



Faculty of Forensic Psychiatry Annual Conference

1 – 3 March 2017

Novotel Madrid Centre

Abstract book

Speaker biographies and abstracts

Listed below are the abstracts and biographies available to us at the time of printing.

Wednesday 1 March

09:25 – 09:45

The Terrorist Threat, Mental Health and Prevent Liaison and Diversion

An overview of the current threats facing the U.K and the role Prevent plays in trying to mitigate these risks. The impact of the threat and Mental Health with a brief example, highlighting the grey area between vulnerability and extremism. An explanation of the key role Channel plays in utilizing existing collaboration between local authorities, other statutory partners, the police and the local community to identify individuals at risk of being drawn into terrorism; assess the nature and extent of that risk; and develop the most appropriate support plan for the individuals concerned. An overview of the Prevent Liaison & Diversion (PLAD) team, a joint police and NHS mental health pilot to support the management of individuals of CT concern who have mental health issues will also be given.

Chief Inspector Matt Cray is a Metropolitan Police officer with 24 years' experience. He has worked on a number of different units and boroughs across London, including the Diplomatic Protection Command in 2004, the largest firearms command in the country. In 2009 Chief Inspector Cray joined the Counter Terrorism Command where he has been responsible for leading partnership work with key agencies to deliver the Prevent agenda across London. He implemented Multi Agency Channel Panels across London to help support individuals who were likely to become involved in extremism. He has worked in partnership intervention with the Charity Commission to disrupt extremist venues and co-ordinated the most successful 'Prevent' Engagement project, delivering to 14,500 schoolchildren using a 'credible voice' in the community. He was responsible for the creation of the Vulnerability Assessment Officer role and supervised the newly formed Safeguarding Unit that was set up in April 2016, in response to minors travelling or attempting to travel to geographical locations under the control of terrorist groups. Chief Inspector Cray has recently overseen the Prevent Liaison & Diversion (PLAD) team which is a joint Police and NHS mental health pilot. The team sees psychiatrists, clinical psychologists, and mental health nurses working jointly with Counter Terrorism officers to support the individuals of CT concern who have (or may have) mental health issues. Chief Inspector Cray is also a National Hostage Crisis and Kidnap Negotiator, and has a BSc (Hons) in Policing and Police Studies.

09:50 – 10:10

There and back again: the study of mental disorder and terrorist involvement

For the past forty years, researchers studied the relationship between mental disorder and terrorist involvement. The literature developed in four paradigms, each of which differs in terms of their empirical evidence, the specific mental disorders studied, and their conceptualizations of terrorist involvement. These paradigms have not, however, witnessed linear and incremental improvements upon one another. Although one paradigm has generally tended to dominate a temporal period, many false assumptions and incorrect interpretations of earlier work permeate into today's discourse. This paper provides a history of the study of mental disorders and the terrorist. First, we briefly outline the core fundamental principles of the first two paradigms, the paper then outlines the core arguments produced by the seminal reviews conducted in paradigm three. We highlight how these findings were consistently misinterpreted in subsequent citations. We then highlight recent innovations in the study of terrorism and mental disorder since the various influential literature reviews of 1997-2005. We conclude by outlining how future research in this area may improve in the coming years by broadening our understanding of both terrorist involvement and psychopathology away from simple dichotomous thinking.

Dr Emily Corner is a Research Associate at the department of Security and Crime Science at UCL. Her doctoral research focused on examining mental disorders and terrorist behaviour. She has published in leading psychology, forensic science, criminology, and political science journals. She has worked on research projects funded by DSTL, the European Union, and the National

Institute of Justice. Prior to her doctoral research she worked across step-down, low, and medium secure psychiatric hospitals, in both inpatient and outpatient settings.

Dr. Paul Gill is a senior lecturer in Security and Crime Science. Previous to joining UCL, Dr. Gill was a postdoctoral research fellow at the International Center for the Study of Terrorism at Pennsylvania State University. He has over 40 publications on the topic of terrorist behaviour. He has conducted research funded by the Office for Naval Research, the Department of Homeland Security, DSTL, the European Union, the National Institute of Justice, CREST and MINERVA. These projects focused upon various aspects of terrorist behavior including the IED development, creativity, terrorist network structures, and lone-actor terrorism. His doctoral research focused on the underlying individual and organizational motivations behind suicide bombing. This piece of research won the Jean Blondel Prize for the best Ph.D. thesis in Political Science in Europe for 2010. He has published in leading psychology, criminology and political science journals.

10:15 – 10:35

Social Epidemics and Public Mental Health: Preventing Gangs and Radicalization

Infectious disease epidemiology can help us understand the spread of violence through subgroups of the population who are at risk, and sometimes entire populations. Ideas, behaviours and styles all spread from one person to another in a culture through the behaviour they generate. The likelihood of transmission is increased according to 'host' characteristics in the population, the power of these ideas and those who disseminate them, together with special risk factors in the social environment. Socially excluded groups and those who see themselves as marginalised are particularly at risk of extremism, potentially leading to violence. Examples of social epidemics will be described, including the spread of gangs and radicalisation. Preventive interventions are still in their infancy and psychiatrists are at the periphery rather than central to these. Psychiatrists are trained to focus on individuals and the psychopathology of severe mental illness when intervening to prevent violence. Few are 'public mental health' practitioners but we need to question how and from where patients get the ideas that target their violence in the context of so-called 'lone actor' terrorism.

Jeremy Coid is Professor of Forensic Psychiatry and retired from his role as Director of the Violence Prevention Research Unit, Institute of Preventive Medicine, Queen Mary University London at the end of 2016. He continues in epidemiological research and teaching with a special interest in Public Mental Health and the Social Epidemics of Violence. He also continues in clinical and medicolegal practice at the individual level as a Forensic Psychiatrist.

10:40 – 11:00

Working with Young People and Families in the Context of Radicalisation Fears

Dr Azer Mohammed, *Central North West London NHS Foundation Trust*

12:00 – 12:50

This house supports the full co-operation of psychiatrists in the Prevent Strategy

Chair: Dr Adrian James

For:

Dr Frank Farnham, *Barnet Enfield and Haringey Trust and team.*

Dr Nicky Fowler, *UK*

Against:

Dr Derek Summerfield, *IOPPN, South London and Maudsley NHS Trust and team,*

Dr Mayura Deshpande, *UK*

14:05 – 14:25

Overview of Treatment for Personality Disorders

This presentation will review the main treatments for personality disorders that have been developed in the last 20-30 years. The main therapy models will be briefly reviewed. The current state of the evidence for these models will be considered, including adaptations for a forensic population where these exist. Current developments and challenges in implementing PD treatments will be highlighted.

Michaela Swales PhD is a Consultant Clinical Psychologist with Betsi Cadwaladr University Health Board and Reader in Clinical Psychology on the North Wales Clinical Psychology Programme, School of Psychology, Bangor University. She trained in Dialectical Behaviour Therapy in Seattle in 1994 / 95 with Marsha Linehan and for twenty years ran a clinical programme for suicidal young people in an inpatient service. After completing specialist supervision in the DBT, she became one of the founder members of the UK DBT Training Team in 1997 and subsequently Director of the Training Team in 2002. She has trained more than a thousand professionals in DBT, seeding over 400 programmes, in both the UK and further afield. She is the author with Heidi Heard PhD of *Dialectical Behaviour Therapy: Distinctive Features* published in 2009 by Routledge and *Changing Behavior in DBT: Problem-Solving in Action* published by Guilford in November 2015. She, along with Dr Heard, won the Cindy Sanderson Outstanding Educator Award at the International Society for the Improvement and Training of DBT at their conference in New York in 2009. Dr. Swales is also participating in the Working Group on Classification of Personality Disorders, which reports to the World Health Organisation (WHO) International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders.

14:30 – 14:50

Personality Disorder and Risk: The Role of Formulation

Personality disorder is associated with harmful behaviour; a high proportion of people who are frequently harmful towards themselves or others have personality problems. However, the functional link between personality disorder and harmful behaviour has been difficult to map because of the challenges of undertaking the kind of research that can explore causal links. This situation poses a challenge to practitioners who are required to understand the past harmful behaviour of their personality disordered clients in order to manage the risk of future harm, and to do so in an evidence-based and transparent way. This paper will begin by addressing the challenges of linking personality disorder to risk empirically. It will then propose the key role of case and risk formulation in creating an understanding of the association in the individual case such as to guide risk management in general and treatment in particular. Recent developments in our understanding of the formulation process and ongoing research into its impact will be summarised.

Caroline Logan is Lead Consultant Forensic Clinical Psychologist in the Specialist Services Network in Greater Manchester Mental Health NHS Foundation Trust and Associate Director of a post-graduate Master's degree course in forensic mental health at the University of Manchester, England. She has worked in forensic services for over 20 years, with both men and women, focusing mainly on risk and personality disorder assessment, formulation and treatment on the subject of which she has published two books and a number of articles.

14:55 – 15:15

Dialectical Behaviour Therapy in Forensic and Correctional Settings

Dr Shelley McMain
University of Toronto

Dr. Shelley McMain is an Associate Professor in the Department of Psychiatry at the University of Toronto, Canada. She is also the Head of the Borderline Personality Disorder Clinic, and a Clinician Scientist at the Centre for Addiction and Mental Health. Dr. McMain has expertise in personality disorders and DBT. She has authored a number of major publications on the treatment of borderline personality disorder and on DBT. Dr. McMain is the recipient of several distinguished research awards including the distinguished scientific awards from the European Society for the Study of Personality Disorders and the American Psychoanalytic Association

15:20 – 15:40

Trials and tribulations of implementing an RCT of mentalization-based treatment for antisocial personality disorder in the Criminal Justice System

Dr Jessica Yakeley
Director, Portman Clinic, Director of Medical Education, Tavistock and Portman NHS Foundation Trust, London

Since 2013, as part of the Offender Personality Disorder Pathway, we have implemented and developed new services across 14 sites in England and Wales offering mentalization-based

treatment (MBT) to male violent offenders with antisocial personality disorder under the management of the National Probation Service. In 2015, led by Peter Fonagy at UCL, we were successful in being granted funding by the NIHR to conduct an RCT comparing MBT to Probation as Usual (PAU). This presentation will summarise the challenges faced in implementing this RCT in today's Criminal Justice System, and suggest that the nature of these challenges may reflect the psychopathology of the offenders being treated and researched.

Jessica Yakeley is Consultant Psychiatrist in Forensic Psychotherapy and Director of the Portman Clinic, and Director of Medical Education, Tavistock and Portman NHS Foundation Trust. She is also a Fellow of the British Psychoanalytic Society. She has published on topics including medical education, violence, risk assessment, prison health, forensic psychotherapy and antisocial personality disorder, is the author of *Working with Violence: A Contemporary Psychoanalytic Approach* (Palgrave Macmillan, 2010), and lead Editor of *the Oxford Specialist Handbook of Medical Psychotherapy* (OUP, 2016), and the Editor of the journal *Psychoanalytic Psychotherapy*. She is Research Lead for the Royal College of Psychiatrists Medical Psychotherapy Faculty and for the British Psychoanalytic Council. She is currently leading the national development of new clinical services in the National Probation Service as part of a multi-site randomised-controlled trial of mentalization-based treatment for antisocial personality disorder, led by UCL, as part of the UK Government's National Personality Disorder Offender Pathways Strategy.

16:30 – 17:05

Keynote - Malingering: challenges for clinical assessment and management

Chair: Professor Tom Fahy, *Institute of Psychiatry, London*

Speaker: Dr Chris Bass, John Radcliffe Hospital, Oxford. I trained in medicine at Cambridge University and St. Thomas's Hospital in London and in Psychiatry at Kings College Hospital in London. I have been working as Consultant in Liaison Psychiatry at the John Radcliffe Hospital in Oxford since 1991 where I have carried out collaborative research with many different hospital specialists and worked in a joint Pain clinic. My main areas of research and clinical interest include patients with persistent medically unexplained physical symptoms and patients with fabricated illnesses, including fabricated or induced illness in children. In 2011 I published a case series of perpetrators of fabricated or induced illness in children [with Dr David Jones]. I have also co-edited *Hysterical Conversion: Clinical and Theoretical Perspectives* (with Halligan P and Marshall J), OUP 2001; and *Malingering and Illness Deception* (with Halligan P and Oakley D) OUP, 2003.

My forensic practice involves the assessment of patients with chronic pain after accidents or occupational stressors. Recently I worked with a multi-disciplinary group at the Royal College of Psychiatrists, which plans to publish guidance for clinicians asked to assess patients in whom fabricated or induced illness is suspected. I co-wrote two reviews on illness deception and fabricated or induced illness, published in the *Lancet* in 2014.

Thursday 2 March

09:30 – 09:45 - What treatments might reduce violent recidivism? - medications, psychological programmes, and harnessing population-based datasets

Most programs to reduce reoffending focus on psychosocial interventions, but their effect sizes are weak to moderate. As psychiatric and substance use disorders, which increase reoffending rates, are overrepresented among jail and prison populations, treatment with appropriate psychotropic medications offers an alternative strategy to reduce reoffending. This talk will review the evidence for pharmacological strategies to reduce risk of repeat offending, and also present the findings of a new population based study from Sweden which followed up 22,275 prisoners for a median of 5 years. This new study investigated whether commonly prescribed psychotropic medications altered risk of violent repeat offending using between and within-individual models. It compared their effects on violent recidivism with three routinely administered psychological programmes in prison (aimed at general criminality, violence, and substance abuse). The main findings were that three classes of psychotropic medications (antipsychotics, psychostimulants, and drugs used for addictive disorders) reduced risk of violent recidivism, while the other two classes (antidepressants and antiepileptics) and a negative control (adrenergic inhalants) did not. Psychological programmes in prison had smaller

effects on recidivism risk, even when programmes were more closely matched to their indications. In summary, evidence-based provision of psychotropic medications to released prisoners may have the potential to make substantial improvements to public health and safety, particularly in countries that are undergoing decarceration.

Seena Fazel is a Wellcome Trust Senior Research Fellow and professor of forensic psychiatry at the University of Oxford. His clinical work is as a visiting psychiatrist to a local prison.

09:50 – 10:05 **Update on the Neuropsychiatry of Traumatic Brain Injury**

Dr Mike Dilley is a Consultant Neuropsychiatrist in Neurorehabilitation and has specialist interests in traumatic and acquired brain injury and severe and complex functional neurological disorder that requires multidisciplinary inpatient rehabilitation.

Dr Dilley provides input across the entire integrated care pathway for patients with neuropsychiatric needs associated with brain injury and sees patients in neurological intensive care, on the acute brain injury unit at St George's Hospital; looks after inpatients at the Wolfson Neurorehabilitation Centre at Queen Mary's Hospital, Roehampton and outpatients at The Wolfson Neurorehabilitation Centre, Wolfson Vocational Rehabilitation Programme and Wandsworth Community Neurorehabilitation Team. As such, Dr Dilley will often support a patient's recovery along their entire journey from acute care to a return to the community. He is also Honorary Consultant Neuropsychiatrist at The Royal Hospital for Neurodisability. He is a member of the Clinical Reference Groups in Neuroscience and Complex Disability at NHS England; the Faculty of Neuropsychiatry, Royal College of Psychiatrists and British Society of Rehabilitation Medicine.

Dr Dilley completed his training at The Maudsley, National Hospital for Neurology & Neurosurgery and Institute of Psychiatry. Before starting his neuropsychiatry consultant career at The Maudsley in 2011, he worked for five years as a General Adult & Community Consultant Psychiatrist and Inpatient Clinical Lead in the Borough of Westminster and was Honorary Consultant Neuropsychiatrist at Queen Square, managing patients with functional neurological disorders.

10:10 – 10:25

Suicide and self-harm – an update

Nav Kapur Professor of Psychiatry and Population Health at the University of Manchester, UK, and an Honorary Consultant Psychiatrist at Greater Manchester Mental Health NHS Foundation Trust. He is Head of Research at the Centre for Suicide Prevention in the University of Manchester and leads the suicide work programme of the National Confidential Inquiry into Suicide and Homicide which collects data on all suicide deaths among people in contact with health services in the UK. He was Chair of the Guideline Development Group for the National Institute for Health and Clinical Excellence (NICE) self-harm guidelines (longer term management) and also chaired the Quality Standards for self-harm. He is currently chairing the NICE guidelines for depression in adults and is topic expert on the NICE guidelines for suicide prevention in the community. He is a member of the Department of Health's (England) National Suicide Prevention Strategy Advisory Group. He has published extensively on suicide and self-harm with much of his research focussing on how health services might best contribute to suicide prevention.

10:30 – 10:45

Update on Autism Spectrum Disorder

Dr Dene Robertson

Neurodevelopmental Services, South London and Maudsley NHS Trust

10:50 – 11:05

Prison healthcare services: The NHS's Ugly Sisters?

Dr Andrew Forrester is a Consultant Forensic Psychiatrist with Lancashire Care NHS Foundation Trust and South London and Maudsley NHS Foundation Trust, and an Honorary Senior Lecturer in Forensic Psychiatry at the University of Manchester. He is Clinical Director of the Offender Health Research Network.

11:55 – 12:10 **Idle thoughts of an idle fellow**
Professor Sir Simon Wessely – President, RCPsych

Sir Simon Wessely is Regius Professor of Psychiatry and Co-Director, King's Centre for Military Health Research and Academic Department of Military Mental Health, Institute of Psychiatry, Psychology and Neuroscience, King's College London. He is a clinical liaison psychiatrist, with a particular interest in unexplained symptoms and syndromes. He has responsibility for undergraduate and postgraduate psychiatry training, and is particularly committed to sharing his enthusiasm for clinical psychiatry with medical students. He also remains research active, continuing to publish on many areas of psychiatry, psychological treatments, epidemiology and military health.

Professor Wessely has over 750 original publications, with a particular emphasis on the boundaries of medicine and psychiatry, unexplained symptoms and syndromes, military health, population reactions to adversity, epidemiology, history and other fields. He has co-authored a text book on chronic fatigue syndrome, a history of military psychiatry and a book on randomised controlled trials, although none are best sellers. He is active in public engagement activities, speaking regularly on radio, TV and at literary and science festivals as well as writing columns for many national newspapers.

12:15 – 12:50
Keynote - Inflammation in Psychosis

Professor Pariante will review the state of the art in the field of immunopsychiatry, an area of research that investigates the relationship between the brain and the immune system in the context of depression and other mental disorders. This area will deliver novel therapeutic approaches targeting the immune system and, for the first time, lead to the blood-test-based, personalized treatment in psychiatry

Carmine M. Pariante is Professor of Biological Psychiatry at the Institute of Psychiatry, Psychology and Neuroscience, King's College London, and Consultant Perinatal Psychiatrist at the South London and Maudsley NHS Trust.

He investigates the role of stress in the pathogenesis of mental disorders and in the response to psychotropic drugs, both in clinical samples and experimental settings. His work focuses on depression and fatigue, with a particular interest in the perinatal period and in subjects with medical disorders. Moreover, he also uses experimental and cellular models.

Professor Pariante has received numerous awards for his research: for example, from the National Alliance for Research in Schizophrenia and Depression (NARSAD), the American Psychiatric Institute for Research and Education (APIRE), and the British Association for Psychopharmacology. He has recently been awarded the 2012 "Academic Psychiatrist of the Year" Award from the Royal College of Psychiatrists, the 2015 Anna-Monika Prize for Research on Depression and the 2016 PNIRS Normal Cousins Award for Research in Psychoneuroimmunology. 2015 Anna-Monika Prize for Research on Depression, and the 2016 PNIRS Normal Cousins Award for Research in Psychoneuroimmunology.

His dream is that new therapeutic tools targeting the stress system will soon be available to alleviate the suffering of patients with mental health problems. He can be followed on Twitter [@ParianteSPIlab](#) and on <http://www.huffingtonpost.co.uk/carmine-pariante/>.

14:00 – 15:25 **Parallel Symposia**

An American Psychiatric Perspective on Solitary Confinement

Professor Reena Kapoor, *Yale School of Medicine, USA*

Approximately 100,000 prisoners are held in solitary confinement in American prisons on any given day. Mental health professional organizations have called for substantial reform to our current correctional practices, largely based on clinical judgment and older scientific studies suggesting that solitary confinement causes behavioral disturbances. More recent and methodologically rigorous studies about the psychological effects of solitary confinement have

yielded conflicting results, with some concluding that the practice is not uniquely harmful to prisoners. The end result is that advocacy efforts have, in many cases, outpaced scientific knowledge. American correctional systems are currently engaged in a heated debate with mental health professionals and legal advocates about if, when, and how to reform solitary confinement—often without adequate data to make informed choices.

In this seminar, we review the existing scientific literature around solitary confinement and the recommendations of leading mental health professional organizations. We then discuss the current legal and political context of solitary confinement reform. Finally, we consider strategies for change and the role of mental health professionals in advocating for improved clinical care of prisoners in solitary confinement.

Supported employment for offenders with mental disorder

Dr Najat Khalifa, *University of Nottingham, Institute of Mental Health*

Miss Emily Talbot, *University of Nottingham, Institute of Mental Health*

Professor Birgit Völlm, *University of Nottingham, Institute of Mental Health*

Academic literature and government initiatives have emphasised the importance of work as a means of improving health and reducing reoffending among offenders with mental disorders. Whilst a number of work skills programmes have shown promise for offenders more generally, evaluation of evidence for their effectiveness for those with a mental disorder is limited, particularly in relation to improving employment outcomes.

This symposium will:

1. Provide a brief synopsis of findings of a systematic review of the literature on the effectiveness of work skills programmes for offenders with mental disorder (Miss Emily Talbot).
2. Present findings from a cluster randomised feasibility trial funded under the NIHR Research for Patient Benefit funding stream. The overall aim of the study is to assess the feasibility of conducting a randomised controlled trial to evaluate the effectiveness of Individual Placement and Support (IPS; a form of supported employment) in improving employment rates and associated psychosocial outcomes in forensic psychiatric populations. There are three major research strands to this study as follows (Dr Khalifa):
 - A. Implementation of IPS in community forensic services: The specific objective of this strand is to embed the IPS model in the community forensic services, in which the feasibility study will be carried out, by bringing employment specialists into clinical teams, raising awareness about IPS within the organisation, forming links with IPS services within the NHS Trust and developing links with employers, as well as conducting IPS fidelity reviews.
 - B. Feasibility Cluster Randomised Controlled Trial (RCT): The specific objectives of this strand are to estimate the parameters required to design a full RCT.
 - C. Process Evaluation: This entails conducting two qualitative studies with patients and staff to identify the structural, legal, organisational and individual-level barriers and facilitators to implementation of IPS in community forensic mental health settings; and also Fidelity Reviews to assess the extent to which the services follow the principles of IPS and to assess how well the employment specialist functions within the community forensic services.
3. Describe the work and structure of Vocational Services in one of the UK's largest provider of forensic services, and findings from a research study that examined staff and patient views on vocational services at a high secure hospital (Professor Völlm).

Trauma Informed Care

Lawrence Jones, *Rampton High Secure Hospital*

#Lifeonthepsychward: The making of a fly on the wall documentary about Forensic Services

Guy King

Rare Day Productions/Channel 4

Dr Tim McInerny

Dr Shubulade Smith
South London and Maudsley NHST

Dr Thomas Fahy
South London and Maudsley NHST

"Oh the places you'll go!"- make the most of your higher training within Forensic Psychiatry

Dr Joanne Parry, *ST6 Trainee*
Dr Matthew Tovey, *PTC Chair*
Dr Trevor Gedeon, *ST5 Trent division*

Based on the poem "Oh the places you'll go!" by Dr Seuss two forensic higher trainees and one newly appointed consultant will give their experiences of making the most of forensic higher training including how to manage the challenges and adversities you may face. From making the most of your training through opportunities in the college, to experiencing an OOPE, through to the conclusion of training and managing failure at the all important consultant interview-presenters give an honest and insightful glance into what they have learned.

With the opportunity for discussion and sharing of ideas we aim to give an invaluable and interactive session for all trainees from existing higher to foundation. The inclusion of a trainee specific session at the conference is novel and of potentially huge interest to the more junior conference attendees.

The educational goals include aiding forensic trainees to meet their curriculum objectives and also maximise their own personal as well as professional development.

"Being mortal: Dealing with terminal illness and expected deaths in secure care"

Dr Ramneesh Puri- Consultant Forensic Psychiatrist, Rampton Hospital and Doncaster Prisons; has patients on high secure villa with the only designated end of life care suite

Professor Chris Packham- *Associate Medical Director for Physical and Public Health, Nottinghamshire Healthcare NHS Foundation Trust*

Dr Pratish Thakkar- *Clinical Director, Forensic Mental Health, Middlesbrough*

Dr Deepak Tokas- *Consultant, Old-Age Forensic Low Secure Service, TEWV Trust*

Dr Maria Dolores Bragado- *Consultant Forensic Psychiatrist, Locked Rehabilitation Service, Cambian Churchill Hospital, London.*

As forensic psychiatrists we sometimes have seriously or terminally ill patients in secure care/prisons who are deemed too risky for discharge or release by the Ministry of Justice but are at the same time seen as "futile" in terms of treatment benefits by our medical colleagues. This can potentially lead to moral and ethical dilemmas, particularly around decisions such as withholding treatment and DNA CPR etc. Should the fact that our patients are detained against their wishes, away from their homes and families, often for a long time, mean the threshold for such decisions should be higher in our settings than on medical wards? How do the GMC, the NICE and the Courts view these issues? And how do these deaths impact on those involved in the care of patient care till their end.

How can violence be reduced in Forensic Intellectual Disabilities medium security inpatient wards? Results of a 3 year Quality Improvement Project

Dr Sanjib Kumar Ghosh.
Violence Prevention Research Unit, Queen Mary University of London & Forensic Directorate, East London NHS Foundation Trust.

Professor Jeremy Coid

Queen Mary Hospital, London

Dr Jane McCarthy
Kings College London and Danshell Learning Disabilities Group

Mr John Rochester
East London NHS Foundation Trust.

Acknowledgements:

Professor Jeremy Coid and Violence Prevention Research Unit (Queen Mary University London)

Background

Aggression and violence are common in psychiatric wards especially amongst detained patients with psychotic symptoms and personality issues. Appropriate management may help recovery and reduce the need for restrictions. The use of restraint and seclusion may exacerbate or maintain the aggression and violence in the unit. The use of sedative medications and secluding patients without actively engaging them in any therapeutic activity does not address patients' needs appropriately, makes them more lethargic and less able to express themselves. The activities in secure units can be limited due to fear that patients may damage the equipment. Patients are expected to reach a reasonable level of stability in their mental state before they can be escorted to off-ward activities. To reduce violent incidents, and increasing engagement without using extra resource is the challenge explored by this project.

Method

This ward-based Quality Improvement Project was conducted on Shoreditch ward. It is a 14-bed Medium Secure inpatient ward for patients with intellectual disabilities at East London Forensic Services.

The primary outcome measures included reduction in the incidents of violence and aggression. The secondary outcome measures included reduction in average length of stay, reduction in seclusion rates, reduction in staff sickness rates with a consequent reduction in use of bank and agency staff. These outcomes were established with staff and progress made was discussed with staff at ward governance meetings held monthly.

The project is one year into its conception. It extends on from a similar project on Clerkenwell ward which is a Low Secure inpatient ward for patients with intellectual disabilities at East London Forensic Services. The project on Clerkenwell ward brought down violent incidents using innovative strategies such as a sensory room and brief "safety huddles" between ward staff to highlight possible new risk-issues.

These were considered at Shoreditch ward in meetings amongst all staff. However, it was instead decided the PDSA-cycles would begin by increasing out-of-hours ward based activities. With further PDSA-cycles, two staff were dedicated to lead these activities. A simple register was added to gauge safety amongst staff and patients. Activities were also evaluated for attendance, and poorly attended activities were replaced by others.

