Faculty of Forensic Psychiatry Annual Conference

5–7 March 2014
Europa Hotel, Belfast

Abstracts & Speaker Biographies
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All speaker presentations that CALC are given permission to use will be made available online after the conference. An email will be sent to delegates when they are uploaded to the Royal College of Psychiatrists’ website.

Wednesday 5 March

09:30-11:30
SESSION 1
Quality assurance in Forensic Services

09:30
Lessons from Francis
Professor Dame Sue Bailey

Sue Bailey is a Consultant Child and Adolescent Forensic psychiatrist and Professor of Mental Health Policy in North West of England.

Interests include development of needs and risk assessment measures for use with young offenders with mental illness and development of community and secure inpatient treatment for young offenders both nationally and internationally.

As President of the Royal College of Psychiatrists she worked with health and social care professionals, patients and carers to help bring about Parity of Esteem between mental and physical health. Now enshrined in Primary Legislation in England.

Made an OBE in 2002 for services to Mental Health and young offenders and in 2013 made a DBE for services to Psychiatry and for voluntary service to People with Mental Health Conditions.

Current Chair of UEMS CAP Section, elected member of EPA Council, secretary of EFCAP and member of programmes meeting of the WPA.

10:15
CQC: friend or foe?
Professor Louis Appleby

Abstract not available at time of publication

10:45
Introducing a culture of excellence in our institutions
Mr John Ballatt

John Ballatt has offered consultation and support to individuals, teams and organisations for over 20 years. His practice is enriched by having worked as a practitioner, trainer and manager in social care and the health service, culminating in 6 years as an Executive Director responsible for an operational division, and for trust-wide strategic organisational change, in a large NHS trust. During that time he led several national and regional learning and development initiatives, mainly relating to mental health.

John has worked independently since 2006. In the last few years, he has offered role consultancy to senior clinical and managerial leaders, facilitated the development and implementation of new clinical models and commissioning strategies, supported complex organisational change and worked with senior teams, mainly in the NHS. John is a trained mentor, with extensive training in group dynamics. He is co-author of ‘intelligent kindness: reforming the culture of healthcare’, and has lectured widely on the subject to a wide range of professional, academic and organisational audiences and Government departments.

John is a Partner in the innovative consultancy organization People in Systems – a multi-disciplinary team of specialists committed to supporting the creative integration of the ‘human’, the professional, the organisational and the business factors in health and social care and other settings.
12:00
The very assertive use of clozapine: Clozapine re-challenge, Nasogastric initiation of clozapine
Dr Ed Silva

After 13 years as a consultant in high security you’d have thought he’d know better than to use nasogastric clozapine and then have the nerve to talk about it. Also the Forensic Faculty rep to NOG.

What do we do when patients with the most serious psychotic illnesses, detained for years in the most restrictive conditions refuse oral clozapine or have a history of blood dyscrasias? Nothing likely to work, a referral to an unsuspecting newly appointed colleague or when that fails to another units are popular. Nasogastric initiation is technically very simple. Clozapine re-challenge presents very difficult decision making. Both are likely to face layers of resistance, but with care and team work can be surprisingly successful when the status quo is unacceptable.

12:40
OCTET: an RCT of CTOS. What next?
Professor Tom Burns

Tom Burns is Professor of Social Psychiatry at the University of Oxford. Before that he was Professor of Community Psychiatry at St. George’s Hospital in London. He qualified from Cambridge University and Guy’s Hospital, London, and trained in Psychiatry in Scotland and London. His research interests are predominantly health services research in community psychiatry, particularly trying to understand the components of complex interventions and the nature of the therapeutic relationship. His current focus is on testing the level and effects of coercion in mental health care, including an RCT of Community Treatment Orders (OCTET). He has published five books – ‘Assertive Outreach; A Manual for Practitioners (2002)’; ‘Community Mental Health Teams; A Guide to Current Practices (2004)’; ‘A Very Short Introduction to Psychiatry (2006)’ and is joint author of the sixth revision of the Shorter Oxford textbook of Psychiatry all published by OUP. ‘Our Necessary Shadow: the nature and meaning of psychiatry’, was published by Allen Lane in 2013. He was awarded the CBE in 2006 for services to mental health care.

OCTET is the third, and largest, RCT of Community Treatment Orders. Like the two that preceded it, it failed to find any clinical advantage from the intervention. Evidence from before and after and controlled before and after studies are contradictory and inconclusive. No RCT is perfect but OCTET complements its predecessors and the conclusion that CTOs do not improve outcome is pretty robust. Further RCTs are unlikely in the immediate future so what should clinicians do? Is the weight of evidence sufficient to recommend the withdrawal of CTOs? Are there specific patient groups that should be targeted? Is there any broader message about the nature of mental health care that can be taken from this finding?

14:15
Two "Diversion" Models from the US: Police Crisis Intervention Teams and Mental Health Courts
Professor Amy Watson

Over 1.1 million people with mental illnesses are arrested in the United States each year, and persons with serious mental illnesses are overrepresented in the jail and prison populations. Jurisdictions across the country are developing approaches to divert individuals with mental illnesses from the arrest altogether, or to minimize their penetration into the criminal justice system. Two diversion models that are being implemented widely in the USA will be described. The Crisis Intervention Team Model (CIT) was developed to improve safety in police encounters with individuals experiencing mental health crises, and when appropriate, divert them to psychiatric services rather than arrest. The Mental Health Court (MHC) model was designed to divert individuals with mental illnesses who have been charged with crimes out of the cycle of arrest, incarceration, release and re-arrest by providing linkage to mental health treatment and monitoring in the community. Both diversion models will be described in detail along with summaries of effectiveness for various criminal justice and mental health outcomes. The presentation will conclude with a discussion promising implications and important cautions and concerns.
14:45
**Testing a New Linkage between Police and Local Mental Health: A Potential Means of Pre-Booking Jail Diversion for Persons with Serious Mental Illnesses**

Professor Michael Compton

The widespread division between mental health and criminal justice systems leads to many persons with serious mental illnesses being arrested and incarcerated when mental health treatment would be more appropriate. As illustrated by the Sequential Intercept Model, the most effective point of intervention within the criminal justice system to prevent unnecessary arrest and incarceration is the initial encounter between an officer and a person with a serious mental illness, which is the first step in criminal justice involvement. This project seeks to implement a trial of a new police–mental health linkage system and to test its feasibility and acceptability among end-users. Our new linkage system consists of three steps. First, individuals with a serious mental illness and a history of criminal justice involvement will give special consent to allow a brief disclosure of their mental health status to be included as part of a registry in the state’s criminal justice information system. Second, when an officer runs an enrolled participant’s name or identifiers as part of a routine background check during an encounter, the officer will receive an electronic message that the person has special mental health considerations, and to call a phone number for more information that will connect to our Linkage Specialist. Third, the Linkage Specialist, who will be a certified mental health provider, will assist the officer by thinking through observed behaviors and potential resolutions with the officer. We expect that in some cases where an arrest is not obligatory, the officer will then choose to refer to or transport to mental health services instead of making an arrest because of the information provided. Three overarching aims guide this pilot intervention project. In Aim A, we will implement a demonstration of the police–mental health linkage system in order to operationalise procedures and develop the protocol manual (for a larger study). In Aim B, we will assess key stakeholder groups’ perceptions of acceptability through focus groups conducted with patients, patrol officers, police department leaders, and mental health services program managers. In Aim C, we will demonstrate feasibility and estimate effect size and other parameters to prepare for a larger-scale study. Feasibility will be examined among 200 participants with a serious mental illness and a criminal justice history.

15:15
**Section 136 of the Mental Health Act - challenges and future directions**

Dr Aileen O’Brien

Senior Lecturer in Psychiatry at St George’s University of London and Honorary Consultant for the fourteen bed Psychiatric Intensive Care Ward at South West London at St George’s Mental Health NHS Trust. She has clinical responsibility for the section 136 suite attached to the PICU. She is director of training and education for the National Association of Psychiatric Intensive care Units and her academic roles include psychiatry teaching lead at St Georges, the Athena Swan lead and personal tutor lead.

16:45

**SESSION 4**

**Debate: We should abandon the current classification of Personality Disorder**

Chair: Dr Colin Campbell

**16:45 For:** Professor Peter Tyrer and Professor Don Grubin

**Peter Tyrer** is Professor of Community Psychiatry in the Centre of Mental Health at Imperial College. He has been interested in the most common mental disorders ever since medical student days and has been particularly interested in anxiety, depression and personality disorder in terms of classification and treatment ever since. He has been a strong advocate of community psychiatry for all this time, and has developed the treatment called nido therapy in connection with improving care outside institutional settings, as our current treatments still remain ineffective for so many people. He is also the lead of the North London hub of the Mental Health Research Network in England and former Editor of the British Journal of Psychiatry.

**17:05 Against:** Professor Jeremy Coid and Professor Tony Maden

**Professor Jeremy Coid** completed medical training at Sheffield University and training in Forensic Psychiatry at the Maudsley and Broadmoor Hospitals. He was trained in research at the Institute of Psychiatry, King’s College London, where he completed his MD. As Consultant Forensic Psychiatrist he established the medium secure service to East London for mentally disordered offenders. He has extensive experience of giving evidence in court as an expert witness in cases of serious violence, sexual offending, and on childcare. He has been an advisor to the Department of Health, Ministry of Justice and Ministry of
Defence on management of high risk offenders. He was appointed Senior Lecturer in Forensic Psychiatry in 1987 and awarded a personal chair in 1995.

Currently, Prof Coid is the Director of the Violence Prevention Research Unit at Queen Mary University of London. The VPRU focuses on research into the epidemiology and prevention of violence. It investigates causal mechanisms that explain violent behaviour in mental health care settings, with an emphasis on the links between violence and both severe mental illness and personality disorder. It evaluates the effectiveness of mental health care services in preventing violence. The research uses quantitative methods with statistical modelling of new instruments for the assessment of violence risk. It provides a unique translational focus into the application of violence risk modelling into risk management applications and interventions. The VPRU is a member of the WHO Violence Prevention Alliance.
09:30
Domestic violence among mentally ill
Professor Louise Howard

The role of trauma in the aetiology and exacerbation of mental disorders is well recognized, particularly childhood sexual abuse. However, there has been limited research until recently on the relationship between domestic violence and mental disorders. I will review the current evidence on the relationship between domestic violence (experiences and perpetration) and mental disorders in men and women, briefly review the evidence base on interventions and discuss the recently published NICE and WHO policy guidelines.

09:50
The Elephant on the Couch: should we take harm from psychological interventions more seriously?
Professor Conor Duggan

Conor Duggan is Emeritus Professor at the University of Nottingham and Head of Research and Development at Partnerships in Care. His research interests are treatment efficacy in personality disordered offenders, their long-term course and the neuropsychological basis of psychopathy. He has written over 140 peer reviewed papers and book chapters. He was until recently Editor of The Journal of Forensic Psychiatry and Psychology and chaired a NICE Guidance Committee on Antisocial personality Disorder. In 2012, he was awarded an OBE for his services to mental health.

While the possibility of harm is emphasised in the training in and research literature of psychological interventions, many argue that it, unlike the prescribing of medication, receives little more than lip service in either clinical practice or in the reporting of clinical trials. These, after all, are only 'talking therapies, so what harm could ensue? Nonetheless, careful long-term follow-up of individuals in clinical trials employing such interventions have demonstrated that those in the active arm in the trial often fared worse than those in the no treatment control and that this occurred even when those receiving the active intervention believed that they had benefited from it. As the efficacy of psychological interventions become increasingly established and more widely employed, this potency ought to stimulate a parallel interest in the harm that they may cause.

Harm can arise from psychological interventions in different ways (i.e. when an ineffective treatment is used when a more effective treatment could have been chosen, or the ineffective implementation of an effective intervention due to a lack of competence by the therapist or due to patient factors such as excessive dependency or masochism etc.).

The literature from clinical trials evaluating psychological interventions is an obvious place to examine harm as here there ought to be (a) a systematic recording of a range of outcomes (including harm) and (b) the trial design controls for a number of potential confounders so that one can attribute a specific outcome to the intervention. Nonetheless, the data from several Cochrane Reviews and of Health Technology Assessment funded trials indicates that this is inadequate.

Finally, taking the possibility of harm from psychological interventions seriously may have a beneficial consequence. For instance, although many trials of psychological interventions show no difference between the experimental and control condition when only the mean effect is examined, this conceals the much greater variance in the active arm of the intervention than that of the control. This suggests that while more are damaged by the active intervention, a greater number also benefit compared with those in the control condition. The publication of this variance, rather than the mean, would allow an examination of the characteristics of those who are harmed (and who benefit) from the intervention thereby leading to an identification of what ‘works best for whom and under what circumstances’.
Psychopathy as a neurodevelopmental disorder
Dr Nigel Blackwood

Nigel Blackwood (@NJBlackwood) is a Senior Lecturer in Forensic Psychiatry at Kings College London, and an honorary Consultant Forensic Psychiatrist with the North London Forensic Service.

We are used to thinking of disorders such as schizophrenia and autism as neurodevelopmental disorders. What about psychopathy? I will review recent work from our own and other labs investigating the neurodevelopmental course of the disorder, from the callous unemotional child to the psychopathic adult.

Criminal Justice Transitions
Professor Jenny Shaw

Abstract not available at time of publication

Is risk assessment a waste of time?
Dr Seena Fazel

Dr Seena Fazel is a Wellcome Trust senior research fellow in clinical science at the University of Oxford, and an honorary consultant forensic psychiatrist. His research work focuses on relationships between severe mental illness and violent crime, violence risk assessment, and the mental health and suicide risk of prisoners. He has given evidence to the UK Government Justice Select Committee and the UN-backed Khmer Rouge war crimes tribunal. He is currently an Associate Editor for the Journal of Forensic Psychiatry and Psychology and BMC International Health and Human Rights.

Update on treatment resistant schizophrenia
Professor Peter Jones

Peter Jones is Professor of Psychiatry and Head of the Department of Psychiatry at the University of Cambridge. His research interests are in the clinical epidemiology of psychiatric disorders, particularly schizophrenia, with a focus on its developmental aspects, and in randomised trials of drug and talking therapies. He is an honorary consultant with the Cambridgeshire & Peterborough Foundation Trust where he works with www.cameo.nhs.uk the early intervention service for Cambridgeshire. Previously, he worked with the Nottingham rehabilitation and community care services (RCCS) and, before that, as an honorary consultant to the psychiatric assertive community treatment service (PACT) in Peckham. Thus, he has helped to manage treatment resistance at several stages of schizophrenia.

Understanding Offending and Mental Illness: Asking the Right Questions
Professor Jim Ogloff

Abstract not available at time of publication

New Research Presentations

1) Assessing violence risk in forensic mental health patients: Results from the VoRAMSS study
Main presenter: Ms Laura Archer-Power
Co-authors: Professor Jenny Shaw, Dr Michael Doyle & Professor Jeremy Coid

Laura Archer-Power is a Research Assistant at The University of Manchester in the Centre for Mental Health and Risk. Research interests include the interface between criminal justice and mental health; risk assessment and violent behaviour. Ex police officer and probation service officer, passionate about the real-world impact of research.

Background
Violence risk assessments are increasingly required in forensic mental health services for public protection and care planning purposes. Guidelines suggest that risk assessment should combine the use of empirically-validated measures with professional discretion and that analysis of protective factors could add value.

Currently, the preferred method is that of Structured Professional Judgement (SPJ), which combines the use of empirically-validated guidelines with professional discretion, ensuring that important personal-individual risk factors are not overlooked. Research is needed to externally validate such risk assessment measures with different samples.

Aims
To examine the validity, reliability and practical utility of:
1. Violence risk assessment tools and guidelines,
2. Protective factors and instruments that measure them for multidisciplinary use in mental health services.

Objectives
Investigate the validity of:
1. The Medium Security Recidivism Assessment Guide, and
2. The Historical, Clinical and Risk; 20 items version 3 to predict violence, and
3. The Structured Assessment of Protective Factors to predict non-violent outcome.

Investigate the validity of the measures based on:
  a. Gender,
  b. Treatment, support and supervision available.

Methods
The study adopted a prospective cohort follow-up design. All discharges from NHS Medium Secure pathways in England and Wales over a 12-month period were included subject to section 251 NHS Act (2006). Case file review and interview with a collateral informant informed scores on measures at baseline (time of discharge). Violent outcome was detected at six and 12 months post-discharge using the McArthur Community Violence Instrument (MCVI) with collateral informants and case file review, as well as Police National Computer (PNC) data. The effects of gender and levels of professional support were also investigated.

Results
Prevalence of violence was considerably higher than that found in previous studies which relied on official records only, reinforcing the value of gathering data from multiple sources. All measures were validated for the prediction of violence post-discharge. Those who had longer stays in secure care, were older and were subject to a community order with restrictions upon discharge, were significantly less likely to be violent during follow-up. Violent outcome was not significantly affected by mental illness diagnosis or levels of professional support.

Findings support the use of SPJ methods, a focus on dynamic risk factors and the assessment of protective factors when attempting to predict and manage violence risk.

2) Homicide-suicide and the role of mental disorder
Main presenter: Dr Sandra Flynn
Co-authors: Professor Linda Gask & Professor Jenny Shaw

Sandra Flynn is a Research Fellow currently working at the Centre for Mental Health and Risk at the University of Manchester, UK. She completed her PhD in 2013 which examined mental illness in perpetrators of homicide followed by suicide. Her research interests include homicide and serious violence by people with mental illness.

Background
Homicide-suicide is a rare event where an individual commits a homicide and then takes his or her own life. Our understanding of these events is limited as most studies are descriptive. There is little reliable evidence regarding mental disorder in individuals who commit homicide-suicide.

Aims
To describe the characteristics of perpetrators and victims; to examine the adverse life events experienced prior to the offence; and to determine the prevalence of mental disorder.

Method

**Results**

60 homicide-suicides were recorded over the 3-year period. Most of these offences were committed by men (53, 88%). The average age of perpetrators was 44 years (range 18-85). The majority of these incidents involved partners and/or the children of the perpetrator and most cases were preceded by separation from an intimate partner. Medical records were obtained for the majority of cases (53, 88%). Over half had previously been diagnosed with mental health problems by a GP, most commonly depression. Over a third visited a GP with symptoms of emotional distress within a year of the homicide-suicide, 15 (28%) within a month of the incident. A quarter (14, 26%) had previously been under the care of mental health services, 7 (13%) within a year of the offence. A quarter of the perpetrators had previously attempted suicide (14, 26%). Over a third had a history of domestic violence (22, 39%), 3 had previously been convicted of homicide.

**Conclusion**

Prevention is difficult in these cases. Despite symptoms of emotional distress and mental disorder being common, two-thirds did not seek help from a GP or mental health professional before the incident. Although GP’s cannot be expected to prevent homicide-suicide specifically, they can treat depression and recognise the risks associated with previous domestic violence.

3) Mental disorder, vulnerability and substance misuse in police custody: Results from the Health Screening of People in Police Custody (HELP-PC) project – phase 3

Main presenter: Dr Iain McKinnon

Co-authors: Dr Samir Srivastava, Dr Gurpreet Kaler & Professor Don Grubin

**Mental disorder, vulnerability and substance misuse in police custody. Results from the Health Screening of People in Police Custody (HELP-PC) project – phase 3.**

Dr Iain McKinnon, NIHR Doctoral Research Fellow, Institute of Neuroscience, Newcastle University; Dr Samir Srivastava, Consultant in Forensic Psychiatry, South London and Maudsley NHS Foundation Trust; Dr Gurpreet Kaler, Speciality Doctor, Northumberland Tyne and Wear NHS Foundation Trust; Professor Don Grubin, Professor of Forensic Psychiatry/Hon Consultant Forensic Psychiatrist, Institute of Neuroscience, Newcastle University/Northumberland Tyne and Wear NHS Foundation Trust

**Background**

Our previous work demonstrated deficiencies in screening for mental disorders and substance misuse among police custody detainees. Given recent developments in custody health care, concerns about deaths in custody, and statutory welfare responsibilities of police sergeants, improved first stage screening is required.

**Aims**

Develop and evaluate a novel health screening tool for custody officers within custody suites.

**Methods**

The screen was developed based upon extant screening tools and data from prior phases of our work. It was developed in conjunction with the Metropolitan Police’s custody and medical directorates along with focus groups of custody sergeants. We piloted the screen in one police station in London.

Once screened by the police sergeant, consecutive detainees were approached to take part in our semi-structured clinical research interview. The screen was compared to clinical opinion.

We tested the null hypothesis that there was no difference between the new screen and the standard police screen. We assessed efficacy in the following morbidity areas:

- Serious Mental Illness, Intellectual Disability and other mental health conditions
- Individuals who need to have an appropriate adult present during police interview
- Problematic Drug Misuse and risk of withdrawal
- Risk of Alcohol Withdrawal Syndrome
- Active suicidal ideation.

