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Lipid monitoring for patients taking clozapine at Guild Park hospital, secure services.

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Aims and Hypothesis: To assess the current lipid monitoring carried out on patients prescribed clozapine at Guild Park hospital against defined standards and examine the proportion of patients treated for dyslipidaemia. The overall aim is to identify areas for improvement to reduce risk and improve patient outcomes.

Background: Compared to the general population, patients with schizophrenia are at an increased risk of morbidity and mortality from cardiovascular disease. Dyslipidaemia is an established risk factor for cardiovascular disease along with other risk factors but is also one of the most modifiable risk factors. Antipsychotic medication used to treat schizophrenia can exacerbate this issue of dyslipidaemia and whilst cholesterol levels can rise the most profound effect tends to be on triglycerides. Raised triglycerides are in general associated with obesity and diabetes. One licensed atypical antipsychotic for treatment resistant schizophrenia is clozapine and this carries an increased risk of dyslipidaemia in comparison to some other first generation antipsychotics. As per Maudsley prescribing guidelines, a fasting lipid profile should be checked at baseline, every 3 months during the first year of treatment and annually thereafter.

Methods: A retrospective study of all inpatients prescribed clozapine at the time of audit at Guild Park hospital. An audit form was generated comprised mainly of closed questions to assess adherence to standards defined in the Maudsley Prescribing Guidelines. Patient records were examined.

Results: 34 patients were included in the audit. For those taking clozapine for more than one year (n=20), only 5% (n=1) had fasting lipids checked at baseline, 5% (n=1) at 3 months, 10% (n=2) at 6 months, 5% (n=1) at 9 months and 5% (n=1) annually. For those patients taking clozapine for less than one year (n=14), then the standard met at baseline was 14% (n=2), 7% (n=1) at 3 months, 21% (n=3) at 6 months and 0% (n=0) at 9 months. There was evidence of dyslipidaemia in 25 patients (73%). 9 of these patients (36%) were prescribed a statin whilst 16 (64%) were not prescribed a statin despite evidence of dyslipidaemia.

Conclusions: Lipid monitoring for patients prescribed clozapine at Guild Park hospital has not met the defined standards and a considerable proportion of patients have untreated dyslipidaemia. It was found that lipids are often checked but these are not fasting lipids so triglycerides are not reported in the result.
Audit on monitoring high dose antipsychotic treatment in the medium secure hospital.

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Aim of this audit: To identify the number of patients on high dose antipsychotic treatment in Medium Secure Unit and to determine whether the guidelines published by the RCPsych Consensus Statement are met. Method: The data was collected by checking every patient’s electronic prescription in the month of September 2017. Patients on HDAT identified and they are checked against the standards of RCPsych Consensus Statement. Results: Total number of patients: 34 Patients on Antipsychotic medication: 32 (94%) Number of patients on HDAT: 4 (12% of total patients) Number of patients not on antipsychotic medication: 2 The standards from RCPsych Consensus Statement were not followed adequately. Recommendations: 1. Improve awareness of documentation, peer review and where to locate HDAT forms on LORENZO as part of audit presentation to the clinicians at The Norvic Clinic 2. The MDT should discuss and review the HDAT monitoring as a part of CPA every 3 months. To assist this, HDAT can be added CPA template.
Improving the physical health of Female Patients on a Medium Secure Unit.

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Aim: To identify the extent of coverage and effectiveness of the current vitamin D testing regimen on the female Medium Secure Ward at the Brockfield House, Essex by determining the proportion of patients who had vitamin D blood assays, the proportion of those tested who were found to have vitamin D deficiency, and the proportion of those with Vitamin D deficiency who were prescribed supplements. Background: The main source of Vitamin D in humans is sunlight (90%), specifically UV-B irradiation. Dietary sources of Vitamin D are limited and usually inadequate on their own to prevent Vitamin D deficiency. There is emerging evidence of a direct link between Vitamin D and the disorders of mind, in addition to various somatic symptoms including bone discomfort or pain (often throbbing) in low back, pelvis, lower extremities, muscle aches, proximal muscle weakness and symmetric low back pain in women. The patients in a Secure Mental Health Unit are at high risk of minimal exposure to Sun light due to the restrictions imposed on the amount of time they can spend out of the Ward, making them prone for Vitamin D deficiency. Method: All the 12 patients’ recent electronic blood tests results were checked to see if they had their Vitamin D levels checked. Those patients who did not, had their Vitamin D levels checked. The results from these tests were categorised in to Normal (>50 nmol/L), Insufficiency (25-50 nmol/L) and Deficiency (<25 nmol/L) based on the Vitamin D levels. Patients who were categorised as Insufficient and Deficient in vitamin D were prescribed Vitamin D supplements as per the guidelines. The data was collected cross-sectionally by checking the electronic records of blood tests results of all the patients on the Female Medium Secure Ward at base line in the beginning of March 2018 and subsequently between mid-March 2018 and Mid-April 2018. Results: Out of the 12 patients who were checked for Vitamin D levels at the baseline, only one patient had Vitamin D levels within normal range (this patient was already on a Vitamin D supplement), five patients had insufficient Vitamin D levels and 6 patients had deficient Vitamin D levels. Subsequently, those patients who were categorised as insufficient and deficient Vitamin D levels have been prescribed Vitamin D supplements, the dose of which differs based on the category of Vitamin D levels. Subsequently, the Vitamin D levels were rechecked after 12 weeks. All patients’ except one had their Vitamin D levels back in the normal range. Recommendation: Patients on the Secure Units should have their Vitamin D levels checked as a routine especially in female inpatients.
Gender and prison mental health: a qualitative pilot study in a women’s prison in Chile

Dr Anne Aboaja, Tees, Esk and Wear Valleys NHS Foundation Trust, Consultant Forensic Psychiatrist

Aims and hypothesis. This pilot study aims to understand the factors that influence the mental health of female prisoners.  

Background. Approximately ten years ago, the Corston report highlighted the negative effect prison can have on the mental health of female prisoners and criticised the lack of gender sensitivity in prisons. A key qualitative study explored the impact of imprisonment on the general health of women detained in two British prisons. The findings showed that women perceived that imprisonment may both benefit and harm their physical and mental health. Undertaking a similar study among female prisoners and prison professionals with a focus on mental health to would provide in-depth and holistic understanding of the relationship between prison and mental health in the female gender context.  

Methods. The present study was undertaken in a female prison in Chile as part of a larger mixed-methods study examining the mental health of female prisoners initially through a cross-sectional survey of 94 women. All seven health professionals involved in prison mental health care, the five identified prison chaplains and 47 women who had completed the survey and remained detained were invited to participate in the qualitative study. Two health professionals and three chaplains consented to take part in individual in-depth interviews each lasting approximately one hour. Six prisoners agreed to join one of two focus groups of 90 minutes’ duration. Audio-recorded interviews and focus groups were conducted and transcribed in Spanish. The multisource data were collated, and thematic framework analysis was undertaken. Quotations were translated into English.  

Results. Prison as a determinant of mental health was an a priori theme strongly supported by the data. Consistent with the literature, regime and interpersonal factors within the prison were reported to increase the risk of common mental disorders and reduce mental wellbeing. Gender emerged as an independent theme and determinant of prisoner mental health. Within this theme arose not only well-known gender stereotypes but also a gender discourse around dress, sexuality and power that has not commonly been reported in relation to mental health.  

Conclusions. Whilst traditional gender themes continue to have a role in understanding and promoting the mental health of female prisoners, contemporary perspectives on the female experience in prison can also inform future prison mental health research and development. There is value in repeating this pilot study on a larger scale and comparing findings in different cultural settings.
Does the UK have too many prisoners? A non-systematic review and critical analysis.

Dr Anne Aboaja, Tees, Esk and Wear Valleys NHS Foundation Trust, Consultant Forensic Psychiatrist

Aims and hypothesis This review aims to critically examine data from a range of sources to determine whether there are excessive numbers of prisoners in the UK. In place of a hypothesis, the review is based on four assumptions: 1) the question is complex, 2) the question is philosophical, 3) the question cannot be answered outside of the global context and 4) the question is relevant to prison mental health services. Background Worldwide there are over 10 million prisoners of which approximately 1% are detained in Great Britain and Northern Ireland. Government circulars describe rising numbers of prisoners in the UK and the media frequently reports overcrowding in prisons. The mental health burden among prison populations is well-known. The question of whether there are "too many" prisoners in the UK is complex and the answer is likely to have an impact on the mental health burden and mental health services in prisons.

Methods This paper presents the rationale for the four assumptions and then describes the present non-systematic review of the literature that was conducted to allow UK data on prisoner numbers to be compared with global data. As part of the review, terminology used to describe prison populations such as prison population total, prison population rate and prison occupancy level were defined and critically examined. Finally, the impact of these key concepts and trends on prisoner mental health and services were considered.

Results Compared to the world median, the prison population rate in the UK was reported as high or low, depending on the nation (E&W, Scotland, NI). Philosophical reflection and critical review resulted in a more complex answer. The global context was helpful in answering the question and highlighted the influence of wider global forces on the UK prison population. The definition of "too many prisoners" was important in understanding the impact the prison population might have on mental health services.

Conclusions An appreciation of the global context is useful in understanding the growing prison population at a national level and prison mental health service planning should consider the trends reported in prison characteristics. Further research is needed in understanding how prison population factors influence prison mental health need.
Analysis of prescribing practices of Nicotine Replacement Therapy across the West London Men’s Forensic Unit

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Aims & Hypothesis: Exploring the extent to which the West London Smoking Reduction & Cessation Guidelines are being adhered to with regards to the prescribing of nicotine replacement therapy and the effects this can have on the mental, physical well-being of patients and the associated risks this can cause. This will enable us to highlight areas of discrepancy; to make recommendations and suggestions of ways to improve adherence to standards.

Background: The smoking restrictions at St Bernard’s Hospital West London were implemented in 2015. It has been noted there has been an increase in prescriptions for Nicotine replacement therapy (NRT) and in the use of electronic cigarettes. It was also noted that patients prescribed NRT were also smoking cigarettes whilst on leave. This can lead to harmful effects on patient’s mental and physical well-being and is known to interact with prescribed antipsychotics. The harmful physical effects of smoking can lead to an increased risk of pulmonary and cardiovascular disease. In addition patients can feel anxious and sleep deprived. The policy advises the use of nicotine patches which is more economical for the Trust as opposed to the use of inhalators which is less cost effective.

Method: This audit was conducted across the male forensic wards at St. Bernard’s Hospital. Ward lists were identified from Rio electronic notes on 04/10/18. Drug charts of every patient on the 10 wards across the site were identified and those with Nicotine Replacement Therapy (NRT) prescribed were reviewed. Data regarding the type of NRT prescribed, the dose and the frequency of use over the last 7 days (26/9/18-2/10/18 inclusive) was collected. Each patient that had NRT prescribed was then interviewed and asked how many electronic cigarettes and regular cigarettes they used over that same time period.

Results: 10 wards, 141 patients were included in the audit. 49 patients were prescribed NRT, 69% were using inhalators, 22% were lozenges and 10% were patches. In those that were interviewed, 54% smoked cigarettes and used NRT, 74% used e-cigarettes and NRT and 44% used both e-cigarettes and smoked cigarettes whilst using NRT.

Conclusions: The use of NRT is not being adhered to for its purpose as patients are still smoking cigarettes and e-cigarettes whilst using NRT. Differences were identified in prescribing practices across the wards. Inhalators were also found to be the most popular type of NRT prescribed and they are the least cost effective for the Trust.
Non-attendance at therapeutic engagements in Broadmoor High Secure Hospital: A cost to personal recovery and a financial burden.

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AIMS The project objective is to explore the prevalence of patient non-attendance at Broadmoor, and the reasons why patients do not attend (DNA) their offered therapeutic sessions. We also aim to evaluate the financial and personal recovery cost of non-attendance. BACKGROUND Broadmoor Hospital has a dual purpose: to treat mental disorder and reduce risk of violence. As part of their recovery within Broadmoor, patients are offered a wide variety of therapeutic groups and individual sessions. Patient non-attendance is a pressing issue across psychiatric services and reducing DNA rates is a priority for mental health providers. Non-attendance impacts negatively upon patient rehabilitation, which may lead to increased length of inpatient stay. Furthermore, non-attendance has financial implications for the hospital, as well as an opportunity cost to other patients who may be waitlisted for the session. METHODS A retrospective chart review of all current inpatients (n=186) was conducted over a one-month period. Data pertaining to demographics, diagnosis and treatment needs was collated. In Broadmoor all attendance at every therapeutic encounter (group or individual) is recorded by the hospital WLBI system. RESULTS Of the 186 patients included, all were male, mean age was 38.2 (SD 9.75) and the commonest primary diagnosis was schizophrenia (54%). Non-engagement varied across levels of dependency. Admissions patients did not attend 52.3% of offered therapy whereas ICU patients did not attend 26.7% of offered therapy. HDU and rehab wards had similar DNA rates (37.3% and 37.2% respectively). The commonest reason for non-attendance was refusal/declining therapy, followed by attending another activity or appointment. Between Psychology and Occupational Therapy 1,190 therapeutic hours were lost through patient DNA’s during the one month period examined. Considering therapist time alone this resulted in a total estimated cost of £22,400 to the service, with additional costs to patient recovery. CONCLUSIONS Therapeutic engagement is essential to recovery in mental health settings. The commonest reason for non-attendance was refusal/declining therapy. The financial burden of DNA’s to the hospital is significant. High secure hospitals are low volume, high cost services with staffing being the largest single component of this cost. Non-attendance at therapy is a pertinent issue at Broadmoor, in terms of aiding patient recovery, managing length of stay in high security and effectively managing scarce financial resources within the service. Understanding the reasons behind non-attendance at therapeutic interventions which have been deemed necessary by the MDT is vital to managing resources and supporting patient recovery.
Practical Measures for Managing Deliberate Self-Harm in a Women's Secure Service

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Serious self-harm is a hallmark of the presentation of many women who enter medium and low secure psychiatric care. Arbury Court provides 27 medium and 44 low secure beds for women who require such care. During the ten years that we have been operational, our patients have taken to using increasingly severe and novel means of self-harm, many of these methods being potentially fatal, and often presenting clinicians with ethical dilemmas, usually related to whether measures conform to guidance relating to least restrictive practice, one of the five overarching principles of the Mental Health Act 1983 (amended 2007) as described in the Code of Practice 2015. We present some of the most challenging and unusual ways in which our patients have self-harmed, and the practical, and occasionally creative, interventions that we have taken to address these in our setting.
Aims: Improve multi-disciplinary team handover process every morning on Ludgate ward to include all service users. Hypothesis: Using a template to remind multi-disciplinary team that all service users are covered in the handover process. Background: We noted that most days there is no structured handover process between members of the multi-disciplinary team in the morning for events that happened during the night/weekend shifts. This has resulted in information being missed and management plans being delayed which impacts the service provided negatively.

Methods: Baseline outcome measure of the morning multi-disciplinary team handover process will be carried out for 1 week duration. Primary and secondary drivers will be analysed in light of the aforementioned data to be collected. Then, change ideas will be applied one at a time followed by repeating the same outcome measure. Results: Quality improvement project is still ongoing. Hence, results are pending. Conclusion: Quality improvement project is still ongoing. Hence, conclusion is pending. There has been no financial sponsorship for this quality improvement project beyond the basic pay that the authors received from the NHS for their primary employment.
RST OFFENCE: WHY DO SOME PEOPLE WITH NO PREVIOUS CRIMINAL HISTORY COMMIT HOMICIDE? A RETROSPECTIVE COHORT STUDY

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Background: One of the most important factors predicting violence and homicide is aggressive behaviour earlier on in life. Little is known about the clinical characteristics of people who commit homicide as a first offence. The National Confidential Inquiry into suicide and homicide by people with mental illness (NCISH) gathers criminological and clinical data on a national sample of homicide perpetrators. Aims: To establish the clinical characteristics of homicide perpetrators with and without a previous history of offending in a retrospective cohort study. This is the first study to explore this. Method: A retrospective study was carried out on a national cohort of 8,422 first time homicide offenders from the NCISH. Results and Conclusions: Homicide offenders with no previous convictions had a significantly higher rate of serious mental illness. Conversely, homicide offenders with previous convictions had higher rates of personality disorder, and alcohol misuse. This has important implications for the policy makers and the service providers.
Leave End Associated Violence Evaluation

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AIMS To evaluate odds of violence against substantive staff in our forensic inpatient unit on their first day returning to the ward following annual leave. BACKGROUND Temporary staff use correlates with violence. A PUBMED literature search by KR 10 September 2018 (locum OR temporary OR bank OR agency) AND (staff OR nurse OR team) AND (violence OR aggress* OR assault OR incident*) identified three relevant papers of 424 in the last five years, Bowers 2013, Munoz 2012 and Jafree 2017, suggesting correlations between violence intensity and temporary staff. Confounding factors and reverse causation make analysis complex. Our trust is innovating in analysing incident data and the clinic has low use of agency. METHOD In our Reducing Restrictive Interventions strategy “Positive and Safe Care”, staff analyse violent incidents and restraint. We gained Service Evaluation ethical permission (SER-17-041). We collected staff leave data from the four adult Medium and Low Secure wards (MSU, LSU). A priori we speculated mediation by relational factors. Staff information was anonymised using payroll number. We included leave of 7-21 days duration, and excluded sick leave. Leaves to attend training, and rostered days off were included. All data was collected for the time period of June 1st – August 31st 2017. We reviewed each violent incident, and whether a staff member on their first day back from leave had been involved. None were. RESULTS There were 90 violent incidents including threats in the time period. 53 occurred on MSU admissions, 15 on LSU, 2 on MSU rehabilitation, and 20 on MSU personality disorder ward. No staff members on their first day back from leave experienced violent incidents. This was consistent with the base rates of violence and leave. There was no correlation at all, against expectations. We discontinued a secondary, shift-based analysis due to no incidents and diminishing returns on data collection. CONCLUSION Staff members working at our site do not appear to be at an increased odds of violence on their first day back from leave – a reassuring finding. Factors driving correlations between temporary staff and violent incidents may not be mediated by processes common to substantive staff having leave. SOURCES OF FINANCIAL SPONSORSHIP: NONE.
Improving outcomes in patients with ‘pre-diabetes’ in a medium secure unit: the development of a health promotion intervention

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Background:

Pre-diabetes is defined by NICE as a glycated haemoglobin (Hba1c) measurement of 42 mmol/l and above. Patients with a measurement above 42mmol/l but below 48mmol/l are viewed as at high risk of developing type 2 diabetes.