Results and Conclusions

The results show an improvement in Clerkenwell's data with regards to reduced violent incidents, and days between violent incidents. This was reflected by Shoreditch's data for a while. However, since November 2015, Shoreditch ward has demonstrated more inconsistent results. This was significantly due to difficulties with a new patient, and a deterioration in a couple of others' mental states. This reflects the importance and influence of the patient mix on violence figures. It also reflects the difficulties with emphasising results with a small sample of patients (i.e. on 1 ward). It also reflects the violence depends significantly on a patient's mental state, and environmental changes are limited in what they can achieve. It is also likely longer-term, rehabilitation units such as Clerkenwell may perform better as there is more time and stability of the patient. The environment can then be more easily adapted to reduce violence. The patient would be more responsive to changes such as increased ward activities.

Sources and expression of bias in expert witness practice

Professor Nigel Eastman
St George's, University of London

Dr Richard Latham
East London NHS Foundation Trust

Expert witness practice of psychiatrists is under increasing scrutiny by the courts and the GMC. Whilst, under medical revalidation, there is a requirement that medico-legal activity conducted outside a doctor's contract of clinical employment is appraised by the Responsible Officer (RO) charged with determining whether s/he should be recommended to the GMC for revalidation. Hence, the College's Centre for Quality Improvement has, with Professor Keith Rix, established and endorsed a feedback system designed specifically for expert psychiatric witnesses ('The Multi-Source Assessment Tool for Expert Psychiatric Witnesses'); complemented by medico-legal cases within case based discussions.

Appraisal of expert witness practice must address not only technical competence, including evidence of a real understanding of the interface between medicine and law, but also ethical probity, which is the more challenging appraisal focus.

Within forensic psychiatry there is much room for 'values incursion', and therefore bias, in the expression of expert opinion, sometimes resulting in 'base line drift'; the risk being enhanced where experts operate in isolation. Whilst the risk of such bias is not restricted to expert witness practice in the courts, being capable of occurring in evidence given to mental health tribunals.

Bias can arise from sources 'within' the expert, including as a reflection of his/her 'relationship' with the subject of assessment or his/her values; or as an inherent reflection of the adversarial legal system. Routes to the expression of bias are numerous, throughout the method of assessment, report drafting and giving of oral evidence.

The symposium will address both the sources and routes to expression of bias, including from real case descriptions. Hence, the educational objectives will be:

- (1) enhancing the ability to recognise the influence of personal and professional values upon forming and expressing expert evidence to courts;
- (2) raising awareness of otherwise 'unseen' or 'unrealised' sources of bias;
- (3) raising awareness of the ways that bias can be expressed in both writing reports and giving oral evidence;
- (4) identifying ways of avoiding expressing bias in expert witness practice
- (5) identifying ways in which bias can be addressed within peer review.

The emphasis will be on interactive method rather than being didactic; with participants being encouraged both to 'think out' what might be their own sources and expressions of bias, and to address means of enhancing the ethical quality of their own expert witness practice.

Nigel Eastman is Emeritus Professor of Law and Ethics in Psychiatry at St George's, University of London and an Honorary Consultant Forensic Psychiatrist in the National Health Service. Alongside his medical training he was called to the Bar. He has carried out research and published widely on the relationship between law and psychiatry, and is first author of the *Oxford Specialist Handbook of Forensic Psychiatry*. He also has thirty year's experience of clinical forensic psychiatry. Much of his work has been concerned with matters of public policy concerning law and psychiatry. He has, for example, given evidence to Parliamentary Select Committees, and been an advisor to the Law Commission, most recently in relation reform of the partial defences to murder and insanity. He has extensive experience of acting as an expert witness in both criminal and civil proceedings, at all levels of proceedings, both in England and Wales and in the jurisdictions of other countries, including in relation to a substantial number of capital cases. He is a member of Forensic Psychiatry Chambers.

Correctional Perspectives from a land of convicts

Pre-Convict Australians in the Australian Correctional Landscape

Presenter:

Dr Jeremy O'Dea FRANZCP: Dr Jeremy O'Dea is a Consultant Forensic Psychiatrist engaged in private practice and, for many years, visiting psychiatrist to a maximum secure correctional centre.

It has been over 25 years since the Royal Commission into Aboriginal Deaths in Custody highlighted the marked over-representation of indigenous Australian deaths in custody, proportionate to the marked over-representation of indigenous Australians in custody, and tabled its 339 recommendations, central among them that imprisonment should be used as a last resort. However, whilst the rates, if not the actual numbers, of indigenous deaths in custody have declined over that time; the general prison population, and the number of indigenous Australian inmates, has risen dramatically. In fact, the proportion of indigenous prisoners has doubled in the past 25 years, with the risk of incarceration at least 13 times higher than for non-indigenous Australians, with these figures even higher in female and juvenile detention.

Indigenous Australians in custody, as in the general community, continue to experience higher levels of general mental health and drug and alcohol problems, in the context of well recognised broader health and socio-economic disadvantage, presenting specific and unique treatment challenges.

This presentation will outline some aspects of the history and extent of incarceration of indigenous Australians, of the progress in the implementation of the recommendations of the Royal Commission, with particular emphasis on mental health initiatives in New South Wales Correctional Centres, and of the ongoing challenges in providing mental health care to indigenous Australian inmates, using a large maximum secure correctional centre in regional New South Wales as an example.

Does the end justify the means: 'Safe cells' for suicidal prisoners in NSW?

Presenters:

Dr Sarah-Jane Spencer FRANZCP: Dr Sarah-Jane Spencer is Deputy Clinical Director Custodial Mental Health with the Justice Health and Forensic Mental Health Network in NSW.

Dr Tobias Mackinnon FRANZCP: Dr Tobias Mackinnon is Statewide Clinical Director Forensic Mental Health with the Justice Health and Forensic Mental Health Network, in NSW, Australia.

The high rate of suicide in prison is an international problem, which equally affects prisons in Australia. A range of measures to address this have been trialled internationally with varying degrees of success. In NSW Australia the approach which has been instituted over the last decade is the Risk Intervention Team (RIT), which involves a multidisciplinary, cross-organisation (corrective services and health) assessment of inmates deemed at risk of suicide. The results of this initiative have been positive in terms of reduction of rates of suicide in prison, but at what price? Part of the RIT approach has been the use of 'safe cells', with cells stripped bare, with the patient often stripped bare or in a 'safety gown' for management of suicide risk, with continuous video camera surveillance, usually for one 'inmate' or patient only, and with no provided activities or materials. The presenters question whether this amounts to solitary confinement, generally seen as a punishment, rather than a treatment. Also, in a reflexive fashion both staff and prison inmates have become aware that the result of expressing suicidal thoughts may be to be placed in such confinement, and this may affect the reporting of suicidal ideation to staff. The presenters look towards international models to question if there are equally effective, but more humane, approaches to the problem of suicide in prison.

Involuntary mental health treatment in a prison setting: the Long Bay Hospital model

Presenter:

Associate Professor Kimberlie Dean: Associate Professor Kimberlie Dean is Chair of Forensic Mental Health at the University of New South Wales (NSW), Australia, and Clinical Academic Forensic Psychiatrist with the Justice Health and Forensic Mental Health Network in NSW.

The prevalence of mental illness is known to be very high amongst prisoners compared to the general population. It is widely acknowledged that prisons are far from ideal environments for providing mental health treatment particularly for those with severe mental illnesses who are

often unable to consent to treatment. Transfer to hospital for such treatment represents best practice for mental health care in such circumstances and legislation exists in most Western jurisdictions to support such an approach. Unfortunately, inadequate service provision often means that prisoners with acute mental health treatment needs experience lengthy delays in being transferred out of prison to hospital. With the exception of treatment under common law provisions in emergency circumstances, involuntary mental health treatment is generally not legally supported in the vast majority of jurisdictions. In New South Wales, a hospital unit within a prison setting has been developed to support involuntary treatment under mental health legislation, with independent tribunal review provisions equivalent to those for patients detained in community hospital settings. The presentation will provide an overview of the Long Bay Hospital mental health unit, a description of the patient numbers treated in the unit, a description of patient characteristics, and will consider the challenges faced by such a model.

Involuntary mental health treatment in a prison setting: Forensic Community Treatment Orders

Presenter:

Dr Sarah-Jane Spencer FRANZCP: Dr Sarah-Jane Spencer is Deputy Clinical Director Custodial Mental Health with the Justice Health and Forensic Mental Health Network in NSW.

Over recent years NSW forensic mental health legislation has been the subject of substantial reform. In 2009 the *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* came into force, resulting in the renaming of the *Mental Health (Criminal Procedure) Act 1990* which included a number of important changes. One of the key additions was the Forensic Community Treatment Order (FCTO) enabling compulsory treatment in correctional centres. Despite the apparent support of the Mental Health Review Tribunal, mental health professionals were slow to embrace the new provision. The presentation will include an overview of the provision, arguments to support its use and some of the ongoing barriers.

Solitary confinement:

Presenter: Dr Danny Sullivan FRCPsych: Dr Sullivan is Assistant Clinical Director of Forensicare, the Victorian Institute of Forensic Mental Health.

Solitary confinement is a contentious correctional intervention. WE examine the evidence that solitary confinement harms mental health, referring to Australian and international perspective. Proposals to address the concern include greater involvement of mental health professions, systemic research to reduce solitary confinement, and programs of external review and scrutiny.

Prison (Mental) Healthcare

Steffan Davies - Co-chair Court Diversion and Prison Psychiatry Network, Quality Network for Prison Mental Health Services and NICE GDG member

There have been very few weeks over the last year when prisons haven't been in the news usually due to the rising levels of self-harm, suicide, violence and drug abuse. There have been numerous reports about these problems and how to reform the English and Welsh prison system. The Government has proposed major reforms for the prison system and a rehabilitation revolution mainly driven by devolving responsibility to individual governors in reform prisons including for commissioning prison mental health and substance misuse services. A Prisons and Courts Reform Bill was included in the Queens Speech. The Prison Governors Association in turn unanimously called for a public enquiry into the state of the prison system.

In spite of the current political and resource climate prison mental health services, whilst under great pressure due to cuts in prison officer numbers, rising rates of mental health problems, self-harm and substance misuse are now more professional, better integrated with physical healthcare and more evidence based than ever before.

This symposia will focus on two major developments in the field of prison (mental) healthcare: The Quality Network for Prison Mental Health Services has developed out of the Quality Network for Forensic Mental Health Services. The pilot phase involving 18 prisons in England, Wales and the Republic of Ireland was completed in early 2016 and the First Cycle of the QNPMHS is

underway with 42 prisons joining. The structure of the standards and lessons for the first cycle will be presented and discussed.

NICE have produced clinical guidelines (out to consultation currently) on both Physical Healthcare in Prisons and Mental Health in the Criminal Justice System. These guidelines are a first in a number of ways including the close collaboration and integration between physical and mental health care in prisons and in being system wide guidelines covering a assessment and treatment of a wide range of mental disorders across a complex service system namely criminal justice. This extends from the first point of contact with the police, street triage and custody liaison, through the court process, and through custodial or community sentences to the point of sentence completion.

Depending on delegate numbers and experience we would see the session consisting of presentations of the main areas: current context and legislation proposals; the QNPMHS; NICE Guidelines. We would aim for active discussion with the audience aiming for 2/3 presentation and 1/3 audience discussion.

Educational goals:

- Inform the participants about the current context for prison mental health services and the impact, as far as possible, of the Prisons and Courts Reform Bill;
- Inform participants about the QNPMHS including current standards and lessons from the pilot phase;
- Discuss the development of the NICE guidelines for physical and mental health care, the published guidelines (or draft if consultation not complete) and potential implications for clinical practice.
- Discussion with participants on how these reforms may impact on the CJS and Forensic Mental Health Services.

Care pathways in long-term medium secure care: NHS vs. independent sector

Birgit Völlm

University of Nottingham & Nottinghamshire Healthcare NHS Foundation Trust

Yasir Kasmir

Partnerships in Care, Manchester

In this workshop we will report findings of a national, multi-centre, NIHR funded study on the characteristics and needs of patients who stay in high or medium secure care for extended periods of time. We will focus particularly on the care pathways in medium secure care and will explore the differences in patient characteristics and pathways between those in NHS and those in independent provider settings.

In particular we will:

- Present findings related to the prevalence of long-stay
- Describe the clinical, offending and risk characteristics of long-stay patients in NHS and independent medium secure forensic psychiatric care
- Outline care pathways of these patients through medium secure care
- Discuss potential implications for service development

Educational Goals

- Understand findings surrounding long-stay medium secure forensic psychiatric care
- Gain a basic knowledge of long-term secure care models in other countries
- Stimulate discussion of the ethical issues around long-stay in forensic care
- Discuss the role of the independent sector in medium secure provision

Developing Outcome Measures in Forensic Psychiatry: Current Proposals and the Way Forward

Dr Pratish Thakkar

Clinical Director, Forensic Mental Health, Middlesbrough

Prof. Pamela Taylor

Cardiff University

Dr Ramneesh Puri
Rampton Hospital

Dr Christopher Clark
Associate Medical Director Forensic Services, Rampton Hospital

Dr Paul Gilluley
John Howard Centre

Dr Jeremy Kenney-Herbert
Tamarind Centre

Maurice Arbuthnot
RCPsych Forensic Psychiatry Faculty Executive

Background:

The Royal College of Psychiatrists recommends use of outcome measures in clinical practice in three domains: clinical effectiveness, patient safety, and patient and carer experience. The forensic psychiatry faculty executive has been asked for guidance on measures particular to this field. This workshop is for seeking wider membership views and expertise on this.

Educational (and other) Objectives of the Workshop:

- Awareness of the principles underpinning outcome measurement, their strengths and limitations
- Knowledge of the evidence base for current and proposed outcome measures in forensic mental health
- Ability to contribute to the development/refinement of outcome measures
- Opening of peer collaborations in this important area
- Influence on the way forward for forensic psychiatric measures

Apps for patient monitoring in secure services

Dr Marco Picchioni
Honorary Consultant Forensic Psychiatrist at St Andrew's Healthcare and Senior Lecturer at the Institute of Psychiatry, Psychology and Neuroscience

Dr Ashimesh Roychowdhury,
St Andrew's Healthcare, former AMD of Informatics and member of the Royal College of Psychiatrists Informatics committee

EDUCATIONAL GOALS

Participants will:

1. Understand the national vision and framework for use of IT in healthcare
2. Explore how use of IT may fundamentally change the way we gather information on patients and therefore alter the clinician-patient relationship
3. Be informed on progress on a real world project that can have wide applicability in other clinical settings
4. Be able to share and generate ideas that can be fed back through the appropriate Royal College forums.

New research Presentations 16:00 – 17:25

16:00 – 16:15

Brief approaches for violence risk assessment: can they be accurate?
Achim Wolf, University of Oxford

Professor Seena Fazel, University of Oxford
Dr Zheng Chang, Karolinska Institute
Achim Wolf, University of Oxford

Dr Thomas Fanshawe, University of Oxford
Dr Susan Mallett, University of Birmingham

Aims

To develop scalable and simple tools for violence risk assessment that can perform as well as current structured approaches.

Methods

Using Swedish national registers, two interview-independent risk assessment tools were developed. The first was a tool to predict violent recidivism in released prisoners and the second was for violent crime in psychiatric patients with psychotic disorders. These were developed using pre-specified risk factors and cut-offs to reduce the possibility of shrinkage when applied to new populations. Both instruments were externally validated using Swedish data at one and two years, and performance across a range of measure of discrimination and calibration was examined.

Results

Two new models were developed from pre-specified routinely collected criminal history, socio-demographic and clinical risk factors. For released prisoners, this the model included 14 items, and showed good measures of discrimination (Harrell's c-index 0.74) and calibration (sensitivity at 76%, specificity at 61% at 1 year using a 10% cut-off) in external validation. For patients with psychosis, the model also demonstrated good measures of discrimination (c-index 0.89) and calibration (sensitivity was 64% and specificity was 94% at 1 year using a 5% cut-off). These models were used to generate simple web-based risk calculators (OxRec and OxMIV) that provide both probability scores and risk stratification based on pre-specified cut-offs.

Conclusions

We have developed risk scores in two cohorts relevant to forensic psychiatry that can be used as adjuncts to decision making in clinical practice by identifying those who are at low risk of future violent offending and higher risk individuals who may benefit from additional risk management. They can potentially be used as brief and scalable methods to anchor more detailed assessments in evidence.

Achim Wolf studied Applied Health Research before joining the Department of Psychiatry at the University of Oxford. He works with Professor Seena Fazel as a Research Assistant and PhD student. His work includes risk prediction, large-scale population studies, and systematic reviews.

16:20 – 16:40

The Older prisoner Health and Social Care Assessment and Plan (OHSCAP): A Randomised Controlled Trial

Katrina Forsyth

University of Manchester

Mrs Katrina Forsyth (1), Mrs Laura Archer-Power (1), Dr Jane Senior (1), Prof Alistair Burns (1), Prof David Challis (1), Dr Dawn Edge (1), Miss Rachel Meacock (1), Miss Kate O'Hara (2), Dr Elizabeth Walsh (1), Dr Roger Webb (1), Prof Richard Emsley (1), Dr Adrian Hayes (3), Dr Stuart Ware (4) and Prof Jenny Shaw (1)

1. *The University of Manchester, England*
2. *Dublin Institute of Technology, Dublin*
3. *University of Oxford, England*
4. *Restore Support Network, England*

Introduction

There has been an increase in the number of older prisoners across developed countries. Older prisoners have more health needs than younger prisoners and those of the same age living in the community. These are often accompanied by a multitude of social care needs. There is no national strategy in England for older prisoners' care. Consequently, care is currently generally *ad hoc* and

largely uncoordinated. The Older prisoner Health and Social Care Assessment and Plan (OHSCAP) was developed through action research by prison staff, healthcare staff and older prisoners themselves. It is a structured approach designed to better identify and manage the health and social care needs of older prisoners. It consists of an assessment, care plan and review of these needs.

Aim

To evaluate the effectiveness and acceptability of the OHSCAP in comparison to Treatment As Usual (TAU).

Objectives

1. To evaluate the effectiveness of the OHSCAP in improving i) the meeting of older male prisoners' health and social care needs (primary outcome); ii) health related quality of life; and iii) depressive symptoms, in comparison to TAU.
2. To assess the quality of care plans produced through the OHSCAP and fidelity of implementation.
3. To evaluate the implementation of the OHSCAP and its impact on staff and prisoners in practice.

Methods

The extent to which prisoners' health and social needs were met was assessed before they received the OHSCAP or treatment as usual, and three months after (n=497). An audit of care plans produced through OHSCAP was conducted to determine the processes involved; quality of the care planning; and fidelity of implementation. Semi-structured interviews with older prisoners who had received the intervention were conducted. Fourteen prisoners were interviewed between 2-4 times. Interviews were held with staff delivering the intervention to gain an understanding of the processes used (n=11).

Results

There were no statistically significant differences, in the meeting of older prisoners' health and social care needs, between the OHSCAP and TAU group at three months follow up (p = 0.618). The audit of the care plans demonstrated that the OHSCAP was fundamentally not delivered as intended. The semi-structured interviews revealed that the OHSCAP was introduced within a 'broken' prison system suffering from staffing levels that were reported as dangerous. Rigid prison processes further impeded the ability of the OHSCAP to meet older prisoners' health and social care needs. The appropriateness of prison officers acting as facilitators of the OHSCAP was also questioned.

Katrina Forsyth is a Research Associate and PhD student at the University of Manchester. She has a Sociology degree and Masters in Research Methods. For the past six years she has been conducting research regarding older prisoners' health and social care needs. Her methodological interests include evaluation and qualitative research.

16:45 – 17:05

STRESS-testing clinical activity and outcomes for a combined prison in-reach and court liaison service: A three-year observational study of 6177 consecutive male remands

Conor O'Neill

Central Mental Hospital, Dublin

Authors

Conor O'Neill^{1,2*}, Damian Smith^{1,2*}, Martin Cadow^{1*}, Fergal Duffy^{1*}, Philip Hickey^{1*}, Mary Fitzpatrick^{1*}, Fintan Cadow^{1*}, Tom Cronin^{1*}, Mark Joynt^{1*}, Zetti Azvee^{1*}, Bronagh Gallagher^{1*}, Claire Kehoe^{1*}, Catherine Maddock^{1*}, Benjamin O'Keefe^{1*}, Louise Brennan^{1*}, Mary Davoren^{1*}, Elizabeth Owens^{1*}, Ronan Mullaney^{1*}, Laurence Keevans^{3*}, Ronan Maher^{3*} and Harry G Kennedy^{1,2*}

¹National Forensic Mental Health Service, Central Mental Hospital, Dundrum, Dublin 14

²Department of Psychiatry, Trinity College, Dublin, Ireland

³*Irish Prison Service, Dublin, Ireland*

Background

People with major mental illness are over-represented in prison populations however there few longitudinal studies of prison in-reach services leading to appropriate healthcare over extended periods.

Aims

We aimed to examine measures of the clinical efficiency and effectiveness of a prison in-reach, court diversion and liaison service over a three year period. Secondly, we aimed to compare rates of identification of psychosis and diversion with rates previously reported for the same setting in the six years previously. We adopted a stress testing model for service evaluation.

Method

All new male remand committals to Ireland's main remand prison from 2012 to 2014 were screened in two stages. Demographic and clinical variables were recorded along with times to assessment and diversion. The DUNDRUM Toolkit was used to assess level of clinical urgency and level of security required. Binary logistic regression was used to assess factors relevant to diversion.

Results

All 6177 consecutive remands were screened of whom 1109 remand episodes (917 individuals) received a psychiatric assessment. 4.1% (95% C.I. 3.6-4.6) had active psychotic symptoms. Levels of self-harm were low. Median time to full assessment was two days and median time to admission was 15.0 days for local hospitals and 19.5 days for forensic admissions. Diversion to healthcare settings outside prison was achieved for 5.6% (349/6177, 95% C.I. 5.1-6.3) of all remand episodes and admissions for 2.3% (95% CI 1.9-2.7). Both were increased on the previous period reported. Mean DUNDRUM-1 and DUNDRUM-2 Triage Security Scores were appropriate to risk and need.

Conclusions

We found that a two-stage screening and referral process followed by comprehensive assessment optimised identification of acute psychosis. The mapping approach described shows that it is possible for a relatively small team to sustainably achieve effective identification of major mental illness and diversion to healthcare in a risk-appropriate manner. The stress-testing structure adopted aids service evaluation and may help advise development of outcome standards for similar services.

Dr Conor O'Neill is a consultant forensic psychiatrist at the Central Mental Hospital, Dundrum in Ireland. He qualified in medicine from University College Dublin and completed higher training in Forensic Psychiatry in Ireland and New South Wales, Australia. Dr O'Neill developed and leads the Prison Inreach and Court Liaison Service (PICLS) at Cloverhill, Ireland's main male remand prison since 2006. His research interests include needs assessment, prison mental health, triage and diversion services.

17:10 – 17:25

Post-deployment family violence among UK military personnel

Jamie Kwan

King's College London

J. Kwan¹, M. Jones², G. Somani³, L. Hull², S. Wessely², N. T. Fear², D. MacManus^{2,3}

¹ *Department of Psychological Medicine, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK*

² *King's Centre for Military Health Research, King's College London, London, UK*

³ *Department of Forensic and Neurodevelopmental Sciences, Institute of Psychiatry, King's College London, London, UK*

Background

Much of the research into violence among military personnel has not differentiated between stranger and family directed violence. We know that military factors such as combat exposure and postdeployment mental health problems are risk factors for general violence but we currently have no data on their impact on violence within the family environment.

Aim

The purpose of this study was (i) to compare the prevalence of self-reported family-directed violence with stranger-directed violence among a deployed sample of UK military personnel; and (ii) to explore the risk factors associated with family and stranger directed violence including the impact of post-deployment mental health problems.

Method

This study utilised data from a large cohort study conducted by the King's Centre for Military Health Research which collected information by questionnaire from a representative sample of randomly selected deployed UK military personnel who were in service at the time of the sampling (n=6,711).

Results

The prevalence of family violence immediately following return from deployment was 3.58% compared to 7.75% for stranger violence. The characteristics of those who reported family violence only were different to those who reported stranger violence only. While both family and stranger violence were most strongly associated with pre-enlistment antisocial behaviour (ASB), only stranger violence remained statistically significantly associated with this variable in the final risk factor model. Deployment in a combat role was statistically significantly associated with both family and stranger violence in the final risk factor models [adjusted OR (aOR)= 1.92 (1.25-2.94) p=0.003 and aOR=1.77 (1.31-2.40) p<0.001 respectively], as did the presence of symptoms of post-traumatic stress disorder, common mental disorders and aggression.

Conclusions

While sociodemographic and military risk factors for stranger violence remain consistent with previous violence research, there were clear differences when compared to the pattern of risk factors for family violence. However, the results demonstrate that exposure to combat and postdeployment mental health problems are risk factors for violence both outside the home and in the family environment and must be considered in violence reduction programmes for military personnel. Further research using a validated measurement tool for family violence would improve comparability with other research.

Jamie Kwan completed a BSc in Forensic Science and Psychology at the University of Toronto in Canada. She went on to complete a Master's degree in Forensic Mental Health Research at King's College London and is currently a second year PhD student in the department of Psychological Medicine at the Institute of Psychiatry, Psychology and Neuroscience, King's College London. She is conducting a data linkage study on in-service offending behaviour in the UK military to examine the impact of deployment, combat and trauma exposure on offending behaviour pre- and post-deployment.

Friday 3 March

Parallel Masterclasses 09:00 – 10:25 & 11:00 – 12:25

Prison Health care services: Is a gold standard achievable?

Dr Andrew Forrester

Offender Health Research Network, University of Manchester

Professor Jenny Shaw

University of Manchester

Professor Sandy Simpson is Associate Professor and Head of the Division of Forensic Psychiatry of the Department of Psychiatry, University of Toronto and is Chief of Forensic Psychiatry and Clinical Scientist, Clinical Research Program at the Centre for Addiction and Mental Health, Toronto.

He is a member of the Advisory Board of the International Association of Forensic Mental Health Services, is a Board member of the Canadian Academy of Psychiatry and Law and is a member of the American Academy of Psychiatry and Law Cross Cultural and Correctional Psychiatry Committees. He is a member of the Psychiatry and Law Committee for the Group for the Advancement of Psychiatry. He is a member of the Editorial Board of Criminal Behaviour and Mental Health and the Canadian Journal of Psychiatry.

His academic, teaching and research interests are in the area of the interaction of the law and people with serious mental illness: how we understand pathways to risk, into criminal justice system and for therapeutic intervention and recovery. He is committed to improved understandings, improved services, improved outcomes and improved jurisprudence for persons with serious mental illness who are criminal justice involved.

Autism and Learning Disabilities in Forensic Services

Dr Harm Boer

Brooklands Hospital

Dr Regi Alexander

Leicestershire Partnership NHS Trust & St John's House

Dr Vicenç Tort-Herrando

Psychiatric Unit CP Homes de Barcelona

Hybrid vs Hospital: psychiatric sentencing recommendations in a post-Vowles world

Dr Nigel Blackwood

Institute of Psychiatry

Dr Richard Latham

East London Foundation NHS Trust

Victoria Beech

King's College London

Dr Catherine Marshall

Queen Mary University of London

What's trending #Recovery? From Supervised Confinement to Peer Trainer in 5 Characters

Dr Gerard Drennan

South London & Maudsley NHS Foundation Trust

Dr Estelle Moore

West London Mental Health NHS

While the recovery movement in mental health has firmly taken root in the UK over the past decade, forensic psychiatry has tended towards maintaining the wary scepticism of a "yes, but ..." position. In spite of this, and perhaps in large measure driven by Commissioner targets over successive years, recovery-oriented care has become a backdrop to all forensic services. But has this made any difference to services beyond cosmetic change? We will invite participants to share their enthusiasm or scepticism for what they have witnessed as a result of the rise of recovery as a paradigm of service delivery. While engaging with the obstacles and the frustrations, we will nevertheless argue that significant changes in the delivery of care are being made and that this process is evolving. In order to make this case, the workshop will be structured around five stories of recovery. These narrative accounts will have been co-produced with patients and multi-professional s

staff in forensic services to illustrate the multiple pathways to personal recovery that have become available through the evolution and modernisation of services. The workshop will make use of video interviews with patients and other first person accounts to illustrate the patient experience. In this way the service user voice and the perspective of the multi-professional team will be animated in the workshop. Current directions in the delivery of care, such as trauma-informed care, peer support worker roles and recovery colleges, will be considered. New directions for research and practice-based evidence will also be highlighted. However, the key messages for the workshop will focus on what responsible clinicians, and the multi-professional teams they lead, can do to enable forensic service users to achieve hopeful, meaningful and safe lives through recovery-oriented care.

