

**Method.** The study is a descriptive cross-sectional study conducted among students of randomly selected tertiary institutions in south western Nigeria. Ethical approval was obtained from the Research and Ethics Committee of the Federal Neuropsychiatric Hospital Abeokuta Ogun State Nigeria. Permission to carry out the study was sought from the University authorities. A multi-stage cluster sampling selection of 850 respondents was done. Consenting students were administered socio-demographic questionnaire, WHO student's drug use questionnaire, the Big Five Personality Inventory (BFI-44), perceived stress scale-10 and academic motivation inventory.

**Result.** Seven hundred and eighty one completed questionnaires were analysed yielding a response rate of 92%. There were 51% males and 49% females with a mean age of 23.3 years ( $SD = \pm 2.29$ ), from monogamous family setting 591(75%) and high socio-economic class (65.8%). Of the respondents, 24.8% reported experience of use related harmful consequences such as engaging in quarrel or argument, unprotected sex and sex regretted the next day. There were significant associations between male gender ( $p < 0.001$ ), urban residence ( $p = 0.028$ ), polygamous family setting ( $p = 0.002$ ), high socioeconomic status ( $p = 0.026$ ) and use related harmful consequences.

Multiple logistic regression showed that the odds of experiencing harmful consequences was less than 1 for agreeableness ( $OR = 0.515$ ,  $df = 1$ ,  $p < 0.001$ ) and openness ( $OR = 0.634$ ,  $df = 1$ ,  $p < 0.028$ ) but greater than 1 for extraversion ( $OR = 1.525$ ,  $df = 1$ ,  $p < 0.036$ ) personality dimensions. This implies that for a unit increase in agreeableness and openness scores, there were decreased odds (8.6% and 79% respectively) of experiencing harmful consequences while there was increased odd (86%) of experiencing harmful consequences from a unit increase in extraversion score.

Both binary and multiple regression analysis revealed that the odds of experiencing harmful consequences is greater than 1 for perceived stress score ( $OR = 1.079$ ,  $p < 0.001$ ) and less than 1 for academic motivation ( $OR = 0.975$ ,  $p < 0.001$ ). This means that perceived stress is positively associated with substance use and experience of harmful consequences while academic motivation is negatively associated with substance use and experience of harmful consequences

**Conclusion.** There were associations between certain socio-demographic factors, personality dimensions, stress perception and academic motivation with substance use and experience of harmful consequences. Thus, clinicians and researchers should consider these factors when designing preventive and treatment strategies.

## A narrative literature review of the typology of psychiatric emergency services in the UK

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**Aims.** This study aims to provide a detailed literature review of the different forms of Psychiatric Emergency Services currently available within the UK.

**Background.** 1 in 6 individuals have one form of mental health disorders. Mental health crisis resulting in an individual requiring access to Psychiatric Emergency Service (PES) can occur at any

time. Psychiatric Emergency Service (PES) is described as one that provides an immediate response to an individual in crisis within the first 24 hours. Presently, several PESs are available in the UK with the aim of providing prompt and effective assessment, management and in some cases treatment and/or referral. Over the years, economic and political influences have greatly determined the service delivery models of PES. Indeed, these services vary in name, accessibility, structure, professionals involved, outcomes and many more.

**Method.** Electronic search of five key databases (MEDLINE, PsychINFO, EMBASE, AMED and PUBMED) was carried out to identify various models of PES in the UK. Various combinations of search terms were used and studies which met the inclusion criteria were selected. Studies were included if they were written in English, conducted within the United Kingdom, and described a form of PES. Search was not limited by years and this is to help have a comprehensive overview as well as show changes over time of the various models of psychiatric emergency services. Studies which did not meet any of the criteria detailed above were excluded.

**Result.** In total, 59 relevant studies were found which identified nine type of PES-Crisis resolution home treatment, police officer intervention, street triage, mental health liaison services in the Emergency Department, psychiatric assessment unit, integrated services, voluntary services and crisis house. There were more papers describing Crisis resolution home treatment services than the others. Furthermore, majority of the papers reported services within England than other countries within the UK.

**Conclusion.** All forms of PES are beneficial, particularly to mental health service users, but not without some shortcomings. There is a need to continue carrying out methodological research that evaluate impact, cost-effectiveness as well as identify methods of optimising the beneficial outcomes of all models of PES. This will inform researchers, educationist, policy makers and commissioners, service users and carers, service providers and many more on how to ensure current and future PES meet the needs as well as aid recovery of mental health service users.

## Mental wellbeing in doctors: the measure matters! development of a core outcome set for measuring wellbeing in doctors

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**Aims.** To achieve a consensus Core Outcome Set for measuring mental wellbeing in doctors.

Hypothesis: A minimum set of valid, reliable and practical wellbeing measures is needed for doctors.

**Background.** The importance of doctors' mental wellbeing to everyone using Health Care is highlighted by the levels of burnout reported in doctors around the world. In 2019 a number of UK policy documents made recommendations for the wellbeing of doctors, but how those wellbeing interventions are evaluated needs to be defined. Core Outcome Sets are increasingly being used in medicine to prevent waste in research, by recommending the inclusion of a minimum set of valid, reliable and practical measures. An

operational definition and Core Outcome Set for wellbeing in doctors is needed to meaningfully progress the work in this field.