In psychiatric inpatients, Hba1c is measured routinely due to increased risks of type 2 diabetes in patients taking anti-psychotic medication. Little is currently known about the burden of pre-diabetes within the medium secure setting, and within our service there are no specific interventions to target lifestyle changes in these individuals.

Aims: 1) To establish the incidence of pre-diabetes among patients at Edenfield medium secure unit. 2) To compare the current standards of interventions provided at the unit to help reduce diabetes risk, with current recommendations by NICE guidelines. 3) To introduce sustainable interventions aimed at lowering diabetes risk, targeted to this group.

Methods: With the assistance of the business information department, we have searched electronic records to enable us to establish the incidence of pre-diabetes in patients on the treatment wards of the Edenfield centre. Individual patient records were manually reviewed for evidence of interventions offered and whether accepted or declined by patients. A multi-disciplinary team approach with patient input has been used to develop interventions. Patients have been consulted on the acceptability and utility of interventions and how this has helped their understanding of diabetes risk.

Results: The data collection and analysis for this project is still ongoing. Interventions offered to these patients vary from GP appointments to individual dietitian appointments, with little consistency from patient to patient or overall adherence to NICE guidelines. An MDT based intervention is in development to target this patient group and to include group and individual sessions and through work with occupational therapy to assist in the practical application.

Conclusions: There is a need for a standardised, sustainable and targeted intervention to reduce diabetes risk in at risk patients in the medium secure setting.
Improving Oral Health in Psychiatric Patients

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Many of the Psychiatric patients have difficulty in self-care which can be limited by their poor mental health and lack of engagement in services. There was an unusually high number of dental referrals and subsequent dental extractions of our patient at the John Howard Centre – The Medium Secure Forensic Psychiatry Unit in East London where they are inpatients usually for long periods of time. It was noted that many of the inpatients drank high sugar fizzy drinks and foods as well as not brushing their teeth which led to poor oral hygiene. Aim: To improve the oral health of psychiatric patients on an inpatient unit by improving education around oral health.

Method: A Dental nurse who is the link worker for Tower hamlets and Hackney gave a teaching session to inpatient Forensic Psychiatric patients on one ward. This was then rolled out to other wards. A staff training session was also offered in order that staff could also promote oral health amongst patients. Conclusion: We have found that patients highly engaged in education around oral health. Our objective is for oral hygiene to improve, leading dental morbidities such as tooth decay and ultimately less dental extractions. Future work would be to incorporate this into education around general wellbeing which will include topics such as sleep hygiene, healthy eating and exercise.
Increasing recovery based activities for patients on a Secure Forensic Unit through staff training in Cognitive Behavioral Therapy

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Aims and Hypotheses To increase patient participation in recovery-based activities by staff training in Cognitive Behavioral Therapy (CBT) principles. We hypothesised training all unit staff in behavioral principles of CBT would: • Increase activity level of patients through motivation in 1:1 sessions • Increase staff confidence to engage in 1:1 therapeutic activities with patients • Improve the ward atmosphere as a whole by improving patient cohesion and feeling of safety and security Background Participating in meaningful activities has been found to contribute to the recovery of forensic patients. CBT can be delivered effectively by mental health professionals and it is effective for clients with schizophrenia with improvements in interpersonal functioning and negative symptoms. There was low participation in formal therapeutic programming on our unit, and thus, a strategy to increase therapeutic engagement and to increase the hours of activities patients partake in was initiated by training all unit staff in the basic principles of CBT. Methods A system was designed to record daily patient activity. All unit staff attended a 1-day training session in CBT principles, followed by 8 x 30 min training and weekly supervision. We administered a the EssenCES to measure ward atmosphere, a questionnaire was competed by staff to assess their confidence in utilizing CBT with patients pre- and post training. Results We found a significant increase in the amount of time patients engaged in therapeutic activities from a mean of 14.65 (SD=14.32) hours per month to 36.49 (SD=25.92) hours per month (t=4.5, p<0.001) over a 5-month period. An improvement in the confidence of staff utilising CBT was found post training (t=1.99, p=0.05). We also found a significant improvement in patient cohesion (mean of 8.71 compared with mean of 10.22, t=2.30, p=0.03). Conclusions The increase in activities coincided with staff CBT training, and maybe due to both a direct increase in 1:1 therapeutic engagement with patients, and also a motivating effect for patients to engage in a broader range of activities. The overall levels of activity are below the recommended target of 25 hours per week set by the Quality Network for Forensic Mental Health Services, but the improvement is encouraging over the relatively short period of time of this initiative. Further research is needed to determine whether the positive effects are sustained, and whether increased engagement in recovery-based activities results in other benefits, such as reduction in adverse incidents and overall length of stay. Financial sponsorship: None
A Descriptive Study of patients admitted to the Orchard Unit, Womens Secure Forensic Unit

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Background  The Orchard Unit is a female only 60 bedded secure unit built in 2007. It is located at the St Bernards Site in Ealing and is part of the West London Mental Health Trust. The unit comprises of six wards and is built of both Womens Enhanced Medium Secure Service (a National Service), Medium Secure Services and Low Secure Services. The Orchard Unit recently celebrated its 10 year Anniversary since its opening. The development of the unit was to address the recommendations made by the Department of Health’s ‘Women’s Mental Health: Into the Mainstream’ consultation paper. This paper highlighted the different presentations and character of mental illness between the two genders and the subsequent different care and treatment needs that they have. The Orchard Unit aims to provide gender sensitive care for women by using effective multidisciplinary team working and using the principles of the Recovery Model. Aims and Hypothesis  The aim of this paper is to describe the patient population of the female secure unit over the 10 years since its opening. We hope to summarise and analyse key demographic details of patients (such as age, occupational level, legal status, past psychiatric history, substance misuse, offence characteristics, diagnostic categories) in order to better inform future treatment and service development. Methods  The data will be collected using a questionnaire specifically developed for the study. Patients will be identified by their electronic record (RIO) number. The data will be taken from patient electronic records. This will then be analysed using Microsoft excel and summarised. Results and Conclusion  To be completed
Aims: To present a case of a 47 year old man with symptoms of Paranoid Schizophrenia with an established diagnosis of Wernicke’s encephalopathy (WE). To conduct an up to date literature review and examine association between paranoid psychosis as complication of WE. Case Report: 47 year old man transferred from prison. Whilst in prison concerns were raised due to his disturbed mental state characterised by paranoia, responding to hallucinations, disorientation, confusion, bizarre-posturing and significant levels of aggression. He has history of substance misuse and alcohol dependency. He had erratic contact with substance misuse team, mainly to relieve distressing symptoms associated with alcohol withdrawal when he could not fund alcohol. He was diagnosed with liver failure secondary to alcohol and prescribed diuretics and Thiamine supplements. He was not compliant with medication. He was admitted to general hospital a week prior to admission to the Humber centre, medium secure forensic unit where he was diagnosed with chronic encephalitis and commenced on Lactulose, Rifaximin and Thiamine. He was also commenced on low dose of Haloperidol while in Humber Centre. A rapid reduction in paranoia and psychotic symptoms was observed following which his compliance improved with the medication. Haloperidol was stopped cautiously. Given no ongoing psychotic symptoms return to custody was deemed appropriate with follow up from in reach team and access to drug and alcohol services in prison. Literature review: Wernicke’s encephalopathy (WE) is an acute brain disorder caused by Vitamin B1 deficiency, commonly linked to alcohol dependence in combination with poor appetite, malnutrition, poor absorption and impaired thiamine storage by the liver. WE may be of sudden onset, 10% of patients present with the classical triad of ophthalmoplegia/nystagmus, ataxia and delirium. 19% of patients have none of the symptoms of the classic triad at the presentation of WE. They can present with confusion, disorientation, poor short term memory, frequent visual, olfactory or tactile hallucinations and variable degree of paranoia. The pathogenesis remains incompletely understood, although gut-derived toxins such as ammonia play a central role. Management strategies consist of reducing the toxins. The standard of care has been Thiamine supplements and Lactulose. Randomised controlled studies have shown that Rifaximin works in conjunction with Lactulose, is well tolerated and it decreases the risk of recurrence. Conclusions: Identification and treatment is essential, failure to treat immediately puts the patients at risk of permanent brain damage and death.
Depression in a Young Offenders Institution: Are the NICE Guidelines being followed?

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Introduction  NICE guidelines offer a clear and structured approach to the treatment of depression in the adult population using a strong evidence base. In the prison environment there may be difficulties in implementing such guidelines in view of the transient nature of the population and limited mental health resources. There has been little research done within the Young Offenders Institution (YOI) system. The aim of this study was to examine whether or not NICE guidelines were being followed in the treatment of depression in Feltham YOI

Methods  A retrospective review of male prisoners who had been newly diagnosed with depression at Feltham YOI between 2012 and 2018. Subjects were identified by clinical coding for depression on System One, the prison electronic record. The records were analysed and data extracted on demographics, diagnosis and symptoms, and whether NICE guidelines had been adhered to. This information was recorded and analysed on Microsoft Excel.

Results  20 subjects were identified. The mean age was 20.2 years. 70% of those diagnosed with depression were not classified into level of severity. The most common recorded symptoms were low mood (100%), sleep disturbance (85%), and poor appetite (60%). Out of the 20 subjects, only 2 were offered Cognitive Behavioural Therapy or low intensity psychological work using the principles of CBT. 85% (n=17) of the subjects were commenced on antidepressant medication. The majority of subjects were placed on a CPN caseload for follow up.

Conclusions  The majority of those diagnosed with depression at Feltham YOI were not subsequently treated according to NICE guidelines. Of most significance was the lack of psychological therapies, in particular CBT, being offered. The majority were commenced on antidepressant medication early, and were followed up by a CPN. This may highlight a gap in resources available at the prison.
Prevalence of Mental Disorder and Unfitness to Plead in Defendants Attending Magistrates’ Court

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Aims: The primary aim is to estimate the prevalence of mental disorder (mental illness, personality disorder and neurodevelopmental disorder) and unfitness to plead (UTP) in defendants facing criminal trial at Magistrates’ Court. The secondary aim is to explore the psychiatric and socio-demographic factors underpinning UTP. Background: In 2016 the Law Commission of England and Wales published their final report on UTP. Recommendations included streamlining the identification of mental disorder and UTP in defendants, and broadening UTP provisions in the Magistrates’ Court. This aligns with wider work developing court liaison services and improving mental health provision in the Criminal Justice System but has significant resource implications. To date there has been limited research into the prevalence of mental disorder and UTP in defendants. Less in known about the factors associated with UTP. Method: We employed a two-stage screening method on a random cross-section of defendants attending two Magistrates’ Courts in South East England. The first-stage comprised a screen to detect mental illness at court (PrisnQuest), Learning Disability Screening Questionnaire, Attention Deficit Hyperactivity Disorder Self-Report Scale, and a screen for UTP. The second stage comprised diagnostic tools (MINI International Neuropsychiatric Interview and Structured Clinical Interview for DSM Personality Disorders), estimate of IQ (Ammons Quick Test), assessment of current symptoms (Brief Psychiatric Rating Scale) and a structured fitness to plead assessment (FTPA). Stage 2 was administered to participants who screened positive for mental disorder or UTP in stage 1, as well as 10% of those who screened negative to assess reliability of the screening tests. Socio-demographic and offence details were collected on participants and non-participants to ensure the study sample was representative. The sample was stratified according to whether defendants came to court from custody or bail. Results: Of the 3322 defendants attending the Magistrates’ Courts during the study period, 504 participated in the study. There were no significant differences in the characteristics of those who took part and those who did not. 51.8% of defendants from custody (99/191) and 30.8% of those from bail (96/312) screened positive for mental disorder. The rates for all mental disorders were high. Around 5% of defendants were estimated to be UTP. Correlations between scores on the FTPA with clinical and socio-demographic measures were determined to assess the factors underlying UTP. Conclusions: The prevalence of mental disorder and UTP at Magistrates’ Court was higher than previous studies have suggested and could lead to significant resource implications. Ethical Approval: NHS REC number: 14/LO/1377 NOMS Approval ref: 2014-225 HMCTS PAA date: 10/12/2014 Funding: PB is funded by a Wellcome Trust Ethics and Society Research Fellowship (099009/Z/12/Z).
CLOZAPINE-LEVEL ASSAY TIMING IN A HIGH SECURE HOSPITAL: A SERVICE EVALUATION PROJECT

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Aims This service evaluation project aims to assess and discuss the appropriateness of the timing of clozapine assays taken over a six month period at Broadmoor, a high secure hospital in the UK.

Background Reference values for clozapine levels are quoted for tests taken at 12 hours post-dose, with meaningful interpretation difficult for samples collected outside of a 12-14 hours post-dose window. Clinical experience suggested that within high security, both dose and sample timing can be difficult to control, and this project aims to quantify the issue, explore causes and implications, and make suggestions to improve clinical practice.

Methods This is a retrospective review over a 2 month period of all clozapine-level results across the hospital. Levels and hours-post-dose of the sample were the primary measurements, though dose, dose-splitting, norclozapine levels, and clozapine/norclozapaine ratios were also considered in the analysis. An estimate of the ‘12 hour clozapine level’ was calculated for each result, assuming a first-order elimination curve, and for half-lives of 6, 12, and 26 hours, (representing fast, mean, and slow metabolisers respectively). Results Of 23 clozapine levels reported during the two-month period, 10 were collected within the advised 12-14 hour window, while 13 were not. The mean time-to-collection of 14 hours 13min, median 12 hours 55min, and a range of 10 hours 50min to 25 hours 5min. Reported clozapine levels ranged between 0.23 mg/L and 1.37 mg/L whilst projected 12 hour levels ranged between 0.24 mg/L and 3.30 mg/L. Reasons for blood tests not meeting the advised time window including practical difficulties with drug administration, as well as the timely obtaining of blood samples.

Conclusions This study demonstrates that there exists significant difficulty in terms of the interpretation of clozapine blood level assays. We found in the worst instance the projected 12 hour level was between 1.4 and 4.5 times greater than the reported clozapine level, due to the sample being taken over 24h post-dose. These estimates do not account for clozapine’s biphasic elimination curve. Work to improve the reliability of clozapine-level sampling is therefore needed, included raising awareness among clinicians and the potential benefits of an electronic prescribing system. These issues are particularly important in a High Security Hospital setting, where many patients struggle with significant levels of treatment resistance and pose a high risk to others when their psychosis is not fully controlled. Findings from this project will form the basis of a prospective study.
Auditing ‘Consent to Treatment’ documentation in a high security hospital.

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Aims and Hypothesis: The purpose of this audit is to establish and improve the quality of medical documentation at The State Hospital, particularly in relation to patient autonomy. The audit aimed to consider hospital compliance with mental welfare commission guidance in relation to consent to treatment form completion. The authors hypothesis that adherence to commission guidance could be improved upon.

Background: ‘Autonomy,’ has long been established as one of the key standards medical professionals must uphold when treating a patient. It is essential that any medical decision that fails to respect a patient’s autonomy e.g. treatment without a patient’s consent, must be done so in order to serve that patient’s best interests and be clearly documented. Part of the Mental Health (Care and Treatment) (Scotland) Act 2003 deals with procedures in relation to the consent to treatment of detained patients. If a patient is able and willing to consent, a T2 (or newer form T2A or T2B) form should be completed. If the patient is unable then a second opinion should be sought and then a T3 (T3A/ T3B) may be granted.

Methods: All inpatients at the hospital were included within this audit. Data was gathered using a data collection tool which was created based on guidance from the Mental Welfare Commission. Data was collected from the following sources: prescription sheets, consent to treatment forms, medical records (RiO database), and the patient’s latest Care Programme Approach (CPA) document. Data was then validated and analysed by the Clinical Effectiveness Department.

Results: During this audit 107 patient records were examined, 102 of these had a certificate completed for them with an additional 3 identified as requiring one. There was a fairly equivocal split between those who consented to their treatment (49% had a T2/T2B) and those who could not (51% had a T3/T3B). Areas of non compliance were examined and the following points were highlighted as areas to improve upon: documenting the route of administration (87%), documenting frequency and dosing details (83.3%) and ensuring consent to treatment forms are visible to prescribers.

