A Systematic Review of Catatonia Following Hypoxic-Ischaemic Brain Injury in Adults

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Aims: Catatonia is a treatable syndrome that can occur due to psychiatric and neurological pathology, such as hypoxic-ischaemic brain injury. Many neuroanatomical pathways may contribute to catatonia but no single pathway has been found to be the sole cause.

A systematic review assessing evidence of adult-only cases of catatonia after hypoxic-ischaemic brain injury and summarisation of the presentation, lesion location, treatment and outcome.

Methods: A PRISMA-2020 compliant PubMed/MEDLINE search of terms related to catatonia and hypoxia/ischaemia was carried out. Catatonia had to be explicitly diagnosed and must have been secondary to a hypoxic-ischaemic insult. Data were extracted based on lesion characteristics, timeline, treatment, and outcome.

Results: Seven studies met the criteria and they were all case reports. Lesions were heterogeneous and included bilateral parietal watershed infarcts, basal ganglia, thalamus,corona radiata, extensive white matter disease, pontine and cerebellar infarcts, and fronto-insular atrophy with inferred hypoxia. Presentations ranged from stuporous catatonia to delirium and affective disorders with catatonic features. Outcomes were generally good and catatonia resolved; however, post-neurological consequences of hypoxic-ischaemic insult remained in a few.

Conclusion: The evidence was limited to case reports and no single lesion causing catatonia was found.The findings supported the disrupted cortico-striato-thalamo-cortical motor pathway and the disconnection pathway as a possible cause for catatonia. There was also evidence for the involvement of neurochemical pathways such as GABA, dopamine and NMDA as a potential cause or treatment focus. Further studies with standardised catatonia measures and imaging are required.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Evaluating Microsoft 365 Copilot for Mental Health Tribunal Report Generation

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Aims: Mental Health Tribunal reports are documents written by psychiatrists to reflect the patient's mental state and justifications for detention. They can be time-consuming and labour-intensive. Reports should include chronology, diagnosis, risk, statutory criteria and an actionable plan. Microsoft 365 Copilot may reduce drafting burden. Copilot-generated reports from clinical notes were assessed and scored to determine their performance.

Methods: Twenty-three questions were identified on a tribunal report which could be answered with an AI-generated response, such as forensic history, circumstances of admission and current progress. A scoring sheet was designed covering each question, scoring 0–5, with higher weights for critical domains. Prompts were refined after multiple runs until a prompt generating a comprehensive, accurate and human-like report was selected. Patient notes were supplied as uploaded Word files. Narrative quality was also scored separately to question performance across 8 domains (scoring 0–4 each) such as coherence, tribunal-appropriate tone and minimal redundancy. A combined final score weighted question performance (80%) and narrative quality (20%). A single clinician reviewer scored all reports.

Results: Five patients were evaluated; 1 patient was generated 3 times to assess repeatability. Seven drafts were scored. All 23 questions were answered in every draft. The mean score per question was 4.9/5. The mean weighted question score was 98%. The average narrative quality was 28/32 (88%). Mean combined final score was 96% and all drafts met the "minor edits" threshold. For the repeated patient, weighted question scores varied minimally. The average time taken to generate a report was 30 seconds. One of the repeated reports contained a single hallucination concerning date of admission.

Conclusion: Copilot consistently produced quick and comprehensive tribunal reports under a structured prompt, but hallucination was found and is a risk. Clinician verification is required. As the prompt was being refined, it became clear that the reports altered significantly based on the prompt used. The quality of the reports signified potential use in generating community treatment orders (CTO) and medical recommendations. Limitations are that narrative scoring has a high subjectivity burden and this pilot only contained 5 patients. Further trials with a larger cohort and multiple assessors are required for more reliable results.

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Characterising the Behavioural Determinants Associated with Developing Antipsychotic-Induced Metabolic Side Effects

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Aims: Antipsychotics are the mainstay of treatment for severe mental illness (SMI) but cause metabolic side effects, such as rapid and clinically significant weight gain, hyperglycaemia, and hypercholesterolaemia, increasing the risk of type 2 diabetes and cardiovascular disease. Metabolic side effects develop through physiological mechanisms (e.g. plasma glucose dysregulation), but also through behaviour changes (e.g. increased calorie intake, sedentary lifestyle). This study aimed to characterise the behavioural determinants associated with developing metabolic side effects by exploring people's experiences of taking antipsychotics for an SMI.

