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

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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

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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

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