Conclusions: The audit results were discussed at the The State Hospital Medicines Committee and the following improvement plan was agreed: 1. Results will be disseminated to medical staff to increase awareness of current commission guidance. 2. Process to be improved to ensure consent to treatment forms are available next to the prescription chart. 3. Re-audit in 12 months time.
Improving efficiency of prison in-reach mental health clinics using a quality improvement approach

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Aims and Hypothesis Using improvement science methodology we aimed to increase the efficiency of psychiatry in-reach clinics at our local prison. We predicted planned interventions, informed by system challenges, would bring significant improvements. Background NHS Lothian has responsibility for mental healthcare of prisoners within HMP Addiewell prison. There is a high demand for psychiatric services within the prison. Providing mental health clinics in a prison environment is challenging. There are delays in accessing the health centre due to security procedures, inmates are housed some distance from the health centre, and prison ‘routes’ restrict prisoner movements. Methods Over 16 consecutive health clinics over 2017, the author timed their movements throughout the prison. This generated metrics on total number of patients seen per clinic, time spent waiting on the first patient to arrive in clinic, mean time waiting between patients, and the proportion of clinic spent in direct patient contact. Informed by this, we constructed a driver diagram. Primary drivers focused on optimising flow of prisoners at the start of the clinic, reducing the wait time between patients, and involvement of senior managerial staff. We implemented several ‘change ideas’ informed by our baseline data: 1. The arriving doctor calling ahead to the health centre on arrival to the car park, proactively encouraging the first prisoner to be sent for. 2. Closer liaison with prison officers to plan the clinic order considering routes and restricted prisoners. 3. Rearranging medical cover to the prison so both clinics were provided over one day. Results Our baseline data found a mean of 2.78 patients seen. Psychiatrists were waiting over 20 minutes from arrival in the clinic to seeing their first patient. The mean time spent waiting between patients was 29 minutes. Following our interventions, over 2018, we are now seeing a mean of 3.61 patients per clinic. The mean time spent waiting on the first patient to arrive has reduced to 7 minutes. The mean time spent waiting between patients has reduced to 12 minutes. Our time spent in direct patient contact per clinic has increased from 61.6% to 70.6%. Conclusions Simple data analysis highlighted key challenges in delivering effective prison healthcare. Several simple change ideas have increased the amount of prisoners seen per clinic, reduced waiting time outside patient contact, and reduced our waiting list. (The authors have no sources of financial sponsorship)
Ten Year Review of Discharges from Shannon Clinic Medium Secure Unit (NI)

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Aims and Hypothesis • This empirical inquiry is the first investigation into the area of forensic mental health and patients’ needs in Northern Ireland and it provides an opportunity to benchmark the regional service against national standards. • This was following a review of discharge data of all patients discharged from Shannon Clinic between April 2005-January 2016. • It is hypothesised that inpatient stay is increased in patients being discharged to community settings.

Background Shannon Clinic is the only secure psychiatric hospital within Northern Ireland and in 2015 celebrated its 10 year anniversary since opening and this review examines the characteristics of patients discharged in this period. Method An analysis was conducted of administrative data relating to all discharged patients between April 2015- January 2016. Male and females were included. 184 patients were discharged over this period. Discharge destinations were prison, community or to another hospital. In the first stage, descriptive statistics were first used to profile the sample and the focus of the analysis was trust area of referral, decision to admit, discharge destination and length of stay. Differences in length of stay were compared against key variables using the Kruskal-Wallis tests. Results The majority of discharges were male (91.8%). The average length of stay was 544.7 days. 43% of referrals came from prison, 30% from PICU, 9% from general psychiatric wards, 7.5% from high secure hospitals and 4.5% from other MSUs. There was no significant difference on statistical analysis on length of stay compared with discharge destination, however the majority of patients discharged to the community had a much higher median and mean length of stay. 54% of patients were discharged to community settings. Some trust areas appear to have longer stays, which were not statically significant however when costs are closely analysed there are clear expense differences. Conclusions There is a greater number of patients discharged to community settings when compared with other areas in the UK and the length of stay on average is longer. This review has highlighted that improved community supported placements are required, particularly in some areas within NI. The issues of prolonged (and possibly delayed) discharges will have implications for bed usage within Shannon Clinic and increased expenditure. Further research is required on the association between legal status and increased length of stay.
Background: There is a limited, but convincing body of evidence that Post-Traumatic Stress Disorder (PTSD) is fairly common among Forensic patients, in prison and secure hospital settings. Patients in secure hospital settings in particular may be challenging to treat, for a number of reasons such as co-morbid mental disorders and significant trauma histories, including trauma induced by their own violent offending. Patients may well be prescribed medications indicated for PTSD treatment for other co-morbid conditions (e.g. SSRIs for depression, antipsychotics for psychosis) but may show a limited response to treatments effective in non-Forensic patient groups. Here, we present two cases of patients with significant PTSD symptoms that did not respond to first and second line treatments but which did respond well to Prazosin prescribed for nightmares. This led to symptoms improvement in non-PTSD illness domains in both cases, linked to sleep improvement.

Method: Two cases admitted on s47/49 to Ravenswood House who were prescribed Prazosin for PTSD are clinically described along with the course of treatment given and impact on their presentation in a medium secure setting.

Results: n/a

Conclusions: Prazosin is a medication worth considering in patients with PTSD sleep disturbance in Forensic settings.
Monitoring and management of vitamin D status in a forensic child and adolescent psychiatric inpatient unit: a half-decade of audit and re-audit

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Aims and hypothesis: To discuss four audits of vitamin D status monitoring and management within a forensic child and adolescent mental health (FCAMHS) inpatient unit. We anticipated a longitudinal increase in completeness of screening and initiation of supplementation.

Background: Vitamin D is required for bone growth and remodelling, control of inflammation and modulation of wider cellular activity. Consequently, hypovitaminosis D has long been implicated in rickets/osteomalacia and multiple sclerosis pathophysiology, and is increasingly linked to depression. Unfortunately, hypovitaminosis D remains common in the UK, with Chief Medical Officers promoting increased awareness of deficiency in at-risk groups. Given raised vitamin D requirements in adolescence, inpatients’ diminished sun exposure and the emergent threat of hypovitaminosis D to physical and mental health, effective vitamin D monitoring and management should be an FCAMHS priority.

Methods: One audit and three subsequent re-audits were conducted by retrospective case note review, in mixed (male/female) populations of psychiatric inpatients aged 13–18 years. Cross-sectional data were collected for all Medium Secure Unit (MSU) inpatients in January 2013 (n=8) and July 2018 (n=8), and for all Low Secure Unit (LSU) inpatients in July 2018 (n=5). Data were collected for all MSU patients resident between March and November in 2014 (n=22) and for all MSU patients admitted between mid-January and mid-April in 2017 (n=10).

Results: The proportion of MSU patients screened was lowest in 2018 (25.0%), far behind 2017 (90.0%) and 2013 (85.7%). Moreover, the proportion screened within a week of admission was greater in 2017 (50.0%) than 2018 (28.6%). The proportion found to have ‘sufficient’ vitamin D levels (>50mg/L) was similar in 2014, 2017 and 2018 (9.09%–12.5%); however, the cumulative proportion of ‘insufficient’ (25–50mg/L) and ‘deficient’ (<25mg/L) generally fell over time. Encouragingly, the proportion of hypovitaminotic MSU patients started on appropriate supplementation increased from 50.0% (2013) and 80.0% (2014) to 100.0% (2017, 2018). However, none of these patients had their vitamin D status rechecked within six months in 2018, versus 77.8% in 2017. In 2018, LSU patients were more likely than MSU patients to have their vitamin D status screened (within a month of admission or ever) and insufficiency identified.

Conclusions: FCAMHS teams may currently be better-equipped to manage than screen for and diagnose hypovitaminosis D. The effect of inevitable trainee turnover may be reduced by structured staff induction and effective handovers. We highlight the role of Physicians’ Associates in the medical management of psychiatric inpatients, as underscored by better LSU than MSU screening.
'The Referral Success Story' - A Quality Improvement Project to Enhance the Standard of Prison Mental Health Team Referrals

Dr Dan Cleall, South London and Maudsley NHS Foundation Trust, CT3; Dr Jon Fitzgerald, Oxleas NHS Foundation Trust, Consultant Forensic Psychiatrist

Aims and Hypothesis  This quality improvement project aims to improve the standard of referrals made to the mental health team at HMP/YOI Isis. A secondary aim is to assess whether there has been a change in the nature and outcome of referrals since the prison age-cap of 18-30 was lifted in April 2017. Background  HMP/YOI Isis is a Category C prison for adult sentenced prisoners in South East London. A service evaluation project completed in 2017 confirmed the observation that the standard of referrals to the prison mental health team varied considerably. The project revealed that 19% of referrals did not include the referral source and 40% of the referrals did not clearly document the referral reason. Following the findings of the 2017 service evaluation project, a new referral proforma was developed and circulated to help prompt referrers to include all necessary information about a referral. Methods All new referrals to the prison mental health team are discussed and documented at a weekly multidisciplinary team meeting. The meeting’s minutes between January and April 2018 were collated, and all new referrals identified (n=82). Excel was used to review the relevant referral information, including the referral outcome. The percentages of new referrals missing the referral source, referral reason and referral outcome were compared to corresponding percentages from the 2017 project. The number of referrals, prisoner age at the time of referral and the most common referral reasons were also compared. Results 82 new referrals were made to the prison mental health team between January and April 2018 compared to 70 over the same time period in 2017. The source of the referral was unclear in 2% of new referrals compared to 19% in 2017. The reason for the referral was unclear in 2% of the 2018 sample compared to 40% in 2017. The outcome of the referral was unclear in 13% of the 2018 sample compared to 30% in 2017. The mean prisoner age at time of new referral was 31 years in the 2018 sample compared to 27.5 in 2017. A previous mental health diagnosis was the most frequent referral reason in both samples. Conclusions The overall quality of referrals to the prison mental health team has significantly improved since the introduction of a new referral proforma. Prisoner age at time of new referral has marginally increased since the age-cap was lifted, however the most frequent reasons for referral remain unchanged.
Aims and hypothesis  Commissioning changes, and LSUs becoming a more integral part of the care pathway in the Thames Valley Forensic Mental Health Service (TVFMHS), may have led to an impact on patient management. We re-audited the length of stay in low secure units (LSU) across the TVFMHS between December 2014 and November 2017, and compared this to the prior three-year period. 

Background  The TVFMHS has two inpatient LSUs, Woodlands House and Wenric House. Together they manage 42 patients, male and female. The main findings of the previous audit (December 2011 to November 2014 – period 1) included that demographically the patients at both units were similar, and close to 90% of patients had been diagnosed with a severe and enduring mental illness (SMI). The average length of stay was slightly higher at Wenric than Woodlands House, although the median stay in both units was identical at 24 months. 

Methods  Electronic records of discharges between December 2014 and November 2017 (period 2) were reviewed by various clinicians. Data collected included length of stay in months, age, sex, diagnosis, admission source, discharge destination, index offence, Mental Health Act Section and regarding any readmissions post discharge. 

Results  The majority of discharges (87%) still have a primary diagnosis of a SMI. There had been a large increase in the total number of discharges in period 2; 82 compared to 36 in period 1. The mean length of stay across both units has reduced to just over two years. Median stay has reduced from 24 to 16.5 months. There has been an increase in the number of patients being admitted to both units directly from the community. There were some differences between units in terms of discharge destination, and an increase in patients managed on criminal, as opposed to civil, sections. 

Conclusions  There has been a large increase in the number of discharges, and a reduced length of stay, in LSU in the TVFMHS for the three years from December 2014 compared to the three years prior. Additional recommendations included that the audit be repeated in a further three years to monitor long term trends. Both wards should develop referral criteria to seek to further reduce both length of stay and the likelihood of non-progressive discharge. Other inpatient units within the TVFMHS should consider collating similar data. Further work would be of benefit to identify factors predictive of positive outcomes for patients detained in LSU.
Gender Identity Disorder: Forensic Considerations

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Aims and hypothesis  1. To review literature in relation to Gender Identity Disorder (GID) in forensic settings  2. To review current legislation around gender identity  3. To consider a rationale for classifying transgender people in terms of their stage of transition  

Background  GID is a condition of atypical gender development in which a person identifies as a gender other than that assigned at birth. There has been an increase in referrals to UK gender identity clinics over the last number of years.  This increase in referrals would seem to suggest that there will soon be an increased number of transgender inmates in Irish prison settings. In Irish prison services there has been a small number of cases of prisoners who identify as transgender.  

Methods  A literature search was completed using the keywords ("gender dysphoria" OR "gender identity" OR transgender) AND (prison* OR inmate OR offender OR criminal), without time restrictions, using PubMed and PsycINFO[Could consider including other databases such as PsychINFO and Embase if you haven’t already done it.].  

Following review of abstracts, 43 articles were selected for appraisal.  

Available legislation/protocols for the management of transgender people in prisons in Ireland and the UK was reviewed.  

A review of several high profile international cases involving transgender prisoners, their index offences and the legal systems involved in their incarcerations was carried out.  

A consensus group met and a method of classification based on legal/medical status was proposed. It was felt that this would be helpful in aiding consideration of how to decide on placement in a forensic setting, based on stage of transition and index offence.  

Results  1. Common issues raised in the limited literature were around placement, management, transition, barriers to care, and challenges to longstanding classification systems in prisons  2. Cases of transgender inmates identified from Irish prisons highlighted the need for an effective protocol  

Conclusions.  There is currently no effective protocol for management of transgender offenders in Ireland. In terms of legal guidance, there is provision for a gender recognition cert (GRC).  

Placement could be determined in terms of legality, or medical transition.  

There has been a general move towards people self-declaring their gender. A diagnosis of GID is not required to obtain a GRC; it is unclear if this is sufficient to decide where a person should be incarcerated.  

Currently there is no systematic way to manage transgender prisoners in Ireland; potentially [change to classification system]this classification system could be developed into a rating system to assist with triage on issues of housing according to offence and stage of transition.
Scatolia in a High Secure Psychiatric Hospital

1. Dr Charlie Daniels (CT1) Broadoak hospital 2. Dr Paul Stephenson (ST6) Ashworth high secure hospital 3. Dr James Collins (consultant) Ashworth high secure hospital 4. Dr Inti Qurashi (consultant) Ashworth high secure hospital

Aims To calculate the incidence of faecal smearing (scatolia) within Ashworth high secure hospital and calculate the associated financial burden. Background Scatolia is a distressing behaviour to both clinical staff and patients. In secure psychiatric settings it is typically associated with patients in seclusion. Scatolia may arise out of protest, mental impairment, mental illness or dementia. The quantitative costs include the need for room cleaning with extra resources required (in the form of a response team) to move threatening/disturbed patients. Other costs include nursing time and allocation of resources away from pro-social activities. We assessed the quantitative costs by focusing on the financial burden attributed to this behaviour. Methods All incidents of scatolia were identified at Ashworth high secure hospital over a 12 month period (1st May 2017 to the 30th April 2018) by searching the electronic medical records of all patients over the review period. Patient care plans and security data provided information how these incidents were managed across the hospital. Each incident was analysed to identify: patient identifier, ward type (mental illness / personality disorder), seclusion (y / n). Quantitative costs associated with each incident were measured by accessing security records (response team) and cleaning company invoices. Results There were 118 incidents of faecal smearing at the hospital across the review period comprising of seventeen patients in total out of 210; an incidence of 8%. 73 incidents (62%) occurred on Personality Disorder wards whilst 45 (38%) occurred on mental illness wards. The range of incidents per individual was 54 and the mean duration of behaviour was 77 days. The majority of scatolia incidents were carried out by patients in long term segregation (105) or short-term seclusion. The response team were required in sixty incidents (28.5%). All incidents required services of an external cleaning company. The quantifiable financial cost of faecal smearing over the review period was £50,253 (cleaning company costs: £13 379; response team costs: £36 874). Four Incidents of faecal smearing were reported to the police; two incidents currently processed through court. Conclusion We believe this is the first systematic evaluation of scatolia in a high secure psychiatric hospital. The associated financial costs were not insignificant. We did not evaluate the emotional impact or effect on the therapeutic relationship. The effect on clinical teams can be counter therapeutic and perhaps closer attention given to formulation and management of recurrent scatolia.
The Importance of Being Jealous: Case Series of Morbid Jealousy in Medium Secure Setting

Dr Catarina Rodrigues dos Santos CT3 Psychiatric trainee, Dr Hany El-Metaal Consultant Forensic Psychiatrist

A central theme in Shakespeare’s Othello, jealousy is depicted as “the green-eyed monster, which doth mock / The meat it feeds on”1. Universally experienced, jealousy arguably brings evolutionary advantages in propagating one’s genes over a true rival. And yet, what if one’s rival is imagined? In morbid jealousy, individuals have a firm, unshakeable belief that their partner is sexually unfaithful. Crucially, the basis for this belief is drawn upon unfounded evidence. It is associated with extreme and unacceptable behaviours, amongst which, the most extreme being the act of destroying one’s object or rival.

Although no exact epidemiological data exists, morbid jealousy has long been recognised as a rare entity by the psychiatric community3. The aim of this case series is to highlight morbid jealousy as a critical aspect of psychopathology in attempted and completed homicide. Cases of forensic psychiatric patients who suffered from morbid jealousy will be explored, in particular classical confirmatory behaviours and the associated risk to partner and suspected paramour. There will also be a focus on associated delusions of persecution and poisoning, sociocultural factors and co-morbid substance misuse. The cases will illustrate the psychological burden on partner and familial distress. Lastly, it will exemplify the fatal consequences of this symptom, emphasising the need for clinical vigilance, early identification and management. A clinician should be guided in their treatment by the underlying diagnosis and substance misuse treatment prioritized. Risk management can include temporary separation in the hospital admission of the morbidly jealous individual and in treatment resistant cases, geographical separation may be the most effective measure.

Affiliation

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A central theme in Shakespeare’s Othello, jealousy is depicted as “the green-eyed monster, which doth mock / The meat it feeds on”1. Universally experienced, jealousy arguably brings evolutionary advantages in propagating one’s genes over a true rival. And yet, what if one’s rival is imagined? In morbid jealousy, individuals have a firm, unshakeable belief that their partner is sexually unfaithful. Crucially, the basis for this belief is drawn upon unfounded evidence. It is associated with extreme and unacceptable behaviours, amongst which, the most extreme being the act of destroying one’s object or rival.