Methods: Participants (n=22) were recruited, as members of the public via Mental Health charities and an existing database of people who had been previously prescribed antipsychotic treatment for an SMI (n=20), and via National Health Service Trusts who were recently initiated on antipsychotic treatment for an SMI (n=2). Sociodemographic characteristics (age group, biological sex, ethnic group, index of multiple deprivation) were collected from participants to ensure a diverse sample. Individual, reflective

interviews with a semi-structured style were undertaken to explore determinants associated with changes in behaviour when antipsychotics were initiated. Template analysis was undertaken, comprising an inductive approach and a priorithemes.
Results: The following main themes were created which were associated with changes in behaviour influencing the development of metabolic side effects: environmental determinants (e.g. Covid-19 pandemic, weather, finances); social determinants (e.g. social exclusion, social support, provision of food from family/friends); emotional determinants (e.g. experience of trauma, low mood, shame); and motivation around healthy eating and physical activity (e.g.convenience, cravings, self-medication). Integrative themes included: impact of weight gain (e.g. on identity, quality of life, comorbidities); experience of being a mental health patient (e.g. clinical support, monitoring of side effects); and impact of medication/side effects on eating and physical activity behaviours (e.g. sedation, decreased energy, prior knowledge of side effects).
Conclusion: There are a variety of determinants influencing behaviours associated with developing antipsychotic-induced metabolic side effects. Current clinical practice is to treat side effects with pharmacological and/or non-pharmacological interventions once they have developed as per National Institute for Health and Care Excellence Guidelines and the Lester Tool. Interventions targeting specific behaviours and determinants should be implemented at the start of antipsychotic treatment to prevent metabolic side effects from developing. Further research should explore interventions and ongoing support appropriate to, and developed in partnership with, this population.

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Late-Onset ADHD: A Diagnostic Mirage or a New Clinical Frontier? A Systematic Review of the Evidence

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Aims: Attention-Deficit Hyperactivity Disorder (ADHD) is a neurological developmental disorder that involves a criterion which requires an onset of symptoms before 12 years of age for clinical diagnosis (American Psychiatric Association, 2013).

Be that as it may, longitudinal studies have identified cohorts of adults with symptoms of ADHD but also lack a clear childhood history of symptoms. This phenomenon challenges the core diagnostic criteria described in the DSM–5 and creates notable uncertainty clinically (Moffitt et al., 2015).

This systematic review aims to critically analyse and evaluate the published evidence that both supports and contradicts the validity of adult-onset ADHD being a diagnostic construct, as well as to investigate other possible causalities for this type of clinical presentation.
Methods: Following PRISMA guidelines (Page et al., 2021), a comprehensive search of PubMed, PsycINFO, and Embase was conducted for peer-reviewed studies that have been published from 2000 onwards, exploring late-onset ADHD. Studies were screened by one reviewer. Due to the heterogeneity of the studies, a narrative synthesis was performed usingthe extracted data to arrange findings into arguments based on the various topics that materialised, pertaining to methodology, aetiology, and differential diagnosis.
Results: The synthesis identified a notable conflict in the evaluated literature. Multiple longitudinal studies provided evidence supporting a late-onset ADHD presenting subtype. Nevertheless, this evidence is countered by literature arguing that findings in support of adult-onset ADHD are attributable to limitations in methodology, including both recall bias when patients self-report retrospectively as well as the failure to detect "masked" childhood symptoms (Faraone et al., 2016). Moreover, a significant amount of literature explores the idea that there may be an overlap of symptoms with conditions that present similarly to ADHD such as complex trauma, emotional dysregulation and misuse of substances.
Conclusion: The evidence analysed and evaluated for a distinct late-onset neurological developmental subtype of ADHD remains inconclusive. These adult presentations outline a complex reality facing the clinicians of which require further meticulous and thorough assessment. This systematic review shows a need for this late-onset ADHD subtype to be further explored and studied with more subjects, as well as investigating possible strategies that could be implemented to mitigate undiagnosed or misdiagnosed patients. Healthcare professionals should make conducting a comprehensive differential diagnosis and recording collateral history a priority, in order to avoid a patient remaining undiagnosed and to distinguish ADHD from similar presenting and/or mimicking conditions.

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The Effectiveness of a 6 Week Family Intervention in Reducing ADHD Symptoms and Promoting Emotional Regulation: A Feasibility Study

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Aims: Attention Deficit Hyperactivity Disorder (ADHD) is one of the most common neurodevelopmental disorders in children and adolescents with an estimated prevalence of up to 5% in children. Since 2019 there has been an average annual increase of 18% nationally, in ADHD medication prescriptions. Therefore with the uncertainty around the long-term effects of medication use and the side effects as we currently understand them, there is the need for other interventions to be available for children with ADHD.

This research evaluated the feasibility of a yoga and mindfulness-based family programme developed specifically for children with an ADHD diagnosis; designed to reduce ADHD behaviours, improve-parent-child relationships, and emotional regulation.
Methods: 17 families with children aged 6–11 completed a 6-week yoga and mindfulness programme. Families completed the E SWAN assessment forms which include questionnaires for ADHD, Disruptive Mood Dysregulation Disorder, Depression, Anxiety and Panic Disorder. Families were also interviewed post intervention.
Results: The quantitative findings were positive with significant outcomes: 94.1% of participants were reported to show an improvement in ADHD symptoms post intervention, with an overall 38.6% reduction in symptoms. The qualitative findings evidenced that post intervention the children were able to independently implement emotional regulation techniques,