**Results**

During a three month pilot in 2012, data from 351 detainees were analysed.

The new screen detected 93% of psychotic disorders, 75% of detainees with major depression and 83%
of those with suspected Intellectual Disability. These results represent improvements in sensitivity compared to the standard custody health screen. Appropriate Adults were called in almost 60% of detainees with psychosis compared to only one-third with the previous screen.

76% of those at risk of alcohol withdrawal syndrome were detected compared to 48% previously. There were non-significant improvements in the detection of those at risk of heroin withdrawal and a small worsening in the detection of those at risk of crack cocaine withdrawal.

Using enhanced detection criteria 77% of those with active suicide risk were detected compared to less than 48% with the standard screen.

Discussion
It is possible to improve the detection of mental disorders by police custody officers, using a structured screening tool. Improvements in both sensitivity and specificity compared to the previous screen resulted in no increase in workload for the HCP. Having shown its potential, we recommend implementation and a wider evaluation of the new screen, ideally a clinical trial of the intervention.

4) Are psychotic symptoms associated with violence in schizophrenia? The mismatch between research evidence and clinical impressions
Main presenter: Dr Clare Oakley
Co-authors: Miss Stephanie Harris, Professor Tom Fahy, Professor Declan Murphy & Dr Marco Picchioni

Dr Clare Oakley is a consultant forensic psychiatrist at St Andrew’s in Northampton and is undertaking research towards a PhD with St Andrew’s Academic Centre at the Institute of Psychiatry, King’s College London. Her research focuses on factors associated with violence in men with schizophrenia.

Aim
Whilst many clinicians consider that psychotic symptoms are associated with violence, robust scientific evidence remains elusive. The VISA study considers factors associated with violent behaviour among men with schizophrenia, this component specifically sought to consider patients’ and professionals’ reporting of psychotic symptoms at the time of a violent offence.

Method
Male patients with schizophrenia with a range of histories of violence were recruited from secure psychiatric units and community mental health teams. Diagnoses of schizophrenia were established using the SCID. Information about violent behaviour was obtained by self-report and from medical notes.

Results
Of the 54 patients recruited, 35 had committed a violent offence. Thirteen of these 35 patients reported psychotic symptoms at the time of their violent behaviour, which was consistent with information recorded in their notes. A further 14 patients were deemed by professionals to be psychotic at the time of their violent offence but this was not reported by the patient. Eight patients were not psychotic at the material time according to either source. The most common symptom reported by both patients (8 of 13) and professionals (19 of 27) was persecutory delusions. Auditory hallucinations were more frequently recorded in the notes than reported by patients. Other psychotic symptoms were both uncommonly recorded, and reported.

Conclusion
Patients and professionals report a close relationship between the violent offence and psychotic symptoms. Despite the inconsistent research evidence supporting an association between persecutory delusions and violence, this work suggests that in clinical practice they are commonly considered to be linked. More professionals than patients report psychotic symptoms which could be due to limited insight.

5) Predictors of abscondion in a forensic psychiatry inpatient sample: A prospective study
Main presenter: Alexis Cullen
Co-authors: Amelia Jewell, Dr John Tully, Dr Suzanne Coghlan, Kimberlie Dean & Professor Tom Fahy

Alexis Cullen is a researcher at the Institute of Psychiatry who has recently completed her PhD examining stress and HPA axis function among children at elevated risk for schizophrenia. Her research interests include identification of young people at increased risk for psychosis and the study of forensic psychiatric populations. She has previously published several studies evaluating cognitive-based treatments for mentally disordered offenders.
Background: Whilst abscondion incidents in forensic secure units are rare, such incidents can have potentially serious consequences and invariably attract media attention. However, surprisingly little research has been conducted to examine predictors of abscondion in forensic settings. The few previous studies conducted to date have employed retrospective designs, and no attempt has been made to develop a risk assessment scale to identify those who are more likely to abscond. In this prospective study, we aimed to identify predictors of abscondion over a two-year period and explore the extent to which these factors could be used to develop a brief risk assessment scale.

Methods: The sample comprised all patients receiving treatment within forensic psychiatric wards in the South London and Maudsley NHS Trust within a two-week period (N=135). At baseline, demographic, clinical, and forensic factors were ascertained from electronic medical records and the treating teams. Incidents of abscondion, defined as failure to return from leave, incidents of escape (attempted and actual), and absconding whilst on escorted leave, occurring during the two-year follow-up period were identified via electronic medical records. Logistic regression analyses were used to determine the strongest predictors of abscondion which were then weighted according to their ability to discriminate absconders and non-absconders. The predictive utility of a brief risk assessment scale based on these weighted items was evaluated using receiver operator characteristics (ROC).

Results: During the two-year follow-up period, 27 patients (20%) absconded. Six factors were significantly associated with abscondion in univariate analyses: inpatient verbal aggression, suspected psychopathy, previous abscondion, history of sexual offending, non-violent index offence, and inpatient substance use (p<0.05). Multivariate logistic regression analyses indicated that non-violent index offence and inpatient substance use did not significantly improve prediction and were dropped from the final model. The predictive ability of a weighted risk scale derived from the four remaining variables was found to be moderate-to-good (ROC area under the curve: 0.80).

Conclusion: In the first prospective study in a forensic inpatient setting, we demonstrate that it is possible to derive a brief abscondion risk assessment scale with adequate predictive ability. Validation of these items in a larger independent sample is needed.

Can Psychodynamic Perspectives on Murder inform Risk Assessment?
Facilitators: Dr Ronald Doctor, Dr Andrew Williams & Dr Gabriel Kirtchuk

Dr Ronald Doctor is a Consultant Psychiatrist in Forensic Psychotherapy. He has edited two books;
1) Dangerous Patient: psychodynamic approach to risk assessment
2) Murder: a psychotherapeutic investigation

Fear of being killed or killing: a conundrum in Forensic Psychiatry
The fear of death is a very compelling and potent feeling that may evoke gross conscious and unconscious acting out behavior, both in the patient and staff. In this workshop we will describe three clinical vignettes to show the enormous challenges facing the patient and staff in dealing with the fear of annihilation. The West London Generic and Forensic Psychotherapy Services see patients for consultation and in this workshop we will discuss patients who have killed another person. Murder occurs concretely in most cases when it has been committed many times previously in daydreams, nightmares and sometimes in unconscious fantasy. Before the deed, conscious and unconscious efforts, such as psychosis and sadomasochism, are designed and devoted to keeping the murder encapsulation from action. Then something takes place internally, usually the fear of death, which breaks loose the murderousness from its cordoned off status, and all the energies of the individual becomes devoted to enacting the murderous deed. The function of the analytic process is to follow the chains of associations as manifested and enacted in the transference and counter-transference to construct the narrative of their history. However when the fear of death occurs in one’s own counter-transference feelings, especially in the community, beyond the secure settings of Forensic Psychiatry, massive acting out may occur to counter one’s own threat of death.

This workshop will begin with a presentation of both theory and brief clinical material from three patients to support the theory, which will be followed by an interactive discussion between the audience and the presenters.

The educational goals of the workshop:
- To gain an understanding of the psychodynamics of murder, risk and acting out behavior.
- To learn about the use of the counter transference in risk assessment and management

Dr Andrew Williams is a Consultant Psychiatrist in Forensic Psychotherapy at the Portman Clinic, Tavistock and Portman NHS Foundation Trust. He is co-editor of a new book: "Forensic Group Psychotherapy: The Portman Clinic Approach" (Karnac, 2014)
Long-term detention and seclusion in forensic-psychiatric care

Dr Vivek Furtado, Dr Jennifer Kilcoyne, Professor Peter Bartlett, Dr Birgit Vollm, Danny Angus, Dr Ben Johnson & Dr Elisabeth Hansen

**Dr Birgit Vollm** is Clinical Associate Professor in Forensic Psychiatry and an Honorary Consultant Forensic Psychiatrist in the Peaks Unit (Dangerous & Severe Personality Disorder Unit) at Rampton Hospital. After studying medicine in Germany and working in psychiatry and neurology in Switzerland and Germany, she came to Oxford in 1999 where she completed her basic psychiatric training. She then moved to Manchester to complete her specialist training in forensic psychiatry and her PhD "neurobiology of impulsivity and social cognition in antisocial individuals" as a Walport Academic Clinical Lecturer. She has been in Nottingham since 2008. Her main research interests include the neurobiology of antisocial personality disorders and social cognition, treatment of personality disorders and comparison between service delivery in different European countries. She is the Chair of the Forensic Section of the European Psychiatric Association. She is on the editorial board of Recht & Psychiatry (Law & Psychiatry), the Open Criminology Journal and Current Drug Therapy. She is PI to the NIHR-SDO funded grant looking at long term care in high and medium secure forensic psychiatric settings.

**Dr Vivek Furtado** is an Academic Clinical Fellow and Specialist Registrar in Forensic Psychiatry at the University of Nottingham and Nottinghamshire Healthcare NHS Trust. He completed his basic psychiatric and higher training in Old Age Psychiatry in Leeds prior to taking up his current appointment. He is currently completing his PhD which focuses on lengths of stay in high secure hospitals in England and Wales. He is co-applicant to the NIHR funded grant into long term care in secure psychiatric settings.

Following two degrees in philosophy at the University of Toronto, **Peter Bartlett** read law at Osgoode Hall Law School of York University, Canada. After his call to the bar in 1988, he served as Law Clerk to the Justice of the Ontario High Court and then as research associate to the Ontario Enquiry on Mental Competency. He obtained his doctorate in 1993, and joined the School of Law at the University of Nottingham, where in April 2005 he was appointed to the Nottinghamshire Healthcare NHS Trust Chair in Mental Health Law. Professor Bartlett's research interests are primarily in the area of mental disability (including both psycho-social disability/mental illness and learning disability), in both in England and Wales and internationally. He has provided advice regarding law reform in Lesotho and Bosnia and Herzegovina, and for six years (four as chair) served on the board of the Mental Disability Advocacy Center (MDAC), a human rights organisation based in Budapest. His research interests include the Mental Health Act 1983 (England and Wales), the Mental Capacity Act 2005 (England and Wales), and the European Convention on Human Rights and the UN Convention on the Rights of Persons with Disabilities. He is also interested in the history of law and psychiatry, particularly in England.

- Dr Birgit Vollm – will speak about the need of a long term secure forensic service in high and medium secure psychiatric setting, research conducted till date from national and international literature about length of stay and possible factors influencing length of stay and how other European countries have responded to this need.
- Dr Vivek Furtado – will speak about length of stay in of patients in forensic psychiatric settings in England in high and medium secure settings using a cross sectional survey methodology and preliminary results on factors influencing length of stay.
- Dr Peter Bartlett – will talk about the ethical and legal challenges in considering the implementation of a long stay unit in the UK.

**Dr Elisabeth Hansen**, BSc (Hons), D.Clin.Psychol, CPsychol, is a Principal Clinical Psychologist at the Beacon Unit, HMP Garth, is a Registered Practitioner Psychologist with the Health and Care Professions Council (HCPC), an Accredited Cognitive Analytic Therapist (CAT) with membership of the Association for CAT and a chartered member of the British Psychological Society (BPS) and a full member of the Division Clinical Psychology. Elisabeth has worked at Ashworth Hospital for a number of years striving to help hard to reach challenging patients working collaboratively with the Positive Intervention Programme (PIP). Currently working developing a new Personality Disorder Treatment Service in HMP Garth

**Dr Ben Johnson** is a Consultant Psychiatrist who has worked with mentally disordered offenders for a number of years and holds a Masters Degree in Medical Ethics and a First Class Law Degree. Currently working as medical lead on the Positive Intervention Programme (PIP) at Ashworth Hospital and is a member of the regional Research Ethics committee at Ashworth Hospital, High Secure Services.

Facilitators:

**Danny Angus** is a psychiatric nurse (RMNH) and Team Leader of the Positive Intervention Programme (PIP) at Ashworth Hospital, High Secure Services. Danny has a number of years experience working with violent offenders in Ashworth Hospital, both as a nurse but for the last six years working with seclusion developing expertise in managing violence and aggression. Specialising in the safe management of
complex challenging mentally ill and personality disordered offenders whose risk is considered so grave that they are detained in long-term segregation. Skills in managing violence and aggression are paramount and he is responsible for training and supporting other staff in facing the challenges that this patient group presents.

**Dr Jennifer Kilcoyne**, (BSc Hons, M.Med.Sci and D.Clin Psychol) is a Lead Consultant Clinical Psychologist for the Ward Interventions and Admissions Service at Ashworth High Secure Hospital. Currently working as the psychological lead for the Positive Intervention Programme (PIP) Service and with high dependency patients in the Personality Disorder Service.

**The session will include:**
- A short presentation about current thinking on seclusion and segregation and its effects.
- An interactive case study of a patient from High Secure Services /or clinical examples from participants own services.
- Presentation of a model of care developed from qualitative research into what factors progress patients out of segregation.
- A short presentation about the Positive Intervention Programme who are a dedicated team of practitioners who work with segregation patients.

**Goals of session:**
- To provide an opportunity to reflect upon current practice and the model of care developed from literature, practice and research.
- To reflect upon the challenges and progress interfering barriers to ending segregation with an opportunity to apply this to a case.
- To consider the applications of the model in clinical practice with segregation patients.
- To share information about innovative practice with this hard to reach group of patients.

**Veterans, Violence and Victims - what every Forensic Psychiatrist should know about military service and its consequences**
Facilitator: Professor Neil Greenberg and Dr Deirdre MacManus

**Professor Neil Greenberg** is an academic psychiatrist based at King’s College London UK and is a consultant occupational and forensic psychiatrist. Neil served in the United Kingdom Armed Forces for more than 23 years and has deployed, as a psychiatrist and researcher, to a number of hostile environments including Afghanistan and Iraq.

Neil has published more than 150 scientific papers and book. He is also the president-elect of the UK Psychological Trauma Society and the Royal College of Psychiatrists’ Lead for Military and Veterans Health.

**Dr Deirdre MacManus** is a Consultant Forensic Psychiatrist and Senior Clinical Lecturer at King's College London. She is Clinical Lead for the London Veteran Trauma Service as well as Consultant Forensic Psychiatrist for HMP Thameside. Her specialist research interest is trauma and violent offending and her research to date has explored this within military populations. She has published and presented on this topic at an international level. She will discuss offending among veterans in general and present some of her own research findings before going on to discuss violence risk assessment of and management options for serving and ex-serving military personnel.

**Psychiatry, leadership and medical education – same, same but different**
Facilitators: Dr Dominic Johnson & Dr Fiona Mason

**Dr Dominic Johnson** started his career in dentistry graduating from Newcastle University with BDS (Hons.) in 1996 and then FDSRCS(Ed) in 1999. He graduated in medicine at Newcastle with Distinction in 2002 after which he took his higher training in Forensic Psychiatry at the Maudsley Hospital. He was selected to take part in a leadership talent management programme within NHS London and worked as Consultant Forensic Psychiatrist in London for 18 months. He was appointed as a Clinical Senior Lecturer for NUMED Malaysia in June 2011 and then Dean of Clinical Affairs in October 2012. Within forensic psychiatry, he has an interest in psychodynamic psychotherapy and personality disorder.

**Morbidity & Mortality in Forensic Psychiatry**
Dr Marco Picchioni, Dr Lade Smith, Dr Fiona Gaughran, Dr Paula Murphy

*Abstract not available at time of publication*

a) Payment by Results (PbR): Allocating patients to Forensic Pathways and the influence of
service development
Facilitators: Dr Elizabeth Artingstall, Dr Josanne Holloway, Dr Sodi Mann

b) Low Secure Clinical Reference Group (CRG): Outcomes from the first year
Facilitator: Dr Paul Gilluley & Dr Shyamal Mashru

Abstract not available at time of publication

MAPPA in practice: An overview of the new RCPsych MAPPA guidance and case based discussion
Facilitators: Dr Richard Taylor, Dr Jessica Yakeley & Dr Don Grubin

Richard Taylor is a Consultant Forensic Psychiatrist working in medium security at the North London Forensic Service. He is a member of the London Strategic Management Board for Multi Agency Public Protection Arrangements. He has an interest in the ethics and practice of information sharing and confidentiality.

16:00-17:30
SESSION 8: 7 PARALLEL WORKSHOPS

Mental health need and service innovations within police custody
Facilitator: Dr Jane Senior, Miss Heather Noga, Dr Iain McKinnon and Professor Jenny Shaw

Dr Jane Senior is an experienced mental health nurse and researcher. Her main areas of interest are prison based mental healthcare, which was the subject of her Doctorate; mental health liaison and diversion services and other early intervention opportunities for people in contact with the criminal justice system; and the dynamics of multi-agency partnerships. Jane manages the Offender Health Research Network, based at the University of Manchester and is a member of the NHS England Health and Justice Clinical Reference Group.

Heather Noga is a researcher at the Offender Health Research Network in the University of Manchester. Her background is in the Sociology of Mental Health and International Criminal Justice. Her research interests include criminal justice, human rights, and offender mental health. She recently completed a Research for Patient Benefit funded project which aimed to improve the identification of mental health problems for people in contact with the police by developing a referral decision tool for use by non-mental health trained personnel.

Format:
We will facilitate an interactive workshop comprising presentations, audience questions and debate and panel discussion.

Educational goals:
1) Identification of the prevalence of mental health needs in police detainees and their service needs;
2) Identification and critical appreciation of the barriers and facilitators to care in a non-clinical setting;
3) Critical appraisal of the barriers and facilitators to multi-agency partnerships and interdisciplinary working at the interface of health and criminal justice systems; and
4) Development of problem solving strategies to ensure a whole systems approach to achieve continuity of care for a morbid and vulnerable population.

Presentation 1: Liaison and diversion services in England: who, what, when and why?
Professor Jenny Shaw will present the findings from a year’s data collection undertaken across 38 liaison and diversion services in England identifying mental health, substance abuse and social exclusion problems in people detained in police custody. The data will describe the client group currently being targeted by these services, making recommendations for improved models of service delivery and better identification of need.

Presentation 2: The role of the police in early identification: skills and systems
Miss Heather Noga will present the findings of a project funded by the National Institute for Health Research (NIHR) which aimed to identify the training needs of police officers dealing with people with suspected mental health problems, equipping them with skills for early identification and sign-posting clients into appropriate clinical services.

Presentation 3: Health Screening of People in Police Custody (HELP-PC): Barriers to effective
health screening in police custody
Dr Iain McKinnon will examine the barriers to effective screening within the custody environment, reporting findings from his NIHR-funded Fellowship. Using an ethnographic approach, a number of themes were identified that were perceived to have an impact upon effective screening. These included issues pertaining to the environment and culture within custody, incumbent processes, changes in roles, interdisciplinary conflicts, and the suitability of custody for the management of vulnerable people in a custody suite. We discuss how these themes are likely to impact upon screening and the delivery of health services within the custody environment, and how these might influence the development of custody healthcare services.

Presentation 4: Information sharing between health and criminal justice agencies: using technology to fill the gaps
Dr Jane Senior will report the lessons learnt from an NIHR funded pilot that developed the MAIS system: an e-health, internet based platform for sharing key mental health and risk information regarding police detainees. The ethics and governance issues arising from such a system will be discussed from the perspectives of service users, clinicians and criminal justice personnel along with our plans for future implementation and evaluation.

Core values and service responses: Common ground and differences in forensic mental health provision in European Union countries
Facilitators: Professor Pamela J Taylor, Alice Cassels-Barker, Paul Gilluley, Elisabeth Holliday, Ellen van Lier

Paraphilias and personality disorder – are they linked?
Facilitator: Dr Jessica Yakeley, Dr Rob Hale & Mr Stan Ruszczynski

Jessica Yakeley is a Consultant Psychiatrist in Forensic Psychotherapy at the Portman Clinic and Director of Medical Education and Associate Medical Director, Tavistock and Portman NHS Foundation Trust. She is also a Fellow of the British Psychoanalytic Society. She has published widely on topics including medical education, violence, risk assessment, MAPPA, prison health, paraphilias, and antisocial personality disorder, and is Editor of the journal Psychoanalytic Psychotherapy. She is currently leading the national development of new services for a multi-site randomised-controlled trial of mentalisation-based treatment for antisocial personality disorder as part of the National Personality Disorder Offender Pathways Strategy.

In this session we will present our research on the prevalence of personality disorders in men referred for the treatment of paraphilias at the Portman Clinic in London. Paraphilias occupy an uneasy place within psychiatric diagnostic classification, and service provision for both legal and illegal paraphilic disorders, remains limited and is at risk of being further reduced due to the changes in commissioning of mental health services.

The workshop will involve a PowerPoint presentation followed by the presentation of clinical material and then discussion. In our presentation we will briefly summarise the nosological history of the concept of paraphilia in the context of the recent publication of DSM-V, critiquing the focus on overt sexual symptomatology whilst neglecting personality pathology. We will then present the preliminary results of an on-going outcome research study at the Portman Clinic: the personality disorder profile as diagnosed by the Shedler-Westen Assessment Procedure (SWAP-200; Westen & Shedler 1999), a clinician-rated assessment measure of personality disorders, on over 100 patients referred to the clinic with a variety of paraphilias.