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Affiliation
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Aims Our aim is to present the first literature review on the use of oxytocin in patients with ASPD. Background 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. 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. Method A previous unpublished literature search was updated. The search looked through relevant databases for original research on effect of oxytocin upon persons with a diagnosis of ASPD or healthy participants with symptoms seen in ASPD. Studies were included if they included healthy participants that evaluated the effect of oxytocin on symptoms relevant to ASPD, including empathy, inhibitory control, compliance, conformity, aggression, violence, and moral responsibility. Results Thirty Six studies met the inclusion criteria and there were a range of study designs, including randomised controlled trials, double blinded, single blinded and unblinded controlled trials. The studies had male participants only, female participants only and both male and female participants. The sample sizes in studies ranged from twenty to 259 participants. The studies looked at participants with a diagnosis of ASPD and participants with symptoms relevant to ASPD, including empathy, inhibitory control, compliance, conformity, aggression, violence, and moral responsibility. Oxytocin was found to demonstrate diversified effects, in most cases being associated with socially positive or non-criminogenic behaviours. However, some studies found opposite, and non-desirable, effects, e.g. an increase in violent inclinations to partners. The 2 studies looking at participants with ASPD had a number of limitations and had conflicting results on the impact that OT has on aggression in ASPD. Conclusions This is the first systematic literature review exploring the potential use of oxytocin in managing ASPD and the symptoms of ASPD. It is apparent that there is a reasonable body of evidence addressing related symptoms in healthy individuals. There were diversified effects with oxytocin showing some benefits in promoting positive effects on symptoms of ASPD, but there were also studies showing non-desirable effects. It is difficult to draw any direct inferences from healthy control studies. Further high quality large sample studies are required to explore the benefits of oxytocin in a population with an established diagnosis of ASPD.
An comparative evaluation and evidence review of history and examination 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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Background  History and mental state examination are the cornerstone for assessing, diagnosing and managing mental health problems and associated risks. Therefore routine comprehensive admission history and mental state examination is done in UK inpatient units. This is a Quality Improvement Project comparing these across 2 (Medium and Low) Secure Units: North (NLFS) and East (ELFS) London Forensic Services.  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  Overall, the standards are close to being met (5 of 14 for NLFS; 16 of 20 for ELFS) are at 90% or above. Most (9 of 14 for NLFS; 20 of 20 for ELFS) are at 80% or above. As well as encouraging global improvement, there is a case for cognitive screening questions to be specifically encouraged. There are 6 parameters which score 0% for NLFS, only because they were only added in the service evaluation tool for the ELFS evaluation after feedback from the NLFS one. For NLFS, the most concerning aspect was the allergies only initially being recorded in 39% of patients. Unless improved, there is a risk of a serious incident in the initial assessment period in the long-term. So this is an important area to improve on. For ELFS this was the third lowest scoring category, although scoring better (83%). Risk to self and others were the areas needing more focus for ELFS (82% each), although significantly better.  Conclusions  The breadth and quality of history and mental state examination is very good. Mental state, including affective and psychotic symptoms, is conducted and documented at almost every admission. Cognition is under-represented as it is not seen as relevant to the population. Improvements can be made in the explicit documentation of risk, despite current high levels of recording. The assessment tool is limited to breadth more than depth. We produced an electronic proforma and delivered it to RIO ICT services to incorporate into their system updates. This was refined by clinicians and service users, and verified at management level. Bilateral feedback was given to, and taken from, our local RiO and CQC representatives. We produced a training presentation to incorporate the findings into clinical practice.
An comparative evaluation and evidence review of clinical investigation recording for admission assessments in Medium and Low security in forensic services in 2 separate Mental Health Trusts in 2 years


Background Specific blood, imaging, and other investigations must be conducted in the initial assessment of a psychiatric inpatient to exclude physical diagnoses for their psychiatric problems, and to monitor and treat physical comorbidities. Current government quality targets put a financially-incentivised emphasis on monitoring physical health conditions including metabolic syndrome. It then comparatively evaluates whether these are being performed and documented in North (NLFS) and East (ELFS) London Forensic Services and 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 Most of the patients have some of the investigations conducted and documented within the initial assessment period. ELFS consistently measured a broader set of blood tests. The most popular in descending order for both services are FBC, U&E, LFT, TFT and lipids at 59%-80%. ECGs were done and commented on in 50-78%. The rest, including glucose, were below 50%. X-ray and imaging were the least considered in both; they were not considered in anyone in NLFS but were in most ELFS cases. 20% had no initial bloods recorded for both services, with only a minority explicitly recorded as having refused.

Conclusions ECG, glucose and lipid level checking should be prioritised. Reasons for below optimal specific bloods and ECGs include training and cultural issues, lack of availability of functioning items, and time constraints. Nursing staff may be able to perform some of these investigations as currently done in some acute medical wards. There is a difference in clinical culture between the 2 services, favouring measuring some parameters over others. Lag and lower results at NLFS compared to ELFS reflects the older data taken from NLFS (which by now would be expected to be similar to ELFS accounting for the improvements made). Despite good compliance, at least 1 in 5 inpatients would benefit from better assessment of investigations. A culture needs to be set to include all the mentioned blood tests and ECGs routinely. We proposed an investigation electronic proforma across the services. This was agreed with input by clinicians, and verified at management level with service user input. The proforma is currently with the RiO electronic records research and development department. This was departmentally presented, and training implemented.
Aims: The goals of this research were: 1) to understand the impact of forensic practice on the children of forensic psychiatrists; and 2) to obtain advice from adult children of forensic psychiatrists regarding strategies to mitigate any perceived risks or harms. 

Background: Stemming from work on professionals directly affected by trauma exposure, such as emergency responders and war veterans, attention has turned to the impact of work-related trauma on professionals’ families including: media and public scrutiny, trauma contagion, marital discord, and over-protective parenting. More recently, colleagues in forensic psychiatry are speaking anecdotally not only about the personal impact of exposure to violence and suffering, but also the impact of this work on their families. However, research in this area is strikingly absent. 

Methods: This project adopted a narrative research methodology that places emphasis on stories and descriptions of events. While there is a tradition of using this methodology in education research, narrative approaches are increasing being used in health care research, encouraging clinicians to reflect on their own experiences. Interviews were conducted with adult offspring of forensic psychiatrists to develop an understanding of the extent of exposure to disturbing material regarding human violence, the impact of exposure, and mechanisms employed by parents in attempting to mitigate risk and exposure. 

Results: It is clear from our research that the work of forensic psychiatrists permeates the family boundaries in many ways, including: direct exposure of their children to traumatizing material; concerns regarding risk to safety of family members; and perceptions of the world. Recommendations made by participants to forensic psychiatrists include: limiting exposure of their children to traumatic material; discussing issues that arise in a manner appropriate to the age of the child; and ensuring that when discussions are held that children are made aware of the anomalous nature of this work and the people encountered within it. 

Conclusions: The stories of adult children of forensic psychiatrists point to a unique life experience in which young people are exposed to brutality and suffering imposed by one person on another in ways their peers are not exposed. Participants describe an awareness of the world that was at times frightening, but at others increased their empathy for others that encounter the law and motivated them to pursue professions related to health care or forensic work.
A thematic analysis of the reasons for Long Term Segregation and barriers to discontinuation of LTS at Broadmoor High Secure Hospital

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Aims and hypothesis  To conduct a thematic evaluation of long-term segregation (LTS) data and explore the barriers to terminating LTS in Broadmoor High Secure Hospital.  Background LTS is unique to high secure hospitals and used to manage and reduce the risk of violence and aggression. All seclusion either short term or long term needs to be both necessary and proportionate to the risk at the time. However all staff in high secure hospitals are aware that in this unique patient group barriers may exist to terminating long term segregation once it has been commenced. Having an understanding of these barriers may assist staff in reducing the use of both short term seclusion (STS) and long term segregation (LTS).  Methods A thematic analysis of LTS at Broadmoor hospital including all patients in LTS between 1 January 2018 and 31 March 2018 was conducted. Demographic data and data pertaining to diagnosis were collated. ‘Seclusion monitoring and restraint group’ (SMARG) review forms and SMARG meeting minutes for January to April 2018 were collated. These included reasons for commencing LTS initially, the reason it needed to continue and what needed to be achieved for LTS to be discontinued.  Results There were 61 episodes of LTS for 59 patients. Of these, 39/63 (61.9%) were within the ‘mental illness’ directorate, the remainder being in the PD pathway. Mean age at commencement of LTS was 36 years. 20% of patients were commenced on LTS within the first month of their admission. Of those on LTS 50% were on hospital order sections of the MHA 1983 with the remainder being prison to hospital transfers (28%) and other sections (23%). 61% of patients had a diagnosis of schizophrenia or psychosis, 13% schizoaffective disorder, 3% bipolar disorder. 18% had a diagnosis of personality disorder without an axis-1 mental disorder. Physical assaults on others was the commonest reason for seclusion (54%) had assaulted. Nine patients were secluded as part of an admission assessment given their recent risk history. 14 were aggressive or violent in other ways. Many of these continued to present as psychotic, hostile or aggressive in short-term seclusion. Conclusion The most common reasons for seclusion was for physical assaults on others with conversion to LTS for on-going high risk of physical violence to others that did not resolve within the first week after the short term seclusion was initiated. Further analysis into the barriers for terminating LTS will be undertaken.
Clinical audit and service evaluation project of prison healthcare wing HMP Chelmsford

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Aims and hypothesis

This project aims to audit the care of prisoners in the healthcare wing of HMP Chelmsford which is run by Essex Partnership University NHS Trust (EPUT). It will use the standards in NICE - NG 66, the Royal College of Psychiatrists - CCQI268 and local standards in HMP Chelmsford - SSOP62 and SSOP64.

NG66 (section 1.4.1) recommends a risk assessment on all mentally disordered offenders. The RCPsych CCQI268 (section i1) recommends the making of follow-up arrangements on released from hospital. HMP Chelmsford SSOP62 recommends that when transferring prisoners to the inpatient healthcare wing, they are assessed for physical health, mental health and substance misuse problems. SSOP64 recommends (section 7.3) that prisoners are referred to the inpatient wing where necessary and (section 11.2) the necessary follow-up arrangements are made on release from prison. Further information about the care and transfer of patients will be collected in order to improve clinical care and patient safety. SSOP64 itself (section 3.1) recommends that the service should be audited and evaluated.

Background

Enabling prisoners to access specialist psychiatric care is essential given the psychopathology and numbers of suicides in prison. In addition to using ACCT (Assessment Care in Custody and Teamwork) documents and regularly reviewing risk, mental health professionals need to be able to accurately diagnose and treat mental disorder and provide a clear pathway of care. There are often significant delays in transferring prisoners to the healthcare wing and external hospitals which poses significant risks.

Methods

This project will look at all prisoners admitted to the healthcare wing from 1st June 2017 to 1st June 2018. Data will be collected using System One prison medical records relating to a number of parameters including length of stay, time to transfer to hospital, diagnoses, types of medication given, ACCT documents and risk assessments.

Results

There were 84 prisoners in the healthcare wing during the study period. The average length of stay in days was 37 (median) and 74 (mean). They were transferred to psychiatric hospital (26), back to ordinary location (31), released (22), another prison (3) or deceased (2). The average length of time from referral to transfer to psychiatric hospital in days was 48 (median) and 99 (mean). The average length of time from MOJ warrant to transfer in days was 3.5 (median) and 5 (mean). Those who were transferred to hospital were done so on section 47 (7), section 48 (14), section 38 (4), section 37 (1) and section 2 (1). Of those released to the community only about half had documentation of psychiatric follow-up. There were high levels of psychopathology. Over 72% were prescribed antipsychotics although only 38% had a diagnosis of psychosis. 83% were on an ACCT document mostly for self-harm. 11 patients had no clear documentation of their reason for being prescribed medication and in 7 cases psychiatrists did not make any documentation of risk.
Conclusions

In terms of meeting guidelines, the prison healthcare wing does adhere to many of the relevant audit standards although there is a lack of documentation of follow-up in half of cases released from prison. There could also be an improvement to risk assessment documentation. In terms of service evaluation there could be an improvement in the reason for prescriptions, especially for antipsychotic medication for those who do not have a diagnosis of psychosis. There is wide variety in the number of days taken from referral to transfer to psychiatric hospital, although there is very quick transfer once an MOJ warrant has been received. Although there are a number of possible explanations, further work is needed to reduce these inconsistencies and to enable clear pathways of care for this vulnerable population.
Service Evaluation of Forensic Service for Older Adults

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Background: Mallard ward, at Roseberry Park in Middlesbrough, is a 14-bedded low secure facility providing individualised care to older men, aged 55 years and older, who are vulnerable, frail and/or have severe physical health problems. Mallard Ward offers a unique and specialised service within the NHS. The ward provides a low secure environment utilising a holistic approach to client care. The aim of the service is to monitor, manage, and reduce risk, assisting patients to lead full and independent lives whilst balancing therapy and security. Mallard ward is unique as it offers NHS psychiatric and physical health care for older persons with various physical health comorbidities within Secure Services. Due to the unique nature of the service, a service evaluation was performed in order to appraise the characteristics of patients admitted to the ward and make comparisons with the referrals rejected.

Methods: Data was gathered for all patients referred to, and accepted into Forensic services for older people (Mallard Ward, Roseberry Park) since it opened in January 2013. Data collection was performed via access to electronic case notes (including referral documents, access assessments and progress notes) and populated on an Excel spreadsheet. Characteristics of each patient were collected (e.g., physical comorbidities, psychiatric diagnoses, offences etc.). Length of stay and discharge pathways of those admitted to Mallard ward was also reviewed.

Results: Data has been collected and we are in the process of analysing results. Once this has been completed, an updated abstract will be forwarded for print in the conference booklet.

Conclusions: This project will allow us to evaluate the characteristics of patients referred to, and accepted into Forensic services for older people (Mallard Ward, Roseberry Park). Data relating to admissions, discharges, and referrals to Mallard Ward will be collected and analysed. This will also give an indication of the external perception of what service Mallard ward offers, as well as potentially helping to develop criteria for referrals into the service in the future.
Therapeutic Engagement and Care Pathways in Broadmoor High-Secure Hospital – A Six-Month Retrospective Study of Multidisciplinary Engagement

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AIMS: The aim of this study is to examine the associations between patient engagement with therapeutic services and their length of stay in Broadmoor high-secure Hospital, and analyse variations between the Mental illness and Personality Disorder pathways, and between level of dependency and diagnosis. BACKGROUND: Active management of length of stay in forensic hospitals is vital from both a human rights and a financial perspective. It has long been understood that therapeutic engagement and recovery (in a broad sense) should be achieved to merit transfer to less-secure settings, or discharge to the community. Forensic psychiatric hospitals in the NHS aim to provide a minimum of 25 hours of therapeutic engagement per patient per week, encompassing a variety of Multidisciplinary Team (MDT) members across a variety of domains (e.g. doctors, occupational therapy, social work etc.). METHOD: We conducted a retrospective study of a complete cohort of high-secure patients in Broadmoor Hospital across a six-month period (n=189). All face-to-face engagements with all clinicians are logged on a central computer database in the hospital. Engagement with the 25-hour therapeutic week was examined, to analyse for relationships between pathway, dependency level and length of stay. RESULTS: Data from 87201 engagements for 189 male high-secure patients were included. Highest mean engagement was on rehab wards (mean = 84.2 hours per week), followed by admission wards (mean = 77.6 hours), ICU (mean = 74 hours), with the lowest on HDU wards (mean = 58.6 hours). This was a statistically significant difference in levels of engagement across the pathway (ANOVA F= 3.213, p= 0.024). The mean level of engagement with the various MDT disciplines also varied across dependencies. Patients with a higher level of engagement, relative to peers at the same level of dependency, were more likely to achieve a positive pathway move, i.e. transfer to a less-secure ward within Broadmoor or discharge to a medium-secure unit. CONCLUSIONS: Engagement with various disciplines varies across levels of dependency within a high-secure setting. Higher levels of engagement on ICU compared to HDU wards may reflect the higher staff to patient ratio and ‘intensive care’ level of treatment offered on that unit. Higher levels of engagement were linked to positive pathway moves. These findings highlight the importance of engagement in order to achieve positive outcomes, e.g. discharge from hospital. We also demonstrate a need to adapt the approach of the various MDT disciplines, depending on the level of dependency.
Audit: The Use and Themes of 'Advance Statements' within Medium and Low Secure Hospitals

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Aims & Hypothesis

To audit the use and quality of Advance Statements within Medium and Low Secure Hospitals across Birmingham and Solihull Mental Health Foundation Trust. Previous audits have shown a significant variance in the use of Advance Statements across the sites and we hypothesise that this continues to be the case.

Background

'Advance Statements' are widely used across the inpatient units to provide patients' views on their future care, particularly if they develop a lack of insight or lose capacity in the future. The quality and content of Advance Statements vary. They should be personal to the patient and provide a place for them to suggest how they would like certain aspects of their care to progress in the future.

Methods

Previous audits were consulted and a standard set: all inpatients should have an Advance Statement (within the first six months of admission). All patients admitted within a specific week in 2018 had their online records assessed. An Excel spreadsheet was used to collate data on: how many Advance Statements a patient had; whether they had a statement or declined; and the themes contained within the statements.

Results

Results showed a large proportion of inpatients have at least one Advance Statement. However, there was variance in the number of statements each patient had and variance in the quality of the statements. There were also various themes, however most focused on: admission, treatment and family.