Dr. Gerard Drennan is a Chartered Clinical Psychologist and Head of Psychology & Psychotherapy in the Forensic Services of the South London & Maudsley NHS FT. Dr. Drennan and Debbie Alred edited *Secure Recovery*, the first published text to focus on the emerging practice of recovery-oriented care in forensic settings. Contributions to recovery-oriented service development have arisen out of further collaborations with the Centre for Mental Health and the RCPsych Quality Network for Forensic Services. Dr. Drennan is training in psychoanalytic psychotherapy and is a restorative justice conference facilitator.

Dr Estelle Moore is the Trust-Wide Strategic Lead for Psychological Services, West London Mental Health Trust and Head of Psychological Services, Broadmoor Hospital in Berkshire, UK. She is a Chartered Scientist, Consultant Clinical and Forensic Psychologist and Visiting Professor in Forensic Psychology at Kingston University. She has worked in forensic settings, mostly high, but also medium and low secure settings for over twenty years with a longstanding interest in the understanding the role of the therapeutic alliance in treatment settings in sponsoring recovery and outcomes. Estelle is the Trust Lead for Restorative Justice having recently trained as an associate practitioner.

13:30 – 15:10

Forensic Psychiatry: a comparison of Spanish and UK systems

Chair: Dr Jose Romero-Urcelay

Medical Director, West London Mental Health NHS Trust

Professor Alfredo Calcedo Barba

Hospital Universitario Gregorio Marañón

Profesor Medical School, Universidad Complutense de Madrid

Guillermo Petersen

Coordinator of Mental Health Office at the Department of Health in Madrid

Mr Jose Manuel Arroyo Cobo

Subdirector and coordinator of Mental Health at Penitentiary Institutions, Home Office in Spain

Ashley Irons specialises in advising hospitals (in the public and private sector) in relation to mental health issues and practical ways of addressing them. He is one of the country's leading mental health lawyers, as is recognised in the Chamber's directory.

Dr David Reiss

Consultant Forensic Psychiatrist, West London Mental Health NHS Trust,

Honorary Senior Lecturer Imperial College London

David Reiss, MA, MBBChir, MPhil, PgD, FRCPsych, FAcadMed

Consultant Forensic Psychiatrist, West London Mental Health NHS Trust, Honorary Clinical Senior Lecturer, Imperial College London. He is Chair of the Forensic Faculty Specialty Advisory Committee of the Royal College of Psychiatrists and Training Programme Director of the North West London Higher Training Scheme in Forensic Psychiatry. Dr Reiss's research interests are in the interface between clinical forensic psychiatry and public policy, including work on personality disorder, recidivism, homicide inquiries and educational issues. His clinical and educational work

focuses on enabling the multidisciplinary team to gain an enhanced understanding of patients, thereby improving care and reducing risk.

Dr Aideen O'Halloran

Consultant Forensic Psychiatrist, West London Mental Health NHS Trust

Poster Exhibition abstracts

The experiences of paid formal lived experience workers within a secure mental health service

Dr Chris Griffiths - St Andrews Healthcare, Ella Hancock-Johnson - St Andrews Healthcare

Formal roles have been created for people with lived experience of mental health issues and mental health services to be involved in the delivery of services. These roles have been defined as a lived experience worker (LEW): a person who is employed in a role that requires them to identify as being, or having been a mental health service user (MHCSA, 2016). These roles can include: facilitating effective and earlier discharge, personal recovery planning support, supporting access to outpatient facilities, facilitating social inclusion and engagement, and training patients or staff (Repper et al. 2013). One specific role that has been operationalised is peer support workers (PSWs).

There is substantial evidence for the benefits of employing PSWs in mental health services, but a lack of research conducted to evidence the impact of LEWs who are not engaged primarily as PSWs. LEWs have been acknowledged as having a key role in the education of recovery for healthcare staff (Wood and Wahl, 2006), may contribute to the facilitation of recovery-oriented services (Byrne et al., 2013), and providing a lived experience perspective to nurses at the start of their career may lead to continual value of the role of service user involvement (Byrne, et al., 2013). However, further published evidence is lacking and there appears to be very few paid formal LSW or PSW roles within secure mental health settings in England. The purpose of this research is to report the experience and impact of paid LEWs who are employed to use their lived experience of mental health issues and service use within a secure mental health provider. The study applied a qualitative approach, using semi-structured interviews and thematic analysis.

Results from this study suggest that employing LEWs in secure mental health settings is valuable to non-peer staff, service-users, the employing organisation, and the LEWs themselves. Findings emphasised the importance of support for LEWs to enable them to fulfil their role and maintain wellbeing, and the need to consider LEWs career progression within and beyond the role.

The findings provide evidence to support employing LEWs in secure mental health settings. The study identifies a requirement for further understanding of LEWs working in this environment. Specific recommendations include: the need for training for non-peer staff about the role of lived experience workers to enhance understanding, acceptance, and reduce stigma and discrimination; specific lived experience workers role training to prepare people for the role; and regular supervision and mental health support for LEWs to maintain wellbeing and prevent burnout.

A survey of psychiatrists' experiences of working with the Ministry of Justice (England and Wales) / Restricted Casework Section (Scotland)

Dr Sophia Anwar, Consultant Forensic Psychiatrist, Oxford Health NHS Foundation Trust, The Oxford Clinic, Littlemore Mental Health Centre, Oxford.

Dr Paula Murphy, Consultant Forensic Psychiatrist and Lead Psychiatrist Women's Service, St Andrew's Hospital

In England and Wales where patients with mental disorders commit serious crimes, the Crown Court can impose a section 37 hospital order together with a restriction order section 41. In Scotland the equivalent section is a Compulsion Order with Restriction Order. There are currently thought to be approximately 6,500 restricted patients in England and Wales, and approximately 350 patients in Scotland. This is occurring at a time when the commissioning of secure services in the future is uncertain. In recent times there has also been a workforce reduction at the Mental Health Casework Section (MHCS) at the Ministry of Justice (MoJ). It is unknown if this has had an impact upon the time taken for various permissions (for leave and transfers) to be sought from the MHCS, and therefore on patient progress and recovery. There is no known national data relating to the experiences of psychiatrists who are joint working with the MoJ/Scottish Government (SG).

Aim: To survey members of the Royal College of Psychiatrists who are involved in the care of restricted patients and obtain information relating to their experiences of working with the MHCS/SG.

Method: An electronic survey was sent to Forensic and ID Faculty members. A selection of quantitative questions were asked and free text comments were also invited.

Results: 241 members responded. 69% worked in forensic services. 95% worked within the NHS. 70% of respondents managed restricted patients. The most valued attributes of joint working were of external boundary setting and shared decision making. 51% of respondents were aware of the MoJ's 10 working day response time for leave and transfer applications. Most felt that this response time was not met for full level transfers (47%), differing security level transfers (90%) or leave applications (91%). Impacts on recovery and progress included cumulative pathway delays, loss of placements and patient relapse. Particular concern was raised about the process of remitting a patient back to prison from hospital, with perceived increases in risks to staff and unnecessary bed costs when delayed. Many respondents praised the MoJ for their speed and efficiency when transferring mentally disordered prisoners from prison to hospital. 47% of respondents had directly requested a Conditional Discharge directly from the MoJ, compared to only 14% having directly requested an Absolute Discharge. The results of this survey could be used as part of a wider investigation into the source of delays within the secure care pathway.

Transforming Care: Developing Community Pathways for People with Intellectual Disability with Offending History in Nottinghamshire

*Dr Abdul Shaikh, Consultant Psychiatrist in Learning Disability, Nottinghamshire Healthcare NHS Trust
Vicky Romilly, Lead Speech and Language Therapist, Nottinghamshire Healthcare NHS Trust*

Aims

This scoping exercise project aimed to identify characteristic and needs of people with intellectual disabilities (ID) and/or Autistic Spectrum Disorder (ASD), where forensic risk was a primary management need and to provide information to support the development of community pathways. The objectives also included identifying workforce needs and providing training to raise awareness of ID, ASD and Speech, language and communication needs (SLCN).

Methods

The project was conducted over 9 months by a consultant psychiatrist and two speech and language therapists. The data was collected for patients referred to the project team by a Community Forensic Directorate in a NHS Trust. The characteristics and needs of the people with ID and/or ASD with offending behaviour within the Community Forensic Services were identified by collecting information on co-morbid mental health conditions, offending behaviours and needs associated with ID, ASD and SLCN impairments. A patient journey was completed to capture a patient's perspective on their journey through services.

The workforce development needs were assessed through staff questionnaires and informal discussion with staff working in front line services. The outcome of training was assessed through Pre and post consultation/questionnaires.

Results

In total, 19 referrals were received for people with ID and/or ASD from October 2015 to June 2016. The results showed mean age of population was 36.8 years and 90% of the referrals were for male patients. In terms of ethnicity 20% were Black British with the remaining 80% being White British. Most patients with Intellectual Disability ID had Mild degree of ID. 58% of this population had co-morbid mental illness and 20% had diagnosis of personality disorder. Physical violence towards others was documented in 63%, damage to property for 10%, arson was present in 21% and sexual assault was in 16% of the cases.

The Key points identified from the patient journey work was about getting the right support at the time of need, forming therapeutic relationships, identifying and addressing forensic issues and needs associated with ID and SLCN. Staff self-reported questionnaire helped in developing understanding of workforce needs. The training workshop data showed improvement in knowledge, skills and confidence of staff to work with people with ID and/or ASD in community.

Conclusion

The specific dual competencies of a workforce skilled in both understanding and managing both neurodevelopmental conditions and forensic issues need to be highlighted as we build community capacity for people with neurodevelopmental disorders.

Staff training on formulation and fire-setting in people with intellectual disabilities

Lead Author: Dr Abdul Shaikh, Consultant Psychiatrist in Intellectual Disabilities, Nottinghamshire Healthcare NHS Foundation Trust

Co-Author: Amy Tostevin, Forensic Psychologist in Training, University of Nottingham

Aims

This study aims to present the development and evaluation of an original training package for staff members on fire-setting in people with intellectual disabilities. It also included training on functional analysis as a model of formulating the fire-setting behaviour. The quality and effectiveness of the training was assessed and is reported in this poster.

Methods

The training was delivered on a ward for people with intellectual disabilities ward in a UK NHS Trust Low Secure Hospital and was attended by various members of the multi-disciplinary team for the ward. The workshop consisted of four modules: Theoretical background of fire-setting, the functional analysis model of fire-setting formulation, offence-paralleling behaviours in secure settings and a case study practice. Level of self-reported understanding of the various aspects of the training was measured by an evaluation questionnaire completed pre and post training.

Results

Analysis of the evaluation forms was completed using the statistical programme Statistical Package for the Social Sciences (SPSS). The results of this study showed that following the training there was a significant increase in self-reported understanding of staff members. The participants reported an increase in understanding of fire-setting, functional analysis and formulation of individuals with an intellectual disability and history of fire-setting.

Discussion

Overall the training appeared to significantly increase the level of staff knowledge and awareness on fire-setting in people with intellectual disabilities. Evaluative measures suggest that after the training, staff were significantly more confident in their understanding of the motivations of fire-setters, the risk factors associated with fire-setting, the functional analysis theory of fire-setting and offence-paralleling behaviours that may be seen in fire-setters in secure hospital settings. Additionally, they felt significantly more confident in their abilities to formulate an individual who has engaged in fire-setting using functional analysis and offence-paralleling behaviour frameworks. This supports findings from a previous study on the use of collaborative psychosocial case formulation with direct clinical staff.

Conclusion

This study highlights the potential for staff training to increase awareness of fire-setting behaviours by people with intellectual disabilities. The staff training in formulation would encourage their involvement in development of team formulations and may subsequently increase their understanding of such individuals.

A survey of Blood Borne Viruses (Hepatitis B, Hepatitis C & HIV) and Hepatitis B Vaccination at Rampton Hospital in 2005, 2007 and 2016

Dr Tarek Abdelrazek - Locum Forensic Specialty Doctor; Dr John Milton - Consultant Forensic Psychiatrist; Dr Elisabeth Milne - Consultant Psychiatrist; Julie Smith - Clinical Audit Manager Forensic Services; Luke Middleton - Clinical Audit Support Forensic Services.

Aims

Identify patients who will benefit from Hepatitis B immunisation and for treatment of chronic Hepatitis C or HIV. To encourage implementation of the Hepatitis B prevention programme and to ensure all patients immunisations are up-to-date. To determine the level of Hepatitis B vaccination at Rampton Hospital

Methods

All patients have been offered a BBV screen. If accepted and is consent given a BBV screen was completed. The results of the screen were entered into the patient's medical record. If positive for Hepatitis C a referral for treatment was made to a Liver Specialist Clinic. All patients who are susceptible

to Hepatitis B should be offered the Hepatitis B immunisation. The sample taken was of all patients at Rampton Hospital in 2005, 2007 and 2016. The data was taken retrospectively from the records and placed into tables within Microsoft Word for analysis.

Results

2005:

Hepatitis B: 88% patients had been tested; 87% Hepatitis B surface antibody was not detected. 17.2% patients started a vaccination programme and of these 7% completed the course.

Hepatitis C: 11% tested for Hepatitis C; 1.7% Hepatitis C antibody was detected, indicating past infection.

HIV: 8% tested negative for HIV.

2007:

Hepatitis B: 75.9% tested for Hepatitis B surface antigen. 1 patient was found to have HBsAG in his blood. HBsAG was not detected in 75.6%. 11% commenced on Hepatitis B vaccination programme and 5.4% immunised against Hepatitis B virus.

Hepatitis C: 28.5% patients were tested for Hepatitis C virus; 71% patients were not tested. 13% patients were found to have Hepatitis C antibody. The 11 patients were potentially chronically infected with Hepatitis C.

HIV: 24% tested for HIV 1+2 antibodies (EIA). 1 patient had HIV1+2 antibodies detected and completed treatment.

2016:

Hepatitis B: 97.5% offered Hepatitis B screening. 95% patients had received Hepatitis B screening. 0.7% patients were identified as Hepatitis B positive. 94% patients had received a Hepatitis B vaccination.

Hepatitis C: 98% offered Hepatitis C screening. 92% patients received Hepatitis C screening. 3% identified as

Hepatitis C antibody detected. 9 patients were identified as Hepatitis C positive were referred to the Liver Specialist Clinic. 5 patients completed treatment and 2 patients were in the process of undertaking treatment. 1 patient had treatment discontinued due to refusal and 1 patient was not eligible for treatment.

HIV: 98% offered HIV screening. 94% patients had received HIV screening. Excellent results achieved, improved patients care and safety of staff.

Blood glucose monitoring and management in a medium security psychiatric unit

Dr S Johnson, Dr H Domagala, Dr S Mathews MRCPsych

Ty Llywelyn Medium Secure Unit, Betsi Cadwaladr University Health Board, Wales, UK

Introduction

Patients with psychosis and those detained in secure facilities are at an increased risk of diabetes. Around only half of such patients have regular monitoring of their blood glucose levels.

Objectives

We wanted to identify if this medium security forensic psychiatric unit was following the guideline recommendations on monitoring blood glucose control as failure to do so would be of detriment to the physical health of patients.

Methods

We performed a retrospective analysis of 16 patients' electronic records to gather dates of HbA1c, fasting blood glucose and lipid profile blood tests since admission. Information regarding dietician and diabetic specialist nurse referrals was taken from their respective databases. Details regarding management of diet and lifestyle were obtained from discussions with nursing staff, management, physiotherapy and occupational health services.

Results

Of the 16 patients, there are 4 existing and 1 new diagnosis of type 2 diabetes, 1 existing diagnosis of type 1 diabetes and 1 patient with prediabetes. 83% of our patients with diabetes had been referred to the diabetic specialist nurse. Admission glucose control (Fasting Blood Glucose or HbA1c) was measured in just 25% of patients. 44% of patients had their glycaemic control measured on a near-annual* basis. In those with psychosis, 50% had fasting blood glucose or HbA1c taken on a near-annual basis. *Taken to mean 12 monthly \pm 4 months and must include the 1st year from admission. In those with a known diagnosis of type 2 diabetes, nobody had a consistent 6 monthly fasting blood glucose or HbA1c, although this improved to 66.7% following referral to the diabetic specialist nurse. On an annual basis, this figure for all type 2 diabetics was 75%. 63% of our patients were referred to dietetic services, including 100% of our diabetic patients. 53% of our patients had lipid levels taken on a near-annual basis. Patients have been offered various healthy living groups and exercise programmes over the past few years but attendance has been poor and none so far meet the criteria for 'intensive lifestyle change programme.'

Conclusion

The unit did not meet the guideline recommendations for monitoring blood glucose and lipid control. Our method of ensuring the necessary tests were done was not sufficiently robust or structured. There is clearly room for improvement when it comes to monitoring and providing the right means of intervention. It is expected the unit would utilise a newly developed physical health record template to ensure any re-audit meets guideline specifications.

THE USE OF IM OLANZAPINE IN ADULT FORENSIC SERVICE

*Dr Pushpindr Ssidhu, CT3 and Dr Fareed Bashir, Consultant Forensic Psychiatrist
Greater Manchester West Mental Health NHS Foundation Trust*

Aim

The primary aim was to monitor whether GMW Trust guideline PHA08 – Guideline for prescribing and administration of Olanzapine Long-Acting Injection within Adult Forensic service was being followed. The objective was to improve clinical care and safety of the patients.

Method

This was a retrospective case note audit done in 2015. The data was provided by Trust pharmacy department and the list included 8 patients. An audit tool was devised and data was collected from the electronic records, ICIS. The inclusion criteria were age 18 years and above and patients admitted in secure services.

Results

The results showed that male to female ratio was 6:2. The age range was 31 to 57 years old. The primary diagnosis was Paranoid schizophrenia. The response to Oral Olanzapine was checked in 65% before IM Olanzapine was given. 65% patients had poor adherence to Oral Olanzapine. 39% patient had no overlap of oral & IM due to adherence issues. Among 61% of patient, few continued on oral Olanzapine despite being on IM Olanzapine for a long period. The blood levels of Olanzapine were tested in 37% of cases. The physical observations were done for 3 hours after each dose by the nursing staff. The evidence of scanned physical observation form on electronic records, ICIS, was 0%. 57% had an incomplete paper record of physical observations and 43% had no records. It is a duty of ward clerk to scan the forms on electronic records.

5 patients were on IM Olanzapine at the time of the audit. The patients who had stopped IM Olanzapine had changed to Oral Olanzapine due to improvement in compliance, Oral Olanzapine after Post injection syndrome and Paliperidone due to poor response to Olanzapine.

Best standards for physical health monitoring of patients taking antipsychotic medications in North Wales Forensic Services.

Dr Hanna Domagala, Ty Llywelyn Medium Secure Unit, Betsi Cadwaladr University Health Board, Specialty Doctor, Dr Thushara Stanly, Betsi Cadwaladr University Health Board, Psychiatry Trainee, Dr Sandeep Mathews, Ty Llywelyn Medium Secure Unit, Betsi Cadwaladr University Health Board, Psychiatry Consultant

It is well known fact that patients with mental health are at high risk of developing severe physical health problems. The systematic screening for and proactive approach in diagnosing diseases like diabetes, dyslipidaemia or hypertension were set as important goals in our hospital.

Aims

- To investigate compliance with guidance for physical health monitoring of patients treated with antipsychotics.
- To compare our local guideline with recommended national standards.

Methods

We conducted full cycle retrospective audit on male patients detained in Ty Llywelyn Medium Secure Unit, who were on antipsychotics between March 2014- March 2015 and October 2015- October 2016. We sampled 94% (n=17) and 100%(n=18) of the total number of patient's notes and electronic records. The data was collected using four different tools, which have been developed based on three guidelines (BCUHB MH&LD division guidelines, NICE and Maudsley).

Results

During first audit cycle the data showed that the most commonly recorded parameters (over 80 %) were: BP (patients on Clozapine), LFT's,U&E,TFT, Temperature and life style advice. 50% of patients had CVD risk, pulse, blood glucose and smoking advice completed on annual monitoring. Less than 50 % of patients established on antipsychotics had ECG done and lipids profile measured. None of the patients during full audit cycle had waist circumference measured and GUSS/LANSERS scale completed, however all the patients have been asked about the side effects during medical interviews and had their BMI recorded. We also found that patients on clozapine have much better compliance with physical health monitoring than patients on different antipsychotics.

In general, the results from first cycle revealed significant underperformance with 35% and 58% (patients on Clozapine) compliance with local guideline, 56% with NICE and 59% with Maudsley guideline. After implementing the changes including: record keeping charts, staff training in ECG and phlebotomy, educational sessions, the significant improvement was seen during second cycle of the audit reaching almost 100% compliance on annual reviews.

Discussion

Despite well-known link between mental illness and increased risk of mortality, there is a lack of universal national guideline that would detail what physical parameters should be measured and how frequently. We identified that some parameters like weight, blood glucose, lipids profile for patients already established on antipsychotics should be measured more frequently than once a year. The better monitoring during initiation period is still needed and side effects measure tool should be implemented. Most importantly we showed that structured approach backed with staff training significantly improves the compliance with existing guidance on physical health monitoring in our hospital.

HIGH DOSE ANTIPSYCHOTIC PRESCRIBING PRACTICES AND PHYSICAL HEALTH MONITORING.

Main Author: Dr Deepu Thomas, Consultant forensic psychiatrist, Kemple View, Partnerships in Care, Blackburn

Co-author: Dr Friederike Yarwood, Consultant forensic psychiatrist, Kemple View, Partnerships in Care, Blackburn

Introduction

The review took place at a 90 bedded hospital that consisted of male low secure and locked rehabilitation wards. Anecdotal evidence suggested that the practice of prescribing high dose antipsychotics did not adhere to existing guidelines.

Aims

1. To identify all the patients prescribed high dose antipsychotics across the hospital
2. Review physical health monitoring to check compliance with existing standards.

Methods

High dose antipsychotics were defined based on the Royal College of Psychiatrists Revised Consensus Statement on High Dose Antipsychotic Medication, which stated: The daily dose of an individual antipsychotic should be within licensed limits or, if a combination of antipsychotics is prescribed, the cumulative dose using the percentage method should not exceed 100%. The recommended physical health monitoring requirements were determined after consulting NICE and Maudsley guidelines.

The medication cards for all patients across the hospital were reviewed. The details of the patients who were prescribed high dose antipsychotics were obtained and collated on the data collection tool. Medical records were checked to obtain information on physical health monitoring.

The results were then pooled and calculated using MS Excel. The results were interpreted, conclusions drawn, and recommendations were made.

Results

Total number of patients: 90.

Total number of patients on high dose antipsychotics: 19

Length of stay: Average: 32 - months, median - 17 months

9 patients were treated without their consent

6 patients were on olanzapine alone and a further 6 had olanzapine augmented with another antipsychotic.

4 patients were on polypharmacy due to the addition of PRN medication: haloperidol in 3 cases and chlorpromazine in 1 case.

3 patients had refused all bloods and ECG and 1 had refused all blood except glucose, HbA1c and ECG.

There were no comments on the patients' capacity to refuse. Their average BNF dose was 185 %. 3 of them were on polypharmacy, of which 2 were given first generation antipsychotics.

Recommendations

- To develop a protocol for initiating and reviewing prescription of high dose antipsychotics.
- Facilitate development of appropriate care plans that ensures timely reviews of the response to treatment and regular physical health monitoring.
- Identify appropriate measurement tools to aid in reviewing mental state and side effects, in line with current guidelines.

Courting Controversy? The Queensland Mental Health Court system

Dr Coghlan is a ST7 in Child and Adolescent Forensic Psychiatry in Oxford. She was awarded the 2015 John Hamilton Travelling Fellowship by the Faculty of Forensic Psychiatry.

Dr Scott Harden is Assisting Psychiatrist, Queensland Mental Health Court and Medical Director of Forensic Adolescent Mental Health, Child and Youth Mental Health Service, Children's Health Queensland.

There is a longstanding but sometimes controversial school of thought that a person is not criminally responsible for a crime if, at the time of the offence, they were believed to be suffering from a mental illness. The novel Queensland Mental Health Court (QMHC) system, in which assisting psychiatrists play a central role, is underwritten by the aforementioned belief. In such cases, defendants are acquitted and

appropriate treatment options, such as a forensic order, which may involve inpatient admission, are considered. This poster describes the QMHC system, its potential advantages and challenges, and prompts the question: Should the Ministry of Justice consider adopting such a model, which is arguably less stigmatising and less costly?

Discharging patients from Broadmoor High Secure Hospital: An analysis of failed trial leaves to medium secure hospital settings.

Dr Yasmin Mohsin, St Mary's London Training Scheme, Psychiatry Trainee; Dr Morris Vinestock, Broadmoor Hospital, Consultant Forensic Psychiatrist; Dr Mary Davoren, Broadmoor Hospital, Consultant Forensic Psychiatrist.

Aims

To identify reasons behind failure of trial leave from Broadmoor Hospital, and link reasons with diagnoses, demographics and destination of trial leave.

Background

An important outcome measure for high secure hospital settings is successful discharge of patients to Medium Secure Hospitals (MSUs). Patients in high secure hospitals are typically referred for a period of trial leave to the MSU, after which their care is transferred to the MSU team. However, for a small number of patients, this period of trial leave proves unsuccessful and they are returned to the high secure hospital. To date, there is a paucity of information on the reasons for failed trial leaves among this group.

Methods

All patients discharged from Broadmoor Hospital to MSU settings over a ten-year period (2006-2015) were identified. A detailed retrospective review of medical records of those patients whose trial leave failed was conducted. Demographic data, data pertaining to diagnosis and reasons for return to high security were collated and analysed.

Results

During the ten-year period 355 patients were discharged on trial leave, of which 32 were returned to Broadmoor Hospital. Patients were discharged to 22 separate MSUs, including 14 NHS units and 8 Independent Sector Units. Length of stay in the MSU was 1.9 times longer in the Independent Sector by comparison with NHS hospitals. Patients from the PD Pathway were significantly more likely to have failed trial leave than those patients from the MI Pathway, however MI pathway patients were returned earlier in their leave. Among MI Pathway patients, the commonest reason for failed trial leave was non-compliance with medication leading to aggression. For those with primary PD the commonest reasons included aggression and subverting security. Drug and alcohol misuse were only cited as reasons within NHS units. In the Independent sector, more patients with an MI diagnosis were returned than with a PD diagnosis, whereas among NHS MSUs the spread of diagnoses was more even.

Conclusions

A small but important number of trial leaves from High secure to MSU settings fail. In this study we found significant differences in terms of failed trial leaves between patients with a primary diagnosis of PD and MI and between those discharged to NHS and Independent sector units. Given the cost of High secure care, MSU care and care in Independent sector settings, an understanding of this key junction on the care pathway out of high security has important implications for services.

Measure of Response Times for Referrals to the Rowanbank Clinic, Medium Secure Facility in Glasgow

Dr Shani Ross, CT3 Psychiatry; Dr Shaun Love, CT3 Psychiatry; Dr Sivakumar Appan, Consultant Forensic Psychiatry

Background

Rowanbank Clinic is a 74 bed, purpose built medium secure unit which opened in 2007 in Glasgow. It is Scotland's largest such unit, providing care to the West of Scotland Health Boards, including NHS Greater

Glasgow and Clyde (NHS GG&C). Elm Ward is a 12 bed male admissions unit within the clinic and no data is currently available on response times for referrals to this unit. In December 2015, the NHS GG & C Forensic Directorate produced local guidelines which recommended that urgent referrals should be seen within 5 working days from the date of first allocation meeting following receipt of the referral, and that routine referrals should be seen within 2 weeks.