Research on the co-morbidity of paraphilias and personality disorders has focused on antisocial personality disorder and psychopathy in the context of risk assessment. However, our results suggest a high incidence of cluster A (schizoid) and cluster C personality disorder (dependent and avoidant) diagnoses in our samples.

We will then outline how we conceptualise paraphilic and abnormal sexual behaviour and personality disturbance from a psychodynamic perspective, and how this informs our treatment approach, illustrated by a detailed case example on the individual treatment of a man with paedophilia.

Educational goals:
- Critique of DSM-V criteria for paraphilias
- Review of the existing literature on the relationship between paraphilias and personality disorder
- Introduce a psychodynamic approach to the diagnosis and treatment of patients with paraphilias.

Death Row Documentaries: Into the abyss with Werner Herzog
Facilitator: Dr John Tully & Professor Tom Fahy
Werner Herzog is a German film director, producer, screenwriter, and actor. He is considered one of the greatest figures in modern cinema. His films often feature heroes with impossible dreams, people with unique talents in obscure fields, or individuals who are in conflict with nature.

"The most important film director alive"
Francois Truffaut

"Herzog has never created a single film that is compromised, shameful, made for pragmatic reasons or uninteresting. Even his failures are spectacular"
Roger Ebert

In 2011, Herzog directed the documentary film ‘Into the Abyss’, about two men convicted of a triple homicide which occurred in Conroe Texas. He followed this with four hour-long documentaries about other condemned prisoners entitled ‘On Death Row’ (2012).

In this workshop we will follow Herzog into the abyss and examine the powerful themes raised in these films, particularly those relevant to forensic psychiatry.

**New research in violence risk assessment**
Facilitators: Dr Seena Fazel, Dr Alec Buchanan & Professor Lindsay Thomson

Dr Seena Fazel is a Wellcome Trust senior research fellow in clinical science at the University of Oxford, and an honorary consultant forensic psychiatrist. His research work focuses on relationships between severe mental illness and violent crime, violence risk assessment, and the mental health and suicide risk of prisoners. He has given evidence to the UK Government Justice Select Committee and the UN-backed Khmer Rouge war crimes tribunal. He is currently an Associate Editor for the Journal of Forensic Psychiatry and Psychology and BMC International Health and Human Rights.

This symposium will present three new pieces of work on violence risk assessment. The first, presented by Seena Fazel, will outline the findings of a new systematic review examining whether there is an authorship bias in risk assessment, namely whether the predictive accuracy findings published by teams that can include an author or translator of a particular risk assessment tool are different to those conducted by independent research groups. It also examines the nature of potential conflict of interest disclosures in published literature. It concludes with some recommendations to clinicians and researchers about how to interpret individual research studies, and the routine registration of research studies. The second paper, presented by Alec Buchanan, reports the results of another review of violence risk assessment studies. This study sought to answer two questions: a) how much variation is there in rates of violence in groups identified as "high risk" by structured risk assessment instruments and b) what are the sources of that variation? The results showed that annual rates of violence in individuals classified as high risk varied both across and within all of the instruments reviewed. Rates were elevated when population rates of violence were higher, when a structured professional judgment (as opposed to actuarial) instrument was used, and when there was a lower proportion of men in a study. Assigning predetermined probabilities for future violence on the basis of an individual’s structured risk assessment is not supported by the current evidence base. The third paper, presented by Lindsay Thomson, will describe the successful implementation of a formal violence risk assessment and management strategy within a high secure forensic care facility. The aim of the implementation was to ensure that each patient had a formal violence risk assessment and management plan that was shared and applied to clinical practice by the patient’s clinical team. The process as a whole, from risk assessment to risk management including appropriate care and treatment documentation is outlined. In this way, the difficulties and problems encountered within the organisational reality of implementation projects will be described. Suggestions and recommendations on how to avoid and manage these will be made. The presentation will further describe the outcome of the risk management project in terms of the results of risk assessment and reduction in violent incidents.

London Pathways Partnership for High Risk of high Harm Offenders and the Primrose Service; working with high risk personality disordered women
Facilitators: Dr Chantal Scaillet, Dr Celia Taylor, Dr Samir Srivastava & Dr Ranjit Kini

Dr Samir Srivastava is a Consultant in forensic psychiatry working in the South London and Maudsley NHS Foundation Trust. He currently works in the offender health service line and is the lead for the Criminal Justice Mental Health Service.

Between August 2012 – August 2013 he worked at the Primrose Service, assessing and treating high risk personality disordered women as part of a multi-disciplinary team including prison officers, with Dr Abebe
Ejara and Primrose lead, Dr Ranjit Kini. This is a unique service where the assessment and treatment for high risk offenders is based within HMP Low Newton, Durham.

**Your Report is your Script in Court: Make it Factual not Farcical**
Facilitators: Ashley Irons, Aideen O’Halloran, David Reiss, Tom Clark & Jo Dow
Abstract not available at time of publication
**Friday 7 March**

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<tr>
<th>Time</th>
<th>SESSION 9 &amp; 10: Skills Master Classes</th>
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<td>09:00-10:30 &amp; 11:00-12:30</td>
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**Medico-legal skills update**
Professor Tom Fahy, Dr Tim Exworthy, Professor Harry Kennedy, Mr Donal Lunny (barrister)

Professor Fahy will present two homicide cases from Northern Ireland. These cases will provide the basis for a discussion on report writing in forensic psychiatry, with an emphasis on difficult Diminished Responsibility cases. Dr Exworthy and Professor Kennedy will discuss aspects of the law applied to psychiatric defences in homicide, with an emphasis on recent developments in the area. Guidance will be offered on achieving excellence in report writing. Critical comments may be offered on the reports presented by Professor Fahy. Mr Lunny will discuss medical expert reports from the perspective of an experienced barrister.

**Risk management and formulation**
Dr Caroline Logan and Dr Michael Doyle

*Caroline Logan* is Lead Consultant Forensic Clinical Psychologist in Greater Manchester West Mental Health NHS Foundation Trust as well as an Honorary Research Fellow in the Institute of Brain Behaviour and Mental Health at the University of Manchester. She has worked in forensic settings for almost 20 years, working directly with clients who are at risk to themselves and others and, in a consultancy role, with the multidisciplinary teams and local and national organisations that look after and manage them. She is a former Board Member of the Scottish Risk Management Authority, the DSPD Programme Expert Advisory Group, and the Project Board of Resettle, the Merseyside clinical risk and case management service for high risk offenders. She is currently a member of the Advisory Panel for the Close Supervision Centres and Managing Challenging Behaviour Strategy in the HMPS Directorate of High Security. She is a co-author of the *Risk for Sexual Violence Protocol*, a structured professional judgement approach to sexual violence risk assessment and management, and a co-author of the 2007/9 Department of Health guidelines *Best Practice in Managing Risk in Mental Health Services*. Dr Logan has research interests in the areas of personality disorder, psychopathy, and risk, and a special interest in gender issues in offending, on which she has published two books and many articles.

**Memory, cognition and offending behaviour**

- **Introduction and amnesia for offences**
  Professor Michael Kopelman
  *Abstract not available at time of publication*

- **Symptom Validity Testing**
  Dr Joanna Iddon
  *Abstract not available at time of publication*

- **Assessment of memories for child sexual abuse and false memory**
  Professor Bernice Andrew

*Bernice Andrew* is an Emeritus Professor of Abnormal Psychology at Royal Holloway University of London. Her research has included recovered memories in therapy, the nature of sexual abuse victims' memories, PTSD in violent crime victims, and delayed-onset PTSD in military veterans and has published extensively in these areas. She is an expert advisor to the National Crime Agency (formerly SOCA) and is frequently called upon to provide expert witness testimony in legal cases involving memory for traumatic events. She was a member of the British Psychological Society’s Working Party on Recovered Memories, and provided advice on this subject to the Department of Health, and Broadmoor Hospital.

**Bipolar Disorder: All you need to know**
Professor Nicol Ferrier and Dr Daniel Smith

*Nicol Ferrier* is Professor of Psychiatry at Newcastle University and Honorary Consultant Psychiatrist for Northumberland Tyne and Wear NHS Trust.

Professor Ferrier works in a clinical capacity for the Regional Affective Disorders Service. His research interests are in psychopharmacology and the neurobiology and treatment of severe affective disorders. He has published over 200 papers on these topics.
Professor Ferrier was the pharmacological lead on the NICE Guidelines for Unipolar Depression and was Chairman of the NICE Bipolar Disorder Guideline. He has served on the MRC Clinical Fellowship and Wellcome Trust Neuroscience and Mental Health Grant Committees. He is head of the North East Hub of the Mental Health Research Network and is Past-President of the British Association for Psychopharmacology.

Daniel Smith is reader in psychiatry at the University of Glasgow. He has a longstanding clinical and research interest in the diagnosis, classification and treatment of bipolar disorder and more recently has been developing a programme of work on the interface between major mental illness and medical comorbidity.

Although this is an ambitious (some would say grandiose) title for a workshop, we hope to be able to provide an up-to-date summary of recent research and clinical developments in the field of bipolar disorder. This will include developments in diagnosis, cognition, aetiology, pathophysiology, treatment and the interface with other psychiatric and non-psychiatric disorders. The workshop will be interactive and there will be an opportunity to discuss bipolar disorder in the context of forensic psychiatry.

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<td>SESSION 11: Modern challenges for psychiatry in the 21st Century</td>
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<td>Chair: Dr Deirdre MacManus</td>
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13:30
**Tackling terrorism as preventive psychiatry**
Lord Alderdice

*Abstract not available at time of publication*

14:10
**Life after paramilitary imprisonment**
Dr Adrian Grounds

*Abstract not available at time of publication*
Factors affecting length of stay in high secure services (HSS): implications for clustering
Amlan Basu, Consultant Forensic psychiatrist; Gwen Adshead, Consultant Forensic Psychotherapist; Fin Larkin, Consultant forensic psychiatrist; James Tapp, PhD, Research psychologist and therapist

Background
The use of Payment by Results as a model for budget management in health care has led to the development of a ‘clustering’ system for defining the care need of different patient groups. Forensic services are high –cost low volume services because they provide long term residential care in accommodation which has specific security requirements. Reductions in length of stay (LoS) are a key quality indicator in the NHS, including secure services, but little is known about the factors the lead to extended (and therefore expensive) stays in HSS.

Method
A retrospective analysis of data already collected for service evaluation purposes; including a comparison of extended stay patients (10 years +) and short stay patients (5 years -) on a range of factors.

Outcomes
This is work in progress. We anticipate that there will be significant differences between groups of HSS patients in terms of LoS; and significant difference between the long-stayers and the shorter stayers in relation to diagnosis, index offence and engagement with therapy. We discuss the implications for clustering and suggest that HSS may need its own clustering system to properly budget for the care needs of the service users. We also discuss the ethical issues that arise when length of stay appears to be influenced by factors that cannot be changed with treatment.

Implementing MAPPA Guidance in a Medium Secure Setting
Dr Elizabeth Artingstall, ST6 Forensic Psychiatry; Dr Gillian Holt, Consultant Forensic Psychiatrist and Natalie Conroy, Secure Division Mersey Care NHS Trust

Introduction
Multi-Agency Public Protection Arrangements (MAPPA) in England and Wales require local criminal justice agencies and health care services to work together to protect the public from serious harm by sexual and violent offenders. All MAPPA-eligible offenders should be identified within three days of sentence or admission to hospital.1

MAPPA offenders are managed at one of three levels according to the extent of agency involvement needed. The great majority of offenders are managed at level 1; this involves the sharing of information but does not require multi-agency meetings. If in hospital, most reviews for offenders managed at level 1 are the responsibility of the health care service. Local guidance is that level 1 MAPPA reviews should occur every 3 months.2,3

Upon admission to hospital, it is recommended that a designated member of the care team should be nominated as responsible for: ensuring that the offender is marked as MAPPA-eligible on the internal management system; and completing the appropriate notification form and sending it to the MAPPA Coordinator.1

In the recent public inquiry into the Mid Staffordshire NHS Foundation Trust, a failure of communication between and within organisations was identified as a major problem area.4 In order to encourage good practice and information sharing, the secure service within Mersey Care NHS Trust, developed a confidential ‘MAPPA database.’ Stored within this are key details regarding all MAPPA eligible offenders. These include: details of the offence; date of MAPPA notification; date of the previous level 1 review; and date of the next level 1 review.

Aim
We looked at the information recorded on the ‘MAPPA database’ for the inpatients and outpatients of a medium secure unit hospital in Merseyside. We wanted to establish how well notification to MAPPA is occurring, and how frequently level 1 reviews are taking place.

Results
A total of 56 service users details were recorded on the MAPPA database. MAPPA notification had been completed for all outpatients (100%) and 21 inpatients (60%). Of both inpatients and outpatients, 48 service users (84%) were MAPPA level 1 offenders. All level 1 offenders (100%) had review dates planned, and 35 of these (73%) had reviews arranged every 3 months.

Conclusion
In a large proportion of cases, MAPPA notification had been completed. Excellent practice of this was identified within the outpatient service. All inpatient and outpatient level 1 offenders had MAPPA reviews arranged, the majority of which were within the recommended 3 month period.

It would appear that the medium secure service is largely successful in notifying MAPPA and arranging level 1 reviews, however improvement is required. These results may indicate that the MAPPA process is not being fully understood and that further training, particularly within the inpatient setting, may be helpful. It may also be useful to clearly identify who is responsible for MAPPA notification.

A service evaluation of the use of Olanzapine pamoate depot in treatment resistant violent schizophrenia patients in a high secure hospital

Dr Nina Baruch CT3, Psychiatry Trainee, Oxford Health NHS Foundation Trust; Dr Amit Sharda ST5, Psychiatry Trainee Broadmoor Hospital; Dr Naomi Smith CT 3, Psychiatry Trainee, Broadmoor Hospital; Dr Tom Bajorek, ST1 Psychiatry Trainee, Berkshire Healthcare NHS Foundation Trust; Dr Fin Larkin Consultant Psychiatrist, Broadmoor Hospital; Dr Suzy Young, Consultant Psychologist and Senior Lecturer, Broadmoor Hospital; Dr Mrigendra Das Consultant Psychiatrist Broadmoor Hospital

Introduction
Oral olanzapine is well established as an effective treatment for schizophrenia. The use of olanzapine in depot form may improve compliance and reduce relapse. However, olanzapine pamoate is expensive, and is associated with post-injection syndrome. Studies of the efficacy of olanzapine depot have therefore been limited.

The patient group at Broadmoor Hospital consists of males with complex presentations. The majority have a diagnosis of schizophrenia and a high propensity for violence. Compliance is a significant problem on discharge from the high-secure setting.

The aims of this evaluation were to explore the clinical efficacy of olanzapine depot, its effect on violent behaviour and its side effects.

Methods
All patients in the hospital prescribed olanzapine pamoate were identified. Anonymised data was collected from the patients’ clinical records, incident reports and hospital medical centre records. These records were used to derive the main outcome measure, Clinical Global Improvement, and secondary outcome measures. These included seclusion hours, violence, number of incidents, side effects and metabolic parameters.

Results
Of the 8 patients with treatment resistant schizophrenia prescribed olanzapine depot, 6 showed a clinical improvement after starting the depot, with an associated decrease in violence. 7 showed a decrease in number of incidents. In 2 patients BMI increased, in 1 patient total cholesterol increased and 2 patients glucose levels increased.

Discussion
To the authors’ knowledge this is the first report to explore the efficacy of olanzapine pamoate in the high-secure setting.

The majority of patients showed clinical improvement in symptoms, with an associated decrease in violent behaviour and number of incidents. In some cases the reduction in violence was marked, and exceeded symptom improvement. The reduction in violence may have been secondary to symptomatic improvement; however 2 patients did not have active psychotic symptoms. It is therefore a possibility that olanzapine may have a direct anti-aggressive effect. Olanzapine is structurally related to clozapine which has been reported to have an anti-aggressive effect. This is an important area for further work.

This was a retrospective, pragmatic evaluation. No control group was used and this study design does not rule out that other factors may underlie the findings. However, the naturalistic design allows consideration of clinically significant outcomes.
Forensic patients present a high level of risk and have poor compliance. Often, therefore, clozapine is not a viable treatment option. A depot medication that reduces violent behaviour might help facilitate discharge and shorter care pathway from high secure services.

**Clinicians’ descriptions of the phenomenon of “gate fever”: Clarifying the concept**

*Dr Vinaya Bhagat*, Consultant Forensic Psychiatrist, Leeds and York Partnership Foundation Trust; *Dr Nishant Bhagat*, Consultant Forensic Psychiatrist, Humber NHS Trust; *Dr Lindsay Jones*, Consultant Clinical Psychologist, Leeds and York Partnership Foundation Trust; *Ms Christina MacDonald*, Trainee Psychologist for Northumberland, Tyne, and Wear NHS Trust

**Aim**
The aim of the current study is to investigate what experienced clinicians mean when they use the term “gate fever”.

Gate fever is a common term in British prison parlance. It is a well-recognised phenomenon in which prisoners’ levels of anxiety and instability increase as they approach release. Anecdotally, staff in secure services also recognise a number of seemingly self-sabotaging behaviours that patients sometimes exhibit when they are close to discharge or a transfer to conditions of lower security, including challenging behaviours and problems in therapeutic engagement. Previous research has highlighted difficulties in the transition process between services, but has largely explored this in terms of flaws within the process itself rather than anxiety on the part of the patient or other factors.

**Methods**
We used a qualitative design using semi-structured interviews to obtain information from 8 senior clinicians on the concept of “gate fever”. The transcripts of the interviews were analysed using Thematic Analysis by two independent raters and the themes were agreed following a consensus meeting.

**Results**
5 main themes were identified relating to staff and institutional processes as well as internal patient factors. The concept was viewed as important and worthy of understanding, however some interviewees viewed the term "Gate fever" itself as being pejorative. The concept was viewed as important in terms of being a way of understanding challenging behaviours which could inform interventions and service design resulting in better outcomes for patients.

**Critique / future research**
Future planned research will explore the concept with patients in order to further understand the issues from the patients’ perspective.

Our research may have the potential to inform therapeutic strategies that will help patients return to lesser secure settings or the community more quickly, reduce the risk of becoming institutionalised and improve their quality of life.

**Forensic patient transfers to Non-psychiatric Hospitals – Can we improve the process?**

*Dr N Bhagrath* ST4 Forensic Psychiatry (BSMHFT); *Dr R Rowe* Consultant Forensic Psychiatrist (BSMHFT)

**The Physical Health Strategy Committee (Forensic Psychiatry Services, BSMHFT)**

**Aims & Background**
This is a preliminary case based study, to find whether any clear strategy exists in the forensic men’s service when patients are admitted to Non-psychiatric hospitals.

**Method**
A qualitative, retrospective, case-based study reviewing Forensic Psychiatry clinical records of five cases of urgent transfer to Non-psychiatric hospital due to acute deterioration of physical health.

**Results**
The mean duration of inpatient stay was 20.8 days. Two patients were identified to have been discharged from the Non-psychiatric Hospital with the same presentation within the previous week.

**Stage 1 - Transfer period**
In 4/5 cases, verbal and written handover occurred between psychiatry doctors and their counterpart at the non-psychiatric hospital.

**Stage 2 - On-going inpatient care**
There was in-person communication by at least 1 member of psychiatry MDT in all 5 cases with staff at non-psychiatric hospital. In 3/5 cases, a formally arranged meeting between psychiatry and non-psychiatry staff occurred. In 2/5 cases, there were in-person reviews by psychiatry OT, nurses, physiotherapists and doctors. In 1/5 cases, there was regular verbal communication with non-psychiatric hospital psychiatry liaison team involving the medical management of the patient. In 4/5 cases, psychiatry consultants attended non-psychiatric hospital to conduct patient review.

**Stage 3 - Discharge**
Written discharge notification was received in all cases which were primarily between doctors.

**Conclusions**
In all 5 cases, inadequate communication was a commonly encountered precipitant for lack of clarity regarding the issue of clinical responsibility between escorting psychiatric staff and non-psychiatry staff. Pertinent situations included assistance with medication, feeding, meeting hygiene needs, using toilet/commode and with changing clothes. Multiple interfaces emerged which potentially contributed to this lack of clarity regarding overall clinical responsibility.

**Recommendations**
1) Regular liaison between psychiatry team and their counterparts at non-psychiatry team should occur throughout patient stay.
2) Coordination with local liaison psychiatry multi-disciplinary team.
3) Upon discharge, there should be a written handover between all members of the multi-disciplinary teams and their counterparts within the psychiatry hospital.
4) Further cases need to be analysed prospectively over a 6 month period, of all cases of acute transfers from forensic psychiatric hospitals to non-psychiatric hospitals.
5) At this early stage, one can still view that ultimately the development of a clear escorting staff policy is important to establish essentially ‘who does what’ with regards to expectations of escorting staff and importantly their limitations. This should be co-developed with non-psychiatry hospital representatives to ensure seamless transition of patients between hospitals.

