Monika Dzalto[6] and Dr Roy L. Soiza[3]

[1]Barts and the London School of Medicine and Dentistry, London, United Kingdom; [2]Queen's University Belfast, Belfast, United Kingdom; [3]University of Aberdeen College of Life Sciences & Medicine, Aberdeen, United Kingdom; [4]National Medical Research Association, London, United Kingdom; [5]University College London, London, United Kingdom and [6]Brighton and Sussex Medical School, Brighton, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.212

Aims. Deep brain stimulation (DBS), an invasive neurosurgical treatment where electrical stimuli are delivered in target brain areas, is an intervention that has traditionally been used for neurological movement disorders, but that has recently been considered for the management of psychiatric conditions, one of these being obsessive compulsive disorder (OCD). This review aimed to identify and assess clinical practice guidelines on the use of DBS for OCD, and, secondly, whether or not recommendations are tailored to individual patient characteristics, such as age, gender and comorbidities.
Methods. A systematic search of MEDLINE, EMBASE, APA Psych Info and Scopus was conducted, along with guideline development organisation websites, using all relevant synonyms of: "Guideline and DBS and OCD". Studies were assessed by two independent reviewers, and discrepancies managed by a third reviewer. The protocol was registered with PROSPERO, following the PRISMA checklist. Included guidelines were appraised using the AGREE-II instrument.
Results. Nine guidelines were identified in total. Eight recommended DBS as a last-line option in the management of OCD,

whilst the National Institute for Health and Care Excellence (NICE) recommended DBS should be used for research purposes only in OCD. Variability in the recommendations was also noted; indeed, only NICE undertook a cost-effectiveness analysis, and only the Congress of Neurological Surgeons (CNS) recommended target areas for electrode placement (i.e. subthalamic nucleus and nucleus accumbens). No guidelines clarified DBS settings, nor peri-operative optimisation measures. Patients' preferences, age groups differences, ethnicity or comorbidities were not considered by any guideline. The guidelines' quality ranged from moderate to high (50–92%), as per AGREE-II, with domains 'scope and purpose' and 'editorial independence' scoring the highest and 'applicability' and 'stakeholder involvement' the lowest across all guidelines.
Conclusion. Whilst eight guidelines supported the use of DBS for OCD as last-line therapy, a lack of cost-analysis, specific DBS settings, peri-operative procedures, and patients' circumstances were analysed. Given the lack of randomised controlled trials in this field, more rigorous research is needed prior to wider DBS implementation.

Staff Perspectives of Emergency Department Pathways for People Attending in Suicidal Crisis: A Qualitative Study

Miss Molly McCarthy[1]*, Professor Rajan Nathan[2], Dr Jason McIntyre[1], Dr Emma Ashworth[1] and Dr Pooja Saini[1]

[1]Liverpool John Moores University, Liverpool, United Kingdom and [2]Cheshire & Wirral Partnership NHS Foundation Trust, Chester, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.213

Aims. Background: The number of suicide-related presentations to emergency departments (EDs) has significantly increased over recent years; thus, making staff often the first point of contact for people in suicidal crisis. Despite this, staff receive minimal psychiatric training and few opportunities for education on the treatment and management of people presenting in suicidal emergencies. Understanding the needs of those who work within EDs is key to maximising the opportunity to reduce suicidal behaviour. Aims: To examine staff perspectives and experiences of working with people presenting to emergency departments in suicidal crisis.
Methods. Qualitative study guided by thematic analysis of semi-structured interviews with ED administrative, medical and mental health staff.
Results. Twenty-three staff participated. Three key themes were identified: (1) factors influencing staff decision-making; (2) quality of care for both staff and patients; (3) staff burnout, mental health and well-being. Staff described an overall lack of confidence and training related to asking patients about suicidal thoughts, which resulted in defensive practice and risk adverse decision-making. Quality of care for both patients and staff were discussed in relation to availability of resources, staffing pressures and team collegiality.
Conclusion. Staff felt inadequately equipped to deal with suicide-related presentations. Organisational support is lacking with increased staffing pressures, poor service availability and lack of beds. Negative staff attitudes often reflected an inherent unintentional use of language. Changing ED culture from top-down is imperative to address negative language and behaviours towards suicidal crisis and improve patient pathways and experience. Mandatory and ongoing training is needed to improve staff confidence, knowledge and attitudes.

Improve Coding Practices for Patients in Suicidal Crisis

Miss Molly McCarthy[1]*, Dr Pooja Saini[1], Professor Rajan Nathan[2], Dr Emma Ashworth[1] and Dr Jason McIntyre[1]

[1]Liverpool John Moores University, Liverpool, United Kingdom and [2]Cheshire & Wirral Partnership NHS Foundation Trust, Chester, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.214

Aims. The recording of suicidal ideation in emergency departments (EDs) is inconsistent and lacks precision, which can impede appropriate referral and follow-up. EDs are often the first point of contact for people experiencing suicide-related distress, but while data are available on attendances for self-harm, no comparable data exist for suicidal crisis.
Methods. Data were collected from six EDs across Cheshire and Merseyside (N = 42,096). Data were derived from presenting complaints, chief complaints and diagnosis codes for all suicidal crisis attendances (suicidal ideation, self-harm, suicide attempt) from January 2019 to December 2021.
Results. There was inconsistent coding within and between ED sites for people presenting in suicidal crisis. Attendances for suicidal ideation were often given the chief complaint code of 'depressive disorder' (12%). There was a high level of missing data related to the coding of suicide-related presentations (65%). Variation in coding was also reported for individual presentations; for example, 12% of attendances reported to be due to 'self-inflicted injury' were given a primary diagnosis code of 'depressive disorder' rather than 'deliberate self-harm'. There was also high variability in the routinely collected data (e.g., demographic information, attendance source and mode, under the influence at time of arrival) both within and between EDs.
Conclusion. Accurate detection and documentation of suicidal crisis is critical to understand future risk and improve services. Research and development in monitoring systems for suicidal crisis should be a priority for health services, and a national data collection tool is urgently needed to maximise accuracy and utility. Better data could be used to inform crisis care policy and to target suicide-prevention resources more effectively.

Measuring the Permeability of the Blood-Brain Barrier in Alzheimer's Disease Using Dynamic Contrast Enhanced MRI

Dr Beth McCausland[1,2,3]*, Dr Nathan Huneke[1,2], Dr Aravinthan Varatharaj[1,3], Dr Claire Gee[1,2], Dr Amy Kunicki[1,2], Dr Angela Darekar[1,3], Professor Jessica Teeling[1,3], Professor Henrik Zetterberg[4], Professor Clive Holmes[1,2], Professor Ian Galea[1,3] and Associate Professor Jay Amin[1,2]