Aims

- 1) To assess response time for urgent and routine referrals made between August 2013 and April 2016, and to ascertain whether local standards were met.
- 2) To assess the proportion of referrals accepted for admission and whether beds were available.

Method

Data was collected from the medical notes of the 43 patients referred to medium secure Forensic Services in NHS GG&C between the above dates. This included date of allocation, source of referral, indication of urgency, date of assessment, date of written response, outcome of referral, and, date and nature of non-written points of contact. Four referrals were excluded due to a lack of information.

Results

The mean length of time from allocation to assessment was 2.82 working days, and 7.0 working days to a written response. 3 of the referrals stated as 'urgent' were seen within 5 days (100%), and the length of time from allocation to assessment was 0, 3 and 4 working days for each. 2 of these were referrals prior to December 2015. 35 out of the 36 routine referrals were seen within two weeks (97.22%). 20 of the referrals were accepted and a bed was available for 45% of referrals. Telephone response was documented for 19% of referrals and date was specified for half of these. Email response was documented for 6 of the 43 patients.

Conclusion

The local standards for response times were met for all urgent referrals and the majority of routine referrals both before and following implementation of the guidelines. However, documentation regarding the urgency of referrals could have been improved. It is recommended that this be clearly stated in referral documents and responses. Documentation of non-written correspondence could also be improved. It is suggested that this audit be repeated in one year to assess change.

Improving the involvement of patients from forensic services in risk assessments and risk management

Dr Michaela Routhu, MRCPsych, PhD.¹, Dr Wajid Iqbal¹, Dr Jim Ormsby, MRCPsych²

1 – Wessex HEE

2 – Southern Health NHS Foundation Trust

Background and Aims

The Department of Health 'Best Practice in Managing Risk Guidelines 2007' advises that a collaborative approach involving service users should be used in the risk assessment process. Furthermore, recovery approaches emphasise that risk management is more likely to be achieved using a collaborative approach. We aimed to look at levels of engagement of our service users in the risk assessments and risk management plans, so that in the next step we could look at improving those.

Methods

We looked at all forensic inpatients in Southern Health NHS Trust aged over 18 years. The standard agreed was that all patients should have their risks assessed, and have some discussion about their risk management at least once in first 3 months of admission and then at least 6 monthly (mirroring CPA schedule). Otherwise, the reason for not involving each patient should be documented. We have selected randomly 5 patients from each clinical team and checked whether the patients were involved in risk management planning within the time scales. This audit formed a part of a wider project of involving service users in risk assessment and management under CQUIN.

Results

The patients' average age was 41; 15 patients from low secure and 30 from medium secure unit. The mean stay in hospital was 757 days. The initial audit showed that 25 patients (55.5%) had quite detailed discussions with them or documented reasons for not discussing the topic, 10 had some mentioning of the discussion, and the information was missing in 10 cases.

Discussion

The initial audit showed a lack of documenting of involvement mainly when patients were not engaging in index offence work, and also during early months of hospitalisation.

The audit showed the need for a reminder to comment on patients not having capacity to engage in risk assessments and management plans.

Results were presented locally in order to establish consistent practice on where record the collaborative risk assessment discussions with patients.

Results of the re-audit

In the subsequent re-audit, 17/20 (85%) of the patients had an involvement in collaborative risk assessment care plan, out of which 12 had detailed involvement. This could be due to individual differences between patients or due to clinical/staff factors.

There was a significant improvement in the recorded involvement. The future plan is to link the collaborative risk assessment to HCR-20 to ensure even better compliance.

A cross platform risk assessment mobile application for precise data collection

Presenting author: Dr Lisa McLoughlin, National Forensic Service, Dublin and WLMHT, Forensic Service, Ealing Hospital, London

Co-authors: Dr Cornelia Carey, National Forensic Mental Service, Dublin; Dr Ian McLoughlin, Galway Mayo Institute of Technology; Professor Harry Kennedy, National Forensic Mental Service, Dublin and Trinity College Dublin

Aims

Our aim was to develop a mobile application based on a risk assessment instrument. We believed this would lead to more precise data collection for both clinical and research purpose. Fundamental to this aim was the security of transmitted data.

From 2013 to 2015, the number of mobile health applications available almost doubled. Compared to advances in other areas of medicine, psychiatry lags behind in application development.

We developed a risk application that had a user friendly interface and would provide a visual output that was time stamped.

Methods

We created a cross-platform mobile risk assessment application. The risk assessment tool we used was the dynamic appraisal of situational aggression (DASA). The mobile application was written in Ionic, a mobile app framework. The operating system was based on Linux and we used a document-oriented database designed to store and retrieve via a RESTful HTTP interface. The mobile devices were joined to a wireless network provided by a router specifically allocated to the study. A Raspberry Pi (designated server) was connected by wire to the router. The mobile application was capable of working while out of range of the wireless network, and would automatically detect the Raspberry Pi, when in range. The overall architecture was that of a closed and encrypted system. The devices were put under the control of the nurse manager. We employed the app in a medium secure forensic mental health hospital in Ireland between March to June 2016. This setting involves the care of patients with a primary psychiatric diagnosis and a history of violence, who require dynamic risk monitoring. We conducted a trial in February 2016, closely replicating the original DASA study to ensure the application was running correctly and that our shortened version of the DASA retained the integrity in risk predication of the original. Following this we collected information from staff users to advise regarding problems with the application. Subsequently we extended this to a four-month period of data collection.

Results

Our application has a unique function in the world of health apps. Over the four-month period we collected 865 responses. All patients were male between the ages of 19 years and 60 years of age. 18 responses were deemed invalid. This left us with 847 responses. Our application yielded a 100% rate of data collection and, because each response was time stamped, showed superiority over hard copy risk assessment tools both for clinical and research purposes. During the same period we collected hard copy

data of recorded incidents. We correlated our mobile application information with the incidents reported and we correlated the mobile app DASA with the hardcopy and clinical and risk sections of the admission HCR-V20 for individual patients during the specified time period.

Closing the loop - Psychotropic Monitoring Audit at Rowanbank Medium Secure Clinic, Glasgow. *Dr Craig Marsh, ST4 Forensic Psychiatry, NHS Greater Glasgow and Clyde.*

Background

The risks and adverse effects associated with certain psychotropic medications are well documented, and monitoring requirements are outlined in a number of national publications. An initial audit of psychotropic monitoring was undertaken in 2013 within the NHS Greater Glasgow and Clyde Forensic directorate at both Rowanbank Clinic (Medium secure) and Leverndale hospital (low secure) following the implementation of local guidelines a few months prior. At the time this demonstrated a good level of compliance.

Aim

Re-audit using the same criteria from the initial audit in 2013 to assess whether psychotropic monitoring continues to be undertaken at Rowanbank Clinic. The criteria included: 1) All patients have a psychotropic monitoring schedule 2) The psychotropic monitoring schedule contains an accurate note of psychotropic medication prescribed 3) There is evidence of appropriate monitoring being undertaken 4) The monitoring schedule is updated to document a 12 month rolling period.

Method

Retrospective case note review, involving examining all kardexes, psychotropic monitoring folders and current clinical notes of each patient within Rowanbank Clinic.

Results

The results demonstrate a decrease in psychotropic monitoring level across Rowanbank Clinic since the original audit cycle in 2013 and large discrepancies between wards. A number of changes were implemented including the appointment of Psychotropic monitoring champions on each ward and a change in side-effect scale used within directorate to GASS.

Creating a Healing Environment to Promote Mental Health

Dr Amanda McGowan, Consultant Clinical Psychologist; Ms Sally Carr, Specialist Practitioner in Recovery; Dr Chris Davis, Consultant Clinical Psychologist

Aim

People who have not experienced a psychologically 'good enough' environment in their early years are more likely to suffer from mental health problems, personality difficulties, substance misuse and/or to demonstrate behaviours that put themselves or others at risk. Experiencing a caring, nurturing environment is critical in supporting people who did not have such experiences during childhood towards recovery and change. For inpatients, particularly those in forensic services, who may experience prolonged admissions, clinical staff are crucial in creating the right conditions to promote personal growth, however, many lack knowledge of the fundamental psychological principles and clinical skills needed to promote a psychologically healing environment. The aim of this project was to increase the psychological mindedness and clinical skills of staff working in medium and low secure forensic services.

Methods

The Forensic Psychological Service developed a training package to educate staff regarding the psychological principles and clinical skills required to create a psychologically healing environment for service users. The training combined presentations on the psychological processes that contribute to significant mental health difficulties with opportunities to develop and practice fundamental clinical skills. The theoretical and practical component was delivered over five consecutive days and was supported by six sessions of clinical supervision to support the implementation of skills in the workplace over the following months. The training was delivered to all grades of clinical staff working in the Forensic Directorate. Questionnaires were administered to staff pre and post training to assess the impact of the

intervention on staff confidence in responding to service users' psychological needs and their use of clinical skills post training.

Results

235 multi-disciplinary staff attended the training. The majority of attendees reported that the skills they had learnt were relevant to their clinical practice and they were able to use those skills in their everyday practice. Post-training the majority of respondents reported an increased use of active listening skills; open-ended questions and the application of transactional analysis to frame their interactions with service users. The majority of respondents also reported a greater understanding of service users' psychological and emotional needs and reported increased confidence in talking to service users about their difficulties, particularly when service users were upset, angry or confused. Respondents also reported greater job satisfaction post-training.

Audit of End of Life Care in a secure hospital

Dr Deepak Tokas – Consultant Forensic Psychiatrist; Dr Mamta Kumari – Speciality Doctor; Ann Thomas – Physical Health Modern Matron; Sharon Walker – Mallard Ward Manager; Karen Naylor – Nurse Practitioner

Introduction

The Leadership Alliance for the Care of Dying People (LACDP), a coalition of 21 national organisations, published *One Chance to get it Right – Improving people's experience of care in the last few days and hours of life* in June 2014. This document laid out five priorities for care of the dying person focussing on sensitive communication, involvement of the person and relevant others in decisions and compassionately delivering an individualised care plan.

Mallard Ward is a low secure psychiatric ward for older age men suffering from cognitive difficulties and significant physical comorbidity in addition to a severe and enduring mental illness. The patient population is such that it will remain the most appropriate placement for some patients until their death. It is therefore vital that staff members on Mallard Ward, and indeed in all parts of the Trust, are aware of the priorities for care of the dying person and that care is provided in accordance with these priorities.

Aim

To measure the standard of care provided to patients who had a natural and expected death whilst in secure care at Roseberry Park Hospital.

Method

The data collection tool was adapted from *End of Life Care Audit: Dying in Hospital*, a national clinical audit commissioned by Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians. Data was collected from both electronic and paper records. No patient identifiable data was collected.

Result

- There were three natural and expected deaths in secure care
- 2 patients were resident on Mallard Ward; 1 on low secure learning disability ward
- Cause of death was cancer for 2 patients and COPD for 1 patient
- The level of care provided was largely consistent with the priorities listed
- Detailed results will be provided in the poster.

Conclusion

The national audit compares performance of only acute NHS Trusts with no data to reflect the performance of mental health hospitals. It is imperative that mental health services work in collaboration with physical health and palliative care services so they are able to continue providing a high level of care to this patient group. Clinicians and staff involved in the care of dying patients also need to be adequately trained.

Assessing risk of violence in forensic psychiatric inpatients (Foxweb)

Dr Hasanen Al-Taiar, Consultant in Forensic Psychiatry, Oxford Health Foundation Trust, Oxford Clinic, Littlemore Hospital; Dr Mark Toynbee, Academic Clinical Fellow/CT3, Department of Psychiatry, University of Oxford, Warneford Hospital; Professor Seena Fazel, Professor of Forensic Psychiatry, Department of Psychiatry, University of Oxford, Warneford Hospital

Aim

The primary aim of this study is to develop a reliable, feasible and scalable way of assessing and monitoring risk of violence in forensic and general adult psychiatric inpatients. In addition, we investigated associations between quantitative changes in risk factors and the timing and number of critical incidents on the wards. The work builds on a successful pilot study of a web-based risk of violence monitoring tool for forensic patients in a community setting.

Method

This is an observational study where patients on a range of general adult and forensic inpatient wards in two English counties have been consented and data collected regularly during the study period of 18 months. The data is comprised of responses on a 5-point rating scale to ten questions focused on dynamic risk factors for violence. Five static risk factor questions, also scored on a 5-point rating scale, were also recorded. We additionally collected data routinely data on critical incidents involving those patients. We used a novel web-based tool based called FoxWeb to collate and display the data.

Results

Preliminary results for the first 84 patients enrolled in the study indicate FoxWeb allows data to be reliably recorded. Ages ranged from 19 - 62 years old (mean 39 years). Forensic wards accounted for the majority of the patients consented at 82%. Schizophrenia was the commonest primary diagnosis (55%, n=46) making up over half the sample. Emotionally Unstable Personality Disorder (18%, n=15) and Schizoaffective Disorder (12%, n=10) were the next most common. There were 590 violent incidents recorded during the first 12 months of the study period. Incidents per person for that period ranged from 0 - 47 with an average of 9 for each person with at least one incident. Woman patients accounted for over three quarters of the violent incidents but were 24% of the sample. Analysis of association between risk factor scores and critical incidents is ongoing.

Conclusions

FoxWeb appears to both practical and feasible to use on both forensic and general adult psychiatric inpatient units. Further work is needed to address predictive validity and to explore its utility in other inpatient settings.

An Audit of Cardiovascular Risk Assessment QRisk2 at Rampton Hospital 2016

Dr Tarek Abdelrazek -Locum Specialty Doctor; Dr John Milton -Consultant Forensic Psychiatrist; David McQueen - Advanced Nurse Practitioner; Julie Smith - Clinical Audit Manager Forensic Services; Luke Middleton - Clinical Audit Support Forensic Services; Laura Moore - Governance Assistant Forensic Services.

Aims

All patients have their 10 year CVD Risk assessed (QRisk2 score). Where the risk is greater than 20% and is diagnosed with hypertension, statin therapy was offered.

Methods

Pseudonymised data was collected from the records in 2016 and was used to calculate the QRisk2. Patients were aged 25-70 years. Collected data was entered directly into the QRISK2-2016 calculator. Patients were banded into <10%; 10-19% and 20%+. The study forms were scanned and the data was transferred to software and analysed.

Results

286 patients were identified and the QRisk2 score was calculated. 80% had a score that was <10. 15% had a score that was 10-19. 5% had a score of 20 or more.

All patients that were aged 25-29 had a score of <10. 96% aged 30-39 scored under 10, 2% scored 10-19 and 2% scored 20 or over. Patients aged 40-49; 76% had a score under 10, 19% scored 10-19 and 4% scored 20 or over. 51% aged 50-59 scored under 10, 43% scored 10-19 and 6% scored 20 or over. 50% aged 60 or over scored 10-19 and 50% scored 20 or over.

10% patients were identified as suffering from hypertension. 32% that were recorded as hypertensive had a score of less than 10, 54% had a score of 10-20 and 14% had a score of 20 or over. 6% were hypertensive and receiving statin therapy. 4% were hypertensive, had a score of 20 or more and were not receiving statins. 26% patients with a score of more than 10 were hypertensive and receiving statin therapy; of which 5% had a score of 20 or over. 7% had a score of more than 10, were hypertensive and not receiving statin therapy; of which 2% had a score of 20 or over. 20% were on statin therapy.

21% of patients had diabetes. 41% were recorded as Diabetic had a QRisk2 score of less than 10. 39% had a score of 10-20 and 20% had a score of 20 or over. 12% were diabetic and receiving statin therapy. 35% that had a score of more than 10 were diabetic and receiving statin therapy; of which 14% had a score of 20 or over. 26% that had a score of more than 10 were diabetic and not receiving statin therapy; of which 7% had a score of 20 or over.

Enrichment activities in the medical school psychiatry programme – could this be a key to engaging medical students in psychiatry? A study from a United Kingdom high secure forensic psychiatric hospital

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2. Kings College London; GKT School of Medical Education, UK
3. Kings College London; Institute of Psychiatry, Psychology and Neuroscience, UK

Background

Psychiatry is not looked upon favourably by medical students as a career choice. In 2011 and 2012, only 83% and 85.3% of Core Trainee 1 posts, respectively, were filled following a second round of recruitment. In the context of a mental healthcare system already under strain, addressing the shortfall of applicants to psychiatric training is pressing. Numerous studies focus on factors influencing career decision making of medical students, however, there is limited literature regarding enrichment activities within medical school psychiatry in the United Kingdom.

Aim

To evaluate the effect of a one-day visit to a high-secure forensic psychiatric hospital on medical students' attitudes towards psychiatry, in addition to exploring students' career intentions and the factors influencing these.

Method

In this quantitative and qualitative study, data was collected from medical students (n = 289) attending one-day structured visits to Broadmoor hospital between August 2014 and May 2015. Students' career intentions and the influencing factors, prior experience of working in mental healthcare and socio-demographic details were ascertained via a questionnaire. Change in attitudes was established using the 30-item Attitudes Toward Psychiatry scale at the start (Time 1) and end (Time 2) of the visit.

Results

Evaluation of 254 responses revealed a statistically significant increase in positive attitude towards psychiatry between Time 1 and Time 2; $t(254) = 7.312$; $p < 0.0001$. Overall, the 'Medical school clinical attachment' had the most influence on a career choice of psychiatry. Of the 6% who expressed a 'Definite' intention to pursue psychiatry, 'Career opportunities' was cited most frequently. For those not choosing psychiatry, 'Patient prognosis' was highlighted and interestingly the perception of psychiatry within medicine had a greater impact than public perception. Qualitative answers revealed views about the speciality being slow paced and emotionally difficult but also becoming much needed in the future.

Conclusions

These findings support existing evidence that the medical school clinical attachment is key to shaping attitudes towards psychiatry. This study also shows, however, that a visit to a specialised unit *outside* of traditional teaching placements can have a significant positive impact not only on attitudes towards

psychiatry but also towards mental illness in general. We propose that enrichment activities within the medical school psychiatry programme can enhance experience gained and broaden the scope of how we engage medical students in the speciality. In addition, they can help combat stigma and perhaps even help advance the idea of psychiatry as a future career.

An evaluation and evidence review of Blood-borne Virus (BBV) screening, immunisation and recording for admission assessments in Medium and Low security in forensic services in 2 separate Mental Health Trusts in 2 years

Dr Sanjib Kumar Ghosh, Consultant Forensic Psychiatrist and Researcher, Violence Prevention Research Unit, Queen Mary University of London & Forensic Directorate, East London NHS Foundation Trust. Dr Nodira Nosratdinova, SASG Doctor, East London NHS Foundation Trust; Dr Laura Samsó Barnet, SASG Doctor, Barnet, Enfield & Haringey NHS Trust; Dr Nargiza Saidova, SASG Doctor, East London NHS Foundation Trust.

Acknowledgements:

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Dr Alex Acosta-Armas, Consultant Forensic Psychiatrist, Barnet, Enfield & Haringey NHS Trust.*

Abstract

Prevalence of blood-borne viruses (BBVs; HIV, hepatitis B and hepatitis C) is elevated in individuals with severe mental illness in the UK and Europe affecting up to 1 in 5 inpatients. We should offer routine testing for HIV, and hepatitis B and C in our in-patient forensic psychiatric units, in line with new Trust guidelines. In the UK, most HIV tests occur in sexual health and antenatal services, but routine BBV testing in psychiatric populations is not widespread. This service improvement project allows us to evaluate the practicality of routinely offering BBV tests to patients with severe mental illness in an UK acute psychiatric in-patient setting, as well as the effectiveness of management of the results.

Method

We used an evidence-based evaluation tool to randomly sample 25% of the total number of patients notes for each ward from NLFS in 2015 (n=44) and ELFS in 2016 (n=60) in Medium & Low secure services. We sampled the admission, intensive care, established treatment, female, learning disability, and rehabilitation wards.

Results

For both services, fewer than 60% of inpatients were noted to have specific checks for BBV in their history taking or have clinical investigations ordered for it. Just less than half had investigations ordered. Hepatitis B, Hepatitis C and HIV were the most popular BBVs checked. Hepatitis A and Treponema are the most common other checks made. 16% had other infection and immunisation statuses recorded, of which Hepatitis A and Syphilis were most popular. With regards to immunisations given: the highest was Hepatitis B for NLFS (7%) and ELFS (8%). Hepatitis C intervention was only noted for ELFS (3%). HIV interventions were not noted in either sample. Flu vaccine was considered for admission only for NLFS (5%).

Conclusions

Both services have similar results. Although, not the 100% aimed for, routine screening for BBVs has been incorporated only in recent years. Improvements can be made in follow up and action, with a protocol for following-up results. One issue for further exploration are concerns among some staff about patients' capacity to provide informed consent and about the possibility that offering tests could be distressing to patients. This project makes a case for a nationwide study to establish the prevalence of BBVs in patients with severe mental illness. The authors have devised a computer-supported protocol and training package, tied in with general admission investigations, with subdivision of responsibility to detect (with consent) and follow-up BBVs.

Forensic Psychiatrists and the Hybrid Order: A Qualitative Investigation

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The use of Section 45A (s.45A) disposals, also known as the 'Hybrid Order', is a contentious issue in forensic psychiatric practice within England and Wales. The Vowles Judgement suggested that s.45A should be the first disposal option considered for the sentencing of mentally disordered offenders. The most common current disposal, Section 37 (s.37), was held to be appropriate only when the offense in question was *entirely* attributable to the defendant's mental disorder and when the offender would *not* remain dangerous after their treatment in hospital. The present qualitative study interviewed 12 Consultant Forensic Psychiatrists to assess their views concerning the recommendation and use of s.45A. Using framework analysis, five main themes (*Appropriate and Inappropriate scenarios for the recommendation of s.45A, the perceived Merits and Demerits of s.45A, factors influencing the recommendation and use of s.45A and future directions for the use of s.45A*) emerged together with numerous sub-themes. Despite the perceived demerits of s.45A, most consultants considered the section to be a valuable disposal option when used under specific circumstances - where the offender has a primary or prominent comorbid personality disorder, is to some extent culpable for the offense, is likely to receive an extended determinate or life sentence and does not have long term mental health needs. Most notably, s.45A was considered to enhance long-term safeguards only if the offender did not have an enduring mental illness (such as psychosis) that contributed towards their future risk and therefore would require long-term psychiatric oversight; in this scenario, s.37 was considered necessary in order to ensure the welfare of the offender and the protection of the public. From a psychiatric perspective, s.37 should remain the principal disposal option for mentally disordered offenders. The findings of this study highlight the importance to forensic psychiatrists of reconsidering the Vowles Judgement.

Case report: Treatment resistant schizophrenia – the use of nasogastric Clozapine treatment Abstract

Dr Alina Luben, North London Forensic Services, Chase Farm Hospital

There is a significant proportion of patients with a diagnosis of treatment resistant schizophrenia with a previous good response to Clozapine who are non-compliant with Clozapine. The quality of their lives as well as the prognosis of their illness is significantly affected as a result. There is currently very limited experience with regards to NG administration of Clozapine. There is a general concern about the steps required in order to consider nasogastric Clozapine treatment in patient who are not compliant with Clozapine.

Aim

This case report is mainly looking at the steps taken in the preparation and administration of NG Clozapine in a medium secure ward.

Method

Within our unit we looked at the procedures and policies required in order to initiate Clozapine through NG administration. We gathered advice from the high secure unit and adapted the policies to our unit. We also asked for further support and training from our colleagues from the eating disorders unit within the trust. We also liaised closely with the unit lead pharmacist, the physical intervention team and the senior management team.

Conclusions

We are currently in the initial stages of Clozapine initiation and we are following the policies adapted to our unit.

CLOZAPINE TREATMENT OF ADOLESCENT REFRACTORY EMERGENT EMOTIONALLY UNSTABLE PERSONALITY DISORDER (EUPD); CHALLENGES IN DIAGNOSTICS AND THERAPEUTICS.

Dr Sarah Whitaker (ST6 in Child and Adolescent Psychiatry, Junction 17, Manchester); Dr Molefi Mathe (Specialty Doctor, Woodbourne Priory)

Background

Adults who have the diagnosis of emotionally unstable personality disorder account for approximately 50% of psychiatric outpatients. In adolescents the prevalence is uncertain due to clinician's reluctance to make this diagnosis.

Despite recent advances precision diagnostic criteria on how best to diagnose and treat EUPD remains debated. Therapeutic indication and appropriate use of antipsychotics including clozapine in this patient group remains unclear.

It is debated about personality disorder being diagnosed in children and adolescents, overall it is much more acceptable for adolescents to be given a diagnosis of 'emerging' personality disorder if they exhibit clinical features of such.

Clozapine has been used (as an off-licence treatment) in adults diagnosed with personality disorder improving psychopathology and quality of life. The common features of these patients are that they had had long and or repeated hospital admissions, were presenting significant risks and had been resistant to other treatments both pharmacotherapy and therapeutic intervention.

Aim and Method

In a secure unit for adolescent girls who meet the criteria for a diagnosis of emergent personality disorder three were given a trial of clozapine. These young people had a background of long and or repeated admissions to hospitals, had been prescribed numerous medications often at high doses and offered a range of interventions all of which had proven to be of little benefit with them continuing to require a secure setting due to the risks they posed to themselves and other.

Their notes were reviewed and the number of incidents which took place in the 8 weeks before Clozapine was commenced, during the titration and after the dose was stabilised were compared.

Results

The off licence use of clozapine in all three patients showed a reduction in incidents, reduced need for polypharmacy and improvement in their qualities of life.

Discussion

One cannot account for these changes being the result of clozapine alone as each young person was prescribed additional medication (though polypharmacy and doses of medication had reduced substantially) and they were receiving other treatments also. These cases add to the growing body of evidence of the benefits of clozapine in patients with emergent personality disorder.

Innovative Approach to Collaborative Risk Assessment

Dr Amanda McGowan, Consultant Psychologist and Jacqui Learoyd, Speech and Language Therapist

Project description

Best practice guidelines in risk assessment and management highlight the importance of working collaboratively with offenders to improve understanding, engagement and adherence to risk management plans. Best practice guidelines also recommend the use of Structured Professional Guidelines that use complex language, and concepts which may be difficult for offenders to understand, and may act as a barrier to effective collaborative working. These barriers may be exacerbated in offenders with intellectual disabilities or cognitive barriers to engagement.

This abstract outlines an innovative approach to collaborative safety planning developed by Speech and Language Therapy and Psychology to promote meaningful engagement in collaborative risk assessment in offenders with intellectual disabilities in a low secure hospital setting.

Methods

Speech and Language Therapy and Psychology services developed a written protocol to guide multidisciplinary staff through the stages of producing a collaborative risk assessment with service users.

This included the collaborative completion of a "Talking Mat", a visual display tool, which could be folded up and taken away by patients. Easy Read care plans were also completed. Ward based teams were trained in the protocol and how to use Speech and Language Therapy tools in innovative ways.

Results

Questionnaires indicated that prior to the training, staff reported low levels of confidence in their ability to work collaboratively with service users with intellectual disabilities and communication impairments. Following the training, staff confidence increased. Before the implementation of the protocol, no service users reported knowledge of their risk assessments and safety management plans. After implementing the protocol, 100% of service users were actively involved in writing and using their personalised safety management plans on a daily basis. The use of visual tools and multi-modal strategies has promoted involvement, encouraged disclosure, built insight and allowed for increased collaboration between professionals and service users.

The influence of the format of presentation of clinical histories (narrative versus template) on clinicians' ability to recall risk related information.

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Background

The increased scrutiny of the clinical application of risk assessment procedures has found current approaches wanting. Whilst the recognition of factors associated with high-harm outcomes is an important element of assessing and managing risk, a focus on the predictive performance of such factors tells us nothing about the utility of risk assessment models and, more importantly, risk management. However, risk factors remain a primary concern in both empirical research and the operational implementation of risk assessment in clinical services.