**Readmissions of patients treated under Section 47/49 and 48/49 remitted to prison from Broadmoor Hospital: An 11-year retrospective cohort study**
*Dr Shaun Bhattacharjee, Clinical Lead and Consultant Forensic Psychiatrist*

**Background and Aims**
There is no national guidance to assist clinicians when making decisions about remissions to prison of patients detained in hospital under Part 3 of the Mental Health Act, 1983 (amended 2007). Nor are there any nationally agreed standards to describe the minimum length of time that should elapse between remission to prison and readmission to hospital before the remission is considered to be successful.

This study aims to generate data:
- To improve clinical decision making when remitting patients from hospital to prison
- To support the development of a standard for auditing readmission rates of patients remitted to prison following treatment under Section 47/49

**Objectives**
Within the study period (2001-2011):
- To determine the number of readmissions to Broadmoor Hospital (BH) of BH patients discharged to non-custodial settings.
- To determine the number of readmissions to BH of BH patients remitted to prison following detention under Sections 47/49 and 48/49.
- To determine the time to readmission of patients discharged following detention under Sections 47/49 and 48/49.

**Methods**
The Broadmoor Hospital Admission, Discharge and Readmission (BHADR) database was examined to establish the number of discharges, returns from trial leave and readmissions.
The Ministry of Justice (MoJ) database was examined to determine whether any of the patients remitted to prison from BH following detention under Sections 48/49, 47/49 or 45A were subsequently readmitted under Sections 48/49, 47/49, 37/41 or 45A to any other hospital.

Of the patients remitted to prison from BH and subsequently readmitted to BH, the BHADR database was used to determine the date of remission to prison and the date of readmission to the hospital.

**Results**

17% of patients discharged from the hospital were either readmitted or returned from an unsuccessful period of trial leave to medium security.

Patients remitted to prison following treatment at BH under Sections 48/49 or 47/49 were significantly more likely to be readmitted than patients discharged to non-custodial settings.

The median time to readmission of Section 47/49 discharges was 12 months.

Patients remitted to prison following treatment under Section 48/49 were significantly more likely to be readmitted than patients discharged under Section 47/49 and were readmitted significantly sooner.

**Conclusions**

Clinicians should proceed with caution and ensure robust liaison with prisons when remitting patients, especially those detained under Section 48/49.

For future audits, 50% would be a reasonable standard for the 12-month readmission rate of patients remitted to prison following treatment under Section 47/49.

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**The prevalence and nature of substance misuse in a low secure forensic unit**

*Dr Holly Blair, Dr Jonathan King & Dr Adil Akram*

**Aims**

To develop a database to identify the number of forensic psychiatric inpatients who have a substance misuse problem and the nature of this abuse. To look for emerging patterns in substance misuse and index offence.

**Methods**

Patients at the Newsam Centre low secure forensic unit in Leeds completed a substance misuse screening tool on admission. This was piloted as part of routine patient care from 2009 onwards. Questions included: socio-demographics, MHA status, children’s details, patient’s perceived support network, substance misuse (type, duration, frequency and adverse outcomes), psychiatric diagnosis, physical health and reason for forensic referral. Data was anonymised and analysed for trends. Between 2009 and 2011, 143 out of 149 inpatients were screened, giving a 96% response rate.

**Results**

From a total sample (n=143), 131 had a history of substance misuse (91%). 78% male, 75% white, average age range 35 to 40 years old. Cannabis was the most commonly used substance (103 patients), followed by stimulants (n=73) and alcohol (n=53). Opiates, ecstasy and hallucinogenics had similar prevalence with between 29% and 33% of patients abusing these. Between 17% and 19% of patients abused tranquilisers, sedatives and solvents. Of the total sample 65% were polysubstance misusers. Violent index offences were recorded for 64 patients. The majority of these abused substances (n=57). Ten patients had a sexual assault index offence. Of these, six were polysubstance misusers, one abused alcohol only and three reported no substance misuse. Cannabis was the most commonly abused substance in both groups, followed by alcohol and hallucinogenics in those with a violent index offence, compared to stimulants, ecstasy and alcohol in those with a sexual assault index offence.

12 patients had arson as their index offence; seven abused cannabis, four abused stimulants and four reported no substance misuse. An acquisitive index offence (n=12) had a high correlation with polysubstance misuse (n=10). All patients who completed the substance misuse screening tool reported they smoked tobacco (n=143) and of these 28 wanted help quitting.

Substance misuse treatment had previously been given to 36% (n=54). The majority of those who had not received substance misuse treatment felt there was no link between their substance misuse and index offence (n=79), whilst over half of those who had previously received substance misuse treatment felt there was a link (n=29).
Audit of a Community Forensic Mental Health Team
Dr Philip Campbell, ST4 Forensic Psychiatry

Aims
This structure and process audit aimed to assess the model of care, working environment and governance of the Northern Trust Community Forensic Mental Health Team. The audit standards were taken for the Standards for Community Forensic Mental Health Services document recently published by the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services.

Method
The Standards for Community Forensic Mental Health were used as an audit proforma. Relevant policies and procedures were reviewed including the operational policy, Promoting Quality Care, a new referrals team discussion form and a level 3 coworking agreement. Several meetings with the team leader of the Community Forensic Mental Health Team were held to gather information on team policies. A visit to the team base was also carried out to gather information on the security of the working environment.

Results
The model of care is subdivided into core functions, forensic case management, referrals consultative advice and specialist intervention, and care pathway management from secure care. The results were as follows: 7 of 8 (89%) of criteria relating to core functions were met with 1 of 8 unmet (11%); 14 of 18 (78%) criteria relating to forensic management were met, 3 of 18 (17%) criteria were partially met and 1 of 18 (6%) were unmet; 2 of 3 (66%) criteria relating to referrals, consultative advice and specialist intervention were met with one not applicable to Northern Ireland; and 3 of 5 (60%) criteria relating to care pathway from secure care were met with 1 of 5 (20%) partially met and 1 unmet (20%). The safe working environment is subdivided into physical security, procedural security and relational security. Of physical security, 1 of 8 (13%) criteria were met, 4 of 8 (50%) were partially met, 2 of 8 (25%) were unmet and 1 of 8 (13%) was not applicable. Of procedural security 4 of 9 were met (44%), 2 of 9 (22%) were partially met and 3 of 9 (33%) were unmet. Of relational security, 15 of 16 (94%) were met and 1 of 16 (6%) was partially met. 4 of 8 (50%) of governance criteria were met, 1 of 8 (13%) was partially met and 3 of 8 (37%) were unmet.

Prevalence, assessment and determinants of aggression in a forensic psychiatric institution in Hong Kong, China
Dr Oliver Chan, Department of Forensic Psychiatry, Castle Peak Hospital, Hong Kong; Dr Kavin Kit-wan Chow, Department of Forensic Psychiatry, Castle Peak Hospital, Hong Kong

Background
In-patient aggression in forensic psychiatric setting is an under-researched subject, despite the magnitude of the problem. No studies have been conducted on the assessment of risk and the examination of the predictors of aggression in a forensic psychiatric population in the Chinese-speaking community.

Aims
To test the psychometric properties of a structured dynamic risk-assessment instrument, the Dynamic Appraisal of Situational Aggression (DASA), and to examine the prevalence and determinants of in-patient aggression in a predominantly Chinese forensic psychiatric population.

Method
A representative sample of 530 detainees consecutively admitted to the Siu Lam Psychiatric Centre, the only forensic psychiatric institution in Hong Kong, was recruited. Qualified nurses completed two risk-assessment instruments, the DASA and the Brøset Violence Checklist (BVC), once daily during the participants’ first 14 days of admission. Aggressive incidents were recorded with a standardised instrument, the revised Staff Observation Aggression Scale (SOAS-R). Sociodemographic data, mental health information and criminal background information about the participants were collected for univariate and multivariate analyses.

Results
A total of 7359 DASA ratings and 375 incidents of aggression were recorded. The prevalence of in-patient aggression was 17.7%. Internal consistency and inter-rater reliability of the DASA were good (Cronbach’s alpha = 0.862, Krippendorff’s alpha = 0.915). The predictive validity was estimated by determining the receiver operating characteristic (ROC), which yielded an area under the curve (AUC) of 0.973, sensitivity of 97%, specificity of 99% and positive and negative predictive values of 0.8 and 1.0, respectively, at a cut-off score of 3. The concurrent validity and construct validity were demonstrated by the strong
positive correlations of the DASA with the BVC and the SOAS-R. Female gender, diagnoses of personality disorder and substance-related disorder, and admission at other correctional institutions were predictors of in-patient aggression.

Conclusion
The DASA appears to be a valid and reliable risk-assessment instrument in a predominantly Chinese-speaking forensic psychiatric population. Specific groups of offenders with increased risk of aggression were identified, and this study laid the foundation for future studies on this topic.

Home Visits: A Reflection on Family Contact in Specialist Forensic Learning Disability Care
Lucinda Cheshire, Social Worker, Partnerships in Care Learning Disability Services; Verity Chester, Research Assistant, Partnerships in Care Learning Disability Services, Dr Fola Esan, Consultant Psychiatrist, Partnerships in Care Learning Disability Services and Dr Regi T Alexander Consultant Psychiatrist, Partnerships in Care Learning Disability Services

Introduction
• Inquiry reports following the Winterbourne View scandal in 2011 criticised the practice of placing hospital patients hundreds of miles from their local areas.
• There is little empirical data on how any forensic learning disability service supports family contact and home visits for their patients, whether they are out of area or otherwise.

Aims
• This baseline audit analyses the family contact and home visits made by patients within one forensic learning disability service over a 1 year period.

Methods
• A retrospective case-note audit examined the rates of home visits, home visit equivalents, and levels of family contact. Factors which affected these were recorded qualitatively for each patient. These are categorised as “service” factors, “patient-family” factors, and “forensic-behavioural” factors.
• The audit covered patient’s resident within a forensic learning disability service between January 2011 and 2012. Mileage distance was calculated between the service, patients’ family, and patients’ local authority funder.

Results
• 64 patients were included in the audit of which home visit or equivalent data was available for 61. 34 patients (56%) had at least 1 home visit (average = 1.45; range 0-11). 17 (28%) patients had four or more.
• 27 (44%) had no home visits. Reasons for this include lack of Section 17 leave (in turn affected by admission date) or behavioural issues (n = 8), offence / risk / victim specific (e.g. SOPO) (n = 6), lack of family contact (often due to risk behaviours / offence) (n = 10), distance (n = 2), and mental health presentation (n = 2). Of the 27, 9 had 2-4 home visit equivalents, 10 had no equivalents and data was lacking for 8.
• 24 families of 64 visited the patient in the hospital, whereas 40 did not. Reasons why not included there being no family, family relationship breakdowns and distance.

Discussion
• While home visits and family contact were affected by distance, what was more significant was the complexity in the relationships between patients and their families, as well as forensic restrictions.
• The mileage data highlighted some idiosyncratic issues about the definition of out of area. What was “out of area” for the funding authority, was not necessarily out of area for the patients family.
• Best practice recommendations will be made regarding the need for personalised approaches to supporting patients with their family relationships and home visits.

An Audit of the use of “As Required” Psychotropic Medication in an Intensive Psychiatric Care Unit in the West of Scotland
Dr Matthew Cordiner, CT3 Psychiatry, NHS Ayrshire and Arran Dr Partha Gangopadhyay, Consultant Forensic Psychiatrist, NHS Ayrshire and Arran

Aims
To evaluate use of as required (PRN) medication in the Intensive Psychiatric Care Unit (IPCU) at Ailsa Hospital, Ayr, which follows NHS Ayrshire and Arran protocols for tranquillisation.
Background
Occasionally it is necessary to use pharmacological means to manage a patient’s agitation or threatening behaviour. Safety is paramount, given the adverse effects of such drugs. National guidelines recommend drugs and physical monitoring regimes deemed best practice. These are adapted for use within NHS Ayrshire and Arran.

Methods
The electronic patient records system was searched for patients admitted to the IPCU at Ailsa Hospital between 1/5/12 and 31/5/13. These records were reviewed for evidence of administration of PRN sedation. For each administration: date of administration, reason for administration, drug and dose administered, administration route and also documentation of monitoring were noted, particularly for intramuscular administration. The data was collated into a spreadsheet to allow analysis - with results compared to locally defined standards.

Results
During time-period, 32 patients were admitted, resulting in 747 unique episodes of administration. Most commonly used agent was oral Lorazepam, followed by combination of oral Lorazepam and Haloperidol. One oral administration of Nitrazepam was noted for daytime sedation - all others within guidelines. 32 counts of intramuscular administration were recorded, 5mg Midazolam most frequently administered – all administrations compliant with guidelines. 13 counts of buccal Midazolam administration noted, out-with guidance. Documentation of physical monitoring following intramuscular administration poor – only 4 episodes had complete documentation. Further investigation showed monitoring was performed, but with an inconsistent approach to where it is documented.

Incidentally, a reduction in dispensing PRN medication was noted over the time period. Also noted was variation in use of PRN medications on different days of the week.

Conclusions
Most prescriptions of PRN medication complied with guidelines - aside from administration of oral Nitrazepam and buccal Midazolam. The audit noted good practice of undertaking physical monitoring post intramuscular administration, but documentation was inconsistent, perhaps due to confusion regarding best place to document (currently no guidance regarding this). Finding of variation when dispensing PRN medication leading to inconsistent approach, some staff more likely to dispense than others. Aims and effects of administration of PRN medication were often not documented. Incidental finding of reduction in administration of PRN medication requires further work to understand this trend better. Appropriate recommendations were made and audit results presented locally, instigating discussions regarding practice within IPCU. Intention will be to re-audit in six months.

Consent to Treatment and Second Opinions – An Audit of Compliance with Section 58 of the Mental Health Act across Oxford Health Forensic Directorate

Dr Robert Cornish, Dr Sophie Behrman, Dr Natalia Pervykh, Dr Mohamed Samiulla, Dr Abdul Hameed-Latif, Dr Robert Croos, Dr Orlando Trujillo, Dr Gautam Gulati – Oxford Health NHS Foundation Trust

Background
There are clear criteria within the Mental Health Act (MHA) regarding administration of medical treatment for mental disorder following the elapsing of three months since medication was first administered. In practice this involves completion of either a T2 form (certificate of consent to treatment) or a T3 form (certificate of second opinion). Best practice is that T2 forms should generally be renewed at least every 12 months and T3 forms at least every five years.

Aims
To assess how compliant all ten forensic wards within Oxford Health NHS Foundation Trust are with the requirements regarding treatment requiring consent or a second opinion.

Methods
This audit was cross-sectional, with data collected from each of the wards between the 22nd April and 2nd May 2013. Medication charts of all patients within the service were reviewed on a given date by medical staff. Information was collated regarding
1) Whether a valid T2 or T3 form has been completed
2) Whether medication prescribed was included on the T2 or T3 form
3) The length of time since completion of T2/T3 form
Results
Of 140 patients 129 were subject to Section 58 of the Mental Health Act. 126 (97.7%) had a valid T2 or T3 form. Of these 126 patients, 122 (96.8%) matched the prescribed medication. Across the directorate almost two thirds 82 (65%) of patients were treated under a T2 form, i.e. with capacity and willing to consent to treatment. The proportion of patients who were felt to lack capacity or who were unwilling to consent to treatment was higher on the acute wards compared to rehabilitation wards with an overall ratio of 2.2:1. Of the 82 patients treated under a T2, 68 (82.9%) forms had been completed within the past 12 months. Generally T3 forms had been used for longer (median 10 months, range 0-62) than T2 forms (median 4 months, range 0-46 months).

Physical assaults by forensic in-patients against staff
Dr Ranjitha Sharon David, Specialty Registrar; Dr Abebe Ejara, Consultant Forensic Psychiatrist, Roseberry Park Hospital, Middlesbrough, UK; Dr Prathish Thakkar, Consultant Forensic Psychiatrist, Roseberry Park Hospital, Middlesbrough, UK; Dr Ranjit Kini, Consultant Forensic Psychiatrist, Roseberry Park Hospital, Middlesbrough, UK

Background
Assaults against staff in secure forensic units are a frequent and serious problem. It has been stated that patients who feel that they have been physically or psychologically injured are at increased risk of committing violence against clinicians especially if their complaints have been dismissed.

The review was conducted in Ridgeway, Roseberry Park Hospital, which is a regional secure unit in Middlesbrough, England.

Method
All incidents of physical violence that had been inflicted against staff by patients in adult forensic inpatient wards between June and November 2012 were included in the review. The patients’ electronic records (PARIS) were used to obtain further information such as the diagnosis, medication, legal status of the patient under the Mental Health Act 1983 and reporting of incidents to the police.

Aims
1. To study the profiles of patients who physically assault staff and to compare the profiles of forensic in-patients who had assaulted staff between the years 2012 and 2006/2008.
2. To determine whether such assaults were reported to the police and also analyzing the outcomes of such reporting.

Results
1. There was no change in the number of physical assaults against staff between the years 2012 and 2006/2008.
2. Incident report data revealed that there were only a small minority of patients who were responsible for a disproportionately large number of assaults. Female inpatients were responsible for majority of assaults.
3. All patients that were responsible for the incidents in the review of 2012 data had a previous history of violence. Twenty three of the assaults out of forty in 2102 had been committed by patients in the 20-40 year age group.
4. Schizophrenia was the most commonly reported diagnosis among violent psychiatric inpatients. Most of the incidents (16 out of 40) in 2012 were caused by patients who had been inpatients for more than 5 years.
5. Majority of the incidents in 2012 (23/40) took place on admission wards as opposed to the treatment wards.
6. In 2012, only 6 out of 40 incidents had been reported to the police. In 2006, 4/43 and in 2008, 6/37 incidents had been reported to the police.

Discussion
Our review showed that only a small minority of the incidents had been reported to the police, which indicated a huge gap in reporting of such incidents to the police. It is possible that staff may be of the opinion that reporting could potentially damage therapeutic relationships or may feel that there may not be any real benefit from reporting. This implies that despite there being various policies and safeguards in place with regard to reporting such incidents, the number of incidents reported still remains low.
Finding the borders of Borderline Personality Disorder: A prevalence study in female offenders

Ms Frances Debell, King’s College London School of Medicine; Ms Chrissy Reeves, HMP Holloway, Offender Care Directorate, Central and North West London NHS Foundation Trust; Dr Gill McGauley; Consultant Psychiatrist in Forensic Psychotherapy, St George’s University of London and Offender Care Directorate, Central and North West London NHS Foundation Trust

Aims
The UK Government’s recent Offender Personality Disorder Pathway strategy aims to improve management of offenders with personality disorders within the Criminal Justice System. To implement the strategy effectively for female offenders, the rate of personality disorder in this population needs to be identified. However, there is a lack of recent UK-based research on the prevalence of personality disorders in female prisoners; in particular borderline personality disorder (BPD). This study had 3 aims. Firstly, to identify existing research on the prevalence of BPD in female prisoners; secondly, to devise and pilot a methodology to find the prevalence of diagnosed BPD and probable BPD in a large, representative female UK prison population and thirdly, to examine the characteristics of women identified as having diagnosed or probable BPD.

Methods
A systematic literature review was conducted to identify prevalence studies of BPD in female prisoners. A retrospective review of 432 prisoners’ healthcare records, representing 84% of all prisoners in HMP Holloway, was undertaken to identify (i) existing BPD diagnoses; (ii) evidence of BPD traits and (iii) other characteristics such as offence, detoxification needs and the presence of childhood sexual abuse.

Results
The literature search yielded 575 studies 18 of which met inclusion criteria. BPD prevalence rates in female prisoners ranged from 6.1% to 54.5%. The only relevant UK study, published in 1998, yielded a rate of 20.0%. Using a healthcare record review in HMP Holloway, we found that 10.2% (n = 44) women had a BPD diagnosis and 18.5% (n = 80) had either a BPD diagnosis or probable BPD (evidence of ≥3 BPD traits). Violent interpersonal offences were significantly over-represented in women with a BPD diagnosis compared with those without (χ² = 7.54; p = 0.01), and had a significantly higher rate in the women with either a BPD diagnosis or probable BPD diagnosis (χ² = 18.11; p = 0.00). A significant association was found between having a BPD diagnosis and requiring detoxification from both alcohol and drugs (χ² = 20.79; p = 0.00). Childhood sexual abuse was also significantly over-represented in women with a BPD diagnosis (χ² = 68.64; p = 0.00) and women with either a BPD diagnosis or probable BPD (χ² = 74.96; p = 0.00). Interestingly, only 59.1% of women with a BPD diagnosis (n = 26) were referred for psychological treatment.