Conclusions

Advance Statements provide a place for patients to discuss their preferences for future treatment; in the case they may lack capacity or insight in the future. They should be updated regularly in line with CPA reviews to ensure they are up-to-date and timely. A more open form with suggested topics may be helpful to allow patients to have a more open dialogue in terms of their preferences.
Understanding decision-making in offenders with mental disorder: findings from a meta-analytic review

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Aims and Hypothesis: This review aimed to clarify the literature on decision-making in offenders with mental disorder by bringing together different neuropsychological tasks of decision-making and examining the performance of offenders with various mental health diagnoses on such tasks. We hypothesised that offenders with mental disorder would make poorer-quality decisions than matched offender groups or healthy controls. Background: The decision to commit a crime has significant consequences upon the offender, the victim, economy and wider society. Mental disorder may influence a person’s decision-making and offenders with mental disorder are at greater risk of violent recidivism following prison release. Despite their potential increased vulnerability to making disadvantageous decisions, no study has previously systematically appraised the literature on decision-making in offenders with mental disorder. Methods: A structured search of PubMed, Embase, PsycINFO, Medline, and CINAHL was conducted with additional hand searching and grey literature consulted. Controlled studies of decision-making in offenders with evidence of any mental disorder, including a validated measure of decision-making, were included in the review. Only studies using the Iowa Gambling Task (IGT) and Secret Agent Task (SAT) provided sufficient data for meta-analysis. Total score on each relevant decision-making task was collated. An overall meta-analysis was conducted comparing decision-making performance between offenders with mental disorder and healthy controls. Two sub-group meta-analyses were also conducted focussing on offenders with personality disorder and psychopathy, and offenders convicted of repeat driving whilst intoxicated offences. Results: Twenty-three studies met inclusion criteria (n=1,820), and ten studies (with fifteen experiments) were entered into the meta-analysis (n=841). Individual studies showed that violent offenders made poorer decisions than matched offender groups or healthy controls; furthermore, specific deficits in decision-making were identified for each specific mental disorder. However, meta-analysis found no statistically significant difference in decision-making performance on the IGT and SAT between offenders with mental disorder and healthy controls. Subgroup meta-analyses were also non-significant. Conclusions: Overall, the decision-making functions of offenders with mental disorder remains broadly unclear, with abnormalities in decision-making processing being identified but no statistically significant effect on overall decision-making function being elicited. Further research, including an analysis of cause and effect, is needed to help understand the underpinnings of these findings. Of particular importance is the collection of longitudinal data, so that we can begin to understand how decision-making may be altered by passage through the criminal justice system, and how it may change during an offender’s rehabilitation and recovery from mental disorder.
Aims and Hypothesis  The primary aim of the audit was to monitor overall levels of prescribing for psychotropic medications within HMP Kilmarnock and to identify any general trends or specific areas of concern within prescribing practices.  

Background  This audit was first undertaken in 2009 and has been repeated yearly allowing data to be analysed over a ten-year cycle.  

Methods  Pharmacy staff were contacted at HMP Kilmarnock and asked to make all prescription sheets available. On the arranged date a doctor attended prison and reviewed the prescription sheets for the relevant psychotropic medications. Identified prescriptions were then documented on a recording sheet.  

Medications to be identified included all medications within BNF sections 4.2 (Antipsychotics and antimanic drugs), BNF Section 4.3 (Antidepressant drugs), BNF Section 4.1 (Hypnotics and Anxiolytics), Section 4.4 ( Medications used for ADHD), and Section 4.8 (Antiepileptic drugs). Propranolol was also checked due to its use as an anxiolytic.  

After completion of the recording sheets the identified medications were collated and summarised to identify frequency of prescribing and to begin a comparison with previous audit records.  

Results  Antipsychotics  Overall the general trend has been towards an increase in prescriptions for antipsychotic medication. The 2018 audit showed the total number of prescriptions for antipsychotics was 48. This showed antipsychotic prescribing had moved back to a similar level of prescribing as 2012 (2018: 48 vs 2012: 49). Quetiapine remains the most popular prescribed antipsychotic however olanzapine now makes up over a third of antipsychotics prescribed.  

Antidepressants  Antidepressant prescriptions have risen significantly over the decade. The most commonly prescribed antidepressant in HMP Kilmarnock is now mirtazapine, making up almost half of all prescriptions for antidepressants. (88 prescriptions in 2018 versus 29 prescriptions in 2009) There has also been a significant increase in amitriptyline prescriptions.  

Mood Stabilisers  There were significant changes during 2018 with a reduction from 52 prescriptions in 2015 to 13 prescribed in 2018. Valproate was the most commonly prescribed mood stabiliser.  

Sleeping tablets and other  The number of prescriptions for diazepam was 9 in 2018. All of these were part of a reducing detox regime. The number of diazepam prescriptions has gradually decreased over the years.  

Conclusions  There have been significant changes in psychotropic medication prescribing over the years. The general trend has been towards an increase in prescribing however this has largely been in the area of antidepressant prescriptions. The prescribing of benzodiazepines has reduced significantly in recent years.
A Systematic Review of Co-Morbid Intellectual Disability and Attention Deficit Hyperactivity Disorder in Adult Offender Populations

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Aims and hypotheses: This systematic review aims to consolidate the available evidence for co-morbid intellectual disability (ID) and attention deficit hyperactivity disorder (ADHD) in offender populations. Background: Intellectual disability (ID) and attention deficit hyperactivity disorder (ADHD) each have a complex relationship with offending behaviour and offender rehabilitation. Studies in non-offender populations with co-morbid ADHD and ID (ADHD+ID) have found difficulties in diagnosis and a potentiation of impaired cognitive functioning. Methods: Studies were identified using CINAHL, EMBASE, MEDLINE and PsychINFO databases, and those which assessed or diagnosed ADHD and ID in adult populations and specified those charged with offences were included. Results: A total of five studies met the inclusion criteria whilst abiding by the exclusion criteria. The studies were heterogenous in terms of the assessment methods used, the populations studied, diagnostic classifications, and types of offences. The prevalence of ADHD+ID in the offending populations studies ranged from 0.2-30%, the wide-range reflecting this heterogeneity. The subclinical IQ range of 70-85 was found to be overrepresented in the prison population, and have a higher odds ratio of ADHD, in keeping with previous studies finding this group to have functional difficulties despite the lack of a formal diagnosis. Despite the high prevalence found in some studies and the known difficulties of those with ADHD and ID, to our knowledge no study to date has explored the incarcerated behaviour, rehabilitation outcomes or recidivism rates for ADHD+ID. Conclusions: This review underlines the need for clearer clinical assessment and diagnosis of ADHD+ID in offender populations. It is hoped this comprehensive overview of data on this clinically significant topic will help to inform and drive future investigation of the impact of ADHD+ID on behaviour and outcomes of offending populations. This is vital to guide effective rehabilitation strategies and lend weight to the specialist assessment of those suspected of having ADHD+ID in offender populations.
Cardiovascular Disease Prevention in Secure Services: Can it be improved?

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Aims and Hypothesis  • To examine whether all patients suitable for lipid modification therapy (LMT) are offered it.  • Hypothesis: There is under-usage of lipid modification therapies where they are indicated.  

Background Patients with severe mental illnesses have shorter life expectancies than the general population, with excess mortality largely related to cardiovascular events. In secure settings, cardiovascular risk is increased by high rates of obesity, sedentary lifestyle, heavy smoking histories, orexigenic psychotropic medications and antipsychotic use. NICE outlines the need for formal 10-year risk calculation where high risk is estimated and where >10% risk is calculated, it recommends treatment with statin therapy. Separate guidance is available for patients with Type 1 Diabetes Mellitus (T1DM), Chronic Kidney Disease (CKD) and suspected familial hypercholesterolemia. Here we investigate the degree of compliance with NICE physical health guidance.  

Methods A retrospective analysis of electronic notes and prescribing records of male patients admitted across three medium and low secure hospital sites in Birmingham (n=190).  

Results Key findings included:  • Of 190 patients, 28.9% were already receiving LMT.  • 20.0% were identified as high risk patients (HRPs) (QRISK >10%/T1DM/CKD stage 3/4).  • Of the HRPs, 26.3% had QRISK >20% 13.2% QRISK >30% 5.3% QRISK >40% and 2.6% QRISK >50%.  • Amongst the HRPs, 39.5% were not receiving LMT. All of these) had been given lifestyle/dietary advice in the past 12 months, and were therefore indicated for LMT.  • Amongst the HRPs not receiving LMT, 93.3% were indicated by virtue of QRISK >10%, 6.7% were indicated by CKD stage 3/4 only with QRISK <10%.  • All patients indicated for secondary prevention LMT were receiving it.  • One patient indicated for LMT by virtue of QRISK >10% was offered it and refused.  • In the HRP cohort, no significant correlation (defined as p value <0.05) was found between whether the patient was offered LMT, and their age, BMI, admission duration, cholesterol/HDL ratio, or hypertension. However correlation was determined between being offered LMT and positive diabetic status (p< 0.05).  • Higher rates of cardiometabolic risk factors were identified compared to general population, including raised BMI, ex-smoking, hypertension and type 2 diabetes when adjusted for age.  

Conclusions The data reveals under-usage of statin therapy amongst those at high-risk for cardiovascular disease. Further to notifying responsible clinicians for patients we identified, we believe further steps are crucial to manage this under-treatment of cardiovascular event risk- at other facilities, and for future inpatients.
A training course for MSU inpatients facing Court proceedings designed to reduce their anxiety and increase their knowledge of the Court process

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Aims and hypothesis,

Aim: Reduce the anxiety that forensic inpatients experience when facing Court proceedings.

Hypothesis: Many forensic inpatients facing Court proceedings have little knowledge of Court procedures and sentencing options and this is an important factor in the anxiety that they experience. We hypothesised that educating them about what to expect would decrease subjective and objective measures of anxiety.

Background,

Many patients in Medium Secure Units (MSUs) face Court proceedings. The Court system and sentencing rules are complex and patients may feel anxious about what awaits them. The stressful experience of Court proceedings may complicate recovery.

Methods,

Participants were inpatients on an MSU and were facing an upcoming Court appearance. Each underwent two individual teaching sessions. Session one focused on the Court environment and procedures, session two on sentencing options.

Pre and post questionnaires regarding the participants’ confidence regarding knowledge of the Court process (measured on a Likert scale of 0-10), subjective anxiety about appearing in Court (Likert scale of 0-10) and objective anxiety (Beck anxiety inventory score) were conducted.

Results,

Of the seven individuals that underwent educational sessions two had no previous experience of the Courts, and two had faced Magistrates Court on one previous occasion only.

Prior to the education sessions the average score regarding confidence in their knowledge of the Court process was 4.3/10. Subjective anxiety about the upcoming Court appearance was 6.0/10.

After the education sessions, three participants said that their confidence in their knowledge of the Court process had increased. The other four showed no change. The average increase was 1.1/10.

Three participants showed no change in subjective anxiety following the teaching while four showed an increase in anxiety. The average increase was 1.0/10.

Two patients showed an increase in Beck anxiety inventory score while five patients showed a decrease. The average reduction in score was 4.9.
Conclusions.

Our subset of MSU patients facing Court showed a low level of confidence in their knowledge of the Court process and evidence of anxiety about it.

After education regarding the Court process:

• Just under half of participants showed an increase in confidence in their knowledge of the Court process, the rest showed no change.

• Subjective measures of anxiety increased in four of seven participants but objective scores decreased in the majority.

Our work is ongoing and we continue to recruit participants. Further work is needed to understand which patients will benefit most from such education sessions.
Audit on Improving Information for patients on Confidentiality, Information Sharing, Complaints Procedures and Access to Medical Records – Forensic Inpatients

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Aim  To determine the level and frequency of information given to patients regarding confidentiality, consent to share information, complaints procedures and access to medical records.  

Background  In today’s healthcare service, there is much emphasis placed on patient-centred care. Amongst one of the vital components of facilitating this is ensuring patients are informed about aspects of their care and feel involved with the process. A peer review survey completed at the North London Forensic Service (Barnet Enfield and Haringey Mental Health Trust), carried out from the 1st to the 31st December 2017 highlighted a possible room for improvement in the information given to patients regarding confidentiality and other topics. (I did not participate in the survey but it helped inform the topic for this audit). 

Method  18 patients’ notes (computerised medical records) were reviewed on a medium secure inpatient forensic ward. Information was obtained from the date of the then current admission only, up to the 1st June 2018. Information was reviewed from the point of admission and up to and including a week subsequently, looking in particular for a record of patients having been given the North London Forensic Service Admission Pack which includes information on Confidentiality. In addition, the computerised medical records were reviewed including specific terms being searched for in the computerised medical records, relating to the audit including “Confidentiality” “Consent” “Records” “Medical Records” “Complaint” “Data” “Secure” for the period of time relating to the whole of the current admission. 

Results  The results showed a variability in information provided to patients and a variability on where this was recorded. With regards to confidentiality, in many cases, information was sought from the patient regarding who they would share information with, but there was a lack of consistency in providing information to the patient regarding the principles of confidentiality. There was also variability in the initial time since admission that a discussion regarding confidentiality occurred. 

Conclusions  This audit highlighted that there is room for improvement in information provided to patients regarding important issues around their care. Recommendations include that information on these topics are to be considered to be displayed on a ward poster, staff to document on computerised medical records when an admission pack has been provided and staff to have a discussion with patients about confidentiality, information sharing and consent and complaints procedures at the point of admission and at regular intervals.
AIMS & HYPOTHESIS: We wanted to know if the need for appropriate substance misuse intervention was being met in a high secure population who were discharged via a prison pathway, namely: How many of these have a substance misuse history? How many were referred to, and completed the substance misuse group while inpatients? Is there evidence that substance misuse was evident during their time in prison before re-admission?  

BACKGROUND: Substance misuse is a significant issue among patients referred for admission to all forensic hospital settings. We know that misuse of drugs increases the risk of relapse in mental state, harm to self and harm to others. 44% of patients who go on trial leave to a medium secure unit (MSU) from Broadmoor completed a substance misuse intervention. Substance misuse was a relevant factor in 14% of these re-admissions. However, some patients are discharged to prison, and we know that drugs are a serious issue in this setting. Substance misuse work is therefore vital in patients returning to either destination.  

METHODS: A list of those re-admitted from prison was compiled using files from Medical Records. A history of substance misuse was determined via a retrospective chart review looking at HCR-20 data and progress notes. The Substance Misuse Service provided their referral and attendance data. Identification of substance misuse in prison was obtained from patients’ pre-admission referrals or medical reports.  

RESULTS: 29 patients have been discharged to prison and then re-admitted to Broadmoor. 27 of these have a ‘partial’ or ‘definite’ history of substance misuse on HCR-20. Nobody completed the substance misuse group on their first admission in the prison group, as opposed to 44% in the MSU group. While in prison prior to readmission: 46% were either confirmed or suspected to have misused drugs, in comparison to 14% in the MSU group.  

CONCLUSIONS: Despite higher rates of drug misuse in those readmitted from prison, substance misuse work was more often completed among those being transferred to MSUs. We could be much better at identifying and referring those with substance misuse history on their first admission, regardless of discharge pathway. Future work could look at why those on a prison pathway are not being offered interventions earlier in their treatment and whether or not this correlates with length of stay in high security.
The development of a forensic psychiatry in-reach clinic within a female criminal justice service in Edinburgh

Dr Leah Jones, NHS Lothian, ST6 in Forensic Psychiatry  Dr John Crichton, NHS Lothian, Consultant Forensic Psychiatrist

Aim: To review referrals and outcomes of patients referred to a forensic psychiatry in-reach clinic within Willow, a female criminal justice service in Edinburgh.  

Background: Willow is a project managed by the City of Edinburgh Council’s Criminal Justice Social Work service and is delivered in partnership with NHS Lothian and other public sector services. Willow accepts referrals for women over 17 who have had contact with the criminal justice service. Their role is to provide a central hub where women can access a range of services. Between May 2017 and 2018 a higher trainee in forensic psychiatry ran a weekly in-reach psychiatric clinic as part of a special interest session. 

Methods: All patients referred for psychiatric input within Willow in a 12 month period were reviewed. Administration staff at Willow kept a record of patient attendance and the psychiatrist kept a record of all referral forms and review letters. 

Results: Over 12 months 13 women were referred for psychiatric input. 12 of which were under a Community Payback Order, with 1 voluntary patient. All patients were female and between the ages of 20 and 59. Referral forms were completed for all patients and discussed with a senior social worker. Reasons for referral varied; the main reasons included queries regarding diagnosis, possible medication prescription and that the patient had no current involvement with mental health services. The psychiatrist offered an initial appointment to all 13 patients. 7 attended for one or more appointments. Out of 49 offered appointments there was a total attendance rate of 39%. The psychiatrist did not prescribe any medication directly and recommendation for the GP to prescribe or review dosing was made on 5 occasions. Of those 7 patients seen 5 patients had a primary diagnosis of emotionally unstable personality disorder, and 3 had co-morbid diagnoses. The psychiatrists diagnosed one patient with a first episode psychosis. None of the patients were referred to a CMHT or admitted. All review letters were sent to the referring key-worker and to the patient’s GP. 

Conclusion: The running of the clinic was similar to that of a CMHT outpatient clinic, with additional support from criminal justice social workers in arranging appointments and liaising with patients. The psychiatrist worked collaboratively with the social work team and with the patient’s GP. The development of this clinic has enhanced access and communication between mental health services and the criminal justice social work team.
Monitoring baseline prolactin levels in a forensic inpatient setting

Dr Leah Jones, NHS Lothian, ST6

Aim: To monitor whether baseline prolactin levels were recorded on admission, or prior to the initiation of antipsychotic medication, in patients admitted to a medium secure forensic unit.