The reality of risk assessment and management in clinical practice can be broken down into 4 steps: (i) the clinician holding in mind complex information about an individual, (ii) assimilating new data as it arises, (iii) determining the relevance of historical and new data to the current scenario, and (iv) making informed therapeutic decisions whilst minimising the likelihood of harm-related behaviours.

Aims

This pilot study set out to examine the first of the above steps (holding complex information about an individual in mind). More specifically, it set out to examine whether or not the way in which real-life clinical case data is presented to clinicians influences how well they retain it in memory. It was hypothesised that clinical information presented in a narrative will be associated with improved retention of the information, in comparison to information presented in a template.

Methods

A case was selected from the NHS England website of homicide inquiries on the basis of a history prior to the homicide which was representative of general psychiatric practice. Relevant risk factors were identified using an expert group of forensic and general psychiatrists. The pre-homicide history was summarised in two formats i.e. (i) within a risk assessment template drawn from clinical practice and (ii) using a narrative. Three authors (RN, CT, & DW) independently examined the two types of text to ensure information was presented in an equivalent manner (e.g., the same risk factor was mentioned the same number of times in both).

A sample of 27 consenting senior trainee psychiatrists were randomly allocated to one of two groups (narrative or template) and asked to read the text in preparation for questions about clinical decisions. Without access to the text, the participants were tested for (i) free recall, and (ii) recall cued by the risk factors.

Results

The above experiment has been concluded and the free recall and cued recall written responses are currently being independently rated by RN and TA for (i) the number of clinically relevant pieces of information correctly recalled, and (ii) the total number of errors. Differences in the mean recall scores between narrative and template groups will be analysed using an independent t-test (or a non-parametric alternative where appropriate). The data analysis, and implications of the results for clinical practice, will be presented at the conference.

An comparative evaluation and evidence review of diagnosis recording for admission assessments in Medium and Low security in forensic services in 2 separate Mental Health Trusts in 2 years

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Acknowledgements:

Professor Jeremy Coid and Violence Prevention Research Unit (Queen Mary University London)

Dr Alex Acosta-Armas, Barnet, Enfield & Haringey NHS Trust.

Background

Psychiatric diagnoses must be coded and recorded in the diagnoses and progress notes sections for initial assessment of a psychiatric inpatient. This must be done at least as working diagnoses within 24 hours of admission. Monitoring and treatment plans are then informed. This project evaluates whether, when and where these diagnoses are documented and corroborated in North London Forensic Services (NLFS) and East London Forensic Services (ELFS) It highlights areas for improvement.

Method

We used an evidence-based evaluation tool to randomly sample 25% of the total number of patients notes for each ward from NLFS in 2015 (n=44) and ELFS in 2016 (n=60) in Medium & Low secure services. We sampled the admission, intensive care, established treatment, female, learning disability, and rehabilitation wards.

Results

For NLFS, 84% diagnoses were recorded at some point after admission, but only 7% recorded in the diagnosis section within the 24hr target. However, 66% recordings were made in the progress notes on time. ELFS scored 98%-100% in 4 of 6 categories. The lowest ELFS score was still good for Diagnosis in 24 hours (77%).

Conclusions

Recording diagnoses is accepted as important. Most records are performed within 24 hours, although this can be improved. The results for the services compare favourably to research studies and evaluations around the UK. Most diagnoses are corroborated within the admission period. ELFS shows higher compliance with standards, partly due to having more recent data and time to embed previous recommendations. More information should be communicated on recording diagnoses within 24 hours into the appropriate section for admissions. Doctors should lead as they are usually involved in formally diagnosing and treating mental illness. In some stakeholder feedback, a reluctance to commit to diagnoses at admission by clerking doctors is reported. This is because they feel diagnosis should be done by the patient's own multidisciplinary team led by a more experienced consultant psychiatrist. However, they should be reassured that these are working diagnoses to guide management only, and subject to change. The clerking doctors need to be reminded at their induction, and at the clerking of a patient to record diagnoses. The ward team must check the relevant sections are complete after each new admission. This is part of the general admissions checklist we provided for these services.

Does sexual offending run in families?

*Dr Sandeep Singh-Dernevik and Dr Noir Thomas.
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Research has suggested that sexual offending is more significantly more prevalent in some families than in others. A recent population based study in Sweden suggested an odds ratio of 5.1 for full brothers, convicted of sexual offences, compared to population controls. The study found weaker but significant risk increases for father and son dyads (odds ratio 3,7) and for half brothers (odds ratio 2.1). The same study used epidemiological statistical modelling that suggested that a majority of the risk increase could be attributed to non-shared environmental factors (58%) and a lower attribution to genetic factors (40%).

Research also has suggested strong familial influence on the prevalence of other types of offending, particularly violent offending. These studies used trajectory models to elucidate predisposing risk factors to study causality. Several underlying or mediating factors have been suggested for familial etiology, ranging from harsh child rearing practices to comorbid conditions such as personality disorders. It is possible that such mediating factors could be quite different for sexual offending and indeed for different types of sexual offending.

Aims

Of the current study was explorative and to discuss and generate hypotheses regarding how familial factors approached as etiological or mediating factors might contribute to increased prevalence. A secondary aim for the study was to suggest how familial and genetic factors might be included in risk assessment and formulation for sexual offending. Family and genetic factors are typically not included in standard risk assessment, such as the Sexual Violence Risk Assessment.

Methods

Two types of methods were used in this study. Firstly, a literature review was carried out using a list of key terms for searches in library registers. Secondly an in-depth case study and genogram of a family with several members who were convicted of sexual offences and perceived as high risk of reoffending and detained in high security conditions. The case study was included to generate hypothesis and to give a deeper qualitative understanding of factors relevant to clinical practice and to case and risk formulation.

Results

A number of possible predisposing and mediating family factors, with varying qualities of evidence base, were generated. A detailed analysis of the case study gave a detailed genogram and generated suggestions on how familial factors might be included in risk assessment and management plans.

An evaluation of the use of electroconvulsive therapy in a United Kingdom high-security psychiatric hospital

Dr. Hector Blott (CT3 Psychiatry, West London Mental Health Trust), Dr. Shaun Bhattacharjee (Consultant Forensic Psychiatrist, West London Mental Health Trust), Dr. Evrard Harris (ST6 Forensic Psychiatry, West London Mental Health Trust)

Introduction

Electroconvulsive therapy (ECT) is an effective NICE-approved treatment for severe depression, treatment-resistant mania and catatonia. The Royal College of Psychiatrists' (RCPsych) guidelines also support its use as a fourth line treatment for treatment-resistant schizophrenia.

Objectives

Evaluate the use of ECT at Broadmoor high-security psychiatric hospital, focusing on the indications for its prescription and patients' capacity to consent.

Method

Analyse case records of all patients who received ECT, and of all patients referred for Second Opinion Appointed Doctor (SOAD) certified ECT treatment under Section 58 of the Mental Health Act 1983 (MHA) due to a lack of capacity to consent, between 01.09.11 and 30.07.15.

Results

All patients who received ECT during this time lacked the capacity to consent to it. 33 referrals were made to the SOAD service for 15 patients. Of these referrals, 30 resulted in certification (with a form T6), of which 10 were not subsequently used. Improvements in mental state and agreement to take clozapine were common reasons for T6s either not being certified or used. Emergency treatment under Section 62 of the MHA was employed 7 times for 4 patients during this period. Of the referrals to the SOAD service, 25 were for treatment resistant schizophrenia, 5 for mania, 3 for catatonia and none for depression.

Conclusions

Those patients requiring ECT within this population tended to be the most unwell, and all lacked the capacity to consent to it. The majority (76%) of patients receiving ECT at Broadmoor do so outside of NICE (but within RCPsych) guidelines. ECT may be an effective strategy for promoting compliance with clozapine.

How safe is Forensic Psychiatry?

Dr Elizabeth Masterson, Derbyshire Healthcare NHS Foundation Trust, Dr Leo McSweeney, Nottinghamshire Healthcare NHS Foundation Trust, Dr Nicholas Taylor, Nottinghamshire Healthcare NHS Foundation Trust

Aims

"So, how safe is forensic psychiatry?" This is a question commonly put to us by medical students, foundation doctors and core trainees at medical careers fairs and recruitment events. We tend to reply by subjectively drawing upon our personal experiences and those of close colleagues. In this pilot study we set out to gather simple, objective data to provide those interested in a career in forensic psychiatry with a more informed answer to this question.

Methods

We sent out an electronic survey to all forensic psychiatry higher trainees and consultants asking 5 simple questions: Have you ever been physically assaulted? When in your career did this happen? Where did it happen? How often do you feel at significant risk in your current role? In your current role, do you feel there are appropriate security protocols in place to maintain your safety? These were simple multiple choice tick box questionnaires taking less than two minutes to complete.

Results

We had 56 responses in total, with 32 consultants, 7 ST 4, 8 ST 5 and 9 ST 6 higher trainees. Of these, 37 (66%) reported never having been physically assaulted. Of the remaining 19 (34%), the majority had been assaulted as a consultant (55%) with the other assaults distributed roughly evenly throughout ST 4, ST 5 and ST 6 trainees.

- 45% of assaults were registered in medium secure placements and 30% in prison. There were no reported incidents in the community, and 10% and 15% in high secure and low secure respectively.
- 56% of respondents reported they very rarely felt at significant risk of physical harm in their current role. A further 40% reported occasionally feeling at significant risk. Only 6% felt they were often at risk.
- 81% of respondents felt there were appropriate security measures currently in place to maintain their safety at work.

Conclusions

Reassuringly, the majority of respondents had not been subjected to physical assaults at work and more than 80% stated they felt appropriate security protocols were in place in their workplace. However, it is notable that over a third of respondents had been the victim of an assault at some point during their career. Although just a snapshot, this simple data provides a useful reference to call upon when one is asked "how safe is forensic psychiatry?" by those who may be considering a career in the field. Our wish is to extend this research to address the small proportion of respondents who reported that they "often" feel at significant risk in their workplace and consider the specific factors that contribute to this and what (if any) measures could be taken to ameliorate this.

The Place for Reflective Practice in a High Secure Mental Health Hospital in the UK.

Dr Minesh Karia, Dr Estelle Moore, Dr Jaleel Mohammed

Reflective Practice is recommended by the Royal College for Health and Social Care Professionals as a way to improve communication and thereby foster the collaborative practice required of practitioners in forensic settings.

A cross-sectional project was conducted within a high secure mental health hospital (Broadmoor Hospital, Crowthorne, UK) to establish reflective practice attendance and accessibility for ward-based staff and to also explore staff experiences of reflective practice. An on-line survey was sent to all staff (n=441) who would have had opportunities to attend a weekly multi-disciplinary team reflective practice. A total of two email reminders were sent at weekly intervals and data was collected for a period of three weeks from June-July 2016.

One hundred and nine staff members participated (response rate: 24.7%). The occupational roles of the staff who responded were varied. Overall, the study found poor reflective practice attendance, with the majority (75%) reporting attending reflective practice on a *monthly* or less basis and with fewer (13%) attending weekly. More than 40% of responders gave insufficient staffing, other commitments, workload or rota related issues as reasons for non-attendance, whilst in comparison only 4.5% identified reluctance to attend as the reason for non-attendance. 45% of staff members agreed or strongly agreed that there have been times when they wanted to attend reflective practice but could not attend.

The majority of participants endorsed a number of different positive outcomes from attending reflective practice including that the process of reflection assists in understanding both patients and other team members' views better and also in thinking about the dynamics of the organisation and its practices. Perceptions by staff of the reflective practice facilitators were largely positive. Half of responders felt that reflective practice has a positive impact on their performance at work.

Overall, staff perception of reflective practice was positive. Whilst this study found there to be poor attendance at reflective practice, it found that staff reported the reasons for this to be largely not due to a reluctance to attend but instead more due to inaccessibility due to staffing pressures or other commitments. This study highlights the need to understand the underlying reasons for non-engagement with reflective practice within psychiatric hospitals which may aid in formulating methods to improve attendance rates.

Women's health and national screening within female secure services

Dr Sameer Kamaluddin Bandali (ST6 Forensic Trainee, Audit Lead); Ms Georgia Garrett (Band 5 RMN); Dr Vivek Bisht (Consultant Forensic Psychiatrist, Lead Director); Dr Blaga Carr (Consultant Psychiatrist); Dr Sharon Hadley (General Practitioner)

Introduction

1 in 8 women are diagnosed with breast cancer¹ and 2 out of every 100 cancers diagnosed in women are cervical. Chlamydia has been shown to encourage HPV induced carcinogenesis.² Risk factors include obesity and smoking amongst others.³ These are frequently seen amongst the psychiatric population. With the odds of attendance for screening decreasing with increasing socioeconomic deprivation.⁴ (another prevalent risk factor) the admission of women represents a missed opportunity.

Aim

The aim was to see whether females in our unit were being asked about screening status on admission and being offered the opportunity to engage with screening during admission (breast, cervical and chlamydia).

Methodology

There were a total of 25 females meeting the inclusion criteria (see appendix 1). Past records from local screening centres were sought and data retrospectively collected from patient notes to establish if they had been asked about screening on admission or offered it during admission.

Results

Of the total sample (n= 25) only 3 had discussions about screening on admission with none being asked about any recent sexual contact.. 15 had undergone previous screening (either breast, cervical or chlamydia), 4 had never been screened and 6 either refused access to records or had no data. Of these 15 with previous screening only 6 had undergone breast or cervical screening within the last 3 or 5 years as recommended, with the majority having either had no previous screening or screening being overdue.

Conclusion

The results show a missed opportunity to engaging this target population. A protocol for the admitting doctor to follow has been developed to identify any screening needs on admission. The patient would then be referred to the lead nurse for screening who would coordinate with local screening services (see appendix 2).

All patients in our audit identified as eligible and who consented for screening went onto be registered with a local GP and invited to screening for breast and cervical cancer. The authors have however to date not been able to negotiate a pathway forward for the screening of chlamydia with local screening services. A significant point of discussion is that for women transferred from immigration centres there is currently no eligibility for screening. The authors ask, is this discrepancy compatible with the duties of a doctor to 'Protect and promote the health of patients'? or compatible with our duty of care to detained patients. Should nationality predict the level of care that you receive whilst detained?

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An analysis of emergency leaves of absence from a United Kingdom high-security psychiatric hospital with a view to identifying ways to reduce their number

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Introduction

Emergency leaves of absence (ELOAs) from high-secure psychiatric care, usually to facilitate an aspect of the patient's physical health care, are costly and increase the risk posed to staff, patients and the general public. ELOAs were analysed to identify ways to reduce their number, such as greater on-site physical health provision, and quantify the potential financial saving to the trust to do so to help inform whether they would be cost-effective.

Method

The clinical records for all ELOAs from Broadmoor high-security psychiatric hospital between 15.5.15-14.11.15 were assessed by a team of psychiatrists and a GP to form a view as to whether they were 'avoidable', 'unavoidable' or 'potentially avoidable', if measures were taken. For the 'potentially avoidable' group we then calculated the staffing cost of these ELOAs to help ascertain whether these measures would be cost effective.

Results

There were 30 ELOAs during the period assessed, costing a total of £79,240. 3 of these were due to assaults, 3 to self-harm, and 7 to sports injuries. Avoidable ELOAs comprised 7% (n=2) and cost £3,973, unavoidable ELOAs made up 40% (n=12) and cost £49,044, whereas the potentially avoidable ELOAs made up the remaining 53% (n=16) and cost £26,223. Within the potentially avoidable group: watchful waiting could've delayed or prevented 10% (n=3) of the total number, saving up to £14,307; on-site x-ray provision 30% (n=9), saving up to £8,326; wound care and suturing training 7% (n=2), saving up to £2,603, and provision of equipment could have delayed or prevented 7% (n=2), saving up to £2,271.

Conclusions

The number of ELOAs from the hospital could be reduced by increased on-site physical health provision and training. Similarly, we should increase awareness amongst Sports and Leisure staff to mitigate the risk from sports injuries. These measures could improve the quality of care patients receive, as well as reducing both the cost to the trust and the risk posed to staff, patients and the general public. We must also consider the large potential costs and risks associated with a patient absconding from high-secure care during an ELOA.

Audit of Seclusion Authorisation and Reviews at Roseberry Park Hospital, Middlesbrough

Dr Elshiem Hamad, Core Trainee; Dr Joanne Parry, Senior Registrar; Dr Shivali Shah, Senior Registrar; Dr Pratish Thakkar, Consultant Forensic Psychiatrist; Dr Bunny Forsyth, Consultant Forensic LD Psychiatrist (Tees, Esk and Wear Valleys NHS Foundation Trust)

Background

The Department of Health's Mental Health Act 1983: Code of Practice defines seclusion as: 'The supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others' (Paragraph 26.103, Department of Health 2015 revision).

When seclusion occurs, it is essential that the procedural safeguards of the Code of Practice are applied to ensure its safety and effectiveness.

Aims

This Clinical Audit was conducted to assess the implementation of the Code of Practice and Tees, Esk and Wear Valleys Trust Seclusion Protocol when managing patients in seclusion.

Methods

This audit was conducted at Roseberry Park Hospital throughout May and June 2016. This covered areas of medium secure, low secure, LD and Adult PICU wards. A data collection audit tool was devised to observe criteria from the Code of Practice and the Trust seclusion policy. Data was collected retrospectively by reviewing electronic seclusion records for each patient, and was analysed using Microsoft Excel.

Results

- 22 episodes of seclusion were analysed
- Where seclusion was not authorised by a doctor, the first medical review took place within the first hour 45% of the time.
- 60% of patients were seen by a doctor on a four-hourly basis.
- Subsequent MDT reviews once in every 24-hour period took place 67% of the time, and in 33% of cases there was no evidence that further MDT reviews took place.
- Independent MDT reviews took place only 56% of the time.

Conclusion

Results demonstrated lack of adherence to the Code of Practice and Trust policy with regards to executing regular and timely medical, MDT and Independent seclusion reviews. A delay or absence in such reviews can prolong seclusion unnecessarily and pose risks to patients due to delayed detection and treatment of physical health problems.

Intervention:

Following this audit, a seclusion training event was delivered to staff. A flowchart summarising the frequency of medical reviews was produced and circulated across the Trust. A Seclusion Reference Checklist was also devised and circulated to help improve compliance.

Re-audit

A re-audit is planned for December 2016/ January 2017 to monitor compliance with standards following implementation of the action plans. Results will be available for presentation at the conference.

Physical health assessment of new patients to Tasman Ward, Park Royal Secure Services

Authors: Dr Emma Padfield, CT2 Psychiatry trainee, Park Royal Centre for Mental Health, Central and Northwest London NHS Foundation Trust; Dr Girija Kotalgi, Consultant Forensic Psychiatrist, Park Royal Secure Services, Central and Northwest London NHS Foundation Trust.

Background

People with mental illness have higher rates of physical health problems compared to the general population. This may be partly due to poorer provision of physical healthcare and side-effects of psychotropic medication. The Central and North West London NHS Foundation Trust and the National Institute for Clinical Excellence provide guidance on essential physical health monitoring for people admitted to a psychiatric hospital and those prescribed antipsychotics.

Aims

To check compliance with this guidance on physical health monitoring on a low secure forensic ward. Method: An audit was done using information obtained from case notes. Data were initially analysed for fourteen male inpatients aged 18-65 admitted during a one-year period (November 2014 – October 2015). A re-audit is currently underway of patients admitted since quality improvement strategies were introduced.

Results: The majority (80%) had their vital signs checked within six hours of admission, 70% had a physical examination done and 65% had a complete set of baseline bloods. Baseline measures such as waist circumference, glycosylated haemoglobin and electrocardiogram were not performed consistently for all patients prior to commencing regular antipsychotic treatment. Appropriate referrals to specialists including further investigations were not done consistently when abnormalities were found. Further review of physical health assessments at the three-month care review meeting were inadequate and did not fully meet the standards. New procedures have now been introduced which include mandatory use of existing templates for admission assessments and implementation of new templates for reviews. There has also been circulation of guidelines and simple flow-charts to staff, and monitoring by nursing and medical staff of colleagues' adherence to physical health policy and guidelines. Re-auditing is currently underway to review the improvement in quality of physical health monitoring.

Brief approaches for violence risk assessment: can they be accurate?

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Aims

To develop scalable and simple tools for violence risk assessment that can perform as well as current structured approaches.

Methods

Using Swedish national registers, two interview-independent risk assessment tools were developed. The first was a tool to predict violent recidivism in released prisoners and the second was for violent crime in psychiatric patients with psychotic disorders. These were developed using pre-specified risk factors and cut-offs to reduce the possibility of shrinkage when applied to new populations. Both instruments were externally validated using Swedish data at one and two years, and performance across a range of measure of discrimination and calibration was examined.

Results

Two new models were developed from pre-specified routinely collected criminal history, socio-demographic

and clinical risk factors. For released prisoners, this the model included 14 items, and showed good measures of discrimination (Harrell's c-index 0.74) and calibration (sensitivity at 76%, specificity at 61% at 1 year using a 10% cut-off) in external validation. For patients with psychosis, the model also demonstrated good measures of discrimination (c-index 0.89) and calibration (sensitivity was 64% and specificity was 94% at 1 year using a 5% cut-off). These models were used to generate simple web-based risk calculators (OxRec and OxMIV) that provide both probability scores and risk stratification based on pre-specified cut-offs.

Conclusions

We have developed risk scores in two cohorts relevant to forensic psychiatry that can be used as adjuncts to decision making in clinical practice by identifying those who are at low risk of future violent offending and higher risk individuals who may benefit from additional risk management. They can potentially be used as brief and scalable methods to anchor more detailed assessments in evidence.

Vitamin D deficiency in Medium Secure Forensic patients: Don't just screen - intervene

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Introduction

Vitamin D deficiency is linked to several skeletal and non-skeletal disorders like cancer, cardiovascular disease and depression. Vitamin D deficiency can occur in in-patients with mental health problems due to poor dietary intake and limited exposure to sunlight. These patients are also unlikely to communicate their vitamin D deficiency symptoms. National Institute for Health and Care Excellence (NICE) and the National Osteoporosis society guidelines recommend screening and intervening in such high-risk groups. The extent to which these guidelines are followed in the forensic units in the United Kingdom is unclear.

Aim

To examine the compliance of testing Vitamin D blood levels and its treatment with local and national guidelines in a medium secure forensic unit.

Method

A cross sectional study was conducted from 25th – 27th October 2016. All patients aged 18 years and above and admitted in an acute ward, treatment ward, pre-discharge ward and female ward in medium secure units of the hospital were included in the study. Patients drug charts; electronic notes and pharmacy dispensing system were reviewed to collect data regarding vitamin D screening and treatment along with demographics. Serum vitamin D levels of <30 nmol/l were considered as deficiency and levels between 30 and 50 nmol/l were considered as insufficiency. Descriptive statistics were used to analyse the data.

Results

A total of 50 patients were included in the study. The mean age was 33 years (range 21 to 53 years) and 92% (46) were men. 86% (43) received Vitamin D screening blood test and 79% (34) of them had serum Vitamin D levels less than 50nmol/l. 65% (22) of the screened patients received vitamin D replacement therapy. However, the actual vitamin D dose given varied with 10 patients receiving only loading dose (40,000 units per week) without further maintenance dose (20,000 units per week). 6 patients received only maintenance dose without the initial loading dose and 6 patients received both the initial loading dose and the maintenance dose. The duration of treatment ranged from 10 days to 461 days with an average of 142 days. Only 9 out of 22 patients (41%) received follow up serum calcium levels.

Conclusion

There is high prevalence of vitamin D insufficiency in in-patients of forensic unit. Compliance with the vitamin D replacement therapy was variable. Screening will be meaningful only when the results are acted upon.

Mental health morbidity amongst people subject to immigration detention in the UK-a feasibility study

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Aims

The UK has one of the largest systems of immigration detention in Europe. The standard of healthcare provision in immigration removal centres (IRC-s) in the UK has been repeatedly cited as cause for serious concern. Despite this, there is very little published research in IRC-s which screen for the full range of mental disorders. The aims of this study were to explore whether it was feasible to conduct psychiatric research in such a setting and to provide an estimate of screened psychiatric morbidity in the male detainee population of an IRC.

Method

Cross-sectional design with simple random sampling followed by opportunistic sampling. Exclusion criteria included inadequate knowledge of English and EU nationality. Six validated tools were used to screen for the full range of mental health disorders including developmental disorders like Personality Disorder, Attention Deficit Hyperactivity Disorder, Autistic Spectrum Disorder and Learning Disability, as well as for needs assessment. These were the MINI v6, SAPAS, AQ-10, ASRS, LDSQ and CANFOR. Demographic data were obtained using a participant demographic sheet. Researchers were trained in the use of the screening battery and inter-rater reliability assessed by joint ratings.

Results

101 subjects were interviewed. Overall response rate was 39%. The highest screened prevalence was for depression (52.5%), followed by personality disorder (34.7%), and PTSD (20.8%). 21.8% were at moderate to high suicidal risk. 14.9 and 13.9% screened positive for ASD and ADHD, respectively. The prevalence of depression was significantly higher than a control group in prison. The overall screened prevalence of other mental disorders and suicidality was similar to prison samples. The greatest unmet needs were in the areas of intimate relationships (76.2%), psychological distress (72.3%) and sexual expression (71.3%).

Conclusions

There should be greater awareness of neurodevelopmental disorders amongst staff in IRC-s. There were limitations to the study like the issue of self-selection, use of screening tools, single-site study, high refusal rates, lack of interpreters, and lack of women and children in study sample. The change to a different model of recruitment using a member of the mental health in-reach team to recruit participants should be employed in future, as well as involvement of all key stakeholders from the outset. The study demonstrates that psychiatric research in IRC-s is feasible. There is a need for a national multi-site prevalence study of at-risk mental health in IRC-s. Such a study should be funded to provide for interpreters and not exclude EU nationals.

Study of transfers from prison to hospital under Sections 47 and 48 of the Mental Health Act over 4 years

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Aim

In England and Wales prisoners with mental disorder of such severity as to warrant inpatient treatment may be transferred to hospital under the Mental Health Act. UK Government guidance recommends that this process should be completed within 14 days; however, evidence suggests that in many cases it can

take much longer. This retrospective service evaluation aimed to evaluate the transfer durations of male prisoners who were transferred under Sections 47 or 48 of the Mental Health Act from four prisons over a period of four years.

Method

The sample comprised of all prisoners successfully transferred between 20/11/2011 and 19/05/2015 under from four prisons located in the East Midlands & South Yorkshire region of the United Kingdom. Two prisons were local prisons with the primary function of serving the local courts and therefore responsible for detaining remand prisoners as well as some sentenced prisoners. The remaining two prisons were training prisons exclusively for sentenced prisoners. Each prison had an operational capacity broadly in the region of one thousand prisoners.

Results

A total of 64 prisoners were transferred from one of four prisons to a total of 26 hospital settings throughout the UK between 20/11/2011 and 19/05/2015. The mean time from referral to admission was 76 days. Prisoners with a psychotic disorder were admitted more quickly. Remand prisoners were admitted more quickly than sentenced prisoners. Overall the transfer time of prisoners far exceeded the 14 day target.

Recommendations

We propose that secure hospitals provide Offender Health commissioners with the option of purchasing a small number of beds where the admission rights would sit with the referring prison psychiatrist. These beds would be available to prison psychiatrists for the most urgent of transfers. We encourage services to actively consider initiatives such as a dedicated clinician who is tasked with facilitating the transfer process.

We welcome a debate about extending some compulsory treatment powers to prisons (perhaps by establishment of units with designated status as hospitals with a prison's secure area). Potential benefits of being able to do this in prison would be shorter duration of untreated psychosis (with commensurate improved prognosis) and significant saving to the health budget from reduced admissions. The issue with prison hospitals however, will always be the non-therapeutic environment and conflicting priorities between security and healthcare.

A comparison of long term medium secure patients within NHS and Independent Sector units

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Professor Conor Duggan, Professor in Forensic Psychiatry, Head of Research and Development, Partnerships in Care

Aims

To compare the characteristics of patients within NHS and independent and charitable sector (ICS) units, that would inform the development of services, given the costs and pressures on resources.