The study findings indicate there is a pressing need for BPD services for female prisoners, and support BPD screening on admission to prison so women can be identified and access appropriate services in line with the Offender Personality Disorder Pathway strategy.

Never Ever? A review of escapes and absconds from two medium and low secure forensic unit between 2008-2012

Dr Catherine Durkin, Specialty Trainee in Forensic Psychiatry; Dr Liam Dodge, Specialty Trainee in Forensic Psychiatry; Dr Gillian Mezey, Consultant Forensic Psychiatrist – Shaftesbury Clinic, Springfield Hospital, London

Introduction
Escapes and absconds by forensic psychiatric inpatients are serious incidents which generate attention and anxiety. Escapes by prison transfers are considered a ’never’ event, yet therapeutic risks are inherent in facilitating patient recovery.

Aims
This aim of this study was to describe the precipitants and characteristics of absconds and escapes of forensic psychiatric inpatients, in order to inform and progress treatment pathways and more effectively manage risk in this population.

Methods
We analysed all completed escapes and absconds from two South London medium and low secure units (The Shaftesbury Clinic, Springfield Hospital, South West London & St George’s NHS Trust and The Bracton Centre, Oxleas NHS Trust) over a 56 month period from 2008-2012. The events were identified via Trust incident reporting procedures. The multidisciplinary case records of all identified patients were
reviewed and the following data was recorded on a proforma designed for this study: demographics, diagnosis, MHA status, months since admission, index offence, triggers/precipitants, circumstances and outcomes of the absconds or escapes.

**Results**
Over 200 incidents of escapes and absconds were recorded between the two units over the study period. 70% of absconds took place during escorted leave. The main reasons given by patients were; wanting to be reunited with family and friends and being unhappy with the ward environment, staff and their treatment. There was no evidence that these events occurred in direct response to psychotic symptoms. Two thirds of the events resulted in, or were motivated by the wish to access drugs and alcohol. Escapes were more likely to be associated with violence, outside assistance, planning and more severe outcomes.

The study highlighted the importance of maintaining patients contact and communication with family members and reducing their sense of isolation in forensic settings. The majority of studies tend to conflated absconds and escapes, however these preliminary data suggest that there may be significant differences in the characteristics and outcomes of the two types of events. Finally, in spite of the anxiety and negative publicity caused by absconds and escapes, both within the local community and at a national level, very few of these incidents resulted in significant harm to self or others. The majority of patients who absconded, returned voluntarily or with the assistance of the police or friends and family.

**A voyage of discovery**

Dr Elizabeth Frayn, year 5 specialist trainee, general adult psychiatry; Joanna Skubek, Occupational Therapist; Dr Helen Smith, Consultant Forensic Psychiatrist, Devon Partnership Trust

**Aims**
To reproduce the principles of a community Recovery College in a format accessible to all patients in Langdon Hospital, (a forensic hospital campus with medium and low security plus open wards).

**Methods**
A steering group was set up in 2012, involving service users, carers, psychiatrists and OT staff, with a small budget from Devon Partnership Trust. The Discovery Centre opened its doors to staff and patients in September 2012. The centre has a physical base on-site, a welcoming space with a classroom area, small kitchen and library, which can be accessed throughout the day. However, many of our students are unable to leave their units, so we also deliver courses within secure areas.

Over our first four terms, over 70 workshops have been offered, based around three themes: developing skills, (e.g. Thai cooking, gardening, food hygiene, customer service skills), creating meaning (e.g. story-telling, confidence workshops and ‘Life after Langdon’) and mental health and well-being (e.g. mindfulness, ‘How to get a good night’s sleep’). Representatives from the local community have also run workshops, e.g. interview training from Sainsbury’s personnel, fire safety training from the Fire Service.

Patients have been involved at all levels, from designing publicity materials to facilitating sessions. In our autumn 2013 brochure, 13 sessions are co-facilitated by people with lived experience of mental health problems, many who are current or ex-Langdon patients.

**Results**
In total 35% of our patient population have attended at least one workshop, as well as many staff members. 8 students achieved formal qualifications (Train the Trainer, Assertiveness and Decision Making). Feedback has been overwhelmingly positive. Comments from attendees included: “Somewhere I can be myself”, “It made me think differently about myself”, “I am more positive about my future”, “It gave me hope”, “I didn’t know people would be interested in my story”, “There’s not much salvation in a place like this; you sometimes need some poetry”.

Comments from facilitators included: “What a fabulous place, full of hope and positivity!”, “I love the ethos of the Discovery Centre”, “Lovely environment, very stimulating”.

**Conclusions**
Our Discovery Centre is a valuable adaptation of the Recovery College model, generating hope, providing positive educational experiences and broadening horizons for people in a secure setting.
The Comprehensive Risk Assessment – Does What It Says On The Tin?

Dr Ruth Grant, Dr Laura Hawkins, Dr. Richard Cherry, Dr Leanne Armitage, Dr Bob Boggs, Dr Helen Toal, Dr Stephen Moore – Belfast & Western Health and Social Care Trusts

Background
The Promoting Quality Care guidelines on assessment and management of risk in acute mental health in Northern Ireland came into force in 2009. At their core is a locally developed risk assessment tool the “Comprehensive Risk Assessment” (CRA), which was designed to assess risk to self and to others. Such tools are frequently criticised as lacking in evidence and not validated.

Aims
To compare the level of violence risk identified by the CRA with that of the HCR-20 Version 2 (HCR-20), a well validated violence risk assessment tool commonly used in the Forensic setting.

Methods
A group of 15 patients known to the substitute prescribing service in Belfast were identified, each had a CRA completed by the multidisciplinary team and regularly these were regularly updated. The HCR-20 was completed for each patient by a group including a Psychiatrist who knew each case well and two Psychiatrists trained in the HCR-20. Reference was made to the patient’s notes and their keyworker contacted if more information was needed. The items for which a risk factor was “present” or “possibly present” were noted. The patient’s CRA was then reviewed and those factors identified from the HCR-20 also captured in the CRA were noted. The rates of capture for each item from the HCR-20 by the CRA were then calculated.

Results
No items identified as present by the HCR-20 were captured by the CRA every time. Employment Problems and Psychopathy were never picked up by the CRA. Most items found to be present when using the HCR-20 were captured less than half the time by the CRA. The average was that items identified as present by the HCR-20 were picked up only 42% of the time by the CRA.

Conclusions
The CRA failed to capture the majority of risk factors for violence identified by the HCR-20 in this sample. This happened despite both assessments being based on the same information and records. Locally developed risk assessment tools remain a poor choice when compared with more robust Structured Professional Judgement instruments such as the HCR-20. It is possible that use of tools such as the CRA may lead to risk factors being missed entirely and risk being substantially underestimated as a result; this in turn puts staff, patients and the public at risk due to a false sense of security.

Physical Environment Study: Staff Perceptions of Safety and Aggressive Incidents within UK Mental Health Services

Dr Stephen Noblett, Consultant Psychiatrist, Scott Clinic, St Helens; Dr Dineka Gray, ST5 Trainee in Forensic Psychiatry, Scott Clinic, St Helens; Mr Andrew Brown, Nurse Consultant, Scott Clinic, St Helens; Ms Rhiannah McCabe, Research Assistant, HaCCRU, University of Liverpool; Prof Richard, Professor of Mental Health, HaCCRU, University of Liverpool

Background
The importance of the quality of the physical environment in healthcare has been recognised since the first therapeutic institutions were established in the late 18th century. Concerns have been noted regarding the current state of provision within UK mental health services; for example MIND report broken furniture, and unpleasant smells experienced by patients on wards. Research suggests that the physical environment on a ward can affect patient outcomes. However, the exact nature of this relationship is complex and the precise features associated with improved outcomes have not been clearly established.

Aim
This study sets out to examine if there is a relationship between the physical environment on mental health in-patient wards and the perceived and actual safety of staff on those wards. The study design is based on a theoretical model depicting the interactions between physical environment, safety outcomes and safety/violence climate. There is scope beyond this project for a follow up study due to extensive rebuild plans throughout Mersey Care NHS Trust over the next five years.

Method
Approximately 100 local and national wards (in forensic and general adult settings) are included in this study. Ward design is measured using the Ward Features Checklist, developed and piloted by the
research team. Various physical parameters and ambient features are measured to yield an overall "quality of design" score. A staff survey measures perceptions of work place safety (Work Safety Scale) and violence climate (Perceived Violence Climate Measure). Levels of actual ward aggression are measured through the Perceptions of Prevalence of Aggression Scale, along with incident data recorded by the trust. Multivariate analysis is used to examine the relationship between ward design, safety climate and aggression levels.

**Results & conclusions**
Preliminary analyses are presented, including the profile of staff respondents and participating wards. Depending on the progress of the study, correlation data representing the relationship between ward design and levels of aggression may be presented, as will plans for higher level analyses. Firm conclusions are not available at the time of the conference as data collection is on-going; however implications of the preliminary results are discussed.

**Hidden Risk Within Addictions Services – HCR-20s in a Substitute Prescribing Service**
*Dr Laura Hawkins, Dr Ruth Grant, Dr Richard Cherry, Dr Leanne Armitage, Dr Bob Boggs, Dr Stephen Moore, Dr Helen Toal – Belfast & Western Health and Social Care Trusts*

**Background**
Substitute Prescribing for opioid dependence in Northern Ireland began in earnest with the 2004 guidelines and is now approaching its tenth anniversary. The nature of the patients engaged in substitution puts them at increased risk of acquisitive crime and possibly instrumental violence related to this. Between 2009 and 2013 the HCR-20 Version 2 (HCR-20) was completed for a total of 30 patients in substitution with the Belfast Substitute Prescribing Team (SPT). Patients can have their prescribing at one of three levels of increasing support, General Practice (GP) prescribing, SPT prescribing, or Enhanced Supervision - for those who have typically failed treatment at least once.

**Aims**
To assess the level of violence risk within the population of substitute prescription patients in Belfast. To compare levels of risk between the three levels of prescribing.

**Methods**
30 patients known to the substitute prescribing service in Belfast between 2009 and 2013 were identified. The HCR-20 was completed for each patient by a group including a Psychiatrist who knew each case well and one or more Psychiatrists trained in the HCR-20. Reference was made to the patient’s notes and their keyworker contacted if more information was needed. The average HCR-20 score for each level of prescribing was calculated, as well of averages of the historical, clinical and risk subscales.

**Results**
The average HCR-20 score in GP prescribing was 14.3 (7.2 Historical, 3.2 Clinical, 3.9 Risk). The average in SPT prescribing was 14.4 (7.3 Historical, 3.1 Clinical, 4.0 Risk). The average in Enhanced Supervision was 23.3 (9.3 Historical, 7.1 Clinical, 6.9 Risk).

**Conclusions**
The level of violence risk within the GP and SPT prescribing groups is very similar, suggesting that they draw on the same pool of patients. The level of risk in the Enhanced Supervision group is somewhat higher and this suggests that the relative treatment resistance of this group may lead to an increase in risk to others. It is possible that patients involved in substitution, especially those with previous treatment failures, may require some input from local Forensic services to support their treating team in assessing and managing any risk they may present.

**Audit to Monitor Standards of Physical Health Monitoring for Patients Prescribed Antipsychotic Medication at HMP Isle of Wight**
*Dr Sarah Hewitt, ST5 in Forensic Psychiatry, Ravenswood House Medium Secure Unit, Southern Health NHS Foundation Trust*

**Background**
It is well recognised that patients diagnosed with psychiatric illness have a higher incidence of physical morbidity than the general population. There are logistical problems within the prison system which can interfere with the ability of clinicians to monitor the physical health of prisoners with mental illness.
Aim
This audit looked at the standard of physical health monitoring in patients prescribed antipsychotic medication in HMP Isle of Wight. The standards for physical health monitoring were adapted from advice given in the Maudsley Prescribing Guidelines. It was decided that all patients prescribed antipsychotic medication should have a FBC, U&Es, LFTs, fasting glucose, fasting lipids, ECG, weight and enquiry into their smoking status annually. It was also expected that all HMP Isle of Wight prisoners prescribed antipsychotics would be under the care of the Community Mental Health Team.

Method
An alphabetical list of all patients prescribed antipsychotics was obtained in September 2012. The notes of every other patient on the list (n=37) were examined for evidence that they had the required tests carried out in the past year and that they were being monitored by the CMHT. Where these standards were not met the reasons for this were sought in the clinical notes. The results were collated in tabular form and analysed.

Results
The audit found that 86% (n=32) of patients prescribed antipsychotic medication were under the care of the CMHT. 14 of the 37 patients had either an incomplete set of blood results or no tests at all. Of the patients 70% (n=26) had U&Es taken in the past year; 68% (n=25) had FBC; 68% (n=25) had fasting lipids; 73% (n=27) had fasting glucose and 73% (n=27) had LFTs. Of the 14 without complete blood 50% (n=7) had not done so as they had not been requested by the clinician reviewing them. Other reasons included patients waiting for blood test appointments (n=3), requests not being followed up (n=2) and blood test refused by patient (n=2). The results for ECG monitoring revealed that 46% (n=17) had not had ECGs carried out in the last year. Of the 20 that had not had ECGs 75% (n=15) had not had them because the clinician had not requested them. Weight was recorded in 73% (n=27) of patients and smoking status in 86% (n=32).

Conclusion
The results from this audit reveal that there is some improvement to be made in all types of physical health monitoring audited. A more structured approach is required to ensure that adequate physical health monitoring is performed.

Impact of Primary Care services on Junior Doctors Non-Psychiatric Workload within a NHS Medium Secure Unit
Dr Sachin Jacob (CT3), Dr Suraj Shenoy (Consultant Forensic Psychiatrist)

Background/Aims
There have been concerns expressed about the physical health of psychiatric inpatients, especially within secure services. In 2008, the non-psychiatric workload of junior doctors within Newton Lodge, The Yorkshire Centre for Forensic Psychiatry, a 90 bedded medium secure unit in Wakefield, Yorkshire was audited. This indicated that a Primary Care service would better serve many of the physical health referrals made to junior medical staff. Following this audit, a Primary Care service was established to provide primary care to the inpatients within Newton Lodge. This re-audit was conducted to investigate the impact of the Primary Care service on junior doctors’ non-psychiatric workload.

Methods
The audit investigated referrals from all seven in-patient wards to junior medical staff within Newton Lodge. It was conducted over a two-week period during normal working hours (Weekdays 9am – 5pm). A semi-structured questionnaire survey was used to collate information about the referrals. In contrast to the previous audit the Primary Care Team nurses also filled out survey form. The form was split into two sections; the secretaries, junior doctors and primary care nurses, filled out the first section. It recorded the date, time, ward, level of urgency, description and source of referral and to whom the task was allocated to. The second part of the questionnaire was filled out by the clinical team member carrying out the task and recorded the date, time, duration and nature of task.

Results
With the primary care service in place, junior medical staff received significantly less non-psychiatric referrals as the majority of referrals were made to Primary Care. Of these 93% were classed as routine, 7% as urgent. No emergency referrals were made during the audit. Time spent on non-psychiatric work by junior medical staff had reduced by up to 7 hours in the two week period audited. This allowed for more time to be spent on psychiatric work enhancing junior medical staff’s training and experience within their forensic placement. Time spent by primary care team on referrals was 13 hours over the two week period; an increase of 6 hours spent on non-psychiatric care compared to the previous audit. This reflected that there was probably an unmet need which has now been met by the primary care service.
Ekbom’s Syndrome (Delusional parasitosis) and violence in patients in a High secure Hospital
Dr Shanmuga Priya Jayabalan, CT3 registrar, Consultant Forensic Psychiatrist; Dr Mrigendra Das, Consultant Forensic Psychiatrist; Dr Jose Romero-Urcelay, Consultant Forensic Psychiatrist; Dr Samrat Sengupta, Consultant Forensic Psychiatrist – Broadmoor Hospital.

Introduction
A significant majority of forensic patients and those in high secure hospitals present with history of psychosis including schizophrenia. The extant literature reports that a vast majority of forensic patients with psychosis are driven to violence by their delusions and that ‘threat control override’ symptoms are significantly associated.

‘Ekbom’s syndrome’ or ‘Delusional parasitosis’ is a disorder in which the patient believes that he is infested by a parasite. International classifications have included this syndrome in non-schizophrenic delusions. However, it has also been reported in schizophrenia, affective disorders, and organic or induced psychosis but there are no reports of its association with violence.

We report 2 cases from a high secure hospital where delusional parasitosis was associated with violence.

Methods
Case histories were obtained for 2 male patients who provided informed consent. The patient’s psychiatric histories were anonymised and evaluated for symptomatology, timeline of progression of psychopathology and nature of association of delusional parasitosis with violence and risk profile.

Results
Patient A is in his forties with a history of dissocial personality disorder with schizophrenia for the last 20 years. He has a long history of violence and impulsive behaviour in custodial and institutional care. He presents with longstanding well systematised delusions of being infested by parasites and somatic hallucinations and believes that the parasites are laying eggs in his body and destroying his brain. He seeks medical intervention and threatens healthcare staff for not treating his condition and his delusions have been resistant to antipsychotics.

Patient B is in his thirties with a history of a relapsing–remitting paranoid psychotic illness in the background of dissocial/borderline personality traits. He has a serious history of arson, and interpersonal violence. He has been in the secure setting for many years. He presents with encapsulated delusions of being infested with insects, under his skin as well as in his personal possessions and threatening arson to kill the insects. He has had a partial response to antipsychotic treatment.

Discussion
The authors are unaware of any documented cases of this syndrome in a forensic patient and the research base is sparse; whereas, other mono-symptomatic delusions such as jealousy, erotomania, misidentification have been reported. The authors explore the existing literature, nosology, epidemiology and treatment of Ekbom’s syndrome in relation to the reported cases. A descriptive analysis of the violence and risk in these patients in relation to their core psychopathology of delusional infestation is presented.

Real Work Opportunities: a brighter future
Dean Swire, Senior Occupational Therapist, Partnerships in Care; Pippa Philipson, Regional Director of Clinical Services, Partnerships in Care; Dr Yasir Kasmi, Consultant Forensic Psychiatrist, Partnerships in Care

Aims
Employment is a major protective factor in the prevention of reoffending (Centre for Mental Health, 2010). Work promotes recovery and rehabilitation, social inclusion, enables structure and increases self-esteem and confidence. The Real Work Opportunities Model (RWO) incorporates all the normal processes that an individual would be expected to go through when trying to gain employment, such as role profiles, job applications and interview processes.

Methods
Work capacity is assessed early in a service user’s admission, to identify previous work skills, roles and goals. Workshops take place including Curriculum Vitae preparation, a mock interview and finally an interview. Verbal and written feedback is given.
Internal roles offered include: allotment supervisor, housekeeping, newsletter editor and catering assistant. The role, environment and individual are subject to risk assessment and management. A graded approach is adopted.

The role is twelve weeks within the therapeutic timetable. Weekly supervision occurs and can discuss skill acquisition, social skills and other issues. At the end of the twelve weeks, a performance review occurs with the awarding of a certificate.

Results
The scheme promotes skills such as reporting sickness, being on time, dressing in appropriate attire, marketing and sales, good communication skills and role knowledge, such as numeracy and literacy.

The scheme has been piloted within four Partnerships in Care hospitals. At one hospital, the scheme has run for twenty months, initially with four roles, growing to twelve roles. There were six applicants for six posts and more recently there have been eighteen applicants, with nine being successful. One service user has worked for fourteen months as the hospital shop manager and newsletter editor. Other units have run the scheme for six months and have increased the number of roles. One unit changed the roles to reflect a different service user group.

Whilst the service users are not legally employed, qualitative feedback has been universally positive. The scheme does not affect benefits due to the allocated hours and payment. The scheme fits into the therapeutic timetable and is purposefully designed not to clash with other therapies.

Future Work
Mandatory training will be rolled out for participants. The scheme is to be extended to all twenty three hospitals. New roles include painter/decorator. Further links will be developed within the community and larger companies. RWO’s effects on risk and incidents will be analysed. RWO is dependent on the service user population, need, demand and funding. Social enterprise is another potential avenue.

Reference

Options in managing Clozapine induced hypersalivation: a survey of secure services consultants
Dr Yasir Kasmi, Consultant Forensic Psychiatrist, Partnerships in Care

Aims
Clozapine-induced hypersalivation is socially embarrassing and potentially life threatening. It can lead to poor compliance, which is of concern for patients in secure settings. Hyoscine hydrobromide is widely used as first line treatment, despite little available evidence. Alternatives are limited, but nineteen different agents are listed in the Maudsley Prescribing Guidelines in Psychiatry, including antipsychotics, antidepressants and other drugs with antimuscarinic properties. Partnerships in Care Ltd have around fifty consultants caring for over a thousand in-patients, with a fair proportion prescribed Clozapine.

Methods
All consultants with clinical responsibilities were contacted regarding their prescribing practices and experiences. Responses were sent back to the author in the form of a non-patient identifiable response via email.