Background: Prolactin is a hormone secreted by the anterior pituitary gland and its release is inhibited by dopamine. Therefore, all antipsychotics have the potential to raise prolactin levels given their anti-dopaminergic properties. Some are known to cause a higher prevalence of hyperprolactinaemia and the effect appears to be dose related. Hyperprolactinaemia is often asymptomatic, but persistent elevation of prolactin is associated with a number of adverse consequences. The Maudsley guidelines suggest a baseline prolactin level is taken prior to the prescription of any antipsychotic, as this can prevent unnecessary investigations at a later stage.

Methods: The sample included all admissions to the Orchard Clinic, a medium secure unit in Edinburgh, in 2017. Admissions of less than 72 hours were excluded. Information was collected retrospectively. Pathology results were accessed through the electronic patient records and individual medication cardex’s were reviewed for the prescription of regular antipsychotic.

Results: There were 44 admissions overall; 41 male and 3 female. 89% had baseline bloods taken on admission, 21% of which included a baseline prolactin level. 41% of those admitted had a prolactin level taken at some point during their admission. 50% had a prolactin within the normal limit, with 17% having a prolactin level exceeding 1000mU/L. 84% of those admitted were prescribed a regular antipsychotic. Of those prescribed antipsychotic medication 19% had a prolactin taken on admission or prior to the initiation of the antipsychotic (these were in fact the same cohort of patients.)

Conclusion: The majority of forensic inpatients admitted in 2017 had baseline blood tests taken on admission, however, less than a quarter of those included a baseline prolactin level. If taken at any other time during admission the prolactin monitoring appears to have been carried out at random points and not necessarily prior to the initiation of antipsychotic medication, therefore unlikely to provide a true baseline level. In conclusion, Maudsley guidance is not currently being adhered to within the clinic. In order to improve baseline monitoring we will ensure that prolactin levels are routinely taken as part of the admission blood investigations. If this is not possible then it would then be advised that a prolactin level is taken prior to the initiation of any antipsychotic medication.
Aims and hypothesis  To establish the frequency and regularity of suicide risk assessment in patients under the care of the Forensic Directorate in NHS Greater Glasgow and Clyde (NHS GG&C). We hypothesized that suicide risk would be assessed at the same frequency and regularity as violence risk. Background The NHS GG&C Forensic Directorate oversees the care of approximately 200 patients in Medium and Low security and the community. Patients are male and female and have diagnoses including mental illness, personality disorder and intellectual disability. The Scottish Government’s Suicide Prevention Strategy 2013-2016 aimed to reduce the Scottish suicide rate by 20%. The HEAT target to train 50% of frontline NHS staff in suicide prevention techniques was achieved in 2010. Forensic patients are subject to extensive risk assessment, often focusing on risk to others. They may also be subject to a local risk screen including risks to self and vulnerability. Healthcare Improvement Scotland’s Mental Health Team Discussion Framework has clear guidance on management of events such as transfer, discharge and multidisciplinary review in relation to suicide. This has been adapted into a ward-based checklist which is currently used acute and general adult sites throughout NHS GG&C but is not currently used in the Forensic Directorate. Methods  We undertook a retrospective case note audit during November 2017, looking at all Forensic sites in GG&C and establishing when and how suicide risk was documented by psychiatrists. A sample of 20 of case-notes from each environment was used. Case-note selection was random but covered consultant teams evenly. Results  For Community patients, 65% had suicide risk recorded at their most recent psychiatrist review and the median time since this was documented was 18 days. This compared to only 10% for those in Medium Security and 0% of those in Low Security. In Low Security 95% of cases had no documentation about suicide risk within the last year and in Medium Security this was 85%. Conclusions  The results varied significantly between areas. It appeared that in dictated letters for Community patients, Psychiatrists routinely documented suicide risk as part of the MSE however this was not replicated in an inpatient setting where the risk focus is often solely on risk to others. It may be the case that negatives are not routinely documented. We presented our findings locally. It was agreed that suicide risk checklists would be adopted as part of MDTs. We will re-audit in Autumn 2018.
Improving the quality of nursing handover on an acute medium secure forensic unit using the SBARD tool

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Shaftesbury Clinic, Medium Secure forensic Unit

South West London and St George’s Mental Health NHS Trust

Current problem:

Currently when temporary (agency or bank) staff work on the ward there can be inconsistency in their awareness of the clinical background and risk profile of patients on the clinic. Permanent staff members have reported that this is due to the limited time to provide clinical handover so they are unable to provide a more detailed background summary. Temporary staff members have reported that they are not always fully aware of the relevant clinical history and risk profile of patients they are allocated to during their shift. This problem was discussed at our team away day and has been identified as a priority area for improvement within the multi-disciplinary team.

Rationale:

Effective communication and information sharing within the clinical is necessary to allow safe and efficient patient care. The SBARD (Situation, Background, Assessment, Recommendation, and Decision) tool, a framework for communication between teams members, which is familiar and already in use on the ward will be adapted to create a brief clinical summary for each patient

Proposed Intervention:

To improve the quality of clinical handovers by providing an accessible and easy to understand brief clinical summary in the SBARD format (highlighting relevant clinical information and risk issues) for each patient specifically for temporary staff deployed to the clinic.

Through carrying out this QI project we aim to bring about the following changes:

1. An increase in the rate of temporary staff who are satisfied that the background clinical information provided during handover is sufficient for them to work safely and effectively during their shift.

2. An increase in the rate of permanent staff who are satisfied that the information they provide to temporary staff during handover is sufficient for them to work safely and effectively during their shift.

3. with little disruption or negative impact on the nursing handover process

Method:

The project will be conducted over a 4 month period. PDSA cycles will be the model for improvement. Data from repeat surveys and focus groups will also be used throughout the project to measure progress and impact. Leonard M, Graham S, Bonacum D (2004) The human factor: the critical importance of effective teamwork and communication in providing safe care. BMJ Quality
TRANSFORMATION OF FORENSIC SERVICES

Dr Ba Min (Adam) Ko, SLP, Darzi Fellow / ST5 Forensic Psychiatry, Dr Mary Harty, SLP, Clinical Director / Consultant Forensic Psychiatrist

BACKGROUND The Five Year Forward View (FYFV) highlights the challenges faced by the NHS with system wide implementation to drive efficiencies. The strategy inherent in FYFV emphasises the need for proactive and preventative approaches to reduce the long-term impact of mental illness on patients. It recommends the delivery of high-quality care including preventing avoidable admissions, supporting recovery and ‘step down’ for people with mental illness who present significant risk, to the least restrictive setting, as close to home as possible. South London Mental Health & Community Partnership (SLP) was formed in April 2017. It consists of a partnership between South West London & St George’s Mental Health NHS Trust, South London & Maudsley NHS Foundation Trust and Oxleas NHS Foundation Trust. It is one of the Six New Models of Care (NMOC) wave 1 pilot sites in the UK for transformation of forensic services.

AIMS - To promote innovation in service commissioning, design and provision that joins up care across in-patient and community forensic pathways. - To improve outcomes for people of all ages and deliver efficiencies based on high quality care. - To eliminate costly and avoidable out of area placements and provide care, in the least restrictive setting, close to home

MODEL The scope of SLP NMOC includes medium & low secure services and community forensic services for the residents of South London within 12 CCGs covering a total population of more than 3.2 million. The model involves a management hub which oversees 5 clinical pathways: Acute, Assertive Rehabilitation, Specialist, Women and Community for patients in secure setting ie: NHS & independent sectors and community setting. The programme includes an Out of Area team. The model is based on 1) Single Point of Access: for referral and assessment, 2) Specialisation: sharing expertise across partnership, 3) Expending Care: reinvesting in step down, rehab and community team and 4) Pathway Standardisation: advancing quality improvement across the pathways.

RESULT SLP repatriated a total of 73 patients to date and the number of patients in independent sectors has reduced to 160 resulting in less spending of £4.4 million since the establishment of SLP, April 2017. The saving generated helped reinvestment in expanding community teams, women’s hostel, clinical decision unit and low secure LD service.

CONCLUSION SLP has been successful in achieving its aims according to the FYFV. We have identified areas for future development and we are carrying out formal evaluation of the programme.
Repatriation of patients under New Models of Care

Dr Ba Min (Adam) Ko, SLP, Darzi Fellow / ST5 Forensic Psychiatry,  Gladman Dimbiri, SLP, Team manager; Dr Shubulade Smith, SLP, Clinical Lead / Consultant Forensic Psychiatrist / Clinical Senior Lecturer, IOPPN

BACKGROUND  The Five Year Forward view (FYFV) highlights the challenges faced by the NHS with system wide implementation to drive efficiencies. NHS England and national media reported in 2017 that many patients were placed a long way from their communities and families. This doesn’t just detract from their rehabilitation and day-to-day patient experience, it makes consistent assessment and case management difficult. Ineffective pathways and long stays, often in expensive and highly restrictive inpatient units, do not support rehabilitation.  The Out of Area Team (OATS) a part South London Partnership (SLP). It was formed in April 2017. It consists of a partnership between South West London & St George’s Mental Health NHS Trust, South London & Maudsley NHS Foundation Trust and Oxleas NHS Foundation Trust. It is one of the Six New Models of Care (NMOC) wave 1 pilot sites in the UK for transformation of forensic services.  AIMS  To reduce the number of patients being admitted to out of area services.  •  By maximizing use of secure inpatient capacity across SLP services ensuring value for money for South London patients  •  By delivering effective care pathways and maximise patient throughput  MODEL  The model involves a management hub which oversees OATS and 5 clinical pathways: Acute, Assertive Rehabilitation, Specialist, Women and Community for patients in secure setting ie: NHS & independent sectors and community setting.  Initially OATS identified 215 patients who were placed outside London. Those patients were profiled according to their complexity: Green (no specialist need), Amber (specialist need but not primary, Red (primary specialist need).  The team started the assessments in April, 17 with Green profile and moved onto Amber and Red. By April 18, all those patients have been assessed.  RESULT  70% of the patients were found appropriate to re-locate to SLP footprint for the same level or step-down unit. There were presented at the pathway meetings and allocated to the suitable pathways for repatriation. SLP repatriated a total of 73 patients to date.  30% of the patients were found to be suitable to continue to stay at their current facilities with the plan to review gain in 3 to 6 month time.  Conclusion  OATS has brought substantial benefit by supporting patient flow in various pathways, maintaining relationships with stakeholders, bringing patient closer to home and supporting with financial saving. However, there are a number of challenges with limited bed availability and delay in discharging patient to CCG funded bed.
Abstract  Introduction  People with mental health disorders are known to be more likely to smoke than the general population and there is growing evidence to suggest a strong link between smoking and mental health disorders [1]. Due to the health benefits of quitting smoking, most inpatient units have banned smoking on hospital premises. The aim of this study is to look at whether patients continued to remain smoke free after they were granted unescorted leave of absence or discharged from secure hospital and their views, attitudes and beliefs around this [2].  Methods  The sample consisted of all inpatients from a large medium and low secure forensic hospital, who were given unescorted leave into the local area or discharged from hospital between September 2017 and August 2018, one year period. Smoking was banned on site in March 2017. We provided them with a questionnaire which asked a number of questions to do with their habits, their attitudes towards smoking, beliefs and their views on the hospital being a non-smoking environment. Discussion  We are aware of the challenges to smoking cessation in open psychiatry wards, underground smoking in particular [3]. However this is less of a problem in secure forensic services. The beneficial effects of stopping smoking and positive behaviour changes are expected as in-patients and subsequently in the community settings (unescorted leaves and after discharge from secure service). The findings will be reviewed and analysed. Further support requirements [4] for continued abstinence from smoking will be discussed depending on the findings.  We will be presenting the findings at the conference  References  Kelly, C. and R. McCreadie, Cigarette smoking and schizophrenia. Advances in psychiatric treatment, 2000. 6: p 327-331.  Review-5, UK Centre for Tobacco Control Studies, Nottingham University, 2012: p 25  Ratschen, E. et al, Implementation of Smoke Free Policies in Mental Health In-patients’ Setting, Br J Psychiatry, 2009, Vol 194, p 547-51  Brown, J. et al, The Case of Stop Smoking Services in England, Br J Psychiatry, 2013, Vol 202, p 74
Low Secure Forensic Service Audit: Length of Stay (LoS) and other characteristics

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Consultant Forensic Psychiatrist

Introduction
Length of Stay (LoS) within forensic services in the UK range from 9 days to 9 years (Brown & Fahy, 2009; Edwards, Steed, & Murray, 2002; Shah, Waldron, Boast, Coid, & Ullrich, 2011; Sharma, Dunn, Toole, & Kennedy, 2015; Völlm et al., 2017). This raises concerns with issues of human rights and treatment efficacy.

Extant research has looked into a variety of variables that may be associated with LoS. However the findings have been diverse and at times conflicting due to different methodologies, samples and analyses.

Furthermore, the majority of research on LoS in forensic services have been conducted within medium and high secure forensic settings. Yet, little is known about low secure forensic services. There is research to suggest that decisions to discharge from low secure forensic settings differ from that of medium secure forensic settings (Martin & Martin, 2016). Pertinent to this decision is the potential outcome of rehabilitation back into the community.

There is currently a paucity of knowledge on LoS and the characteristics of individuals within low secure forensic services. Along with increasing financial pressures on the NHS and higher than desired LoS statistics (NHS England, 2017), it is imperative that we further understand factors associated with LoS in low secure forensic settings.

Methods
A retrospective review of data within two low secure forensic inpatient wards located at Park Royal Centre for Mental health

- Data is collected for individuals who were discharged from Tasman or Java ward between April 2012 – July 2018
- Data was gathered from the electronic data system (JADE); main sources of information included discharge reports, tribunal reports, Historical, Clinical, Risk-Management 20 (HCR-20) reports, psychology reports, occupational health reports, case notes and documents relating to legal status.
- Variables for the audit were identified through consultation with the Consultant Forensic Psychiatrist and Chartered Clinical Psychologist, as well as reviewing extant research.
Discussion/Results

- The current research reviewed 67 clients admitted onto the Park Royal Low Secure Forensic Unit between 2013-2018. The majority (76%) of clients had a LoS of less than 1 year, while 16% had
a LoS of 1-2 years, and 8% had a LoS of more than 2 years. The majority of individuals having a LoS of more than 1 year where people who were also admitted onto Java ward, a step-down rehabilitation unit that promotes independence and integration into the community; were Java ward not there, most individuals would have been discharged into the community instead.

• Many variables were reviewed in this exploratory study, and the graph below provides an overview of variables correlated with LoS. Due to the small sample size, it currently lacks power for in-depth analysis for what variables influence LoS, however it provides interesting insight into the characteristics of adult males admitted onto the low secure unit. Of note, from initial correlational analysis of variables with LoS, the following were found to be statistically significant: longer LoS was correlated with more impaired Activities of Daily Living (ADL) skills in productivity and cognition; higher presence and relevance of violent attitudes; having mental health support identified for discharge; having poor engagement with overall rehabilitation treatment on unit; being transferred from …; having more previous psychiatric admissions; having a psychosis diagnosis; being discharged to the community; and being discharged on CTO.
How stable is diagnosis in secure services? An exploratory qualitative study.

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Aims To explore the stability of life-time psychiatric diagnosis among patients in a Low Secure Unit in the Northwest of England. Background Diagnostic stability in psychiatry is increasingly a matter of academic and clinical debate. However, there is a paucity of research in this area. Secure services provide a unique opportunity to retrospectively analyse the life course of psychiatric diagnosis because a majority of patients have been in contact with a range of mental health services over an extended period of time. Methods We studied all patients on a low secure unit in Northwest England during the period May - August 2018. The researchers analysed key agreed documents including discharge summaries, tribunal reports and social circumstances reports examining contemporaneous diagnosis across admissions to secure services. We used qualitative research methods to draw out themes from textual analysis, until a theoretical saturation of emergent themes was achieved. We developed a data extraction tool using consensus approach. We selected excerpts of diagnostic relevance including associated psychopathology. The team also examined criteria for proxy indicators such as referral to other specialist services (specifically diagnostic pathways such as ASD assessment and personality disorder pathway referrals) to understand the prevailing diagnostic dilemmas. Results Out of a preliminary sample of n= 17 patients; n=14 had a current diagnosis of F20 (schizophrenic illness). N=2 had a diagnosis of schizoaffective disorder(F25). N=1 had a diagnosis of autistic spectrum disorder. All patients had a co-morbid substance misuse diagnosis other than one. Preliminary key emergent themes are as follows. Most patients have a diagnosis of schizophrenia, but a substantial number in this group demonstrate historical variability in diagnosis. Secondly, there has been a consistent dilemma around the primary diagnosis (personality disorder vs psychotic illness) of n=2 patients. Thirdly, n=4 patients in whom the diagnostic journey started with a mood disorder have subsequently had the diagnosis revised to schizoaffective disorder. In one interesting case mono-symptomatic delusional disorder with co-morbid antisocial and narcissistic personality traits was considered as an alternate diagnosis to paranoid schizophrenia. In the same case, proxy outcome measures such as medication regime suggests a consideration of ADHD. In some, despite clear evidence of psychosis, the diagnosis of mood disorder continued to prevail until presentation to secure services. Conclusions Preliminary analysis suggests a substantial lifetime diagnostic variability in our sample. We feel further research is required to develop diagnostic paradigms for patients with co-existent personality disorder, psychosis and substance abuse.
Sleep Apnoea in MSU in-patient group – Improving Access to Care Pathways and Monitoring Associated Outcomes

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Aims: Our aim is to screen patients at Ravenswood Medium Secure Unit for obstructive sleep apnoea (OSA). For those that screen positive using the STOP BANG and Epworth Sleepiness Scale (ESS) we aim to offer referral to the local sleep service for formal diagnosis. For those that are diagnosed with OSA we aim to offer forensic appropriate treatment. We then aim to reassess them for improvement in OSA and psychiatric symptoms. We then aim to make the assessment, diagnosis and management process a resilient part of the physical health screening at Ravenswood.