Methods

Long stay in this study was defined as a duration of 10 years or over in high secure and 5 years and over in medium secure or 15 years if patients had stayed in both, high and medium secure care consecutively. Using a piloted proforma, descriptive variables in around sixty categories were collected on the census date on 1.4.13.

Results

178 LTMS NHS patients and 107 ICS patients were included. 20% of the entire sample had spent more than 20 years in continuous care and a third had spent 10-20 years in continuous care.

NHS units acted as custody diversion units with ICS units dealing with other hospitals and the community. The majority of NHS patients were detained under Section 37/41 of the Mental Health Act, 1983 (NHS 71.9% vs ICS 50.9%) and more ICS patients were detained on Section 3 (10.1% vs 23.4% $p=0.003$). Higher proportions of ICS patients were diagnosed with personality disorder (23.2% vs 24.5%) and learning disability (9.6% vs 19.8% $p=0.015$).

There were more violent offenders in the NHS group and the ICS group had higher proportions of mixed, sexual and non-offenders along with higher mean HCR-20 scores. More NHS patients were not involved in incidents in the last 2 years (NHS 42.2% vs 28.0% $p=0.017$) or not requiring seclusion in the last 5 years (62.7% vs 39.6% $p<0.001$). ICS patients were more likely to have been involved in a serious incident necessitating seclusion in the last five years (NHS 27.7% vs ICS 47.2% $p=0.001$), including assaults on staff and others.

Conclusions

Services streams were used differently for different types of patients, but both were not progressing. ICS patients presented with significant challenging behavior. Significant proportions in both groups were not involved in incidents. Clinical teams need to justify the continuing use of medium secure placements, given their expense and limited resources.

Forensic Psychiatry and Novel Psychoactive Substances (NPS): Prevalence of NPS Drugs in Urine Samples Submitted for Toxicology Testing in Forensic Psychiatric Patients, Glasgow, Scotland

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Background

There are approximately 220 patients in the NHS Greater Glasgow and Clyde Forensic Directorate managed in medium secure, low secure and community settings. The patient cohort has a range of diagnoses, although around 70% have a primary diagnosis of schizophrenia. Many forensic patients have co-morbidity (76% of those in community setting), with either harmful use of or dependency on illicit substances and alcohol. The majority of patients are detained under a section of either the Mental Health (Care and Treatment) Scotland Act (2003) or the Criminal Procedure (Scotland) Act 1995. It is routinely a condition of the patient's suspension of detention or condition of discharge that they should not use illicit substances, alcohol or novel psychoactive substances (NPS). Patients under the care of the forensic psychiatric services are regularly screened for drugs of abuse. It is unknown if this cohort of patients are using NPS, as they are not known to be routinely detected by current urine screening tests.

Aim

To investigate the prevalence of use of NPS agents in forensic psychiatric patients cared for in NHS Greater Glasgow and Clyde

Methods

The Forensic Medicine and Science, University of Glasgow Toxicology Dept developed testing procedures for a range of NPS. Urine samples were obtained in a naturalistic way, starting in January 2016. Patients in the forensic directorate were already required to provide random urine samples for drug testing. When a routinely collected sample was sent to biochemistry, the remainder of the sample after routine testing was anonymised then sent to the Forensic Medicine Toxicology Dept where it was tested for NPS. The anonymised results were reported back to the research team. Each patient was only screened once for NPS agents. Ethical approval was obtained from NHS GG&C ethics committee.

Results

By July 2016, 64 urine samples had been obtained by the laboratory and tested for a range of NPS. Three samples tested positive and these were sent for confirmatory testing to Cardiff, where they were confirmed to contain synthetic cannabinoids. Testing is ongoing and is done in batches. The laboratory has now received over 100 samples.

Discussion

This is the first study actively testing for NPS in Forensic Psychiatry patients. The research team did not have a hypothesis regarding the number of samples that would test positive, however three of 64 samples seems small given the scale of media interest in NPS. During the course of the study there was a legal change whereby NPS which had previously been legal became illicit. It is not clear if this had an impact on the study. It is however clear that testing for NPS is a feasible addition to testing for other psychoactive substances. During the course of the study the laboratory developed tests for NPS which were confirmed to be effective by an independent laboratory. Given this positive result, the study has now been approved for expansion to the General Adult psychiatric population in NHS GG&C.

The impact of formulation sessions on the clinical teams' understanding and management of risk with in a low secure inpatient setting

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Background

Following feedback that the low secure wards (Bede ward) response to relational security training was reactive opposed to proactive, it was agreed that regular formulation sessions would be trialled for a period of time to see if it would help develop the teams understanding of the patient group further and understand the circumstances which may precipitated risky behaviour. These sessions are open to all members of the clinical team and are facilitated by a psychologist. Each session is focussed on one current in patient. The session covers both factual information regarding the patient's history, but also includes time for reflection and the emotional impact of working with the patient. At the end of the session, there is time to review current care plans and adapt these depending on the outcome of the discussion

Aim

The aim of the study is to gain feedback from the staff regarding the impact of these sessions on the clinical team and risk formulation and management.

Method

The proposed way of gathering this information is through a staff survey and questionnaire. The questionnaire will be generated electronically using "survey monkey". This will then be sent as a link through the trust email system to all members of the clinical team (Bede distribution list). The email will also contain a brief explanation regarding the purpose of the study and what the aims are. It will then be up to the individual staff member to complete the questionnaire if they so wish. It is presumed that if they complete the questionnaire they are consenting to participate. All responses will be anonymous. The information will be collated by the investigating team and the results analysed using Microsoft Excel.

Results

The data has not been collected yet but it is anticipated that the staff will feel more confident in their understanding of each patient and have a clear explanation for why certain decisions are made. It is also hoped that the clinical team will feel that there is collaborative approach to risk management and that their safety on the ward is not compromised. There is the possibility that only staff with either extreme positive or negative views may respond thus causing some bias.

Conclusion

It is anticipated that the formulation session will have a positive impact on the clinical team through nurturing a collaborative approach to risk management and the development of robust care plans. It is expected that formulation will become an ingrained ward practice that will provide a safe space to engage in discussions about clinical management and thus maintain a therapeutic environment for both staff and patients.

Differences in secluded and non-secluded patient characteristics and Health of Nation Outcome Scale outcomes

Dr Chris Griffiths; Dr Alessandra Girardi; Dr Ashimesh Roychowdhury

Background

Many forensic mental health facilities have seclusion rooms. Secluded and non-secluded patients differ on factors which include demographic and clinical characteristics (Happell et al. 2010; Trauer et al. 2010). The Health of Nation Outcome Scales (HoNOS) is a measure of health and social functioning and the HoNOS-secure scale assesses need for secure or forensic care. HoNOS has been employed to compare secluded and non-secluded patients revealing that secluded patients score higher on behaviour, impairment and social related items and that HoNOS scores can predict future likelihood of seclusion (Happell et al., 2010; Husum et al., 2010; Trauer et al., 2010).

Aims

The study investigated the impact of seclusion and factors associated with seclusion on recovery as measured with the HoNOS-secure subscales and factors.

Methods

Anonymous data on age at admission, gender, hospitalisation days, ICD-10 diagnosis, seclusion, and HoNOS-secure subscales exit and entry scores were extracted from clinical records database. Ninety-six secluded patients were compared to 251 non-secluded patients across the four largest diagnostic groups: paranoid schizophrenia (44%), emotionally unstable personality disorder (37%), Asperger's syndrome (14%) and organic personality disorder (14%).

Results

Secluded patients were significantly younger than non-secluded patients but there were no differences in hospitalisation days between the two groups. Scores on the clinical and secure subscale significantly improved over time across all diagnostic categories, supporting research indicating sensitivity to change (Dickens et al., 2010; Long et al., 2010; 2011; Sugarman et al., 2009). However, secluded patients with paranoid schizophrenia did not significantly improve on secure scale, personal and emotional wellbeing factors indicating that there are differences in the needs and progress of secluded paranoid schizophrenia patients compared to other patient groups. This finding suggests that HoNOS-secure should be used with caution as a measure of progress for decisions as to whether secluded patients should be discharged. Total and factor scores did not discriminate between secluded and non-secluded patients with organic personality disorder and Asperger's Syndrome suggesting that the scores did not capture the factors relevant to seclusion in these patient groups. Finally, secluded patients with emotionally unstable personality disorder improved significantly more than non-secluded patients on the clinical total scores and the severe disturbance factor. Overall, the results indicate differing needs and expected rates of progress in these groups.

Healthy Heart Week – An initiative to improve Physical Health

Ruth Prince, Senior Nurse, Betsey Walker, Occupational Therapist, Dr J Srinivas, Consultant Forensic Psychiatrist, Dr Amanda Mcgowan, Consultant Psychologist

Introduction

A significant number of Service Users in Forensic Mental Health settings experience difficulties in managing their physical health. Five year Forward View of Mental Health (2016) notes that people with Mental Health Problems have poorer physical health than general population and experience unnecessary health inequalities. People with severe mental illness die on average 15-20 years earlier than the general population.

Forensic Directorate at South Staffordshire and Shropshire Healthcare NHS Foundation Trust organised a weeklong event across its Medium and Low Secure service to raise service user awareness of physical health issues, predominantly focussing on effects of poor physical health management on the heart. The programme was developed in collaboration with Staffordshire and Stoke on Trent Partnership 'Together4Health' which is a community based healthy lifestyles service which promotes positive lifestyle behaviors and the Trust's recovery college which facilitated sessions co-produced with service users with lived experience. All disciplines were involved in development and delivery of the programme.

Method

Prior to the event, service users completed a Healthy Heart Passport containing relevant physical health parameters including weight, BMI, Waist circumference, pulse and BP. Their clinical investigations were also reviewed. From this data, an average Mr Rehab and Mr Acute were created to allow service users to compare differences with the national averages.

The programme involved a number of formal and informal sessions including presentations, quizzes and interactive activities with the main focus being on 'healthy hearts'. The emphasis was on helping service users to make small yet sustainable lifestyle changes. Activities covered topics like healthy heart, healthy lifestyle, getting Motivated, Mood and Food, medication management, New ideas for physical fitness and How to work together to make changes.

An event was organised to celebrate service user commitment to the initiative. Service users were awarded certificates and received goody bags containing a water bottle, pedometer, lifestyle information including British Heart Foundation information leaflets.

Results

Each session was evaluated. Service users commented positively on the event and made useful suggestions on engaging other service users. A number of service users made a public commitment to change aspects of their lifestyle. Collaborative care plans were completed to support their commitment. There was an observed immediate increase in physical health activity. Information boards containing visual aids to support continued healthy choices were developed for each of the wards. A Re-audit of the passport data will be undertaken in December 2016.

A Synergistic Approach to Improving Outcomes for Homeless Mentally Ill Offenders

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Introduction

The Prison Inreach and court liaison service (PICLS) at Cloverhill Prison has had success accessing mental health care for mentally ill remand prisoners. Rates of homelessness among this group were high and this often impeded their ability to access care. A housing support worker (HSW) joined the team with the aim of supporting these individuals in accessing housing and other supports upon release.

Aims

We aimed to support homeless mentally ill offenders by improving their access to housing and arranging appropriate mental health care, the intention being that a synergistic "housing first" approach would lead to improved outcomes. In addition, we aimed to measure:

- i. Prevalence of homelessness for the two-year period before and after the introduction of the HSW
- ii. Demographic and clinical variables
- iii. Homeless status of individuals seen by the HSW at the time of committal.
- iv. Housing and mental health outcomes achieved following the intervention

Methods

PICLS screened all new committals to Cloverhill Prison between 1st January 2012 and 31st December 2015. From 1st January 2014, PICLS referred homeless individuals seen to the Housing Support Worker (HSW). The z-test statistic was used to test for differences in the prevalence of homelessness, housing outcomes and housing registration status, before and after the introduction of the HSW.

Results

There was no significant difference in the proportion of homeless individuals seen between the two time periods ($p=0.15$).

The HSW met with 123 separate committal episodes (90 individuals). The lifetime prevalence of psychosis was 63% ($n=57$), and 92% ($n=83$) of these individuals had a history of polysubstance abuse.

At the time of discharge, 16% (n=20) required hospital admission and 53% (n=66) were followed up by community based outpatient or primary care services.

30.1% (n=37) of new committals seen by the HSW had been sleeping rough at the time of committal. No participants were released to rough sleeping and the majority accessed more stable accommodation at the time of release.

The HSW newly registered 25 individuals (28%) with their local housing authority, resulting in an increase of registration among individuals seen from 38% (n=34) to 66% (n=59), by the end of 2015 (p<0.001).

Conclusions

Homelessness is prevalent among mentally ill remand prisoners. These individuals have high rates of psychosis and polysubstance abuse. Housing outcomes were improved following input from the HSW including improvement in housing status, increased registration with local housing authorities, and enhanced links with community based supports.

The Older prisoner Health and Social Care Assessment and Plan (OHSCAP): A Randomised Controlled Trial

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5. *The University of Manchester, England*
6. *Dublin Institute of Technology, Dublin*
7. *University of Oxford, England*
8. *Restore Support Network, England*

Introduction

There has been an increase in the number of older prisoners across developed countries. Older prisoners have more health needs than younger prisoners and those of the same age living in the community. These are often accompanied by a multitude of social care needs. There is no national strategy in England for older prisoners' care. Consequently, care is currently generally *ad hoc* and largely uncoordinated. The Older prisoner Health and Social Care Assessment and Plan (OHSCAP) was developed through action research by prison staff, healthcare staff and older prisoners themselves. It is a structured approach designed to better identify and manage the health and social care needs of older prisoners. It consists of an assessment, care plan and review of these needs.

Aim

To evaluate the effectiveness and acceptability of the OHSCAP in comparison to Treatment As Usual (TAU).
Objectives

1. To evaluate the effectiveness of the OHSCAP in improving i) the meeting of older male prisoners' health and social care needs (primary outcome); ii) health related quality of life; and iii) depressive symptoms, in comparison to TAU.
2. To assess the quality of care plans produced through the OHSCAP and fidelity of implementation.
3. To evaluate the implementation of the OHSCAP and its impact on staff and prisoners in practice.

Methods

The extent to which prisoners' health and social needs were met was assessed before they received the OHSCAP or treatment as usual, and three months after (n=497). An audit of care plans produced through OHSCAP was conducted to determine the processes involved; quality of the care planning; and fidelity of implementation. Semi-structured interviews with older prisoners who had received the intervention were conducted. Fourteen prisoners were interviewed between 2-4 times. Interviews were held with staff delivering the intervention to gain an understanding of the processes used (n=11).

Results

There were no statistically significant differences, in the meeting of older prisoners' health and social care needs, between the OHSCAP and TAU group at three months follow up (p = 0.618). The audit of the care

plans demonstrated that the OHSCAP was fundamentally not delivered as intended. The semi-structured interviews revealed that the OHSCAP was introduced within a 'broken' prison system suffering from staffing levels that were reported as dangerous. Rigid prison processes further impeded the ability of the OHSCAP to meet older prisoners' health and social care needs. The appropriateness of prison officers acting as facilitators of the OHSCAP was also questioned.

Beyond the Walls: An Evaluation of Ireland's First Pre-Release Planning Programme for Mentally Ill Sentenced Prisoners.

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National Forensic Mental Health Service, Central Mental Hospital, Dundrum, Dublin 14¹; Academic Department of Psychiatry, Trinity College Dublin²; Irish Prison Service³

Background

Previous initiatives by our service have focused on developing inreach mental health care for sentenced mentally ill prisoners. When these individuals come to the end of their sentence there is an increased risk of morbidity and mortality. A pre-release planning programme with social work expertise was established.

Aims and Objectives

To evaluate the first eighteen months of the Mountjoy Prison Pre-Release Planning Programme by:

1. Measuring the success of the programme at reintegrating mentally ill prisoners with community mental health services.
2. Comparing agreed pre-release mental health and housing plans with actual post-release outcomes.

Methods

In March 2015, the National Forensic Mental Health Service in Mountjoy Prison (Dublin, Ireland) established a social work service to develop a pre-release planning programme. A process of participatory action research was used to evaluate the service as it evolved over the subsequent eighteen-month period.

Results

The pre-release planning programme supported 32 committals (29 individuals) during the first eighteen months of its implementation, representing 13% (32/252) of all new assessments by the inreach mental health team during this period. The majority had a primary diagnosis of psychotic disorder (78%, n=25) and 81% (n=26) had previous contact with psychiatric services. At the time of committal 56% (n=18) were homeless.

Interagency pre-release planning meetings were held for 22 committals (69%) to which community mental health, housing, probation, family and other relevant supports were invited. Following the intervention 89% of referrals were accepted by community mental health services. 18% were transferred for involuntary hospitalisation and the rest received outpatient follow up. Of these individuals, 88% were confirmed as making their first appointment. In most cases pre-release mental health plans were achieved, however other social outcomes such as accommodation were often not accomplished. The post release plans for two patients with a primary diagnosis of intellectual disability were not achieved due to a lack of funding. These individuals were released to emergency homeless accommodation.

Conclusions

This pre-release planning innovation has shown that collaboration between the National Forensic Mental Health Service (Health Service Executive, Ireland), the Irish Prison Service and community based services, greatly improves sentenced mentally ill prisoners access to care in the post release period. Eighty-nine percent were accepted by community mental health services.

The project identified two vulnerable subgroups whose needs were not adequately met: those with an intellectual disability, and homeless prisoners, who may be most at risk of self-neglect and reoffending.

Patient Perspective of a Pilot Doctor and Pharmacist led Medicines and Health Education Programme

Naeema Majothi and Dr Abdul Hameed Latifi: Pharmacy Department, Whiteleaf Centre, Oxford Health Foundation Trust

Introduction

Psychoeducation may be defined as the education of a person with a psychiatric disorder regarding the symptoms, treatments and prognosis of that illness¹. There is well documented evidence that psychoeducation can improve outcomes for patients with mental health conditions². A Cochrane review about psychoeducation for schizophrenia illustrated that psychoeducation may improve a range of indicators, including relapse rates, readmissions and encourages medication compliance as well as reduce hospital stays¹. The aim of this pilot was to assess if pharmacists could effectively deliver psychoeducation in the form of a medicines and health education programme and to assess service user's perspective of the programme. If the pilot is successful it could potentially be delivered in a range of services at Oxford Health.

Table 1: Service user questionnaire

- 1) Do you feel that your knowledge of mental health conditions has improved by attending medicines education classes?
- 2) Do you feel that your knowledge of mental health medicines and their side effects has improved by attending medicines education classes?
- 3) Do you feel more confident to discuss mental health conditions with a pharmacist after attending these classes?
- 4) Do you feel more confident to discuss treatments and side effects of medication after having attended these classes with a pharmacist?
- 5) Do you feel more confident to be involved in discussions about different treatments for your mental health condition with your doctor or pharmacist?
- 6) Do you feel medicines education classes are beneficial?
- 7) Are you more likely to agree to health monitoring such as ECG and bloods tests after attending classes about physical health monitoring?
- 8) Are you more likely to agree to take medication after having attended these classes?

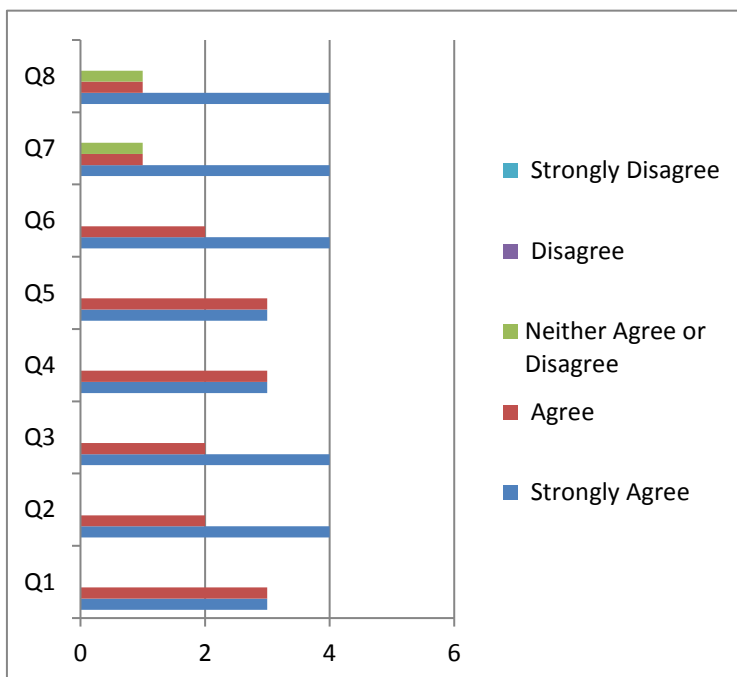
Method

A 10 week education programme was developed and delivered at Woodlands House. The program included ten 1 hrs classes delivered to service users over ten consecutive weeks from October – December 2015. Each session included a PowerPoint presentation of health topics including interactive activities and video links to aid learning. The following classes were delivered: Week 1: Introduction to schizophrenia, Week 2: Medicines to treat schizophrenia, Week 3: Management of antipsychotic side effects and monitoring, Week 4: Smoking and effects on health, Week 5: Depression, Week 6: Medicines to treat depression, side effects and monitoring, Week 7: Anxiety disorders, Week 8: Medicines to treat anxiety disorders, Week 9: Bipolar disorder, Week 10: Mood stabilising medication

The course aimed to educate service users about a mental health condition, medicines used to treat these conditions, management of side effects and health monitoring requirements. Each session aimed to be interactive and participants were encouraged to ask question and share experiences of their mental health conditions. Service users were given the opportunity to enrol for the education program; this was facilitated with the occupational therapist ward activity programme. 7 service users who had expressed interest were available to attend the classes. Eight classes were delivered by a pharmacist and pre-registration pharmacists and two classes were delivered by a staff grade doctor. The format of each pharmacist led-session was as follows introduction of topics, rules and boundaries were established, power point presentation delivered, interactive game to reinforce knowledge or video shown and finally question and answer session. Each session was 1 hour in length. On completion of the ten week program participants were asked to take part in a survey to ascertain information about what they thought about the education programme. The survey focused on questions about their knowledge of mental health conditions and medicines, communication with health professionals and about service users perceived future health choices.

Results

Six service users completed the whole course. All service users responded to a survey after completing the education programme and responded to answers utilising a Likert scale. Results of the survey are summarised in Graph 1. Service users were given the opportunity to provide more information to each question. Service user's responses have been summarised in table 2. All service users questioned would like more medicines and health education classes to be offered in the future. Service users responded positively either agreeing or strongly agreeing to all questions (Q1-5) about knowledge improvement and discussing health and medication issues with pharmacists in the future. Service users have responded positively to question 7 and 8 about future medicines taking and physical health monitoring behaviour. Six service users



agreed/strongly agreed that after having taken the course they are more likely to take medication in the future and more likely to complete physical health monitoring. All service users agreed/strongly agreed that the medicines education programme was beneficial. The results of the survey indicate that the Pilot Pharmacist led Medicines and Health Education Programme was successful as there were no negative responses either disagreeing or strongly disagreeing with any positive statement about the education programme. This programme was delivered at Woodland House which has long stay service users which facilitated enrolment on a 10 week programme. Clearly the sample size surveyed was too small to draw any inference from the data

collected.

Conclusion

Service users have responded positively to the classes and have requested more classes be delivered in the future. Further health and medication classes are being developed for physical health conditions to be delivered at Woodlands House.

Table 2: What service users said about the education programme.

- “I have more insight into my illness and all of my medication
- My knowledge with this group has been very much satisfactory
- I am more likely to approach a pharmacist now than before
- I feel more confident now (to discuss medicines and side effects with a pharmacist)
- I really enjoyed discussions with the pharmacist and the doctor
- I feel that this group has been beneficial to my therapy
- I have learned more about my condition and medicines and this was my favourite ward class.
- I have more awareness of the medicines I need and understand why is important to take medication
- I feel confident to talk to a pharmacist about my health and medication
- Enjoyed the class very much and would like more classes “with the pharmacist
- Through the class have realised why taking medicines is important and helps him understand why I need to take medicines “

If the education programme is delivered again it would be useful to survey service users before and after the education programme to measure changes in knowledge and compliance with medication or health monitoring requirements. This pilot has demonstrated that pharmacists can successfully deliver health education programmes. Similar programmes could be delivered across Oxford Health for both inpatient and out patients’ services.

References: 1 Xia J, Merinder LB et. al. Psychoeducation for schizophrenia (2011). Cochrane Database systematic review. Bechdorf A et al (2010). 2 Randomized comparison of group cognitive behaviour therapy and group psychoeducation in acute patients with schizophrenia: effects on subjective quality of life; Australia and New Zealand Journal of psychiatry. Feb 2010 144-145

Antilibidinal Medications in Forensic Learning Disability Services: Are They Under-Prescribed?

Dr Peter Rennie, Specialty Registrar and Dr Fergus Douds, Consultant Psychiatrist.

Introduction

Historically, people with learning disabilities (PWLD) were over-prescribed psychotropic medications, including antilibidinals, within institutional settings. In clinical practice today, educational, behavioral, psychological and social interventions would all be the first line treatments for inappropriate sexual behaviors within LD (and other forensic) services.

Aim

In this poster the authors will document the role for and mode of action of antilibidinals, consider some of the legal and ethical issues and describe recent successful interventions, focusing on one clinical vignette.

Method

Undertaking a literature search; noting the relevant findings from the 2015-2016 Annual report of the Mental Welfare Commission (MWC) in Scotland; detailing a clinical vignette.

Discussion

What is the place for antilibidinals in clinical practice?

Antilibidinal medication should be considered as the second line for those not responding to psychological and other interventions, where there continues to be major concerns about behavioral disturbance and risk to others. There are significant ethical considerations when using antilibidinal medication for PWLD, with issues around capacity/consent and potentially serious side effects.

The authors have recent experience of antiliberals being used with great success in a number of individuals who have proved to be refractory to other interventions and who have become “stuck” within the High secure environment of the State Hospital; this has enabled two of these individuals to move on from high secure care. A vignette will be described illustrating one case.

How does it work?

Antiliberinal medication reduces testosterone levels, thereby decreasing sexual interest and arousal. Response is not instantaneous and it may take a number of months before effects are maximal. The two most commonly used antiliberinal agents are Cyproterone Acetate (“Androcur”) and Triptorelin.

Legal and Ethical Issues

In Scotland, when patients are detained under the 2003 Mental Health (Care and Treatment) (Scotland) Act, the use of antiliberinal medication is subject to statutory safeguards. The Mental Welfare Commission’s annual report from 2015-2016 revealed that only 8 assessments were completed for the purpose of giving antiliberinal medication on a compulsory basis (to detained patients who could not or were not consenting to treatment).

Determinants of progression from acute to longer-term medium secure care, versus low secure; retrospective evaluation of patient characteristics using Health of the Nation Outcome scales (HoNOS), HCR-20, clustering (Payment by Results and Five Forensic Pathways) data

Dr Martin Williams, Associate Specialist, Elysium Healthcare & Dr Amitabha Chatterjee, Consultant Forensic Psychiatrist, Thornford Park Hospital

A longer-stay, medium secure rehabilitation ward was opened at the authors’ place of work in summer 2014. Patients in the acute medium secure wards are assessed for suitability to progress either there, or along a low secure pathway. This decision has typically been based on a global assessment by the Responsible Clinician and the multi-disciplinary team, with consideration given to ongoing treatment needs, and broad risk profile.

It is proposed to introduce the DUNDRUM Quartet (structured professional judgement instruments for admission triage, urgency, treatment completion and recovery assessments) for both medium and low secure wards at site over the next year and this will subsequently be evaluated against outcomes.

Meanwhile this analysis of existing data seeks to establish whether it is possible to predict readiness for progression using data already collected. Over two years 20 patients were discharged from the acute medium secure wards to either medium secure rehabilitation (n=11), or low secure care (n=9.) The forensic HoNOS, HCR-20 (version 3) and clustering data immediately prior to discharge were examined (raw scores only used in analysis.) Certain patients were excluded.