Results
Twenty one consultants (under fifty percent) replied. In the absence of Hyoscine Hydrobromide, there was overall little confidence in alternatives. Clinicians tended to advocate one or two alternatives. Atropine, either sublingually or via eye drops was relatively popular and the eight clinicians that supported its use had some confidence in it. All the medication recommendations received were in the latest Maudsley Prescribing Guidelines in Psychiatry, except Procyclidine. Most options consisted of drugs with antimuscarinic properties such as Pirenzepine and Trihexyphenidyl. Dose reduction of Clozapine was recommended by one consultant. The author and another consultant have had some success with Glycopyrrolate syrup, but this is an expensive option.
Medication/option | Frequency n = 21 | Percentage (%)
---|---|---
Antimuscarinics (non-specific) | 1 | 5
Amitriptylline | 4 | 19
Atropine sublingual/eye drops | 8 | 38
Benztropine and Terazosin | 1 | 5
Dose Reduction | 1 | 5
Glycopyrrolate | 2 | 10
Pirenzepine | 4 | 19
Procyclidine | 1 | 5
Trihexyphenidyl | 4 | 19

Conclusions

Clozapine induced hypersalivation is a potentially difficult to manage condition that can lead to poor compliance, which is a concern for inpatients within secure services. The wide range of options and lack of evidence does not support clinicians in their attempts to continue treatment. National guidance is required on this. In circumstances where patients do not respond to Hyoscine, the most popular choice with relative confidence was sublingual Atropine. Further meaningful trials are required.


Seclusion of patients in a medium secure setting in North London: A review of practice

Dr M King (CT3 Trainee, North London Forensic Services); Dr L Wooster (ST4 Forensic North London Forensic Services), Co-authors: Dr J Perry (ST4), Dr C Bailey (CT1), Dr K Jahangeer (CT3), Dr T Rogers (Consultant Forensic Psychiatry)

Introduction

Seclusion is a means used in inpatient psychiatric settings to contain and control disturbed patient behaviours which are likely to cause harm to self or others. Because of the particularly restrictive nature of seclusion, guidelines on its use are featured in the Mental Health Act Code of Practice (MHA COP) and in individual trust seclusion policies. Due to the advent of the “Hospital at Night” model of working, in some Mental Health Trusts junior doctors are no longer resident overnight which may impact upon the way seclusion practices are carried out.

Aim

To assess the conduction of seclusion practice in a medium secure inpatient setting in North London (Camlet Lodge) which has a “Hospital at Night” model of working, and compare practice against the MHA COP and the trust seclusion policy.

Method

The documentation of seclusions over a six month period (November 2012-May 2013) was scrutinized to assess various parameters as set out in the MHA COP and local trust seclusion policy. Standards reviewed included reason for seclusion, the timing of nursing and medical reviews and whether senior reviews took place as set out in the literature. Following initial findings, a “checklist” style poster was placed directly outside seclusion rooms in the unit and a re-audit was carried out during the following six month period (August 2013-January 2014).

Results

Initial results identified 36 seclusion episodes across 5 medium secure wards during the first review period (60 seclusion episodes during the second). It was found that in all cases there was an appropriate reason for seclusion with average time in seclusion ranging from 24 hours during period one to 143 hours in period two. During period one it was noted that 96% of seclusions were attended to within 4 hours by a doctor as per the local trust policy (91% during the second period). Negative findings were that in only 76% of cases a 2 hourly nursing review was completed (58% during second period), 52% a four hourly doctors’ review (47% during second period) and 40% had a senior review every twelve hours (61% during second period).

Discussion

The study highlighted some shortfalls in seclusion reviews which could place patients and staff at risk from both physical and psychological harm. Less than half of patients were seen within an hour of being placed in seclusion and only 40-50% were subsequently reviewed appropriately as per national and trust guidelines. Despite the introduction of an intervention there was poorer compliance with guidelines during the second period. It was noted that particular patients were repeatedly secluded and/or spent lengthy
periods in seclusion. This was beyond the scope of this study but further study is recommended. It was also advised that there should be a clearer trust seclusion policy with specific guidelines for reviews out of hours.

**A Qualitative Audit of the Experience of Psychotherapy Training of Higher Specialist Trainees in Forensic Psychiatry at West London Mental Health NHS Trust**

*Dr Nicholas Christian Larsen, Speciality Registrar (ST5) in Forensic Psychotherapy, West London Mental Health NHS Trust*

**Introduction**

The training curricula of the Royal College of Psychiatrists describe psychotherapy training requirements and competencies for core trainees; higher trainees in psychotherapy; and higher trainees in other psychiatric specialities. Published studies have shown that attainment of these competencies varies, but that trainees generally express an interest in psychotherapy training.

The **aims** of this study were: to audit qualitatively forensic higher specialist trainees’ experience of psychotherapy training against standards derived from the College curriculum; to explore their views regarding these standards; and to explore their views regarding the relevance to forensic psychiatric training of specifically psychodynamic psychotherapy.

**Method**

Audit standards were derived from the College curriculum. Semi-structured interviews incorporating these standards were conducted with 5 higher specialist trainees in forensic psychiatry at West London Mental Health NHS Trust. Some of these trainees originated from other training schemes, being placed in West London for specific training experience. Interviews were recorded and partially transcribed, and data analysed using grounded theory.

**Results**

Subjects reported a varying degree of attainment of College competencies, and generally expressed an interest in psychotherapy training. The majority expressed support for a minimum requirement with regard to psychodynamic training, and all stated a belief in the relevance of psychodynamic thinking to forensic psychiatry.

**Discussion**

The layout of the College curriculum was felt to be unhelpful. Views differed regarding the need for clearly defined or less clearly defined psychotherapy competencies. All subjects focused on the delivery of formal psychotherapy itself rather than considering the application of psychotherapeutic thinking in a broader range of professional situations. A recurring theme was that of the perceived variation in accessibility of psychotherapists themselves; and the effects of this, on trainees’ interest in and experience of psychotherapy training, were considered. Practical difficulties as well as psychological resistances to psychotherapy training were considered. Limitations of the study include the small sample size, and biases inherent in the methodology.

**Recommendations** are made concerning the content and delivery of the College curriculum, with specific regard to psychotherapy competencies. Recommendations are also made with regard to ways in which psychodynamic psychotherapists could enhance the accessibility of their discipline to non-psychotherapist forensic colleagues. Future research directions are also considered.

**Staff attitudes toward administering community psychological treatments to patients considered sexual offenders**

*Dr Alexandra Lewis, CT3 Psychiatry, Buckinghamshire Psychological Services and Complex Needs Service, Oxford Health NHS Trust*

**Aims**

To investigate which patients were perceived as sexual offenders by staff working at Psychological Services and Complex Needs and whether there was a reluctance to treat these patients for co-morbid psychological conditions in the community, should they otherwise be a suitable patient for intervention.

**Methods**

A questionnaire was designed and distributed to all therapists working at Buckinghamshire Complex Needs Service and North Buckinghamshire Psychological Services. The questionnaire included items on job role, training, classification of a “sexual offender”, reasons for reluctance in accepting this type of patient into therapy and feedback on support methods to reduce this reluctance.
Results
17 staff members responded to the questionnaire. The majority of those who responded were qualified therapists (71%) working at Psychological Services (65%). Only 12% of responders had previously worked in forensic services but 65% reported having had experience of patients whom they would describe as "forensic" outside of that setting.

Whilst the majority of responders considered illegal acts to be sexual offences, 41% considered patients who had fantasies of sexual contact with children as sexual offenders. Assuming that the patient had been deemed "low risk" of offending at assessment, 41% of therapists still felt that they would need further input prior to commencing therapy and around a quarter (24%) said that they would refer for a forensic assessment.

Over half of responders (53%) said that they would be reluctant to take on a patient whom they considered to be at risk of sexual offending. Of those, 89% cited risk management as one of the reasons why. Other reasons included concerns over their own ability (78%) and personal feelings about sexual offenders (67%). 100% of responders said that they would be more likely to treat these patients if they had an increased level of supervision. 88% would be more likely if the local policy on referral inclusion and exclusion criteria was clear.

88% of all therapists who responded felt that these patients should be treated by non-forensic community psychological services.

Discussion
This investigation suggests that whilst the majority of therapists feel that patients with a history or potential for sexual offending should be treated for co-morbid psychological problems in non-forensic community services, more than half feel reluctant to take part in this treatment themselves. This may be due to risk management concerns and therapists concerns about their own ability to contain these patients. Increased levels of supervision and clear Trust policies about referral criteria and reporting may help to reduce therapists’ anxiety about treatment.

Documentation and quality of mental capacity assessment of inpatients at the Oleaster Unit
Dr Nazir Mahomedaly, CT3 Forensic CAMHS, MRCPsych, Dr Uzuazomaro Okpokoro CT1, Birmingham and Solihull Mental Health Foundation Trust

Introduction
The Department of Health in the Mental Capacity Act Code of Practice has made recommendations as regards to the standards of documentation and quality of mental capacity act. The Trust has put in place a number of guidelines to ensure these standards are kept with.

Aims
1. To investigate the documentation of mental capacity act on admission against the standards set by the trust and compare to previous audits where applicable.
2. To check the documentation of mental capacity when there is a change in the legal status of inpatient.
3. To review the quality of documentation of the mental capacity assessment.

Method
Admission data was retrieved from Rio electronic documentation. The data encompassed all patients that were admitted or transferred to the Oleaster hospital from 01/01/2013 and 29/02/2013

Results
A total of 83 patients admitted directly to the Oleaster unit between the 01/01/2013 and 29/02/2013. 11 patients were transferred from ‘other wards’ during that time.
1.84 %of the patients had documentation of mental capacity assessment during inpatient stay .This is an improvement from previous audit but is still far from the 100% standard.
2. The Oleaster achieved 64% compliance with regard to documentation of capacity assessment within 24 hrs which is better than ‘other wards’.
3. Documentation of capacity with change in mental health act status-The results show that the Oleaster is doing poorly in this regard, they achieved 41%, Overall the Oleaster did better than ‘other wards’.
4.92%of the patients had all sections of capacity forms completed. This is an area that has been highlighted by the Care Quality Commission in the past.
5. The results show that, of the capacity assessments done on admission, the nurses documented slightly higher percentage compared to the admitting doctors, they have done slightly better in the quality of documentation and if documentation was done within 24 hours of admission.

Recommendations
1. Nursing team should employ the use of checklist during their routine morning handover to ensure capacity assessment does not elapse beyond 24 hrs for every admission.
2. Short formal training on the mental capacity and how to complete appropriate forms should be done locally, for every new clinical staff employee.
3. Medical teams should ensure a capacity assessment is done with every active change of mental health act status concerning admission and treatment patients.

Implementation of the Forensic Commissioning for Quality and Innovation standards (CQUINs) for Physical Health

Dr Rebecca Marriott, ST4 Forensic Psychiatry, Oxleas NHS Foundation Trust; Dr Elizabeth Zachariah, Consultant Forensic Psychiatrist, The Bracton Centre, Oxleas NHS Foundation Trust; Dr Deborah Brooke, Lead Consultant Forensic Psychiatrist, The Bracton Centre, Oxleas NHS Foundation Trust; Mr Anthony Muonweokwu-Egbunike, Database Performance Manager, The Bracton Centre, Oxleas NHS Foundation Trust

Aims
On 1st April 2013, Pan-London Commissioners (now NHS England) introduced new Commissioning for Quality and Innovation standards (CQUINs) and extended reporting requirements for Forensic Services. The remuneration for these represents some £500,000 of additional revenue.

This data management project involved creating a database and workflow system that would complement our existing electronic patient record system and fulfil the following aims:
- To produce a minimum set of clinical standards to improve the physical healthcare of forensic patients
- To provide an alert if a CQUIN standard might be missed
- To monitor rate of compliance with CQUINs and facilitate production of detailed reports and outcomes for Commissioners to maximise Trust remuneration

Methods
I worked with multidisciplinary colleagues to agree database standards, design and interrogation techniques. Audits were performed at various stages to monitor progress.

A Physical Health Manual (a working document that can be updated) was written with specific milestones and responsible persons identified for each variable. The Manual and the database were presented to colleagues in November 2012 before a pilot of the database began in December 2012.

A Performance Manager was employed whose explicit task was to work with clinical teams to update the database and drive improved collection and recording of physical health variables.

Training sessions were held in March 2013 (before database went live on 1st April 2013) and in September 2013 (for new staff).

Results
Baseline audit before implementation of CQUINs showed that although many of the physical health variables were measured, they were not always recorded consistently or in a timely manner:
- 37% had a physical examination completed within 24 hours of admission (but not to CQUIN standard)
- 35% had physical health monitoring completed within 72 hours of admission (but not to CQUIN standard)

Audit of the Physical Health standards pilot for the patients admitted in quarter 4 (January to March 2013) showed that we were falling short of the CQUINs:
- 59% of 24 hour checks were completed (but no patient achieved full CQUIN standards)
- 39% of 72 hour checks were completed (but no patient achieved full CQUIN standards)

Audit of the first live data (quarter 1 April to June 2013) showed 100% compliance with 24 hour and 72 hour physical health CQUINs.
Preliminary results from quarter 2 (July to September 2013) do not show 100% compliance, possibly due to change-over of doctors.

The introduction of these CQUINs has highlighted the growing recognition of the physical health needs of this group of psychiatric patients, and has inspired optimism that clinical outcomes may also be improved.

**A NICE audit; reviewing compliance with NICE guidance for Schizophrenia comparing a high secure service with other inpatient environments**

*Dr Katy Mason and Dr Fintan Larkin – West London Mental Health Trust*

**Introduction**

In 2009, The National Institute for Health and Clinical Excellence produced guidance regarding the care of adult patients with schizophrenia to attempt to address variations in quality of care.

**Aims**

To re-audit a high secure forensic hospital’s compliance with several aspects of NICE guidance and compare against other hospitals within the same trust.

To build on information gained from a 2010 audit which had a low response rate and limited understanding of the findings of the data collected.

**Methodology**

Random sample of 1/3 of patients with schizophrenia and like disorders obtained from data warehouse.

Audit tool developed for previous audit was used to ensure continuity. This assessed various aspects of assessment and treatment including psychological service provision and use of advance directives.

One assessor reviewed all case notes, rather than each Responsible Clinician to increase response rate.

**Results**

Response rate was 96%. The results showed that the majority of NICE standards were met

However, it was found that no patients had made advance decisions or directives.

100% of patients in the high secure service had regular and thorough contact with psychology compared with between 46-58% in other hospitals; however 1:1 manualised CBT for psychosis was given in 10% of cases compared with 16-54% in other hospitals. A CBT for psychosis group was often used instead of 1:1 CBT although formal data was not collected on this.

**Discussion**

Results were presented to the Mental Illness Clinical Improvement Group and Trustwide Audit group. It was felt that teams worked closely with patients to comply with their wishes and that there was evidence to support this within their care plans. However, there was acknowledgement that this is not formalised in the form of advanced directives, and yet this may still be applicable in the high secure environment. Further work should be done to establish whether patients ever had the capacity to make advance directives during their stay.

A review of the NICE guidance was done and it was found that the evidence to support 1:1 manualised CBT for psychosis was based on evidence for community patients, and the recommendation was made on the basis that it reduced symptoms and hospital admissions. This raises questions about whether NICE guidance regarding psychological services is applicable to high secure patients.

**An evaluation of the decision making process for patients made subject to Compulsion Orders with and without Restriction Orders in NHS Lothian since the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003**

*Dr Michelle McGlen, ST5 in Forensic Psychiatry, The Orchard Clinic, Royal Edinburgh Hospital, Edinburgh; Dr Nicholas Hughes, ST6 in Forensic Psychiatry, Rohallion Secure Care Clinic, Murray Royal Hospital, Perth; Dr Johanna Brown, ST5 in Forensic Psychiatry, The Orchard Clinic, Royal Edinburgh Hospital, Edinburgh; Dr John H. M. Crichton, Consultant Forensic Psychiatrist, The Orchard Clinic, Royal Edinburgh Hospital, Edinburgh*
Aims
This service evaluation focused on individuals made subject to Compulsion Orders with and without Restriction Orders in order to evaluate practice against both the Code of Practice criteria for the making of such orders and also against criteria used for recommending Orders for Lifelong Restriction, a type of order with similar restrictive implications used for the non-mentally disordered population.

Methods
Patients made subject to Compulsion Orders with and without Restriction Orders in NHS Lothian since the enactment of the Mental Health (Care and Treatment) (Scotland) Act 2003 were identified. This included individuals made subject to such orders whilst under the care of NHS Lothian and those placed on orders whilst in the State Hospital who then transferred to NHS Lothian. A structured questionnaire was used to extract data from case notes and court reports. Data was compared and analysed against best practice guidelines published by the Scottish Executive and the Risk Management Authority.

Results
54 patients subject to Compulsion Orders (CO) without Restriction Orders and 22 patients subject to Compulsion Orders with Restriction Orders (CORO) were identified. SPJ tools were used to inform decision making more frequently in the CORO group (59% of cases, n=13) than in the CO group (20% of cases, n=12). In both groups little evidence was provided to the court on issues surrounding risk and risk management. In the CORO group, courts were frequently not being provided with written evidence detailing risk scenarios, the link between mental disorder and risk of violence, likely victim groups, warning signs for future violence and the potential level of future harm. In both the CO and CORO groups, the assessment of personality was poorly documented (17% and 32% respectively). 82% (n=18) of cases proceeding to CORO involved an initial period of assessment subject to an interim Compulsion Order. When compared with the guidance for recommending OLRs, reports on those made subject to COROs generally met the necessary minimum requirements made for recommending an order except for the lack of thorough risk assessments being undertaken in 41% of cases (n=9).

Conclusion
Our study demonstrates a need for an improvement in the way risk is assessed and reported to the courts when making decisions about recommending Compulsion Orders with and without Restriction Orders. This suggests a need for increased awareness about best practice guidance to those involved in providing psychiatric reports to the courts and also those involved in their interpretation.

An Audit into the Monitoring of Physical Health and Health Promotion on a Medium Secure Forensic Unit
Dr Leo McSweeney BMBS, Dr Gemma Hopkins MRCPsych, Dr Srinivasan Thirumalai MRCPsych

Aim
We designed this audit to assess whether standards of physical health monitoring and health promotion were being met in the forensic long-stay population, in response to the development of physical health problems in some of the patients under our care.

Method
Trust Policies on psychotropic medication monitoring, antipsychotic induced Hyperprolactinemia, smoking cessation and weight management were assessed using a questionnaire to review patient notes of all 28 inpatients currently residing at Marlborough House, Milton Keynes. Of patients prescribed an antipsychotic medication, the following should be measured in 100%: BMI; waist circumference (if BMI more than 25), blood pressure, pulse, fasting lipids, fasting glucose, ECG, smoking status and alcohol status. Of patients prescribed an antipsychotic known to cause a sustained raise in prolactin; 100% should have had a prolactin level measured, and 100% should have been screened for symptoms of Hyperprolactinemia in the last 12 months. For all patients, if BMI greater than 25: 100% have had cardiovascular risk factor calculated in the last 12 months, and had their antipsychotic treatment reviewed in the last 12 months, 100% have a care plan for weight management, 100% have been offered dietary advice in the last 12 months, 100% have been offered an exercise regimen in the last 12 months. For all patients, if a smoker, 100% of patients have been offered smoking cessation advice for the last 12 months.

Results
All 28 inpatients were on antipsychotic medication. In the last 12 months, 81% had their BMI checked. Only 45 had their waist circumference measured. 96% had pulse and blood pressure measured and one patient had consistently refused any monitoring. Fasting lipids and fasting sugar levels had been measured in 63% and 59% respectively. 24 inpatients were recorded as smokers. Only eight had smoking cessation support.
Of the 22 patients who had recorded BMI, 86% had a BMI of over 25. Only 21% had their ten year cardiovascular (risk) calculated and 42% had weight management care plan. 68% of patients had been offered dietary advice.

Of 19 inpatients prescribed antipsychotic known to induce Hyperprolactinemia, only 26% had been assessed for symptoms of Hyperprolactinemia and 53% had their prolactin formally measured. This audit highlights the shortcomings in the physical health care monitoring, and the need to improve the overall physical health care of long-stay inpatients. This reminds psychiatrists that health promotion has an important role in the welfare of long-stay psychiatric inpatients.

**Are the recommendations of Structured Clinical Risk Assessments transferred into Care Programme Approach (CPA) care plans?**

Dr Craig Morrow, ST5 Forensic Psychiatry, NHS Greater Glasgow and Clyde; Dr Prathima Apurva, ST5 Forensic Psychiatry, NHS Greater Glasgow and Clyde; Dr Rona Gow, Consultant Forensic Psychiatrist, Rowanbank Clinic; Dr Melanie Baker, Consultant Forensic Psychiatrist, Leverndale Hospital

**Aims**
To determine if the outcomes and recommendations of structured clinical risk assessments carried out within the Greater Glasgow Forensic Directorate were being adequately translated into Care Programme Approach (CPA) care plans.

