

threshold value of 105 l/minute in different samples.

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Detection of depression in patients with communicative impairments after stroke

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Background: The early detection of depression poststroke is essential for optimizing recovery after stroke. Depression after stroke is strongly associated with communicative impairments, which are present in over 40% of stroke survivors. However, assessment of depressive symptoms in these patients is difficult, and to date no valid and reliable instrument is available. The Signs of Depression Scale is an observer rated scale. The evidence for the psychometric properties of this instrument is still scarce, which may be due to the dichotomous rating scale. Therefore, we transformed the original instrument into a four point Likert Scale (the Signs of Depression Scale-Revised) and investigated the reliability, validity and clinical utility of the Signs of Depression Scale-Revised, administered by nurses.

Material and methods: We included 116 consecutive stroke patients, of which 53 patients with communicative impairments, and 107 relatives. Major depression disorder was diagnosed using the Composite International Diagnostic Interview. Validity was determined using a reference test strategy; in patients without communicative impairments a diagnosis of depression was made interviewing patients themselves as well as their relatives, and in patients with communicative impairments only relatives rated patients mood. Also, the Bartell Index was used as a non-language based external validator. To determine the diagnostic accuracy, the sensitivity, specificity, positive predictive value, and negative predictive value were calculated. The interrater reliability was established by different pairs of nurses, who independently rated the patient's mood using the SODS-R. The clinical utility was measured with the questionnaire 'Clinical Utility of the Signs of Depression Scale'.

Results: The correlation between the Signs of Depression Scale-Revised and the Composite International Diagnostic Interview was large in patients without communicative impairments, and small in patients with communicative impairments. Correlation with the Bartell Index was moderate. The diagnostic accuracy was best at a cut-off score of = 3. The internal consistency was $\alpha = 0.80$ (95%CI 0.74–0.85). The interrater reliability exhibited an ICC of 0.78 (95%CI 0.67–0.85). The clinical utility of the Signs Of Depression Scale-Revised was rated good with an agreement of 90% or more on all items of clinical utility.

Conclusion: The results of our study indicate that the Signs Of Depression Scale-Revised is

a reliable and valid depression screening instrument, and that this instrument can be used for the initial assessment of patient's mood to identify those patients in need for further diagnostic assessment.

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Evaluation of the performance of an in-hospital risk prediction tool for depression after stroke

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Background: Post-stroke depression (PSD), a serious and common complication after stroke, has a negative impact on recovery after stroke. Early identification and treatment of PSD increases functional recovery and decreases severity of PSD. The timely detection of post-stroke depression, however, is complicated by a decreasing length of hospital stay. Therefore, the Post-stroke Depression Prediction Scale (DePreS) - a clinical prediction model to identify stroke patients at risk for depression in the second month post stroke - was developed, showing good predictive performance. Nevertheless, to use this instrument with confidence in daily care, a study in a new sample of patients with stroke is needed to confirm the predictive performance of the DePreS.

Materials and methods: In a multi-centre prospective observational design, 46 consecutive patients with stroke who were able to communicate were included. In the first week post stroke, the risk for PSD was identified with the DePreS. In the second month post stroke, the presence of major depressive disorder was diagnosed using the Composite International Diagnostic Interview (CIDI). The predictive performance of the DePreS was determined with the predictive values sensitivity, specificity, positive and negative predictive values, likelihood ratios and area under the receiver operating characteristic curve (AUC). **Results:** In the second month post stroke, four patients of the 46 were diagnosed with major depressive disorder. In the first week post stroke, the DePreS identified 18 patients at high risk for PSD. The sensitivity and specificity were 1.00 (95%CI 0.40–1.00) and 0.67 (95% CI 0.50–0.80), respectively. The positive and negative predictive values were 0.22 (95% CI 0.07–0.48) and 1.00 (95%CI 0.85–1.00). The AUC was 0.821.

Conclusion: Despite the small sample size and the limited numbers of patients diagnosed with major depressive disorder in our study, the findings suggest that DePreS confirms the good predictive performance found in the original study. Clinicians can use the DePreS in clinical stroke patients to identify patients to be at risk for depression in the second month after stroke. Provided the early identification is followed by adequate treatment and follow-up, this will contribute to reduce the burden

of depression and its negative impact on the recovery.

A-P-11

The inception of an adult Mental Health Liaison Team in Cwm Taf UHB

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Introduction: The aim of the presentation is to provide information about the new Mental Health Liaison Team in Cwm Taf UHB. We aim to explain how our service works, including the rationale for its inception, and provide preliminary data on outcomes.

LHBs are required to 'ensure effective liaison services to assure needs for people with mental health problems in the district general hospital (DGH) setting are met.' The Adult Mental Health Liaison Team was established in March 2015 to ensure this need is met, including an extension of the remit to include all adult inpatient beds.

Context: A snapshot survey of all Cwm Taf adult inpatient beds (excluding Obstetrics, Paediatrics and Palliative Care) in September 2012 showed that almost 3 in 4 hospital beds in Cwm Taf were occupied by patients over 65, 1 in 4 beds occupied by someone identified as suffering from dementia and 1 in 12 by someone identified as suffering from a solely mental health problem.

A clear need was identified for the development of a Mental Health Liaison Team to help patients presenting with mental health difficulties within a DGH setting.

Methods: The role of the Adult Mental Health Liaison Service is: to provide responsive and comprehensive assessment of the mental health needs of those referred to the service; work collaboratively with healthcare professionals in general settings to meet the mental health needs of those patients referred and to promote patient centred; provide short term interventional management of identified mental health need; provide support and advice to patients and carers in managing their mental health needs; provide support and advice in the management of the acutely disturbed patient; signpost patients with serious mental illness (SMI) to appropriate mental health services.

Educate and support inpatient staff in identification and appropriate management or referral of patients with co-morbid physical health needs and SMI; provide support to staff in managing difficult patients and situations, including stress management and debriefing when appropriate.

Results (evaluation and impact): Early indications suggest: Patients with mental health difficulties are being seen significantly faster than was previously the case, resulting in enhanced patient care and ensuring ward staff feel supported. Large number of interventions being utilised including management support, medication advice, cognitive assessment and screening, psychological intervention as well as