The HoNOS historical scores and the H factors of the HCR-20 were significantly higher in the medium secure rehabilitation group; other HoNOS scores (current; and secure, once controlled for confounders), C and R factors of the HCR-20 and clustering data did not differ significantly between the two groups of patients. Mann-Whitney U test was used.

This suggests that there is still scope to measure readiness for progression with a focus in more treatment-related areas (rather than items which are heavily loaded towards historical offences.) Therefore DUNDRUM could provide more satisfactory measures than those metrics analysed. The authors’ data provides a baseline against which changes in practice could be measured.

Female Sex Offenders

Dr Nick Hallett, South Essex Partnership Trust, Female Forensic Services

Aims

To identify the characteristics of female sex offenders, their victims and prevalence of mental disorder and to raise awareness of what is an under-researched but significant area of forensic psychiatry

Methods

Literature review

Results

Female sex offenders mainly offend against children but females account for less than 5% of reported sexual crimes against children overall. However, victim studies suggest that up to 24% of children report being sexually abused by a female perpetrator.

Female perpetrated sexual abuse often goes undetected under the guise of bathing, dressing and changing nappies, and it may be that it is under-reported for fear of not being believed.

Characteristics of female sex offenders include perpetrator histories of neglect and sexual abuse themselves, mental disorders (personality disorders, post-traumatic and anxiety disorders), lower intellectual functioning, substance misuse in adolescence, high rates of co-offending with intimate male partners and often offences occurring against their own children.

Victims are usually children aged 6-12 and a majority of the children abused are female themselves, particularly if there is a male co-offender.

Although a heterogeneous group, Wijkman et al. propose four sub-types of offenders:

- Young assaulters (often during babysitting)
- Rapists (sexual predators using penetration – although 'statutory rape' does not exist in the UK for female perpetrators)
- Psychological disturbed co-offenders (often with their intimate partners)
- Passive mothers (against their own children but playing no active role in the sexual abuse)

These typologies overlap with previously described sub-types in the literature such as Teacher/lover, Male-coerced and Predisposed sex offenders.

Conclusions

Female sex offenders are often regarded sympathetically or stereotypically seen as 'maternal' and therefore frequently overlooked. However they are a group who commit extremely serious sexual offences which can go undetected for decades. Their heterogeneity makes it impossible to describe a 'typical' female sex offender but typologies can help to categorise patterns. Raising awareness of patterns of offending will aid risk assessment and management although further research into these areas is needed.

Dialectical behavioural therapy for women with borderline personality disorder in a forensic setting

Dr Nick Hallett, South Essex Partnership Trust, Female Forensic Services

Aims

To describe the relevance of dialectical behavioural therapy (DBT) for women in a forensic medium-secure unit.

Methods

Literature review and service evaluation

Results

DBT was originally designed for chronically suicidal females with borderline personality disorder in the community. There is a substantial evidence-case for its efficacy and it is recommended by

NICE (National Institute for Health and Care Excellence) in the UK. However the application of DBT in forensic settings is less well-researched.

DBT is particularly relevant to forensic populations due to:

The high incidence of personality disorders (up to 70%) and Axis I disorders

The vulnerabilities of patients exposed to others exhibiting life-threatening behaviours on an inpatient ward

A clear behavioural hierarchy (life-threatening behaviours > therapy-interfering behaviours > quality of life-interfering behaviours)

The ways in which DBT can address staff burnout which is common in forensic settings
DBT skills include mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Forensic adaptations in some studies have included 'random acts of kindness' and a 'crime review' of the index behaviour itself using DBT principles such as chain analyses. Difficulties with implementing DBT in forensic settings include involuntary incarceration and coercion, legal restrictions, co-morbid antisocial personality disorders and the overall complexity of patients. Some 'dialectical dilemmas' include treatment vs security, acceptance vs change and criminal responsibility vs lack of criminal responsibility.

Brockfield House forensic medium-secure unit has provided a DBT programme since 2009 for female patients with borderline personality disorder. Substantial resources have been utilised in individual therapy, group consultation, skills group and out-of-session coaching by any member of DBT-trained staff at the hospital day or night in order to provide a comprehensive and robust package of therapy. Many patients have benefited by reduced psychopathology in addition to reduced rates of incidents of violence and aggression. Some patients are admitted to Brockfield House primarily in order to benefit from the DBT programme when their offending is thought to closely relate to their personality disorder.

Conclusions

DBT is an evidence-based therapy for borderline personality disorder which can be adapted to forensic settings. There are a number of difficulties in using a traditional model but many of the strengths of DBT are highly relevant to forensic populations both in addressing mental health problems and in reducing antisocial and destructive behaviour.

Improving Section 17 Leave in a Low Secure Unit and Patient Involvement in their own Risk Management

Dr Emily Jones (ST5 in forensic psychiatry, Mersey Deanery),

Robert Kelly (Ward Manager, 5 Boroughs Partnership NHS Foundation Trust),

Dr Ros Tavernor (Consultant Forensic Psychiatrist, 5 Boroughs Partnership NHS Foundation Trust).

Therapeutic leave is an important part of the care and recovery of in-patients. Detained patients leave is authorised by their Responsible Clinician under Section 17 of the Mental Health Act. Marlowe Low Secure Unit in Warrington has 15 male patients, all detained under parts 2 or 3 of the Mental Health Act. Leave can be a time of risk, so the process of granting it should involve a comprehensive discussion within the MDT, which must include consideration of these risks.

This project was completed to improve the process of granting leave, with a particular focus on managing risk better. An audit identified some key areas that needed to be improved:

- Rationalising the number of leave forms
- Improving risk assessment prior to leave – making sure that all information on the leave form was relevant and accurate.
- Improving the quality of feedback when a patient used their leave to inform future leave planning. We developed a short 'post-leave' feedback form, which could be filled in either by staff, or the patient.

We developed a simple 'pre-leave' risk assessment to improve the dynamic risk assessment in collaboration with the MDT. This included collaborative risk assessment with patients to help them understand their own risks in an accessible way. We also developed an algorithm to make decisions about granting Section 17 leave.

A re-audit showed improvements in all the above areas. There was a significant improvement in the individualised risk assessments (from 23% to 100%). Feedback from staff indicated the pre-

leave form gave more structure to their assessment of a patient prior to permitting leave, and sometimes it made authorising leave less anxiety-provoking.

The new post-leave feedback form provided an accessible way to record events on leave, and this was more easily fed through to the MDT. The post-leave forms are also a useful way of the patients being able to openly discuss any issues they had on leave, and to help them realise their strengths.

The improvements that we made during this project were discussed with the wider Trust, where introduction of the new forms is being considered.

Clinical Audit: Psychiatric Inpatient Violence Towards Staff

Dr Daniel Whiting; Dr Susan Hardy Oxford Health NHS Foundation Trust

Introduction

The burden of violence within healthcare settings is considerable. In May 2015 NICE updated guidelines for short-term management of violence and aggression, citing figures that between 2013 and 2014 there were 68,683 assaults reported against NHS staff in England. The majority (69%) occurred in mental health or learning disability settings. Possible sequelae include the impact on sick leave, staff morale and turnover, as well as detracting from the overall therapeutic milieu of a ward. The prevalence and profile of such violence is relatively well established; the issue of prosecution is far less widely studied however. A dilemma is posed for staff regarding the appropriateness of involving police that can involve various ethical considerations.

Aims

The aim of this audit was to understand the profile of inpatient violence towards staff within Oxford Health NHS Foundation Trust, and whether such incidents are reported to the police in a consistent manner.

Methods

Incident reports of violence/aggression between 1st July and 31st December 2015 were accessed. Data extracted included setting and the coded impact of the incident (no, minor, moderate or major injury). A summary of the incident and whether or not the police had either been informed or this was discussed was recorded by combining information from the incident report and/or clinical notes. Finally, a judgement was made on whether the incident crossed a threshold of severity that could have warranted police involvement.

Results

In the 6 months audited there were 204 violent incidents, the highest number occurring in the General Adult inpatient setting. 66% were coded as resulting in no injury. Of the 204 total incidents, 128 (63%) involved 35 patients who were involved in more than one violent incident over that period. From the descriptions, regardless of whether the incident was coded as resulting in injury or not, there were 102 incidents that crossed the threshold for consideration of reporting to the police. 26 of these (25%) were reported to police. Incidents not recorded as reported to police included 32 coded as causing minor injury, and nine causing moderate injury.

Discussion

Findings are in line with the established prevalence of such violence. Reporting to police appears to be relatively low and with a variable threshold. From our data one can only speculate as to the particular reasons for this pattern. The ethical issues brought into play are complex and further work is suggested to better understand the barriers to reporting.

“Audit of Compliance with modified NICE Guidelines for Emotionally Unstable Personality Disorder Patients in a Low Secure Forensic Inpatient Unit”.

Dr Priyadarshini Tandle, Senior Registrar ST5, Dr Chakrabarti. Consultant Child and Adolescent Psychiatrist, Westwood Centre, West lane Hospital Middleborough.

Aims

To determine the compliance with the NICE Guidelines for young people with the diagnosis of borderline personality disorder in the low secure forensic adolescent inpatient unit in England.

Methods

This is a retrospective audit of cases notes. The criteria for the audit is based on the NICE Guidance on Borderline Personality Disorder. In addition, one criteria from the Hospital's guidelines was also included to reflect the local practice. All patients on Westwood centre who had diagnosis of emotionally unstable personality disorder between 01/07/2016 to 20/08/2016 were included in the audit. The cohort for the audit included both current and previous patients admitted to the Westwood Centre and were either discharged to community or other inpatient units in the country. The data collection for the purpose of the audit was gathered from the weekly team meeting notes, medical team review meeting notes, psychotherapy documentation, care program approach meetings, dietician documentation, drug Kardex, tribunal reports and discharge and transfer summaries.

The data was collected solely by the project lead to maintain consistency and accuracy and was analysed by using Microsoft Excel sheet. The patient confidentiality was maintained by anonymising the names and were assigned number 1 to 10 on the data collection forms. A total of 10 records were assessed for the purposes of this audit on the modified NICE audit tool.

Results

There are several areas in the audit results which highlights the excellent care provided to the patients with emotionally unstable personality disorder.

The standards were met in 100% of patients in the following domains relating to **patient assessments, in giving autonomy and choice** and **forming trusting relationships** with the patients. The other areas where the standards were met in 100% of patients were in offering **psychological interventions** and **forming robust care planning** and **drug interventions**. Furthermore, in the Trust's audit criteria of **physical intervention**, the standards were compliant in 100% of the patients.

The audit has identified two areas which needed improvements, where most patients were noncompliant with the recommendations. The main issue identified is the **communication with the service user** pertaining to the provision of written information recommended by NICE ('Understanding NICE guidance booklet') to the patients and their carer. In addition, there was non-compliance with providing the **care plan to the primary care physician at the time of transitions**.

A review of effectiveness of training/understanding of Relational Security

Sam Mason, Senior Nurse, Wayne Harvey, Security Manager, Dr J Srinivas, Consultant Forensic Psychiatrist

Background

Relational security is the knowledge and understanding that staff have of a patient and of the environment and translation of that information into appropriate responses and care. Department of Health has developed a suite of materials to assist people who work in secure mental health services to understand and implement the concept of relational security. These include:

- A handbook for staff ("See, Think, Act")
- Relational Security Explorer
- Posters

The "Explorer" presents a series of questions to promote discussion amongst staff and uses a rating scale to score how confident they feel about 8 dimensions which contribute to safety on the

ward. These questions were used as the basis for investigating multidisciplinary staff views of relational security within the Forensic Directorate based within South Staffordshire and Shropshire Foundation NHS Trust.

Methodology

An audit tool was designed based on standards contained within the "See , think , Act" handbook for staff. The Survey was sent out to all staff across the Forensic directorate using survey monkey. Data was collected during the months of May and June and the audit was completed in July 2016.

Results

Results were measured using a Likert Scale based on how confident staff felt about each statement, 1 not confident at all to 10 being extremely confident.

The response rate for completed questionnaires was 124 out of a possible total of 235 giving a response rate of 52.76%. Overall, confidence levels were scored as more than satisfactory across all domains. There were a number of questions which scored most highly for confidence level; however the highest average score was 8.9 for question 14 which was:

"There are management plans in place for all escorted leaves of absence"

The following questions had the lowest average score both scoring 7.5:

Q3. We know how our patients are feeling day to day and care plans are up to date to reflect this.
And

Q8. We know how patients feel about other patients around them.

A similar audit was undertaken in 2012. A comparison of results showed that average results were similar to previous audit with improvement in some areas.

Recommendations

- Disseminate survey findings within the Forensic Directorate and more widely.
- Incorporate findings to improve security awareness training.

Title: A Psychological Consultation service in the National Probation Service: Offender Managers' Views and Experiences

Ms Victoria Blinkhorn (University of Liverpool), Dr Michael Petalas (Mersey Care NHS Trust), Dr Mark Walton (Mersey Care NHS Trust), Dr Julie Carlisle (Mersey Care NHS Trust), Dr Frank McGuire (Mersey Care NHS Trust), Ms Sarah Kane (National probation Service), Ms Julie Moore (National probation Service)

Objectives

This research investigated offender managers' views and experiences of the Psychologically Informed Consultation Service (PICS). The PICS is a clinical psychology led service. It is a novel approach, born out of the OPD pathway - a collaborative initiative between NHS England and the National Probation Service. PICS was developed in 2013, within the OPD pathway, for the Merseyside and Cheshire National Probation Service areas. The service offers Offender Managers (OM) psychologically informed consultation, including case formulation, thus aiding a better understanding of the offender, and helping OMs identify appropriate pathways, which meet the needs of individual offenders with PD traits.

Design

Interpretative Phenomenological Analysis (IPA) was the qualitative research method used in this research. IPA was selected due to its phenomenological focus. That is, IPA allowed for the interviews to focus on both OM's personal experiences as well as consultation process issues.

Method

Three focus group meetings were arranged, one for each of the clusters (central Liverpool, East and West, and Cheshire). Within each group, there were five OMs. A semi-structured interview was used to elicit participants' personal views and perceptions of the consultation process. The focus group meetings were recorded, transcribed, and analysed using IPA guidelines in the context of focus group research.

Results

It is expected that OMs' experiences of the consultation service would vary, but that all will report some positive views and experiences. OMs will comment on their personal experience of the consultation process and the impact on their ability to manage offenders. This research is currently in progress – as such, the results will be reported at the upcoming conference in March.

Conclusions

In progress - The implications of providing a psychologically informed consultation service in the national probation service and future directions will be discussed. This will include practical considerations for improving the service, implications for prospective service developments, and future research.

The management of acute psychological and behavioural distress in a forensic hospital

Dr. Michelle Rydon-Grange; Dr. Sandeep Matthews; Dr. Julia Wane; & Dr. Christopher Lucas

Aim

To examine the management of acute psychological and/or behavioural distress in an adult male forensic hospital

Method

A prospective design was employed. Staff completed a pro-forma detailing the use of pharmacological and non-pharmacological interventions to manage each episode of acute psychological and/or behavioural distress over a 12-week period. All patients detained at the hospital were eligible for inclusion (N=17). Descriptive statistics were used to analyse the data. The audit received local health board approval.

Results

73 episodes of acute psychological and/or behavioural distress were recorded during the 12-week period.

Pharmacological intervention: In 51% of cases ($n=37$), psychotropic *pro re nata* (PRN) was administered to manage distress. The most frequently reported indication for PRN use was anxiety (84%). Other indications included aggressive behavior (8%), paranoia (5%), and irritability (3%). Anxiolytics (92%), antipsychotics (5%), or a combination of both (3%) was administered. In 38% of cases ($n=14$), the use of non-pharmacological interventions was explored prior to PRN administration. Factors influencing the non-exploration (62%; $n=23$) of alternative interventions prior to PRN administration included the patient's reluctance to discuss distress, nursing staff observing overt indicators of distress, and insufficient staffing to support the use of non-pharmacological intervention.

Non-pharmacological intervention: Non-pharmacological intervention (e.g. relaxation) was used to manage acute distress in 16% ($n=12$) of cases. The following non-pharmacological interventions were used: distraction, 1:1 session, and supporting the patient to utilise skills learned during evidence-based psychological intervention [i.e. Dialectical Behaviour Therapy (DBT)]. In 9 cases the patient requested PRN but non-pharmacological interventions were used.

Combined intervention: In 33% cases ($n=24$), a combination of pharmacological and non-pharmacological intervention was used.

Conclusions

The use of PRN medication to manage acute distress is common practice within in-patient settings. The current audit highlighted that psychotropic PRN was used to manage half of all episodes of distress. Given the concerns associated with PRN use such as high-dose prescribing and polypharmacy, non-pharmacological alternatives should be supported. There is a growing body of evidence supporting the value of behavioral intervention methods specifically for reducing reliance on psychotropic PRN medications, however, staff training is required to support the routine use of such interventions. A re-audit could be implemented following such training in order to examine any changes in PRN administration rates.

Quality Improvement Project: Setting up an inpatient Clozapine clinic in a forensic unit Abstract

Dr Alina Luben, under the supervision of Dr Rebekah Stamps, Consultant Forensic Psychiatrist, NLFS

Clozapine is used for treatment resistant cases of schizophrenia. At the moment there are only a small number of established Clozapine inpatient clinics in the UK. The idea of setting up an inpatient Clozapine clinic in the forensic service in Chase Farm Hospital arose from an audit which showed that there are a significant number of patients on Clozapine in the service and that the trend has been towards even further increase in the last few years.

The North London Forensic service is a large service, of low and medium secure units, and has in average 180 service users at any time. It has a number of 7 medium secure wards and 3 low secure wards.

The original arrangement for Clozapine bloods monitoring involved individual team junior doctors, having to organize phlebotomy appointments, and track relevant processes to update with the Clozapine patient monitoring service.

With the increasing number of patients on Clozapine, there was a significant workload for the junior doctors in the service.

Trainees were complaining that with the high number of patients on Clozapine they were restricted in the time they were able to spend with the patients and this was having an impact on their training.

The junior doctors are doing shift work and they also rotate every 6 months and this meant that there was limited continuity of care. A lot of patients were delayed in having their blood tests as a result.

Also the process of booking the blood test, having the blood test done and then chasing the results and informing the CPMS was time consuming. Therefore an idea arose about how to make the process more efficient overall and improve patient care.

There is a lot of literature about physical health monitoring of patients in the outpatient clozapine clinics. In contrast our focus is different as it is mainly looking at improvements in the service in an inpatient setting.

Another focus was on the challenges encompassed in the process of setting up the clinic and the way in which those challenges were overcome.

Method

An initial audit was conducted in June 2015 which looked at the number of patients on Clozapine in the service and the efficiency of the initial set up in terms of the amount of time the junior doctors were spending dealing with Clozapine related issues.

The Clozapine clinic was set up in November 2016 and another audit was done in June 2016 which showed a significant improvement in terms of both efficiency as well as continuity of care.

Summary and conclusions

The inpatient Clozapine clinic in the forensic unit has been running for the last 6 months. The FBC samples are run through the unit Pochi machine.

There is currently one member of staff running the samples through the machine and the required time for this is 4-5 hours twice a week.

For occasional issues such as delayed blood test results, amber/red results or refused blood tests the additional time required has been approximately 2 hours/week. These are being dealt with by the physical health manager, band 5 physical health and wellbeing nurse and the speciality doctor supporting the clinic.

The initiation of the Clozapine clinic has led to quality improvement of the service. It is ensuring continuity of care which is vital for patients on Clozapine.

There is currently consistency in blood taking.

It has also significantly reduced the junior doctors workload improving their experience of their forensic psychiatry placement.

Overall, this has significantly reduced the amount of time spent on organising the blood tests, running the samples and informing CPMS. The most significant aspect is that it has helped in ensuring that no blood tests are missed and therefore ensuring a better monitoring of the Clozapine blood tests whilst ensuring that the time is used efficiently. It has also overall made the service run more efficiently.

THE SAFETY PROJECT – USING A STRUCTURED RISK ASSESSMENT TOOL TO PREDICT AND PROACTIVELY MANAGE VIOLENCE IN A HIGH SECURE HOSPITAL

Mark Thorpe¹- Nurse Project Lead for Safety

Dr Panchu F Xavier¹- Consultant Forensic Psychiatrist

Introduction

The 'Safety Project', was set up in Ashworth Hospital through a project funded by The Health Foundation's Framework on Measurement and Monitoring of Safety.

Aim

The primary aim of this aspect of the project was to identify and use a predictive violence risk prediction tool to proactively manage violence within three high dependency/admission wards in Ashworth Hospital.

Background

Ashworth Hospital, part of Mersey Care NHS Foundation Trust, is one of three high secure psychiatric hospitals in the United Kingdom, located in Liverpool. It has on average about two-hundred in-patients.

The 'Safety Team' consisted of a senior mental health nurse, a forensic psychiatrist and a project - management lead and was tasked with improving safety onwards.

Method

Routinely collected incident data was collated and analysed for three high dependency admission wards. It was clear that violence and aggression aimed at staff was our primary issue.

We undertook a literature search for structured tools to help predict violence in mental health settings. We narrowed our search to either testing the Dynamic Appraisal of Situational Aggression -Inpatient Version (DASA-IV) or The Brøset Violence Checklist (both recommended by NICE). We studied and utilized both the tools on a small cohort of patients and agreed on using the DASA-IV. The DASA, which was completed once in a 24-hour period, was quicker to complete for nurses and the Red/Amber/Green ratings of DASA were easily understood and allowed prioritising of resources for patients.

The Safety team prepared the training package and delivered the training for all ward based staff on three high dependency/admission wards over the course of a few months.

The DASA-IV scores for each patient was then agreed to be discussed at 'nursing handovers' and a plan put in place to support patients based on their score.

Conclusion

Utilising the DASA-IV over a six-month period we were able to reduce the need for physical restraints on our three high dependency wards by about 46%.

The impact of this reduction in restraints is being studied currently as it would have resulted in a reduction in staff going off work with work-related injuries and would have had further impact on ward atmosphere, staff morale, need for seclusion and patient safety.

'I'll let the hot doctor take my blood' Sexual harassment of trainees in the workplace – a national survey.

Trevor Gedeon

Background and Aims

Bullying and harassment is any behavior that makes a person feel intimidated or offended.

Harassment is defined as unlawful in the Equality Act 2010.

Harassment can take many forms and may be an isolated incident or a persistent and ongoing form of abuse. It can be carried out by an individual, a group of individuals or by a third party.

Attitudes towards experiences of sexual harassment in the workplace differ greatly but nonetheless can have a profound and catastrophic effect upon individuals.

This survey aims to explore the prevalence and experiences of sexual harassment experienced by psychiatry trainees.

Methodology

A national anonymised survey was created and disseminated via surveymonkey exploring the experiences of psychiatric trainees with regards to sexual harassment in the workplace by both patients and staff alike.

Trainees were asked to identify incidents of sexual harassment, who the perpetrators were and the attitudes of the organizations around them. In addition, they were asked whether they received support around these episodes and the impact that this had upon their development and training.

Results

The survey commenced in November 2016 and will close in January 2017. Whilst the survey continues to amass data, it would appear that sexual harassment is an occurrence experienced by some trainees and the attitudes and impact of these incidents varies.

Conclusions

Sexual harassment of any member of staff is a serious and unacceptable incident. It is the responsibility of the employer to ensure that managers and supervisors are fully aware of their responsibilities to staff and the legal consequences of any such actions. Trainees should always be supported and encouraged to report any such incidents. Regardless of gender, sexual harassment is always unacceptable.

Smoke Signals: Does the introduction of e-cigarettes have an impact on the prevalence of smoking related incidents in low and medium secure wards over a six month period.

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Objective

Research has shown that detained patients with mental illness are three to four times more likely to smoke (70-80% prevalence) than the general population, putting them at risk of serious health issues. Consequently, Greater Manchester West implemented a smoke free site for Prestwich hospital in January 2015. This increased the number of smoking related incidents. This study wished to observe whether the number of smoking related incidents fell after the introduction of e-cigarettes in low and medium secure wards from September 2016.

Method

This is a cross sectional study looking at six months of data before and after the introduction of e-cigarettes. E-cigarettes were approved locally after a consultation period for smoking cessation and harm reduction purposes. Smoking related incidents were defined as episodes when patients were found smoking on the ward. Data was gathered from medium and low secure wards and open wards were excluded, as the same restrictions did not apply.

Results

181 smoking related incidents were recorded across all wards six months prior to the introduction of e-cigarettes. 38 in low secure wards and 143 in medium secure wards. Data to date, over two months, showed total smoking related incidents after the introduction in all wards were 34. 6 in low secure wards and 28 in medium secure wards. This shows a strong trend in the reduction of prevalence of incidents given provisional data.

Conclusion

E-cigarettes are controversial but have recently been licensed by the Medicines and Healthcare Products Regulatory Agency. Smoking does not only cause harm to the health of patients but can cause serious incidents when patients wish to smoke but are restricted in doing so. Ideally smoking cessation should be promoted but the introduction of e-cigarettes is a promising practical measure, with limited health consequences noted to date, in reducing the prevalence of smoking related incidents in secure settings.

An extended 6 year evaluation of patient profiles, waiting times and responsible clinician feedback of SOAD requests in a Medium (MSU) and Low (LSU) Secure regional forensic unit.

Authors:

Dr Sanjib Kumar Ghosh, Consultant Forensic Psychiatrist and Researcher, Violence Prevention Research Unit, Queen Mary University of London & Forensic Directorate, East London NHS Foundation Trust; Brenda Taylor, Mental Health Act Office, Forensic Directorate, East London NHS Foundation Trust

Acknowledgements:

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Background

Mental health legislation in England & Wales requires review by a Second Opinion Appointed Doctor (SOAD) to safeguard the rights of patients detained in a hospital under this law if they refuse certain treatments or are incapable of consenting. This has been in place for 6 years in MSU and 4 years in LSU at East London Forensic Services (ELFS). The authors' audit was presented and measures were taken to inform clinicians to increase communication with the MHA Office. This study evaluates the patient profiles, and whether SOADs are completed appropriately and on time.

Method

Data was collected from the Mental Health Act administrator on all SOAD requests in 6 years for all in-patients in an English medium security unit (n=495; September 2009-November 2015) for an affiliated low secure unit (n=113; June 2011-November 2015). We retrospectively sampled all forensic patients for whom an electronic SOAD had been requested. We sampled all the wards including admission, intensive care, established treatment, female, learning disability, personality disorder and rehabilitation.

Results

The population were predominantly on Section 3 (MSU: 34%, LSU: 39%) and section 37/41 (MSU: 38%, LSU: 42%) of the MHA. They were predominantly and roughly equally composed of White British, Black Caribbean and Black African origin ethnicities. The average date of request to visit time was 20.8 for Medium Secure (range 0-177 days), and 30.5 (range 0-294 days) for Low Secure patients. The average proportion of mandatory consultant feedback of the SOAD outcome to patients was 14.5% for Medium Secure, and 12.8% for Low Secure patients. The most popular reasons for each SOAD request were Refusing Medication (MSU: 67%, LSU: 27%); lack of capacity to consent to medication (MSU: 25%, LSU: 6%) and change of medication (MSU: 1%, LSU: 49%).

Conclusions

The 14 day completion target is met by 49% of MSU, and 42% of MSU cases currently. The MSU has used the system longer, and shown both reduced time taken from SOAD request to completion, and reduced missing data. Both show trends of improvement. Key problems include a

shortage of SOADs in the area. Regional inter-trust cooperation, training and duty arrangements are needed. Changes proposed include asking each SOAD to take on at least one additional long-standing request when onsite. Educational updates and training would reinforce the new requirement of Responsible Clinicians to feedback to patients and document the outcome of SOAD evaluations. Electronic, e-mail linked alerts would improve documentation.

Physical health monitoring of patients with First Episode Psychosis (FEP) in Broadmoor Hospital

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Introduction

Numerous research has described the physical comorbidities associated with Schizophrenia. Furthermore studies have shown cardiometabolic risk factors are easily modifiable if treated during an early intervention stage. NICE Guideline 178 states that for people diagnosed with FEP, a comprehensive physical health screening should be carried out before commencing antipsychotic treatment, after 12 weeks of treatment and every 6 months thereafter.