**Method**
Through agreement within a multidisciplinary group and in line with local policies a proforma by which the translation of risk assessment information into CPA care plans would be rated was agreed. A total of seventy-two patients (roughly one quarter of the directorate caseload) were identified by randomised selection for evaluation including medium security, low security and community based patients. An equal number of patients were allocated to a multidisciplinary team of eight professional evaluators. To ensure inter-rater reliability and familiarity with the proforma the evaluators jointly rated one assessment as a pilot. Over the following four week period the evaluators gathered data from the casenotes rating in line with the previously agreed operational criteria. The evaluators first retrospectively reviewed the risk assessment to determine if key recommendations were being made in various areas (e.g. victim safety plans) and, if so, assessed the care plan to determine if these recommendations were adequately incorporated. All responses were then collated and analysed. Those who had not had a CPA meeting since their last risk assessment update were excluded from the review as the opportunity to update the care plan with new information may not yet have arisen.

**Results**
Areas where the care plan best represented the details of the risk assessment included supervision requirements (86% of care plans were considered reflective of the risk assessment) and monitoring requirements (81%). Assessments to be completed and Treatments to be provided were only slightly less complete with 72% and 70% respectively. Where the risk assessment had suggested that further information be collected to ensure optimal assessment of risk in future this had been incorporated into the care plan on 50% of occasions. The translation of victim safety recommendations from the risk assessment to the care planning process was the lowest rated and was achieved on only 21% of the care plans reviewed where intervention in this area had been a recommendation of the risk assessment.

**Discussion**
The study suggests that in the core areas of supervision, treatment and monitoring translation of structured risk assessment recommendations into the care plan was occurring in the majority of cases, although there remains room for improvement. Victim safety planning appears to be a particular area where recommendations are not being transferred into care plans. Modification of CPA paperwork to include a specific prompt for victim safety planning within the care plan may assist in improving the inclusion of such recommendations.

**A cost comparison study of GPS-assisted Electronic Monitoring in a medium secure forensic psychiatric service**

Dr Paula Murphy, St Andrew’s; Dr Lucy Potter, South London and Maudsely NHS Trust; Dr John Tully, South London and Maudsely NHS Trust; Dave Hearn, Security Lead, South London and Maudsely NHS Trust; Prof Tom Fahy, Behavioural and Developmental Psychiatry Clinical Academic Group, Institute of Psychiatry; Prof Paul McCrone, Centre for the Economics of Mental and Physical Health (CEMPH) Institute of Psychiatry
**Background**

‘Electronic Monitoring’ (EM) is the use of the electronic devices to monitor the whereabouts of individuals. It is normally used in the criminal justice system to track offenders who do not pose a risk to the public and has been found to be a cost-effective alternative to custody. It was first used in health settings for dementia patients. In 2010, following a series of high-profile incidents related to absconding, EM using GPS-assisted technology was introduced in the medium secure forensic psychiatry service of the South London and Maudsley Foundation Trust in order to monitor individuals on leave. An analysis of use in the first two years revealed that EM was associated with increased unescorted leave and reduced leave violation within the service. However to date the comparative costs of using EM have not been established.

**Aims**

To compare the costs of using GPS Electronic Monitoring (EM) in forensic psychiatric patients on leave from a medium secure service by comparing the average cost per leave episode with EM and without EM.

**Methods**

Costs were compared before and after the implementation of EM and an average cost per leave episode was calculated. The total cost of leave for each study group was calculated. The cost of EM was added only to the group using the device. The total cost for each group was divided by the number of leave episodes to generate an average cost per leave episode for each group.

**Results**

The cost per leave episode without EM was £73 compared to the cost per leave episode with EM which was £61.

**Conclusions**

The results suggest a monetary benefit to the use of EM within a forensic psychiatric setting. Of note, the cost of leave violations were not included in the figures suggesting that the benefits are even more substantial than stated which has wider implications on emergency resources and cost to the public purse. The results represent provisional findings only and the authors recommend that a further economic evaluation is carried out under rigorous trial conditions.

**Eye Gouging: violent behaviour – the last taboo? A case series with a psychodynamic perspective**

**Dr Shari Mysorekar, MB ChB, MRC Psych, MA, Specialist Registrar in Forensic Psychotherapy, Newton Lodge Hospital, The Yorkshire Centre for Forensic Psychiatry, Wakefield**

**Background**

The act of eye enucleation or gouging is deemed to be a taboo subject in the field of sport or interpersonal violence. There is a strong sense of the distaste surrounding this act as described in literature. In Shakespeare’s King Lear, the use of eye gouging is in relation to the torture and punishment of others. Oedipus Rex describes eye gouging as a response to overwhelming guilt. In the present day, it is still used as a form of torture in some parts of the world. In the UK, a recent domestic violence case became high profile as the victim unusually had both eyes gouged rendering her blind. Within a forensic psychiatry setting, such acts remain as unusual and difficult to comprehend and there is limited literature on the subject.

**Case series**

Recent clinical work has led to contact and assessment of patients who had been involved in eye gouging. One patient had made significant attempts to eye gouge whilst the other had gouged the eye of a victim, leaving him permanently blind. The patients involved were male, had a diagnosis of paranoid schizophrenia and had acted in the context of an acute paranoid psychosis. Neither patient had a significant history of interpersonal violence or forensic history.

After further assessment, each patient described, or alluded to an extreme state of paranoia involving the victim. The author was then able to identify a further two cases of eye gouging from case files and profiles of those involved developed further.

**Discussion**

Such extreme and apparently incomprehensible acts may benefit from a different perspective. A psychodynamic formulation can provide a hypothesis which allows for further discussion. The author would postulate that there are complex dynamics underpinning these acts. In psychodynamic terms, there is a projective identification involving the victim, i.e. there are unwanted or unmanageable feelings belonging to the perpetrator which are then ‘got rid of’ by means of projecting them into the victim. The
act of gouging the eye out is complex, but may perhaps be linked to the perpetrator 'seeing' that which is got rid of, in the eyes of the victim. This may be unbearable for the perpetrator and hence the eye which is mirroring the experience he has tried to rid himself of, is obliterated. This occurs in the more developmentally primitive state of acute psychosis. In the cases identified, there are marked difficulties in exploring the offence, either due to denial based on psychotic reasoning or due to guilt and shame. As such, a psychodynamic perspective is able to add to clinical and risk assessment.

Short-Term Assessment of Risk and Treatability (START): Systematic Review and Meta-analysis
Miss Laura O’Shea & Professor Geoffrey Dickens – St Andrew’s Academic Centre, King’s College London Institute of Psychiatry

Aims and hypothesis
The aim of the current paper was to investigate the psychometric properties and predictive validity of the Short-Term Assessment of Risk and Treatability (START). It was expected that the Vulnerability scale would be a stronger predictor than the Strength scale, and that predictive efficacy would be superior for aggressive outcomes.

Background
The START can be scored reliably and has received positive utility ratings from mental health professionals in medium secure mental health units. There is evidence of its predictive ability for some of the identified risk outcomes (violence to others, self-harm, suicide, substance abuse, victimisation, unauthorised leave, and self-neglect), but to date there have been no systematic reviews or meta-analyses of its psychometric properties or predictive validity.

Methods
We conducted a systematic search of five electronic databases for records up to January 2013. Additional papers were located by examining references lists and hand searching. A meta-analysis was conducted using a macro written for SPSS.

Results
Twenty-one papers were included in the narrative review and nine studies involving 543 participants were included in the meta-analysis. The START had good internal consistency, inter-rater reliability and convergent validity with other risk measures. It demonstrated strong predictive validity for various aggressive outcomes, but was less robust at predicting other outcomes. The Vulnerability scale produced stronger mean weighted effect sizes than the Strength scale for most outcomes, and the best predictive efficacy was obtained for physical aggression against others.

Conclusions
The START appears to be a valid and reliable tool and can predict aggressive outcomes at levels much better than chance. However, it is not as accurate in predicting the other intended outcomes, although there is currently insufficient evidence to draw strong conclusions. Further research of the predictive validity of the START for the full range of adverse outcomes, using well designed methodologies and validated outcome tools is needed.

All things being equal? Predictive validity of the Historical, Clinical, Risk-Management 20 (HCR-20) among heterogeneous groups of secure psychiatric inpatients
Laura O’Shea, Dr Fiona Mason, Dr Marco Picchioni – St Andrew’s Academic Centre, King’s College London Institute of Psychiatry, Northampton; Prof Geoffrey Dickens – St Andrew’s Academic Centre, King’s College London Institute of Psychiatry Centre for Health and Wellbeing Research, University of Northampton

Aims
To compare the differential predictive efficacy of the Historical, Clinical and Risk-Management-20 (HCR-20) for physical aggression by gender, diagnosis, age and ethnicity in the largest and most heterogeneous known dataset of risk assessment and inpatient aggression data.

Introduction
The HCR-20 is the most widely used structured violence risk assessment tool in medium secure units in England and has demonstrated good predictive validity for inpatient violence. However, previous research has utilised relatively small, homogeneous samples and little is known about whether its predictive ability varies between different clinical and demographic groups.
Methods
This study was conducted amongst inpatients at St Andrew’s (N=505). Demographic (age, ethnicity, gender), clinical (diagnosis) and routinely collected risk assessment data (HCR-20) were collated. Incidents of aggression were coded using the OAS for the three months following assessment.

Results
ROC analysis revealed that the HCR-20 total, Clinical scale and Risk Management scale were predictive of all types of aggression; the Historical scale was a significant predictor of verbal aggression and physical aggression towards objects but not physical aggression towards people. The predictive efficacy of the HCR-20 differed according to gender and diagnosis, with superior performance obtained with women and those with a diagnosis of personality disorder.

Conclusions
This study provides further evidence about the predictive validity of the dynamic scales of the HCR-20 for inpatient aggression. However, it reveals differences in efficacy between groups. Further development and optimisation of the HCR-20 may be required. An alternative explanation is that interventions to prevent aggression are more effective among some groups. Future research should address these important issues.

Translating Structured Professional Judgement risk assessment into evidence based risk management
Dr Marco Picchioni, Department of Forensic and Neurodevelopmental Sciences, Institute of Psychiatry, London; Prof Geoff Dickens, St Andrew's Academic Centre, St Andrew’s, Northampton

Abstract
Structured professional judgement (SPJ) approaches have become increasingly influential in the assessment and management of the risk of violence in psychiatric patients. The best example is the HCR-20, that is now mandatory for all patients in high, medium and low secure psychiatric care in the United Kingdom.

The clinical utility of these guides has however been called into question, as their ability to be translated from risk assessment to risk management remains elusive.

We present a model framework that was designed with the clinical psychiatric setting in mind. As an approach it helps to turn risk assessment into treatment targets and evidence based risk management. The model assists meaningful clinical implementation of risk informed intervention plans that allows teams to prioritise resources and assess treatment efficacy and risk management success. The model requires few additional resources and also helps to facilitate communication between clinical teams at times of transition, as well as between clinicians and patients.

An audit of antipsychotic side effect monitoring in forensic in-patients
Dr Mark Suett, Dr Ayesha Muthu-Veloe, Dr R Bethamcharlia, Dr Stephen Attard – Men’s Service, St Andrew’s, Northampton; Dr Marco Picchioni – Men’s Service, St Andrew’s, Northampton; St Andrew’s Academic Centre, Institute of Psychiatry, King’s College London & Department of Forensic and Neurodevelopmental Science, Institute of Psychiatry, King’s College London

Background & Aims
Psychiatric patients die between 10 -15 years younger than the general population. They are exposed to multiple risk factors that compromise their physical health, including a sedentary lifestyle, higher rates of smoking and poor diet. For many the psychotropic medicines that they are prescribed are also thought to be a risk factor. This may in part be because of their metabolic side effects, but exacerbated by the manner in which they are prescribed, and a lack of awareness of their side effects. Failure to manage side effects also compromises patient compliance.

This audit aimed to identify the proportion of long stay male forensic in-patients who were prescribed antipsychotic medicines and to establish patterns of side effect monitoring against national guidelines.

Method
We developed an audit tool from the NICE Schizophrenia Guidelines and the 11th edition of the Maudsley Prescribing Guidelines. Participants were adult male patients within the low secure and locked wards of the Male Service at St Andrew’s. Data were extracted from case notes over the preceding 12 months.
Results
41 patients across 3 wards were included. 29 patients had some sort of inquiry about side effects recorded in their records over the preceding 12 months. However, only one patient had been evaluated for side effects using a standardised systematic and structured guide. Where side effects were assessed these tended to be through general open questions that were not followed up by more detailed enquiry or evidence of a plan to address those side effects.

Conclusions
Every patient should have their side effects monitored using a standardised systematic structured guide. Side effect monitoring within our in-patients did not meet those expected national standards.

We have established an Action Plan that includes:
- introduce the modified Glasgow Antipsychotic Side effect rating Scale (GASS-m) and incorporate this into the electronic patient records
- record side effects with medicine dose and serum level information at initiation and dose titration
- advise clinical teams to formulate plans to address side effects identified and monitor progress

An audit of high dose anti-psychotic monitoring in secure in-patients
Ms Sharonie Fitzhugh – Men’s Service, St Andrew’s, Northampton; Dr Marco Picchioni – Men’s Service, St Andrew’s, Northampton; St Andrew’s Academic Centre, Institute of Psychiatry, King’s College London & Department of Forensic and Neurodevelopmental Science, Institute of Psychiatry, King’s College London

Background & Aims
Patients with schizophrenia die 15-20 years early, representing a unique cardiovascular disease high risk cohort.

Patients are exposed to the obesogenic complications of psychotropic medicines that are often prescribed multiply and at high doses. Side effect monitoring is advised in guidelines, including the NICE schizophrenia guidelines 2009.

Our aims were to:
- establish the performance of a typical secure in-patient service at identifying those on anti-psychotic medicines and those on high dose and multiple anti-psychotics
- establish clinical practice in side-effect monitoring
- compare the service’s practice with relevant local and national guidelines.

Method
Retrospective data collection from electronic notes of male in-patients in secure and locked services between September 2012 and January 2013. Audit standards were based on local and national guidelines.

Results
59 out of 64 (92.2%) patients were prescribed at least one anti-psychotic, of them 9 (15.3%) were prescribed two. 23 (39.0%) were additionally prescribed a mood stabiliser, and 18 (30.5%) an antidepressant.

Mean antipsychotic dose (chlorpromazine equivalents) was 348.5mg (0 to 1060mg). 15 patients (25.4% of those on antipsychotics) were on combined doses that exceeded BNF maxima. 12 of these patients had medication chart warning notes, but only 8 had care plans to manage monitoring.

60 (100%) patients had weight and height data recorded and 54 (91.5%) pulse and blood pressure. 46 (77.9%) patients had blood glucose recorded and 32 (54.2%) a fasting lipid profile. 44 (74.6%) had an ECG, the QTc interval ranged from 378 to 483ms. No patients had side effects recorded using an objective scale.

Conclusions
Patients taking antipsychotics should be regularly monitored for side-effects. This is an essential part of good quality physical health care. Clinical audit has identified local short-comings in physical health monitoring and suggested areas that need improvement, including the use of a structured validated side effect monitoring scale.
An audit and service evaluation of the treatment of schizophrenia in the personality disorder service at Rampton Hospital
Dr Boris Pinto (ST6 Forensic Psychiatry), Dr Ian Yanson (Consultant Forensic Psychiatrist), Dr Samal Nori (Staff Grade Doctor)

Introduction
The rationale of the project was to ensure that the treatment of co-morbid schizophrenia within the Personality Disorder (PD) Service at Rampton High Secure Hospital was congruent with the NHS Outcomes Framework and the key priorities of the NICE Guidelines for the treatment of schizophrenia.

Method
- The audit was a retrospective review of medical records spanning August 2011 – August 2013. There were eight criteria for review (see Results). The standard for each criterion was 100%. Data collection took place in August 2013.
- 15 patients (27.8% of total population of 54) were identified as having co-morbid schizophrenia within the PD Service.
- 13 patients were deemed suitable to be included in the audit (two had been on long term leave).

Results
1. Physical health monitoring was generally excellent and embedded in standard practice.
2. Consideration of clozapine for treatment resistant schizophrenia was in line with current guidelines.
3. Discussion with patients and documentation of T2 forms was generally very good.
4. There was variation in practice with regard to discussion of IR1 incident forms at subsequent ward rounds; over a third (35.4%) were not specifically noted.
5. Levels of involvement with Occupational Therapy were excellent. About two-thirds of patients were also receiving speech and language input.
6. All three patients who were receiving or completed CBT for psychosis (CBTp), had begun their treatment within the mental health directorate prior to transfer. Six patients were receiving other psychological therapy that incorporated cognitive work on psychotic-type symptoms; three were deemed not suitable for CBTp at that time.
7. Recovery was built into all Care Programme Approach meetings with evidence of regular discussions about individual recovery plans, particularly through named nurse sessions.
8. Just under half of the patients surveyed provided feedback (six or 11.1% of total PD service population). In the main, they were positive about activities available but half wanted more activities at weekends. Most of the patients were keen to receive more written information about their mental disorder(s) and treatment.

Outcome & Recommendations
A number of recommendations were made including drawing up agreed practice on discussion of incident forms (to aid thorough risk review at MDT meetings) and developing the ethos of recovery within the service by providing more access to written information about mental disorders.

Review of transferred prisoners to a medium-secure unit near to their Earliest Date of Release
Dr Irfan Rafiq, Dr Victoria Sullivan & Jessica Williams (Research Assistant), Greater Manchester West NHS Foundation Trust

Aims
To determine the number of determinate-sentenced prisoners transferred to the Edenfield Centre, a medium-secure unit, under section 47 / 49 Mental Health Act 1983.

To assess how close these transferred prisoners are to their Earliest Date of Release (EDR) on transfer and for those prisoners transferred within 3 months of their EDR, to examine the reasons for their admission to hospital.

Methods
All prisoners with a determinate sentence who were transferred to the Edenfield Centre from prison between 01 January 2005 and 31 December 2012 were included. Prisoners under s47/49 who were transferred from other hospitals or those with indeterminate sentences were excluded. Information including basic demographics, sentence expiry date and reasons for transfer was collected.
Further information about prisoners who were transferred with less than 3 months of their EDR remaining was collected to look for length of stay and progress of their admission.

**Results**

43 prisoners with determinate sentences were transferred to the Edenfield Centre within the time period. The average number of days remaining on the sentence was 426 days.

24 (55/8%) remained in hospital following their sentence expiry and were converted to a notional section 37. 14 (32.6%) returned to prison before their EDR and 5 (11.6%) remained in hospital on s47/49. Of the patients detained under a notional section 37, 12 (50%) were discharged from hospital and 12 (50%) remain detained in hospital as of 31 December 2012.

The average number of days the patient remained in hospital following their EDR, for those discharged from a notional s37 or remaining an inpatient was 464 and 368 days respectively.

11 (25.6%) prisoners had less than 3 months remaining before their EDR. One prisoner was transferred to hospital on the day of release from prison and two prisoners were transferred to hospital the day before their release. 6 (54.4%) of this group were discharged from hospital after their EDR date with an average number of 708.5 days in hospital following this.

Reasons for transfer to hospital included psychosis (63.6%), risk to others (45.5%), risk to self (36.4%) and refusing to engage with treatment in prison (36.4%). One prisoner was transferred to hospital within 3 months of his EDR in order to arrange supervised community treatment.

**Diversion Case Series: Characteristics of a year of consultations by a forensic psychiatrist**

*Dr Keith Reid* Consultant Psychiatrist Northumberland Tyne and Wear NHS Trust

**Background**

Our criminal Justice Liaison and Diversion Service operates in six sites in the North East of England. We provide attendance from CPNs to custody and magistrate cells, courts and associated probation attendances. Two of the sites have autonomy regarding data collection for funding reasons. Funding has been provided for one consultant planned activity for each site. The doctor provides telephone and face to face advice for complex cases, medical input into leadership and design of the pathway, liaison with non-clinical professionals and other court users, liaison with providers of health care and teaching to the nurses. The nurses attend from 0700hrs and see cases referred by police and court users. We have a year of data.

**Aims**

To delineate the population of defendants and offenders whose cases make contact with the psychiatrist attending the diversion project.

**Methods**

Data was anonymously collected for a year by the consultant and covered all cases discussed using an a priori data collection sheet. Demographic, offence and clinical data were collected as well as estimated of utility such as source of referral, nature of advice, likelihoods of avoidance of an adjournment, and days of remand saved, based on referrer estimates once the help had been given.