**Method.** The Centre for Workforce Wellbeing (C4WW), a collaboration between the University of Southampton and Health Education England, was created to support research into the nature, assessment and enhancement of wellbeing in physicians. A Systematic Review of wellbeing measures used in doctors and the robustness of those measures, along with surveys of 250 UK doctors of all grades and specialities and patient and public involvement is informing what a core outcome set could be. A Delphi Study among 37 UK experts has been initiated to establish the consensus Core Outcome Set.

**Result.** Publication of research into doctors' wellbeing is growing internationally. In the UK alone data are being captured by multiple national organisations including: the Care Quality Commission, General Medical Council, British Medical Association and the Royal Colleges. Health and Social Care Organisations are, therefore, keen to "do something" and are spending money on wellbeing interventions with little, or no, evidence base and a lack of appropriate, comparable evaluation. A Core Outcome Set for measuring wellbeing in doctors is ethically required to reduce waste, to replace burnout measures and to refine wellbeing interventions.

**Conclusion.** Wellbeing measures that actually measure wellbeing, and not burnout, which are validated, reliable and practical, are needed to inform local organisational, national government and international research policy. An absence of burnout does not equate to wellbeing. The focus of measurement needs to shift to capture in what contexts we thrive, not just survive. If everyone used the same Core Outcome Set to measure mental wellbeing, direct comparisons could be made, and money invested, in creating infrastructure, processes and cultures that really work.

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## What is mental wellbeing?

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**Aims.** To explore the theory of wellbeing and to propose an operational definition for wellbeing in doctors.

Hypothesis: An operational definition for wellbeing in doctors is needed in order for it to be measured and interventions to improve it developed.

**Background.** There is no internationally recognised definition for wellbeing and yet wellbeing is an increasingly fashionable topic of research and development, including in doctors. This is because wellbeing can be described using either hedonist, or eudonist philosophy and there is a lack of conceptual clarity about what wellbeing is, and how it works. Research into the measurement of mental wellbeing has been dominated by individualist societies, with the inherent bias towards measuring self-centred components and not the other-orientated components that might be valued more in collectivist societies and by doctors.

**Method.** The Centre for Workforce Wellbeing (C4WW), a collaboration between the University of Southampton and Health Education England, was created to support research into the nature, assessment and enhancement of wellbeing in physicians. A literature review of the philosophy, definition and measurement

of wellbeing was undertaken with a focus on mental wellbeing at work and specifically in doctors.

**Result.** A concept map of the relationship between wellbeing terms has been created and was used to understand and classify where mental wellbeing itself was being defined and measured in studies, as opposed to a component of wellbeing, or determinant of wellbeing. Thematic analysis was used to develop an operational definition of wellbeing for doctors.

**Conclusion.** Measurement of wellbeing and interventions for wellbeing cannot be developed if you cannot clearly define what wellbeing is. An operational definition of mental wellbeing in doctors is ethically required to prevent research waste and to allow us to identify and recreate when doctors thrive, not just survive.

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## A state hospital survey of movement disorders including intention tremor

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**Aims.** In a survey of movement disorders in patients in a State Hospital the finger-nose test was included because of increasing interest in the cerebellum in schizophrenia. It was expected that this would reflect the pathobiology of schizophrenia and be unrelated to the type of medication.

**Background.** Abnormalities of movement and involuntary movements have gone from being considered part of schizophrenia to side-effects of medication to now demonstrably present in those who have never taken anti-psychotic medication. Soft neurological signs (SNS) are increased in schizophrenia, unrelated to medication, considered not to indicate brain localization, yet often include the finger-nose test which localizes to the cerebellum.

**Method.** All available patients in a State Hospital were examined for movement disorders. They were rated on the following scales: Abnormal Involuntary Movement Scale (AIMS) for Tardive Dyskinesia (TD), Simpson-Angus Neurological Rating Scale for Parkinsonism (SANRS), Barnes Akathisia Scale (BAS), a Dystonia scale and the finger-nose test.

**Result.** 250 patients were included, 174 were examined or observed for movement disorder: 120 had no missing data, 54 refused part of the exam. Their mean age was 47, 62% male, 53% black, 26% Hispanic, 17% white.

Medication: First Generation Antipsychotic (FGA) 35 (mean CPZ equivalent dose:1177mg), Second Generation Antipsychotic (SGA) 159 (734mg), both FGA and SGA 56 (1907mg), no antipsychotic 3; anticholinergic or amantidine: FGA 57%, SGA 16%, both FGA and SGA: 50%.

Tardive Dyskinesia: all 23%, FGA 36%, SGA 25%, both 7%

Parkinsonism: all 38%, FGA 43%, SGA 33%, both 34%

Akathisia: all 3%, FGA 0%, SGA 4%, both 3%

Pseudo-akathisia: FGA 11%, SGA 4%, both 13%

Dystonia: all 10%, FGA 13%, SGA 11%, both 8%

Intention Tremor: all 16%, FGA 0%, SGA 21%, both 16%

Half of those with Intention Tremor had Parkinsonism, a third had TD and a half were on anti-Parkinson medication.

None of these differences were statistically significant at  $p = 0.05$  though intention tremor did show a trend ( $p = 0.08$ ). The difference between FGA and SGA only became significant when all movement disorders were added together with those on anticholinergics with no movement disorder.