Hypotheses: We hypothesise that there will be a higher proportion of patients at Ravenswood diagnosed with OSA than in the general population. We also hypothesise that treatment will have a beneficial effect on quality of sleep, a reduction in night sedation use and a reduction in overall medication use.

Method: We screened all the patients at Ravenswood who agreed to the screening and who were not being nursed in the Intensive Care or in seclusion. We used the STOP BANG as the initial screening tool and then for those that were high risk we also used the ESS as this is a better indicator of progression. We then referred those that were high risk to the local sleep service for diagnosis.

Results: 71 patients were initially considered. 1 had already been diagnosed. 20 refused all or part of the screening or treatment and five were in Intensive Care. 13 of the remaining 50 screened as positive for OSA and were referred to the sleep clinic.

Conclusion: OSA is likely to be more prevalent in secure services than was previously recognised. Due to the limitations of medium security it will take some time to assess and diagnose all the patients. Once this has happened then we will be able to consider the effect that treatment has had on their sleep and psychiatric symptoms.
**Recovery Maps in Broadmoor High Secure Hospital: Supporting patients’ understanding of complex care pathways.**

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**Aims** This project aimed to enhance patients’ understanding of care pathways and treatment options on two high secure admissions wards. Recovery maps were identified as a tool which may convey this information in a simple format.  

**Background** Patients admitted to High Secure Hospitals need to process large amounts of information relating to care pathways and treatment. This can be challenging, as many are acutely unwell. A recovery pathway map (recovery map) is a type of node-link map that synthesises complex information into one simple diagram where key recovery domains (nodes) are connected by lines (links) demonstrating their relationship to one another. They have advantages in aiding memory, attention and therapeutic alliance. They are commonly used in other areas of psychiatry, including addictions psychiatry. There is also a wide evidence-base for their use to improve communication in other fields such as education and business.  

**Methods** A recovery map was developed from focus group discussions. The map was offered to each patient and each staff member working on two mental illness admissions wards in Broadmoor Hospital. Likert scale questionnaires were used to measure patient and staff satisfaction with three domains, at baseline, then two weeks, and two months, after the map was offered to the groups. The domains included information provided about care pathways, treatment options and discussions about both of these topics. Qualitative data was also collected.  

**Results** The baseline questionnaire was completed by 76.1% of patients and 56% of staff. At baseline 32.7% of patients were very dissatisfied or dissatisfied with knowledge about their care pathway, 61.5% very dissatisfied or dissatisfied with knowledge about treatments, and 30.8% very dissatisfied or dissatisfied with discussions with staff on these topics. At baseline 15.4% of staff members were very dissatisfied or dissatisfied with the information provided to patients about care pathways, and 12.5% very dissatisfied or dissatisfied about information provided about treatments and quality of discussions on these topics. After two weeks, 62% of patients and 52% of staff completed the follow up questionnaire. After two months, 48% of patients and 48% of staff completed it. After using the map, levels of dissatisfaction among both patients and staff decreased in all three domains.  

**Conclusions** Our findings indicate that the use of recovery maps can assist patient and staff discussions about care pathways and the recovery journey. Understanding of the importance of recovery pathways may assist therapeutic engagement in this vulnerable patient group.
Forensic Psychiatry in the Victorian Era: A retrospective review of male admissions to Europe’s oldest Forensic Hospital (1850-1860)

Dr Marie Lynch, Central Mental Hospital, Registrar; Dr Eimear Counihan, Central Mental Hospital, Registrar; Dr Lisa Mc Loughlin, Central Mental Hospital, Consultant

Introduction  In 1821, the Lunatic Asylums (Ireland) Act empowered the Lord Lieutenant to direct establishment of asylums throughout the country. The Central Criminal Lunatics (Ireland) Act 1838, in keeping with European contemporaneous legislation, introduced committal to asylums for individuals who were considered to be dangerous. In 1850 the Central Mental Hospital (formerly the Central Criminal Lunatic Asylum) was opened; today it remains Europe’s oldest functioning purpose-built Forensic Psychiatric Hospital. Aims  1) The primary aim was to record demographic data, nature of offending and outcome for all male patients admitted to the Central Mental Hospital from October 1850 – October 1860. 2) A secondary aim was to record descriptive psychopathology associated with admission diagnosis, and comparison to modern conceptualisation of illness. Methods  A retrospective review of the Register of Inmates was completed, and demographic, clinical and offense-related data was recorded for all male (n=141) patients admitted between October 1850 and October 1860. The records contain photographs of patients admitted to the hospital and dysmorphic pathology was examined within the context of a modern understanding of genetic conditions. A Literature Review was completed searching for historical psychiatric nosology and classification of disease. Results  Age at admission ranged from 16 – 74. Diagnostic information was divided into 7 categories for analysis purpose (affective symptoms - depressed, affective symptoms – manic, psychotic symptoms, epilepsy, intellectual disability, infection, undefined symptoms/no identifiable mental illness). 28% were convicted of Homicide, 30% for violent non-Homicide, 30% for Larceny/Burglary, 2% for Sexual Offences, 5% for non-specific “Felony”, 2% for Miscellaneous (bigamy, sacrilege, laying stones on a railway track), and 2% did not have a recorded offence. Discussion Analysis of the data demonstrates heterogeneity in diagnostic classification of mental illness; some patients were noted not to be suffering from mental illness at the time of admission. It is notable that conditions such as epilepsy were sufficient to warrant detention during this period (4% in this cohort). 51% of this cohort remained at the Central Mental Hospital until death. 23% were transferred to another asylum and 6% to prison. 14% were released, 1 escaped and the remainder did not have a recorded outcome. Conclusions This study highlights the diagnostic nosology and offending patterns in an inpatient population in Europe’s oldest Forensic Psychiatric facility. Further areas of research include comparison with patient cohorts across Europe during this era, and comparison of this cohort with other cohorts at defined time periods, to allow trends in diagnostic and offence patterns to be examined.
Introducing Full Chain of Custody Dual Sampling Oral Fluid Testing for Restricted Patients in a Regional Forensic Service

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Background    Guidance on drug testing for restricted patients in Scotland seeks to standardise approaches and make those testing methods more robust and able to withstand judicial scrutiny. On benchmarking local practice against these standards we took steps to improve the defensibility of drug testing methods which led to a 9 month pilot study of full chain of custody Oral Fluid Testing (OFT) using a dual sampling method. This enables one sample to be available for testing and the retention of another sample which could be independently tested in the event of a legal challenge. Aims    To pilot the use of full chain of custody dual sampling OFT for restricted patients managed by NHS Lanarkshire Forensic Service inpatient and community teams. To evaluate the views of patients and staff with regard to the time taken for sampling, the suitability and comfort of the sampling procedure, and record turnaround times for sample results. Methods    Establishment of a multidisciplinary working group covering the community and inpatient parts of our service. Training of staff and setting up a standard drug testing panel. Development of a questionnaire seeking the views of patients and staff on the testing process, supplemented by independent feedback via advocacy services. Results    120 OFT were taken from 12 inpatients, 4 of whom became community patients within the study period. Only one screen positive test for methadone arose which was later confirmed as a negative result on confirmatory testing. The average time taken for sampling was 5 minutes. Turnaround time for results averaged 3 days. The large majority of both patients and staff reported OFT as preferred over urine testing. Reasons given included it being quicker, less intrusive, more dignified and the fact that gender issues did not affect the sampling process. Conclusions    The pilot was considered successful. In addition to improved dignity for patients the likelihood of sample tampering or adulteration is much reduced with OFT and staff found patients much less likely to refuse to provide a sample, leading to significant time savings. The results of this study have been presented to local management with agreement that OFT now becomes the routine method for drug testing in our restricted patient group. In time we expect this to be rolled out to all patients within our service. The findings will be of interest to forensic services who wish to improve the defensibility of drug testing procedures. Funding for this study was provided by NHS Lanarkshire.    Word Count: 395
Least restrictive practice? The safe management of unescorted ground leave in Secure Units with no perimeter fence

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**Background:**

Ravenswood House (RWH) is a medium secure unit, where patients are restricted to the unit (unless they have Ministry of Justice permission). They have severe mental disorders and pose a risk to others. Many have histories of subverting security, and many have histories of substance misuse that can worsen mental state and increase risk of harm to others.

Until recently, patients were able to have unescorted ground leave at the Responsible Clinician’s discretion, although RWH does not have a perimeter fence.

However, due to increased incidents of Novel Psychoactive Substances (NPS) / contraband items being bought back into the unit, a unit ban on unescorted ground leave was imposed. Escorted ground leave ran as normal and it did not affect community leave.

Information was collected for all incident reports of contraband between November 2016 – November 2017 (6 months on either side of the ban).

**Method:**

All of the incident reports relating to ‘room searches’ and ‘drugs / illicit substances / novel psychoactive substances’ were searched for the following key words:

- Substance
- Alcohol
- Novel
- Psycho
- Active
- Pregabalin /gabalin
- Smoking
- Cigarette
- Tobacco
- Etoh
- Match(es)
- Capsule
- Vape
- Contraband
• NPS
• Spice
• Drug(s)

Results:
• 62 incidents between November 2016 – April 2017
• 32 incidents of contraband between May 2017 – November 2017
• smoking paraphernalia was the most common form of contraband

Conclusions:
This audit showed a positive reduction (52%) in risk items being found in a MSU. The unit management team agreed to continue with the blanket ban on unescorted ground leave.

There was discussion within the team about least restrictive practice – was this course of action too restrictive or was it appropriate for the patient population who pose an increased risk to others? Is it less restrictive if it promotes a safer and more therapeutic environment where patients can engage in therapies to reduce overall length of stay? Is it fairer to have a blanket ban or to individualise it based on risk assessment?

The Care Quality Commission (CQC) were critical of this policy as too restrictive. It is not clear whether the element of risk was considered by the CQC or whether this was based purely on patient interview. Which should carry more weight?
WIDENING PARTICIPATION – THE IMPACT OF 5 YEARS OF MEDICAL STUDENT ELECTIVES IN FORENSIC PSYCHIATRY

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AIMS AND HYPOTHESIS:

Arnold Lodge Medium Secure Unit has been hosting one of the largest forensic psychiatry elective schemes for more than 5 years, and advertises this opportunity through a website (www.forensicpsychiatrytraining.co.uk). Given the current emphasis on widening participation and increasing the proportion of state-educated medical students, we wanted to determine the impact of the elective scheme. Does the elective scheme attract students reflecting the national picture for NHS Consultants, most of whom are privately educated, or whether those choosing to come would show evidence of a broader demographic more representative of the general population.

BACKGROUND:

Widening participation is one of the strategic objectives of the Higher Education Funding Council for England, which attempts to increase not only the numbers of young people entering higher education, but also the proportion from under-represented groups, such as those from lower income families, people with disabilities and some ethnic minorities. It aims to redress the inequalities in participation between social classes, and much work is being done to address this via the undergraduate admissions departments at many universities. Medical elective schemes are being used as an attempt to drive recruitment into some specialties, including forensic psychiatry.

METHODS:

Students wishing to undertake an elective placement at Arnold Lodge are requested to send a CV prior to arrival, and this was used to collect data on the educational establishments attended.

RESULTS:

In total, we have had 58 elective students at Arnold Lodge between 2013 and 2017, 12 of whom did not forward on CVs. Of the remaining 46, 2 had attended both private and state education, 14 private schools and 30 state educational institutions. We hosted 34 undergraduates, 23 state educated and 11 private, and 12 postgraduates, 7 state educated and 5 private.

When reviewing the data by country of education, of the 28 UK educated students, 19 were state educated and 7 privately. Two UK students were both state and privately educated. Of the remaining 18 international students, 7 had been privately educated and 11 in state schools.

CONCLUSIONS:

The data collected supports our hypothesis that the forensic psychiatry elective scheme reinforces the widening participation agenda, and that advertising such opportunities online is an effective way of promoting this. We accept however, that this will not address the issue of widening participation for medical students as a whole, and more work needs to be done on this. We hope to continue collecting data on our elective students and review this data regularly as an ongoing project.
Audit of the Monitoring of Adverse Effects of Clozapine use at Rampton Hospital

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Dr I Yanson BSc MD MRCPsych

Aims and hypothesis

To examine the effectiveness of monitoring of adverse effects of clozapine use in the high-secure inpatient setting at Rampton Hospital.

A standard was set of recording a minimum of one description of side effects of clozapine within the six-month period of investigation.

Background

Clozapine is useful in the management of treatment-resistant schizophrenia and in reducing the risks associated with refractory psychosis in forensic inpatients, but its problematic side effect profile can often lead to delay, avoidance or termination of treatment. Some effects can potentially be life threatening.

A number of tools have been developed to aid clinicians in assessing adverse effects of clozapine treatment. Such systems have been partially adopted at Rampton Hospital and this audit examines the effectiveness of these in increasing detection of adverse effects.

Methods

The retrospective audit focused on identifying documentation of clozapine adverse effects in electronic records by prescribers, alongside records of weight, bowel function and side effect monitoring charts. Inpatients at Rampton prescribed clozapine between November 2017 and April 2018 were included in the sample. Electronic and physical records for the same period were retrieved. These were searched manually by a psychiatrist for specific terms describing adverse effects of clozapine. Comparisons were drawn between cases where monitoring charts were in use and those without such charts.

Results

Fifty-two patients were prescribed clozapine over the period of interest. Of these, forty-four were found to have a record of clozapine adverse effects within the six-month period. Patients in whom side effect monitoring charts were employed were found to have increased frequency of reporting of side effects of clozapine. An average of 2.32 reports per patient month were identified on charts that were not recorded in electronic notes.

Conclusions

The findings identify opportunities to improve the monitoring of side effects in clozapine use at Rampton Hospital. It is rare that clozapine use will be associated with no adverse effects at all, and such effects can result in termination of treatment where other approaches have not succeeded.

In general, the use of monitoring forms for adverse effects in the use of clozapine appears to improve frequency of reporting of these effects. This affords opportunities to tackle problematic symptoms and potentially improve treatment outcomes. A reaudit is planned in one year to examine
the effectiveness of implementation of a standardised monitoring chart for inpatients prescribed clozapine.
Plasma clozapine assay sampling in a medium secure hospital

Dr Ross Mirvis, Merseycare NHS Foundation Trust, ST5

Background Clozapine is one of the main pharmacological treatments offered at Scott Clinic (a medium secure hospital outside Liverpool). Monitoring its plasma assay level is important to ensure its effectiveness, check compliance and observe any changes that could be influenced by external factors (e.g. smoking). There are limited guidelines on clozapine assay sampling both nationally and locally. Mersey Care NHS Foundation Trust’s ‘Clozapine Physical Health Monitoring Standards’ recommend performing assay sampling “at end of titration, annually and consider after dose change, side effects, smoking cessation or clinical need”. An audit was conducted at Scott Clinic to investigate whether clozapine assay levels were taken in line with the Trust’s standards. It was also helpful to investigate whether there was any pattern observed in the sampled forensic population.

Methods The pharmacy department provided a year’s worth of assay results for patients who were at the clinic on 2 February 2018.

Results 29 of the 62 inpatients at the clinic were prescribed clozapine (24 males and 5 females). The average age was 35.4 (range 19-61). 93 assays were done. The average dose was 374mg (378mg male, 355mg female). The number started on clozapine that year was 10 (8 male, 2 female). The number already established on clozapine was 19 (16 male, 3 female). 27/29 (93%) patients had assays that year. Of those started on clozapine that year the average number of assays done was 1.9 (range of 1-4). In those established on clozapine the average number of assays was 3.8 (range of 0-7). 33% of doses (30) were within the recommended range (0.35-0.5mg/L). 50% (46) were above this and 17% (16) below.

Conclusions It was reassuring that 93% of patients had had a clozapine level done within the year. 50% of assay results were above the recommended range. This perhaps reflects the emphasis placed on ensuring forensic patients are receiving a dose of clozapine that is treating their illness. The suggested ranges are somewhat arbitrary and historically there has been variation in the recommended maximum clozapine dosage. The results were presented at the clinic’s medical meeting and arrangements made to ensure assays were taken for the two patients who had not had an annual one done. Further work could investigate whether assays were specifically done after dose changes, experiencing side effects or changes in smoking status.
The PROSPECT Partnership: an innovative approach to collaborative working

Dr Ros Tavernor, Northwest Boroughs Healthcare NHS Foundation Trust, Consultant Forensic Psychiatry Dr Ross Mirvis, Northwest Boroughs Healthcare NHS Foundation Trust, ST5

Aims and hypothesis: The PROSPECT Partnership brings five separate mental health providers together in the North West of England to provide a unified secure care pathway for individuals with mental illness, personality disorder and neuro-developmental disorders. The aim is to use collaborative working and standardised clinical decision making to improve service user experience and outcomes, reduce length of stay and enhance community care as close to home as possible.