**Results**

N=70. The average age was 34 and 82% were male. Most commonly, 77% of the advice included advice to clinicians, secondly 23% to probation, and thirdly 13% to lawyers. Most common points of referral were "police" and "nurse" (typically the liaison nurse) at 29% each. Most common offence descriptors were 33% "violent", 27% "property" and 20% "against family member"; these descriptors were not exclusive. Where estimable (1 omission) the most common provisional primary diagnoses by ICD-10 subchapter were substance 32%, personality disorder 29%, schizophreniform 12%. Clinical supervision was an element in 67% of cases, liaison with providers in 57%, and preliminary advice regarding disposal in 21%. Overall, remand time was reduced or remand avoided in 13% of cases. For relevant cases the reduction was 13.5 days of remand. The overall mean days saved per court case of court time (length of case management) was 2.5 days but not all cases benefited from this. The overall risk of avoiding an unnecessary day in court was 24%.
Audit of transfer of prisoners from HMP Winchester to hospital under the Mental Health Act

Dr Catherine Sherwin, Ravenswood House Medium Secure Hospital

**Aims**
To compare transfer times from a Category B remand prison to hospital against the 14-day target proposed in the Bradley report and identify the cause of delays.

**Method**
Notes for all hospital transfers from HMP Winchester between September 2010 and May 2013 were examined. Data was collected on ethnicity, psychiatric diagnosis, type of offence, Mental Health Act Status at transfer and level of security of receiving hospital. Data was also collected on the location of the admitting hospital and whether the unit was NHS or Independent. Comparisons were made between the date the prisoner was first identified for transfer, the date of the second medical assessment, date accepted for transfer, and date of actual transfer.

**Results**
There were a total of 61 prisoners transferred to hospital. The most common diagnosis was psychosis (43 [71%]) and the majority of transfers occurred under Sections 48 and 47 of the Mental Health Act (35 [57%] and 18 [30%], respectively). Most prisoners were of White British ethnicity (60%) and the majority had committed violent crimes (34 [55%]).

The largest group of referrals was to Medium Security Units (46 [75%]), with two referrals to a High Security Unit reflecting repeat referral of the same prisoner. There was a significant outlier of 141 days in 2013, which related to a transfer to high security. Overall, a majority (79.3%) did not meet the 14 day target for transfer to hospital. Delays in transfer were identified in time to second assessment (median 12, 3, 7 and 18 days) and between acceptance and transfer (median 15, 3, 10 and 13 days). There was a notable delay in time to second assessment in 2013. 26 (42.6%) transfers were to the locality medium secure unit with a median time to transfer of 21 days (range 4-61 days). 10 were transferred to Independent hospitals with a median time to transfer of 29 days (range 12-41 days).

**Conclusion**
Overall time to transfer to hospital was not significantly different between 2010 and 2013. There were delays obtaining a second assessment in 2010 and 2013. In 2010 this reflected the lack of regular specialist registrar input in the prison and in 2013 the requirement of a second assessor from out of area as the local medium secure ICA was being refurbished. There was a significant delay in transfer to high security in 2013.

The Outcomes of Legislation Allowing Certain Psychiatric Patients in Scotland to Appeal Against Detention in Conditions of Excessive Security

Alexander Slater (Medical Student), Professor Lindsay Thomson (Professor of Forensic Psychiatry at the University of Edinburgh, Medical Director of the State Hospitals Board for Scotland and the Forensic Mental Health Managed Care Network)

The Mental Health (Care and Treatment) (Scotland) Act 2003 introduced the right for patients in high security psychiatric care in Scotland to appeal against detention in conditions of excessive security. A previous study examined the demographic, legal and clinical characteristics of the first 100 patients to appeal under this provision. It was found that applications supported by the patient’s responsible medical officer, and already being included on a transfer list, correlated with successful appeals.

In this study, I examine the characteristics of the next cohort of 110 patients to lodge an appeal against detention in conditions of excessive security. Data were collected by retrospective case note analysis, with the exception, in some instances, that responsible medical officers used a questionnaire to indicate their support for individual appeals. Once the data was codified, groups of patients were compared using the non-parametric Levene test and Kruskal-Wallis test.

The aims of this study were twofold. The first was to look for any change over time in the characteristics of patients making appeals, by comparing these 110 patients with the 100 patients described in the previous study. The second aim was to look for demographic, legal or clinical characteristics which correlate with successful, or unsuccessful, appeals.

In this study, 38% of patients were successful in their appeal, whilst 27% were unsuccessful. The remaining 35% of appeals did not progress to a final hearing. When the characteristics of this cohort of patients were compared with those of the first 100 patients to lodge an appeal, no significant difference was found. As found in the previous study, those patients with the support of their responsible medical
officer, and those already included on a transfer list, had a significantly better chance of success at appeal (p=0.00). However, it was also found that a diagnosis of learning disability correlated with unsuccessful appeals (p=0.015), and that a history of alcohol abuse correlated with successful appeals (p=0.002). These characteristics had not shown significance in the previous study. These findings are discussed and several recommendations are made for improving practice at the State Hospital.

Asenapine Augmentation and Violent Treatment-Resistant Schizophrenia in the High Secure Hospital Setting
Dr E. Naomi Smith, Dr Vijay Druge, Dr Samrat Sengupta, Dr Mrigendra Das. West London Mental Health NHS Trust

Introduction
Asenapine is a novel, recently introduced antipsychotic. It has a unique receptor profile and it is licensed in the UK for the treatment of Bipolar Disorder. However, there is evidence for its effectiveness in schizophrenia and it is licensed for schizophrenia treatment in a number of countries.

Significant numbers of patients within the high secure hospital setting suffer from treatment resistant schizophrenia. Many patients fail to respond to adequate antipsychotic trials, and require augmentation with other antipsychotic or mood stabiliser medication.

We report on our experience of using Asenapine, for augmentation of other antipsychotics in three male patients with treatment-resistant schizophrenia. The patients provided informed consent to participate in this case-series.

Methods
Data was collected from the patients’ clinical records, incident reports and hospital medical centre records. These records were used to derive primary and secondary outcome measures. These included symptom profile, seclusion hours, violence, number of incidents, side effects and metabolic parameters. Symptoms were rated pre and post augmentation with Positive and Negative Syndrome Scale (PANSS), the Modified Overt Aggression Scale (MOAS) and Clinical GlobalImpression Rating Scales (CGI’s).

Results
All patients have diagnoses of treatment-resistant schizophrenia and histories of serious violence. The patients were prescribed Olanzapine, Haloperidol and clozapine respectively. The patient on haloperidol had co-morbid diagnoses of chronic renal impairment and type-two diabetes. All the three patients showed an improvement after the addition of Asenapine. These improvement were characterised by a reduction in global PANSS scores, in the PANSS excitability component, a reduction in scores of violence, overall incidents and reduction in seclusion hours; and it was well tolerated

Conclusion
We found Asenapine to be an effective augmentation agent with other antipsychotics in treatment resistant violent schizophrenia patients. To our knowledge this is the first report of Asenapine to be used as an augmentation agent in violent treatment resistant schizophrenia patients. Clinical improvement was noted within weeks, and it was associated with a reduction in violence and it was well tolerated. Its unique receptor profile as a 5-HT2A, α2-adrenergic, and D2 antagonist and partial 5-HT1A receptor agonist may make it a suitable augmentation agent.

The case series nature and small sample size limits our ability to draw firm conclusions from our data. However, retrospective analysis has allowed us to take a naturalistic approach that this augmentation strategy may be advantageous on an individual patient basis in a high secure hospital setting.

Section 62: need for a national form?
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Aims and method
There are recent concerns that Urgent Treatment under Section 62, MHA 1983, is being increasingly used due to delays in getting a second opinion. It is therefore of paramount importance that it is used and recorded appropriately. The Code of Practice recommends that it should be the approved clinician in charge of treatment who decides the treatment and completes the form. We were aware of practices differing across different areas, with some Trusts adopting the approach that it can be the core or higher trainee who decides and records urgent treatment.
We therefore surveyed 193 trainee psychiatrists and 141 Consultant Psychiatrists within the Yorkshire area to ascertain their current understanding of urgent treatment.

Results
There was a response rate of 35% to the survey. We felt this was a good response considering the topic. Our survey showed that there is no consistency in the authorisation of urgent treatment with a degree of ambiguity about who should complete a Section 62 form. A quarter of respondents in the trainee group had completed a Section 62 form despite not feeling confident in this area. A number of respondents in the consultant group did not feel confident about commenting on current practice due to a lack of awareness in this area.

Clinical implications
The uncertainties about who should record Section 62 treatment in this survey highlight the need for a national standardised form. In our opinion a national form would make the administration of urgent treatment more uniform and safer across the country.

Survey of Provision of Services for Adult Attention Deficit Hyperactivity Disorder - National Compliance with NICE Guidelines

Dr Liz Tate ST6 Forensic Psychiatry Southfield Low Secure Unit & Dr Tamsin Peachey, Locum Consultant Forensic Psychiatrist Bluebird House Adolescent CAMHS

Aims
Despite recent NICE guidance there remains ongoing uncertainty over the role of secondary and tertiary mental health services in managing adult ADHD. The aim of our survey was to establish national compliance with the NICE guidelines concerning this issue

Background
NICE guideline CG72 issued in 2008 (updated 2013) addressed ADHD in children, adolescents and adults and upheld the concept of ADHD as a “persisting” disorder. Drug treatment was recommended as first line in adults with either moderate or severe symptoms, with methylphenidate being the preferred choice. Treatment should be initiated under the guidance of a psychiatrist or other specialist practitioner and should form part of a comprehensive management plan. Commissioning guidance on adult ADHD was issued by NICE in February 2009 in response to ongoing lack of provision. This strongly promoted the principle of commissioning services for this group of patients.

Methods
We designed an online survey which was distributed via the Royal College of Psychiatrist to faculty leads in July 2013. The majority of respondents were from the General Adult faculty. Responses were collated and analysed using a web-based survey instrument.

Results
We received 287 responses from across England and Wales. 86% of respondents told us they worked in General Adult services. 91% were senior clinical practitioners and 9% were medical or clinical directors. 71% said they had treated adults with ADHD in the past year. 66% said there was no specialist team for adult ADHD in their area; 29% said one was provided principally by a single person with a special interest. There was considerable uncertainty around commissioning; 40% said they were not commissioned to continue ADHD treatment to those with established diagnoses or diagnose and treat new cases in adults. 80% said methylphenidate was their first line treatment.

Conclusion
Compliance with NICE guidelines on adult ADHD remains poor. Clinicians are uncertain about commissioning in their locality. Services for affected adults are largely reliant on individual professionals taking a special interest. More needs to be done to develop sustainable services in line with NICE recommendations.
A Ten year retrospective study of incidents of absconding and characteristics of patients who have absconded from Scotland’s first medium secure unit

Dr Fionnbar Lenihan, Consultant Forensic Psychiatrist, The Orchard Clinic, Edinburgh; Dr Carlo Thomas, Registrar ST6, The Orchard Clinic, Edinburgh

Introduction
Absconding has been an important area of concern in the field of Forensic Psychiatry. Despite many years of interest in this topic little is known about which patients abscond, why they do and what strategies could be implemented to prevent absconding.

Our study looks at the characteristics of patients who have absconded from the unit over a period of 10 years from its inception. The data was tabulated in a readable format so that comparisons with available literature could be made. Relevant calculations in terms of rates of absconding over the years was also be calculated.

Aim
Retrospective study of all absconding incidents and corresponding patient characteristics since the Orchard Clinic opened in 2001.

Methodology
Lists of incidents were obtained for the corresponding period from the computerized incident reporting system (DATIX). The required details were cross referenced with the patient’s notes. The data was tabulated on excel sheets under the relevant sub headings and analyzed for results.

Results
- 11 patients accounted for 41 incidents
- 1 patient accounted for 13 incidents
- Apart for 2 patients, incidents of absconding per patient did not exceed 3 incidents.
- Males over represented
- Clear link with substance misuse
- Schizophrenia over-represented
- Clear link with the type of area where the patient was admitted/ stage of treatment
- Majority type of absconding were delayed return from passes (50/85 incidents)
- Next highest majority were opportunistic (22/80)
- Clear link with age

Recommendations
These include procedural and risk management measures. The use of GPS tracking devices was also suggested.

Conclusion
We would argue for the collection and monitoring of data on these events routinely at a national level. The data would need to incorporate some measure of the ‘time at risk’, together with a clear idea of the denominator involved. Statistically outlying performances by individual organizations could then trigger further investigation, just as it happens with surgical mortality data. Such an investigation would then take a more qualitative approach in examining processes and procedures. Even the best risk assessments are probabilistic. We would argue that process may be more important than outcome, and examining this rather than over-relying on the raw figures would lead to more benefit for patients overall.

Risk assessment of psychiatrists inpatients for VTE

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Aims and hypothesis
To ascertain whether risk of Venous Thromboembolism (VTE) is being adequately assessed in the Tyrone and Fermanagh Hospital.

Background
“Assess all patients on admission to identify those who are at increased risk of VTE.” (NICE Guidelines)

In 2005 VTE was the underlying cause of death for more than 250,000 patients in the UK. Antidepressants and antipsychotics increase the risk of VTE. Some psychotic, elderly or confused patients may have difficulty communicating symptoms of VTE to staff.
All medical and surgical patients in general hospitals across all of Northern Ireland are routinely assessed for risk of VTE as part of their admission. Admissions to Psychiatric wards are not in all parts of the province.

The Tyrone and Fermanagh Hospital is a psychiatric unit on an old asylum site.

**Methods**

We created a new VTE risk assessment proforma based on the tool used in general hospitals as well as additional risk factors as identified above. As well as this any contraindications for VTE prophylaxis were also identified.

Each inpatient (total=127) who was an inpatient on the audit day was assessed using the tool. We also examined whether any previous VTE risk assessment was undertaken.

**Results**

127 patients (100%) had at least one risk factor for VTE identified on audit. Only 4 patients (3%) were risk assessed for VTE in admission. 11 (8%) patients had contraindications for prophylaxis.

**Conclusions**

VTE risk assessment is not being routinely undertaken on admission, and high degree of potential risk is being missed at present.

**Discussion**

VTE prophylaxis is important, we had two VTEs in the last six months. Screening for VTE risk should be a routine part of Psychiatric admission to protect patients’ physical health.

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**Patient and staff attitudes towards obesity at a regional secure unit**

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**Background**

Obesity is a public health concern within the general population. Within the forensic psychiatric population this matter is compounded by numerous issues including physical limitations on accessing exercise, severe mental illness, psychotropic medication, poor motivation and unhealthy diets. Forensic services will have to take increasing responsibility for the prevention of obesity within this population.

**Aims**

The aim of this study was to ascertain the views of patients and staff working within a regional secure psychiatric hospital with regard to obesity.

**Method**

Two questionnaires were developed, one for patients the other for staff. They were distributed between January and April 2013. Data were analysed using Microsoft Excel.

**Results**

29 patient questionnaires and 44 staff questionnaires were completed. Patients most frequently estimated that 70-90% of service users were overweight, whereas staff estimated that 40-50% were. 77.8% of patients said that they were overweight; of these 45% said they were bothered ‘a lot’ by their weight. 88.2% said this affected their physical health, 64.7% said this affected their mental health and 70.6% said this affected their self esteem. Medication was found to be the number one contributory factor according to patients, whereas staff reported this to be patient motivation. 53.6% of patients and 54.5% of staff said that the service did not provide enough support with weight management. 26.2% of staff said that they did not feel confident in providing advice on weight management.

**Conclusions**

The results of this survey are likely to be fairly typical of this population. Staff and patients were in agreement that more could be done about this problem and motivating patients to opt for a healthier lifestyle is likely to be crucial to reducing the problem of obesity. Opening a dialogue with staff and patients is perhaps the first step to tackling this problem collaboratively. Further research is also required to gain more insights into the issues and to evaluate any interventions in due course.
**DSM-5 and new diagnostic criteria for schizophrenia: implications for psychopharmacotherapy**

*Dr Sarah Elizabeth Whitaker Bsc MB ChB MRCPsych*

**Introduction**

Most of the national and international guidelines for the pharmacological treatment of schizophrenia are based on DSM-IV-TR or ICD-10. It remains unclear how the diagnostic criteria changes in DSM-5 impact upon pharmacological treatment and therapeutic choices of antipsychotics for schizophrenia.

**Objective**

To investigate if changes made to the diagnostic category "Schizophrenia Spectrum and Other Psychotic Disorders" in DSM-5 would have any implications on the pharmacological treatment of schizophrenia.

**Methods**

DSM-5 criteria for diagnosis of schizophrenia was reviewed and compared to DSM-IV. Guidelines including the National Institutes for Health and Clinical Excellence (NICE), American Psychiatric Association (APA), Canadian Psychiatric Association (CPA), Royal Australian and New Zealand clinical practice guidelines for treatment of schizophrenia (AUS), and World Psychiatric Association (WPA) were reviewed to see if any pharmaco-therapeutic recommendations would be impacted by the new changes.

**Results**

In DSM-5, the intention is to improve validity and reliability of psychiatric diagnosis. Criterion A in schizophrenia has been changed. It is no longer enough for the diagnosis to have bizarre delusions or commentary or conversing hallucinations. However, the change in the definition of psychosis in DSM-5 does not impact significantly on the reported prevalence of schizophrenia. These changes eliminate approximately 2% of patients diagnosed based on DSM-IV-TR. Another change in DSM-5 is deletion of the subtypes of schizophrenia. These subtypes have limited clinical value since they do not show strong relationships to biological variables, and also they are not consistent in the long term and are interchangeable with one another. Catatonia is the only subtype that is kept in the new DSM-5, but as a specifier since catatonia is no longer mutually exclusive for schizophrenia. Catatonia can be associated with other mental disorders (e.g. bipolar disorder, depressive disorder), or can be due to a physical health condition (e.g. hepatic encephalopathy) or unspecified. NICE, APA, CPA, AUS, and WPA guidelines were reviewed to see if any therapeutic recommendations would be impacted on by the new changes. The APA clearly mentions that schizophrenia is not treated differently based on the different subtypes; catatonia is an exception in which benzodiazepines and electroconvulsive therapy are recommended. Every subtype of schizophrenia benefits from first generation antipsychotic (FGA) medication regardless of the subtypes. The CPA guidelines do not recommend any changes in treatment based on the traditional subtypes. The NICE guidelines are based on ICD-10. However both DSM-IV-TR and ICD-10 agree on the symptoms of schizophrenia. In the NICE guidelines no significant differences between the FGAs regarding treatment of acute episode of subtypes of schizophrenia have been demonstrated; the choice was made based on the side effects of medications. The WPA did not have individual guidelines but it compared available guidelines for schizophrenia. They came to the conclusion that most practice guidelines are based on methodology of moderate quality and their pharmacotherapy recommendations are fairly similar. The AUS guidelines regarding the impact of new changes, in these guidelines it was found that ECT is an option for catatonia treatment and for refractory or affective symptoms.

**Conclusion**

It appears that the diagnostic category changes in DSM-5 may not significantly impact psychopharmacotherapy of schizophrenia.

**Novel Clozapine augmentation strategies – service evaluation in a high secure hospital**

*Dr Paul Young (Ashworth Hospital, Mersey Care NHS Trust); Dr Edward Silva (Ashworth Hospital, Mersey Care NHS Trust)*

**Aims and Hypothesis**

To determine the effectiveness of novel non-antipsychotic clozapine augmentation strategies with: lamotrigine, topiramate, allopurinol, memantine.

**Background**

The management of treatment resistant schizophrenia unresponsive to clozapine has a limited evidence base. Adding D2 blockade to the receptor profile of clozapine with an additional antipsychotic is the most common strategy. If unsuccessful, common practice entails serial trials of antipsychotic augmentation.
However alternate strategies to inhibit glutamate release (lamotrigine), directly potentiate GABA (topiramate) increase adenosine (allopurinol) or antagonise NMDA (memantine) may offer some benefits and have different and occasionally beneficial side effect profiles.

**Methods**
Current patients at Ashworth Hospital prescribed clozapine and augmentation with lamotrigine, topiramte, memantine or allopurinol within 3 years and remaining for at least 6 months were identified. Effectiveness was assessed by retrospective analysis of patient notes in order to rate clinical global impression (CGI), CGI improvement and clozapine dose at initiation. Reasons for any discontinuations were documented.

**Results**
Lamotrigine augmentation was used in fifteen patients, topiramate in three, allopurinol and memantine in one each. There was an observed overall CGI improvement with clozapine augmentation in Lamotrigine, Memantine and Topiramate, with the biggest improvement with Topiramate. Unexpectedly, weight loss with Topiramate was not observed, with 2 of the 3 patients having increased weights. An independent samples Kruskal-Wallis test did not show a statistical difference between augmentation strategies for CGI score at start of therapy, CGI improvement scores or change in BMI over the study period. There were 3 discontinuations. Allopurinol was ineffective, one patient’s psychosis deteriorated with lamotrigine and another had a non-serious rash.

**Conclusions**
Pharmacological alternatives to the addition of D2 blockade are easily deliverable, can be evaluated simply and may be effective for some patients without adding to the side effect burden. The small sample size prevents strong conclusions being drawn.