In forensic settings, previous studies have suggested the incidence rates of FEP are much higher (3%) than the UK incidence rate (0.015%). It is therefore imperative that comprehensive physical health screenings are carried out in this population.

For those patients with FEP admitted into high security however, a physical health screening is often difficult to obtain due to the disturbed nature of the patient. This is exacerbated further if they are placed in seclusion.

Aims

This study aims to evaluate physical health monitoring for new admissions to Broadmoor Hospital with FEP.

Objectives

1. To record the baseline physical health of patients admitted to Broadmoor Hospital with FEP
2. To compare the current practice with NICE Guideline 178.
3. To explore the reasons why in some cases NICE Guidelines were not followed.

Methods

All new admissions to Broadmoor hospital were retrospectively analysed between 1st July 2015 and 30th June 2016.

All individuals with FEP were included in the study. Their medical records were analysed and the following were recorded:

1. When a comprehensive physical health screen was first carried out
2. Whether a physical health screen was carried out (as stipulated by NICE)
 - a. prior to commencing antipsychotic medication
 - b. after twelve weeks of treatment
3. The reasons for any delay.

Results

In one year there were 43 admissions, 9 (21%) of whom who were admitted with FEP (seven times the national average). Of these 9, 3 (33%) had a physical health screening within one week of admission; 4 (44%) had a screening within 28 days, and 2 (23%) had their first screening 61 days after admission.

No patient had a physical health screen before commencing antipsychotic medication. Only one patient had a repeat physical health screen twelve weeks after starting treatment.

The main reason for delay was due to patients being in long term seclusion.

Self Esteem levels of Service users in the Forensic Healthcare Service

Tara Kirby Co author Dr Jake Harvey Forensic Psychiatrist, Dr Moustafa Saoud Forensic Psychiatrist

Self-esteem, an individual's confidence in their own worth and abilities has previously been reported to be low amongst forensic service users. Low self-esteem has been linked to slow progress through secure care and discharge whilst many patients may show conceptually linked emotions including anger and a lack of motivation. Additionally, low self-esteem has been associated with repeated acts of undesirable behaviour. This suggests that improving the self-esteem of service users is important during recovery. One early outcome of increased service user involvement and leadership within Sussex Partnership Forensic Healthcare Service has been to highlight self-esteem as a priority issue. Service users reported that building self-esteem was the first step towards recovery as it gave them a sense of purpose and direction. The Rosenberg Self-Esteem scale, a long established self-report questionnaire, which has been validated across many disparate populations, was distributed across the Forensic Healthcare Service in order to collect a baseline sample (both community and inpatients). Our aim was initially to assess whether deficits in self-esteem is a significant issue for this population. We are yet to collate all results from the service, and the rest of the results will be collected before the conference. However, the results analysed so far predict that the self-esteem amongst inpatient and community service users is low. This further suggests that introducing interventions specifically aimed at enhancing self-esteem may be highly beneficial in supporting the recovery journey of service users. Specific measures to enhance self-esteem within a forensic context have been limited to date, suggesting the importance of developing these in the future. The strengthened focus on service user involvement and leadership within the Forensic Service has enhanced our awareness both of the importance of this concept for service users and carers, and also of the existence of courses (led currently by Sussex Recovery College) which have been developed to specifically address and enhance self-esteem. These specific courses involve exploring what self-esteem is, where it comes from and what maintains low self-esteem, as well as how it can be boosted. By enhancing their self-esteem, these courses could guide service users to achieve greater and faster progress on their road to recovery. We are currently in the process of developing a Secure Recovery College within the Forensic Service and hope to use the results of this study to prioritise areas of need and the development of specific courses.

The role of Oxytocin in Antisocial Personality disorders: A systematic literature review

Trevor Gedeon

Joanne Parry

Birgit Völlm

Background and aims

Antisocial personality disorder (ASPD) is an enduring mental disorder that is associated with significant disease burden and treatment difficulties. This is particularly apparent within forensic populations. Current guidance highlights the limited role for pharmacological or psychological treatments. Systematic reviews have previously highlighted the limited evidence base for pharmacotherapy in ASPD.

Oxytocin is a hormone normally produced in the hypothalamus and stored in the posterior pituitary gland. Studies have explored oxytocin's role in various behaviours including in social bonding. The oxytocin receptor belongs to the rhodopsin-type (class I) group of G-protein-coupled receptors. Oxytocin receptors are expressed by neurons in many parts of the brain and spinal cord.

There is growing evidence to suggest that treatment with oxytocin could have some benefit in treating a range of psychiatric disorders. There are no reviews studying the use of oxytocin for patients with ASPD. We aim to present the first literature review on the use of oxytocin in patients with ASPD.

Method

The search looked through relevant databases for original research on the use of oxytocin in various symptom groups that one might expect to see in persons with ASPD. Different outcome measures were analysed depending upon the focus of the various papers. Papers were included if they were original research focussing upon oxytocin being administered in healthy individuals or healthy controls and with outcomes focussing on various symptom groups seen in ASPD. The abstracts of all the papers were reviewed by TG and JP for relevance. The references of these papers were also searched for additional potentially relevant papers.

Results

1745 papers were generated in the original literature search. From these 19 papers were deemed to meet the suitable inclusion criteria for the study. There was a wide range of study design methodologies including blinded and non blinded studies, randomised and non randomised controlled trials. Included studies had a range of both male and female participants with a total number of participants from all included studies being 1341. The included studies examined a variety of outcome measures. These include: intuitions about free will and moral responsibility, compliance, memory, social conformity, empathy, facial empathic recognition, inhibitory control, in-group favouritism, aggression and violence, and interpersonal perception.

Conclusions

This is the first systematic literature review exploring the implications for oxytocin in managing the symptoms of ASPD amongst healthy controls. It is apparent that there is a significant body of data addressing this. The majority of studies were large sample, randomised control trials. The studies explored interpersonal relationships, compliance, empathy, emotional processing, moral judgment, deceitfulness and conformity. However findings were highly dependent upon context and the participant's premorbid states. Oxytocin has been shown to demonstrate diversified effects, in most cases being associated with socially positive or non-criminogenic behaviours. However some studies found a positive correlation between oxytocin and aggression. It is crucial to note that the studies participants were healthy controls, hence there needs to be a degree of caution to draw direct association with possible management of ASPD. Further high quality large sample studies are required to explore the benefits of oxytocin in a population with an established diagnosis of ASPD.

The Risk Reference Panel: a Thematic Analysis of a Multi-Disciplinary Forum for Complex Cases

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Background and Aims

The Aneurin Bevan UHB Risk Reference Panel was developed to provide a forum for community mental health professionals to seek expert advice in managing exceptionally risky or complex cases. This study describes the model of the Risk Reference Panel and its functions, then characterises the referrals presented and outcomes produced from panel meetings.

Method

A structured thematic analysis was performed on verbatim transcripts of 48 cases presented to the panel between 2010 and 2016. The transcripts were reviewed for discrete ideas ('codes'), recorded as a simple tally. Similar codes were then grouped into 'sub-themes', which could be further grouped into over-arching themes. A 'Thematic Map' was generated to help understand the relationships between themes.

Results

The 79 codes identified were grouped into eleven sub-themes, namely 'history of physical abuse'; 'history of sexual abuse'; 'aggressive behavior in childhood'; 'offences'; 'established diagnoses'; 'problematic behaviour'; 'police/criminal justice involvement'; 'factors affecting current presentation'; 'risk to others'; 'risk management measures'; 'team working issues'; 'funding issues' and 'trust level issues or escalation.' Four principal themes were identified. 'Childhood risk factors' and 'current presenting difficulties' capture the characteristics of the cases presented to the panel, while 'risk management' and 'wider organisational issues' encapsulate the output of the meetings. Quotations are given to illustrate the complexity of cases presented and the recommendations that the panel have been able to make are described.

Clinical Implications

This innovative model provides a valuable source of special expertise in the management of complex and exceptional cases where risk of harm is significant and clinical teams have ongoing concerns. The panel uses relatively few resources in terms of clinician sessions but provides a crucial additional tier of support for community teams to reduce the risk of harm associated with mental illness. The model could be reproduced in other areas where clinical teams feel it would have a beneficial role, and could be used to inform CPA unmet needs, training needs within the staff workforce and service development needs.

PREVALENCE OF VITAMIN D DEFICIENCY IN A GROUP OF PATIENTS RESIDENT IN A HIGH SECURE FORENSIC PSYCHIATRIC UNIT IN ENGLAND

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1 Ashworth Hospital

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Introduction

Several studies have identified a deficiency in vitamin D in patients with a diagnosis of paranoid schizophrenia. It has been hypothesised that obesity, insulin resistance, hyperlipidemia and cardiovascular diseases seen in patients with schizophrenia might be related to vitamin D deficiency.

Aim

The aim of this cross sectional evaluation was to study the prevalence of vitamin D deficiency in patients at Ashworth Hospital.

Background

Ashworth hospital is one of three high secure psychiatric hospitals in the United Kingdom, located in Merseyside. In February 2016 there were 208 in-patients with a diagnosis of a mental disorder or a personality disorder or both in the hospital.

Around 1 in 5 adults, and around 1 in 6 children, may have low vitamin D status – an estimated 10 million people across England. According to the Mid-Mersey Medicines Management Board (Liverpool) criteria, Vitamin D deficiency is defined as a serum 25- Hydroxyvitamin D total concentration ≤ 30 nmol per litre and 'insufficiency' is if levels are > 30 -50 nmol/litre. Routine testing of vitamin D is not recommended. Testing is advised when risk factors and symptoms of vitamin D deficiency are present or if clinically appropriate. The risk factors identified within the cohort of patients at Ashworth hospital include; longer term hospital stay, obesity (BMI > 30) and use of concomitant antiepileptic medications.

Method

Serum 25- Hydroxyvitamin D levels obtained by the health care at Ashworth hospital prior to February 2016 were investigated and prevalence studied.

Results

Out of 208 patients, a total of 81 patients were excluded as they 'refused a blood test' or 'an appointment had been booked' or 'were awaiting results'. A total of 46 patients were identified as having a 'deficiency' of vitamin D (36%) and 35 patients as having an 'insufficiency' of vitamin D (28%). Forty-six (36%) were identified as having 'adequate' or 'optimal' levels.

Conclusion

Three in five patients tested had sufficiently low levels of Vitamin D to require treatment. Treatment was offered to all patients that met the criteria.

Serum Vitamin D levels in forensic patients within a medium secure unit. Is routine screening required?

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Background

Numerous studies have identified forensic inpatients to be high risk of vitamin D deficiency through low UV exposure. Our Local Health Board provides a "Vitamin D Check List" for identifying patients that may need investigating. This guidance does not account for forensic inpatients or provide information regarding replacement regimens. By measuring serum vitamin D levels, patients with low levels could receive replacement.

Aim

The aim of this study was to determine whether all patients admitted to forensic Medium Secure Unit should be screened for serum vitamin D deficiency.

Methodology

We conducted retrospective audit to investigate serum vitamin D (25-OHD) levels within our own 16 patient population. This group comprised only males between the age of 23 and 56 years. 1 patient refused to participate in the study making the total number of participants 15. The demographic detail of each patient was noted. None of the patients were receiving oral vitamin D3 supplementation during the time of study. Samples were collected over a 6 month period. The standards followed for the audit were set by primary care guidelines (GP Update, 2014).

Results

The results demonstrate that 60% (n=9) of forensic inpatients were deficient (<30 nmol/L) in serum vitamin D (25-OHD) levels. 20% (n=3) of the patients were classified as having inadequate

levels (<50nmol/L). 20% (n=3) were classified as having sufficient serum levels of vitamin D. These results were classified in accordance to GP Update guidance (2014).

Discussion

It is clear from the results that the majority of patients within the studied forensic Medium Secure Unit are deficient in vitamin D. A wide range of varying guidance exists across the UK for measuring and treating vitamin D deficiency. Our results also indicate that under the current local guidelines, none of our patients meet the criteria for vitamin D investigation. Following our study we decided to implement a vitamin D screening program for new inpatients. This will be as a one off initial level taken on admission to the hospital. They will also be offer Vitamin D supplementation on admission accordingly to their Vitamin D blood levels. Despite these significant results there are numerous counter arguments to vitamin D screening of forensic inpatients. Primarily, the cost of the investigation and evidence for associated health risks of vitamin D deficiency, which is still tenuous. A large scale randomised clinical trial is required to establish the actual risk of long term vitamin D deficiency on health.

Why are trainees in Forensic services giving such good feedback on risk reporting?

Dr Ruairi Page, CT3 Trainee, Birmingham and Solihull Mental Health Foundation Trust

Dr Fiona Hynes, Consultant Forensic Psychiatrist, Birmingham and Solihull Mental Health Foundation Trust

Feedback gathered from trainees in the 2016 GMC national training survey indicated that risk reporting by forensic trainees at Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) was a green outlier, indicating that trainees view risk reporting mechanisms positively within forensic services. This raises the question as to why trainees feel that risk reporting mechanisms are more robust in forensic services compared to other services. We have considered a number of possible explanations as to why this may be, including our induction, learning environment and culture and risk reporting mechanisms.

Forensic services at BSMHFT offer an additional service induction in addition to trust induction. Risk reporting is addressed specifically at the local forensic service induction, in addition to the importance of environmental, relational and procedural security. Trainees are issued with a local forensic handbook which includes incident reporting protocol.

The management of risk is at the core of Forensic Psychiatry. Perhaps it is understandable that trainees develop an awareness of risk assessment and management due to the ethos of Forensic services, where an open and transparent culture with regards to raising concerns is encouraged. Trainee feedback is intricate to safe service delivery. At BSMHFT, there are forensic trainee representatives present at service delivery and Clinical Governance meetings, where trainees are given an integral role in highlighting clinical safety concerns. Trainees also have a separate feedback forum to discuss any clinical concerns with a consultant trainer.

Analysis of risk reporting data within BSMHFT indicates that medical staff in forensic services report a higher proportion of adverse incidents via trustwide incident reporting mechanisms in comparison to their medical colleagues working in non-forensic services. This formulates the question as to whether medical staff working in forensic psychiatry are more aware of the importance of incident reporting or if it is just that there are more adverse incidents occurring within forensic settings. Given the number of the patients served by BSMHFT, and the relative small proportion of those who are in forensic services, it is disproportionate that there has been such a large number of incident reports by those working in forensic services.

We hypothesise that the learning environment and culture in Forensic Psychiatry directly results in a greater awareness of the importance of clinical incident reporting, and that this explains both the high proportion of incident reporting from the service and the outstanding feedback given in this domain from the GMC trainee survey.

STRESS-testing clinical activity and outcomes for a combined prison in-reach and court liaison service: A three-year observational study of 6177 consecutive male remands.

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Background

People with major mental illness are over-represented in prison populations however there few longitudinal studies of prison in-reach services leading to appropriate healthcare over extended periods.

Aims

We aimed to examine measures of the clinical efficiency and effectiveness of a prison in-reach, court diversion and liaison service over a three-year period. Secondly, we aimed to compare rates of identification of psychosis and diversion with rates previously reported for the same setting in the six years previously. We adopted a stress testing model for service evaluation.

Method

All new male remand committals to Ireland's main remand prison from 2012 to 2014 were screened in two stages. Demographic and clinical variables were recorded along with times to assessment and diversion. The DUNDRUM Toolkit was used to assess level of clinical urgency and level of security required. Binary logistic regression was used to assess factors relevant to diversion.

Results

All 6177 consecutive remands were screened of whom 1109 remand episodes (917 individuals) received a psychiatric assessment. 4.1% (95% C.I. 3.6-4.6) had active psychotic symptoms. Levels of self-harm were low. Median time to full assessment was two days and median time to admission was 15.0 days for local hospitals and 19.5 days for forensic admissions. Diversion to healthcare settings outside prison was achieved for 5.6% (349/6177, 95% C.I. 5.1-6.3) of all remand episodes and admissions for 2.3% (95% CI 1.9-2.7). Both were increased on the previous period reported. Mean DUNDRUM-1 and DUNDRUM-2 Triage Security Scores were appropriate to risk and need.

Conclusions

We found that a two-stage screening and referral process followed by comprehensive assessment optimised identification of acute psychosis. The mapping approach described shows that it is possible for a relatively small team to sustainably achieve effective identification of major mental illness and diversion to healthcare in a risk-appropriate manner. The stress-testing structure adopted aids service evaluation and may help advise development of outcome standards for similar services.

The Place for Reflective Practice in a High Secure Mental Health Hospital in the UK.

Dr Minesh Karia, Dr Estelle Moore, Dr Jaleel Mohammed

Reflective Practice is recommended by the Royal College for Health and Social Care Professionals as a way to improve communication and thereby foster the collaborative practice required of practitioners in forensic settings.

A cross-sectional project was conducted within a high secure mental health hospital (Broadmoor Hospital, Crowthorne, UK) to establish reflective practice attendance and accessibility for ward-based staff and to also explore staff experiences of reflective practice. An on-line survey was sent to all staff (n=441) who would have had opportunities to attend a weekly multi-disciplinary team

reflective practice. A total of two email reminders were sent at weekly intervals and data was collected for a period of three weeks from June-July 2016.

One hundred and nine staff members participated (response rate: 24.7%). The occupational roles of the staff who responded were varied. Overall, the study found poor reflective practice attendance, with the majority (75%) reporting attending reflective practice on a *monthly* or less basis and with fewer (13%) attending weekly. More than 40% of responders gave insufficient staffing, other commitments, workload or rota related issues as reasons for non-attendance, whilst in comparison only 4.5% identified reluctance to attend as the reason for non-attendance. 45% of staff members agreed or strongly agreed that there have been times when they wanted to attend reflective practice but could not attend.

The majority of participants endorsed a number of different positive outcomes from attending reflective practice including that the process of reflection assists in understanding both patients and other team members' views better and also in thinking about the dynamics of the organisation and its practices. Perceptions by staff of the reflective practice facilitators were largely positive. Half of responders felt that reflective practice has a positive impact on their performance at work.

Overall, staff perception of reflective practice was positive. Whilst this study found there to be poor attendance at reflective practice, it found that staff reported the reasons for this to be largely not due to a reluctance to attend but instead more due to inaccessibility due to staffing pressures or other commitments. This study highlights the need to understand the underlying reasons for non-engagement with reflective practice within psychiatric hospitals which may aid in formulating methods to improve attendance rates.

Ticking Time bomb: Prisoners waiting for psychiatric hospital beds

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Background

We are all aware of the high prevalence of mental health disorders within the prison population. The largest survey in England and Wales carried out to date found that 58% of male remand prisoners and 39% of male sentenced prisoners had a neurotic disorder compared to 12% of the general population. Ten per cent of prisoners displayed symptoms of a psychotic disorder. With the 'equivalence of care' initiative majority of the prisoners are treated in the prison itself. However, there are circumstances when a prisoner needs to be transferred to a psychiatric hospital for inpatient treatment. This is usually when the prisoners present with complex needs or are acutely unwell with severe mental illness. They cannot be safely managed in prison as compulsory treatment under the Mental Health Act is not allowed in prison or some treatment (like clozapine) cannot be initiated in prison.

In his review of mental health and learning disabilities in prison, Lord Bradley recognised that, despite DoH guidance, transfers continued to be taking too long. He recommended a 14-day target as a formal recommendation and the DoH has subsequently issued good practice guidance on how this could be achieved

We realised that in our local prisons that there are a number of prisoners who are waiting for a hospital bed. Previous studies have looked at number of factors which cause this delay including the seriousness of offence, level of security. We asked NHS England to provide us with number of prisoners waiting nationally

Main findings:

- On the 1st May 2016, there were 120 prisoners waiting for a hospital bed in the prisons.
- Majority were in London (28) closely followed by North West (24).
- There were 10 times more males (109) than females (11)
- Greatest demand was for Medium Secure beds (89). Considerably less demand for Low (19) and High (12).

Conclusions

There is great demand for medium secure beds. The longer a prisoner remains untreated the greater are the risks. We feel that unless addressed nationally, it is a ticking time bomb. Opening new units is not an option currently but we need to look at our length of stays. We also need to look at remitting certain prisoners back to prison

"Adverse Childhood Experiences and cardiovascular risk in men with schizophrenia detained in long-term residential care."

Authors: Dr Tom Barton, Southern Health NHS Foundation Trust, Dr Gwen Adshead, Southern Health NHS Foundation Trust, Dr Alexandra Kenchington, Southern Health NHS Foundation Trust.

Aims

To determine if different levels of adverse childhood events, as measured by the WHO Adverse Childhood Events measure (ACEs), have value as predictors of cardiovascular risk in a population of men with schizophrenia who live in long-term residential care. This would allow us to identify at risk children who experience different levels of adverse childhood events, stratify their risk of developing future cardiovascular disease, and tailor our physical health monitoring and intervention accordingly resulting in a reduction of this risk.

Method

We work in a specialist secure services providing low and medium residential secure care to 102 males. All patients with a diagnosis of schizophrenia (and other forms of psychosis) are already assessed for risk of heart disease using the QRISK2 tool; and they are also asked about childhood adversity as part of the HCR-20 risk assessment process. This data is already collected routinely and used for Care Programme Approach pathway monitoring.

We propose to introduce the WHO ACEs measure of childhood adversity; and investigate if different levels of ACEs score predict different levels of QRISK2 score, using logistical regression analyses. The ACEs will be given to all of those patients with a diagnosis of schizophrenia and psychosis who are currently living in Ravenswood House Medium Secure Unit as well as those within the Low Secure Service at Southfield. The collection of ACEs data will be carried out over a period of 3 months in total.

Results

We are currently working on the logistical regression of the data but the preliminary findings of this project show that the mean rating on the ACEs completed so far is 6.2 out of a possible maximum score of 10. The lowest score so far recorded is 4 and the highest 8. The modal score was 6. Data collected from 7,970 men in the US showed that only 9.2% of that population scored 4 or more on the ACEs questionnaire.

The QRISK2 scores, which represent the risk of a patient experiencing a heart attack or stroke in the next ten years, were highly variable amongst the male inpatient population measured. The range was from 0.1% to 25.5% with a mean score of 4.69%. These results again show the disparity between the general population and the inpatient mental health patient population. Early work seems to show a link between those with the highest ACEs scores and the highest predictive values for stroke or heart attack as measured by the QRISK2 tool; although data collection for the ACEs has not been completed at this point in time.

Chaffinch Ward: Audit of Discharge and Outcomes since opening in 2008

Dr Tim McInerney, Dr Donald Servant, Nina Lloyd, Katie Waddell

Introduction

Chaffinch ward is a forensic unit opened in 2008 at the Bethlem Royal Hospital as a 'pre-discharge' service. It was initially in the medium secure facility, River House, however moved to a low secure setting in 2012. Its aim is optimising outcomes for patients prior to discharge to the community. This audit looks retrospectively at the progress of patients discharged from Chaffinch ward and their outcomes, in particular relapse, recall and reoffending.

Method

The clinical notes were reviewed of all discharges from Chaffinch ward since opening in 2008. Data collected included basic demographic data as well as diagnoses on discharge, forensic history and length of stay, and health and offending outcomes post discharge.

Results

In total 132 patients were discharged during the 7-year period. Average length of stay was 8 months. The majority had a serious index offence on admission with 18 having committed homicide, 26 having committed GBH or wounding and 12 having committed arson.

On review of patient outcomes, patients with a diagnosis of a personality disorder predominantly remain well in the community with none readmitted or reoffending. This compares with 47% stable in the community for those with a diagnosis of schizophrenia and 37% of patients with a diagnosis of schizoaffective disorder. Overall 49% of all patients remained stable in community after discharge.

Of those that reoffended, only 4 out of 132 discharged committed serious offences up to GBH while 19 committed minor offences.

Conclusion

Chaffinch rehabilitates high risk offenders with complex mental disorders who are usually under MHA restrictions with MOJ involvement, and discharges them in an efficient manner. The severe and enduring nature of most patient's mental illnesses means that the risk of relapse is significant. Forensic rehabilitation should however aim towards ensuring that future mental illness relapse is safe for the individual and the public.

The audit completed indicates that focused MDT pre-discharge rehabilitation can result in positive outcomes with half of discharged patients remaining stable in the community and when mental illness relapse occurs it is generally safe for the individual and the public. The audit notes that a diagnosis of schizoaffective disorder is most likely to lead to relapse and recall.

DEATHS IN CUSTODY: A RETROSPECTIVE STUDY OF CAUSES OF UNNATURAL DEATHS BETWEEN 2009 AND 2014 IN THE IRISH PRISON SERVICE

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Background

Psychiatric morbidity and mortality rates are higher in prisoners. Mental health problems and co-morbid polysubstance misuse are commonly associated with suicides and unnatural deaths by prisoners.

Objectives

This study examines the mental health and drug related factors that might be associated with unnatural deaths in custody.

Method

This is a retrospective analysis of deaths in Irish prisons between 2009 and 2014. All deaths were identified from the records held at the Irish Prison Service (IPS), and cross checked with the office of Inspector of Prisons. Details of custody, history of self-harm, clinical information, and contact with psychiatric addiction services were collected from the IPS medical records. Files of the deceased prisoners, held at the coroner's office were examined for post mortem drug toxicology results, and verdicts.

Results

During the five years there were 69 deaths. At the time of writing, data on 58 detained prisoners was collected from Prison Healthcare Management System. Data on 39 deaths was completed after reviewing the files in Dublin's Coroner's Office. 15 Deaths out of 39 fell into the "other" category, which included natural causes, unlawful killings, narrative and open verdicts. 10 out of 39 people (26%) died due to suicide. 3 out of these 10 prisoners had negative toxicology report. Result was not available for 1 death. Toxicology result was positive for drugs in 6 out of 10 deaths due to suicide. Benzodiazepine was positive in 4 out of 6 of these prisoners. 14 people out of 39 (38%) had a recorded verdict of death by misadventure. 12 of these deaths were due to combined drug toxicity. Opiates and Benzodiazepines was a common combination.

There were no deaths by drug overdose in prisoners held in the country's largest remand prison, Cloverhill, where visits are 'screened', unlike visits to the sentenced prisons.

Toxicology reports and verdicts are being examined in deaths in prisons outside Dublin. Results will follow.

Conclusion

A significant number of unnatural deaths in prisoners were caused by overdosing with illicit drugs. Availability of illicit drugs in sentenced prisons is a major contributory factor to deaths in custody. Only by having reliable information can we influence policy and inform the public and visitors who are bringing in contraband that they are contributing to deaths in the prison. Other practical measures may include extending the practice of 'screened visits' to drug users in sentenced prisons, taking into account the human rights implications.

A systematic review of mental disorder and intimate partner violence victimisation among military populations

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Introduction

Mental disorders are associated with intimate partner violence (IPV) victimisation among the general population, however, it is not clear whether this is the case for military populations. A better understanding of mental health problems as risk factors for or consequences of IPV is required in order to provide services which meet the needs of military personnel and their families. This review aimed to establish the association between IPV victimisation and specific mental health problems among military personnel.

Methods

Systematic review: searches of four electronic databases (Embase, Medline, PsycINFO, Web of Science) were supplemented by reference list screening.

Results

Thirteen studies were included, with only four reporting on past-year IPV. Heterogeneity among studies (primarily regarding the timing and type of IPV studied) precluded a meta-analysis. Data from individual papers indicate stronger evidence for an association between IPV and depression/alcohol problems than between IPV and PTSD. Furthermore, this review highlighted more consistent evidence for an association between depression/PTSD and IPV among veteran compared to active duty samples. However, this pattern was not observed for alcohol problems. Finally, stronger evidence was found for an association between depression and psychological IPV than for depression and physical and/or sexual IPV, among active duty samples.

Conclusion

There is evidence that, just like among civilian populations, the potential burden of mental health need may be significant among military personnel who are victims of IPV. Research is needed in order that effective interventions can be developed to reduce IPV victimisation and the mental health consequences among military personnel.