Background: NHS England’s ‘New Models of Care Programme’ aims to give responsibility and authority for service design, budgetary management and strategic decision making to local clinicians and managers. Cheshire and Merseyside mental health providers have been selected to become a wave 2 site for the new models of care programme for low and medium secure services. The PROSPECT Partnership comprises of Mersey Care NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust and independent sector providers, Elysium Healthcare and Cygnet Healthcare. PROSPECT stands for P Prospective (planning care pathways prospectively) R Recovery-oriented O Outcome focused S Safe P Place-based (keeping service users as close to home as possible) E Efficient C Community Solutions (working with a network of partners to develop safe community care) T Transparent (clear care pathways based on realistic care and outcome expectations) A Clinical Network comprising clinicians from all five organisations has been set up. This agreed on a single standardised assessment access process with defined admission criteria. A trusted assessor agreement means that a single assessment undertaken by low or medium secure or jointly will be accepted across the partnership and regular case-based discussion focusing on management of the pathway for complex cases. Within the secure care inpatient group there are discrete cohorts based on gender, referral source, diagnosis and discharge destination. To plan a care pathway prospectively, and reduce clinical variation, the Partnership has developed ‘Care Bundles’ for each different service user cohort. These will specify likely length of stay, level of security, treatment and outcome expectations. A partnership wide ‘Clinical Oversight Group’ will be responsible for monitoring service user progress against agreed clinical objectives. This multidisciplinary group of senior clinicians will provide a systematic and efficient means for governance. Results: The new model of care and the algorithms for triaging referrals and standardised decision making have been tested using case examples. These are presented along with the care bundles and service user and carer initiatives.
Aims and hypothesis  We developed a novel approach to predictive analysis of self-harm in an inpatient child and adolescent mental health service (CAMHS) unit. From clinical observation, staff thought that pairs of individuals correlated their incidents of self-harm. Statistical demonstration of this at a significant level on a real-time basis would be clinically valuable.  

Background  Self-harm is common in young people with mental health difficulties. Self-harm is commoner in inpatient settings and it has been suggested that ‘modelling’ or ‘contagion’ occurs.  

Methods  We retrospectively analysed incident reports from episodes of self-harm at Redburn at Ferndene, Prudhoe, Northumberland, Tyne and Wear NHS FT. We anonymised and reviewed data from 8 months from January to September 2017.  

Results  A total of 250 incident reports for self-harm were logged on Redburn and 25 patients had inpatient stays on the ward within the period. 13 of the 25 patients had at least one incident of self-harm. The maximum number of unique pairs from 13 is 78. In fact, 22 pairs were excluded as their admissions did not overlap in time, leaving 56. 12 pairs of the 56 pairs (21.4%) were found to have a statistically significant relationship using Fishers Exact of co-occurring self-harm within 24 hours. If it were random, chance would have suggested 5%, i.e. 2 or 3 pairs.  

Our results show we can identify significant relationships between patients regarding repeated and reciprocal self-harm. We could give odds ratios for the likelihood of a patient self-harming following their paired peer doing the same. These ranged from around 2 to 14 times the odds to baseline for that person, with a median of around 3.  

Conclusions  Using a novel approach to the counting existing self-harm data in a clinical environment where self-harm is common, we are developing methods of statistical real-time analysis to inform clinicians on the 24hr risk of self-harm in pairs of patients. Implementing this approach would be simple and uses existing incident reporting systems. The information and analysis generated could form part of daily clinical handover and inform allocation of resources to reduce self-harm, restrictive practice and promote recovery.
Mental Health & Counter-terrorism pilot study; a descriptive study of individuals with a psychiatric history who are subject to Prevent involvement

Dr Alistair Morris  NHS Lanarkshire  Locum Consultant Forensic Psychiatrist

Aims & Hypothesis; There is currently no published evidence regarding the prevalence of mental disorder in individuals subject to Prevent referrals in Scotland. Anecdotally, Prevent officers report a high prevalence of mental disorder in Prevent subjects. Accordingly this study aims to describe the epidemiology of mental disorders & identify risk factors for violence in individuals subject to Prevent. It also aims to develop the empirical evidence base for assessing and managing risk in this population.  Background & Method; Prevent is part of the National Counter Terrorist strategy that aims to stop venerable individuals being drawn into terrorism. As part of the process of assessing referrals to Prevent officers liaise with the NHS regarding the potential for mental disorder to be relevant to that particular individual’s presentation. 23 requests for previous psychiatric contact checks were received over a 24-month period from Prevent officers. A total of 9 individuals were found to have previous psychiatric contact. Their psychiatric notes were reviewed for evidence of mental disorder and risk factors for violence.  Result & Conclusions; Mental disorder is common in Prevent subjects, with 39% having a previous psychiatric diagnosis. The most common diagnoses were substance misuse (67%), personality disorder (44%), depression (33%) and psychosis (22%). The group display a number of risk factors associated with increased risk of violence, including; previous offending; early behavioural difficulties; problems at school; substance misuse and cluster B personality disordered traits. If Prevent subjects are identified as having previous psychiatric history, this should inform treatment & management strategies.
Food and fluid restriction in personality disordered females – the ultimate self-harm? The challenges faced by secure services and how to approach it.

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Rationale    Disordered eating patterns have been widely recognised in patients with Emotionally Unstable Personality Disorder (EUPD), which may be part of a broader picture of challenging behaviours. A survey, published in 2013 (Long et al.), attempted to look at the extent of the problem in the secure setting by identifying patterns of disordered eating in female patients across two secure settings. The authors reviewed 131 patients and found that 21 (16%) of girls and women had a recognisable eating disorder – all of whom had a primary diagnosis of EUPD. When food and fluid restriction is seen in patients with EUPD as a means of self-harm, rather than as part of an identifiable eating disorder, there remains even less clarity and guidance on how best to approach this issue, and specialist eating disorder input can be difficult to obtain in the secure settings. This is of particular concern given the potential medical consequences associated with this behaviour.

Session objectives    The presenters will demonstrate the challenges and risks of managing patients with EUPD who present with food and fluid restriction, illustrated by case examples in their practice. How to approach treatment in the short and long term will be discussed, as well as the legal basis underpinning treatment, re-feeding syndrome and complications with force-feeding.

3 key learning points 1. Physical health ramifications of food and fluid restriction and re-feeding syndrome 2. Understand the legal basis behind forced feeding in detained patients with PD 3. Management in the short and long term
Does the mostly commonly used violence risk assessment and management instrument in forensic mental health services have a robust evidence base?

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(1Cheshire and Wirral Partnerships NHS Foundation Trust, 2University of Chester, 3University of Liverpool)

Aims and hypotheses  To evaluate the empirical evidence base supporting the use of the HCR-20 in accordance with the manual.  

Background  Structured professional judgement (SPJ) is the preferred approach for violence risk assessment in forensic mental health services. The guidance for the most commonly used instrument, HCR-20, describes key principles:

1. The HCR-20 is “an approach to violence risk assessment and management” which aims to reduce risk.  
2. Its use involves a sequence of steps (1. gather information; 2. code presence of risk factors on scale of certainty; 3. consider relevance of factors in given case; 4. formulate integrated account of risk; 5. generate specific risk scenarios; 6. recommend risk management strategies; 7. document summary judgements).  
3. In contrast to actuarial approaches, the HCR-20 process does not rely on numerical estimates of risk factors or overall risk.

Methods  A literature search on Embase, CINAHL and PsycINFO was undertaken in June 2018 using the term ‘HCR 20’ with no limit of time. Removing duplicates resulted in 353 papers which were reviewed using a piloted (n=20 studies) and revised template/rules to categorise study methodology.

Results  The full review will be presented at the conference. Of the 65 studies reviewed to date (working back from the most recent), 47 are empirical studies, of which 32 had the HCR-20 as the focus. Where it was possible to tell from the abstract (n= 22), studies evaluated step 2 (n=21) and step 4 (n=1). Full papers will be reviewed for the remainder (n=10), but at this stage no study has been identified that used the complete HCR-20 process or that studied steps other than 2 and 4. All bar one (which assessed step 4) used a summation of certainty codes converted into numerical scores. One study considered change in risk over time, but none adopted a methodology to evaluate the risk management objective.

Conclusions  This preliminary review of the empirical literature provides strong evidence for step 2 of the HCR-20 (in the form of summary scores derived from codes) as an actuarial risk assessment instrument. However, most studies used the HCR-20 in a way that contravenes the manual and there is very limited support for the use of the HCR-20 as it has been designed to be used. To empirically test whether the HCR-20, and other SPJ tools, achieve their stated objective of managing as well as assessing violence risk, alternative methodologies should be adopted.
Minimising the risks associated with Bipolar affective disorder-an analysis of the management of individuals in the 6 months following inpatient treatment for manic episode.

Dr Shay-Anne Pantall, BSMHFT  Dr Hannah Aslam, BSMHFT  Dr Lisa Brownell, BSMHFT  Mahomedaly Nazir

AIMS AND HYPOTHESIS  To determine the pharmacological interventions provided to individuals in the 6-month period after discharge from an admission for manic episode, and to describe the clinical outcomes in terms of readmission.  

BACKGROUND  Individuals with bipolar affective disorder are most at risk of violence during the manic phase. It is therefore important to optimise the pharmacological management of such individuals. Here, we explore the management in the critical period following manic episode.  

METHODS  Retrospective case note review exploring the management in the community for 6 months following discharge from hospital following treatment for manic episode (n=105) 

RESULTS  Key findings include: - 98% individuals (n=103) were prescribed antipsychotic medication at the point of discharge from hospital. In the 6 months following discharge, in 50% cases, this antipsychotic was continued unchanged, but in 33% cases the antipsychotic was discontinued, in 11% the dose was increased and in 8% the dose was reduced.  

The most common reasons for discontinuation were side effects (35%) and poor response (15%). In the 6 months following discharge, an alternative antipsychotic was prescribed in 41% cases.  

Lithium was prescribed at the point of discharge in 18% (n=19) cases. This was discontinued within the following 6 months in 16% (n=3) cases. A further 1 individual was started on lithium following discharge. Of these, 19% (n=10) discontinued it within 6 months. A further 4% (n=4) were started on valproate. A small number of individuals (2%) were discharged from hospital on an antidepressant. This was discontinued in both cases. A further 5 individuals (5%) were prescribed an antidepressant in the 6 months following discharge. One third of individuals had at least one readmission in the 6 months. (23% had one, 6% two, 3% three and 1% 4 further admissions)  

CONCLUSIONS  Changes to treatment were common in the 6 months following a manic episode. This may reflect the choice of medication during a manic episode being less acceptable or effective in the long-term treatment of bipolar disorder. It may also, however, contribute to the lack of stability in this group, which did suffer a high rate of relapse requiring readmission. We were surprised by the low levels of use of lithium, which is recommended by NICE as the most effective long-term treatment.
Autism Spectrum Disorder and Offending in Ardenleigh Forensic CAMHS Medium Secure Unit

Miss Charlotte Nesbitt, University of Oxford, Medical Student  Dr Tina Irani, Birmingham and Solihull Mental Health NHS Foundation Trust, Consultant Child and Adolescent Forensic Psychiatrist

Aims and Hypothesis: To report on the demographics of inpatients at Ardenleigh medium secure forensic CAMHS unit with respect to a diagnosis of Autism Spectrum Disorder (ASD), and their offence. It is predicted that traits of ASD, particularly stereotypical interests, rigidity, and difficulties with social interactions, influence the likelihood and type of criminal behaviour. Background: The literature is controversial as to the association of ASD with offending behaviour: prevalence of ASD within prison populations is markedly increased compared to normal population, yet longitudinal studies suggest that offending is equally likely in individuals with a diagnosis of ASD than those without. Classical features of ASD exhibit likely risk and protective factors for offending behaviours. Methods: This is a small demographic population report (n=10), comprising patients aged fourteen to eighteen at Ardenleigh fCAMHs inpatient wards. Data was collected using electronic records and CPA reports, including; forensic history, and psychiatric diagnoses. Convictions were categorised by offence type, as described by the Metropolitan police. Most patients have a history of multiple offences, hence represented in multiple groups: data is shown as the proportion of patients having committed each offence type within the ASD and no ASD groups. Any offences for which the young person was not convicted through the criminal justice system have been excluded, but later assessed qualitatively. Results: The prevalence of ASD within the unit was 30%: of these patients, only one had received criminal charges. Across the whole unit, regardless of ASD diagnosis, the most common offences were violence against a person and additional criminal offences. The high prevalence of more violent crimes across the unit is likely to bias due to the nature of the unit. Quantitatively, there are fewer criminal convictions within the ASD group. Qualitatively, patients within the ASD population have disclosed criminal behaviours, to include stalking and arson, which show a greater association with typical ASD characteristics. Conclusions: Within this population, the rate of conviction is lower in the ASD group. Criminal activity within the ASD group was more commonly due to stereotypical behaviours and interests. We hypothesise, the need to engage in archetypal interests, common in ASD, might surpass adherence to pro-social rules and regulations leading to participation in offending behaviours. This sample comprises only a single unit over a short period, with a specific patient group and hence is too small to make any wider conclusions or a clear association between offence type and ASD diagnosis.
Audit of The Healthy Weight Management Plan Section of CPA Documents in The State Hospital

Dr Molly Neville, NHS State Hospitals Board For Scotland, CT3; Dr Amy Preston, NHS State Hospitals Board For Scotland, Speciality Doctor; Dr Khuram Khan, NHS State Hospitals Board For Scotland, Consultant.

Aims and hypothesis  The aim was to assess the quality of the documentation of the Healthy Weight Management Plan (HWMP) and the recommendations that are generated. This included whether the discussion regarding the HWMP was documented. The completion of the Variance Analysis Tool (VAT) was also looked at, along with the recording of the patient’s weight.

Background  65% of Scottish males are either overweight or obese. Within The State Hospital, this figure peaked in 2014 at 94%. Scottish obesity levels are predicted to exceed 40% by 2020. The patients in The State hospital suffer from obesity and associated physical/mental health problems, which has been provoked by high calorie intake, side effects of psychotropic medication, and sedentary lifestyle. Since 2011, when The State Hospital became smoke-free, patients have had more income to spend on supplementary foods. In the first year of the new environment, patients gained 2-3kg. In September 2016 the Supporting Healthy Choices Implementation Group was created and number of interventions were implemented including the new HWMP which was introduced in CPA reports. Recent results show a continual increase in patients with a healthy BMI. The percentage of patients that have a healthy BMI had increased to 18.69%. The percentage of patients that have unhealthy BMI has decreased to 76%.

Methods  A tool was created to collect data on the 6 main questions. The CPA document for every patient in The State Hospital who had a CPA in August and September 2017 was looked at, with the data documented in the tool. This was then used to create graphs and pie charts.

Results  The first cycle showed that of the 32 patients, 22 had the HWMP plan completed. 13 of those had it completed fully, 9 partially, 1 had a separate weight management document. 20 of 32 patients (62.5%) had their weight management objectives recorded. 9 of 32 patients (28.1%) had their weight management discussion documented. 22 of 32 patients (68.8%) had their change in weight recorded and commented on. 11 of 32 patients (34.4%) lacked any documentation of discussion regarding weight management. 22 of 32 (68.8%) had the VAT forms completed appropriately. The results of the re-audit are pending.

Conclusions  The results of the preliminary audit highlighted that there was a disparity between the hubs regarding what documentation should be used, and how best to use it. Five recommendations have been generated, which will be included in the re-audit.
Experience and Attitudes of Domestic Staff in Sussex Partnership Secure Services

Dr Olumide Oluwole ST4 in Forensic Psychiatry, Sussex Partnership NHS Foundation Trust  Supervisor: Dr Richard Noon, Consultant Forensic Psychiatrist, Sussex Partnership NHS Foundation Trust

Background  Domestic staff are important members of the non-clinical team. Their role in ensuring the cleanliness of ward environment, and in meal preparations, invariably has a major effect on the quality of inpatient stay. We know that working in secure services can be rewarding but it can also be stressful and challenging for all staff members including domestic staff.  AIM  To evaluate the experience and attitudes of domestic staff working on secure inpatient wards  

METHOD  A questionnaire was designed featuring 8 questions; 5 on experience and 3 on attitudes. Respondents answered yes/no to questions on experience and used a 5-point Likert Scale for questions on attitudes. Questionnaires were distributed to all domestic staff at both centres by their respective managers.  

SUMMARY OF RESULTS  ●No significant difference between the two centres in terms of staff being approached to subvert security (15% vs. 14%)  ●No significant difference between the two centres in terms of staff being exposed to self-harming behavior (25% vs. 29%)  ●No significant difference between the two centres in terms of staff witnessing physical assault (45% vs. 43%)  

●Slightly more staff at Chichester Centre, LSU, experienced verbal threats compared to Hellingly Centre, MSU (50% vs. 45%)  ●Slightly more staff at Hellingly Centre, MSU, experienced verbal abuse compared with Chichester centre, LSU (55% vs. 50%)  ●Slightly more staff felt safer working at Chichester Centre, LSU, compared with Hellingly centre, MSU (71% vs. 65%)  

●No significant difference in the number of staff at both centers who had an induction before commencement of duties (65% vs. 64%)  ●Significantly more staff at Hellingly centre, MSU, agreed that they knew what support was available following exposure to violence (66% vs. 43%)  

CONCLUSIONS  ●Low secure units felt relatively safer compared with medium Secure units (71% vs. 65%) – this could reflect the level of security and category of patients  ●Subversion of security is an area of concern – Similar proportion of domestic staff were approached at both centres (15% vs. 14%)  ●There is a need to raise awareness of availability of support for domestic staff in secure services following episodes of violence  ●There is a need for induction to be made mandatory for all domestic staff – attendance is less than 100% at both centres
Quality improvement in forensic mental health: the East London forensic violence reduction collaborative.

Dr Owen P O’Sullivan, East London NHS Foundation Trust, Wolfson House, Specialty Registrar; Nynn Hui-Chang, East London NHS Foundation Trust, Improvement Advisor; Day Njovana, East London NHS Foundation Trust, John Howard Centre, QI Sponsor, Head of Nursing & Associate Clinical Director; Dr Philip Baker, East London NHS Foundation Trust, John Howard Centre, Consultant Forensic Psychiatrist & Head of Forensic Services; Dr Amar Shah, East London NHS Foundation Trust, Consultant Forensic Psychiatrist & Chief Quality Officer.

Aims and hypothesis: Inpatient violence and aggression carries immediate consequences for patients, staff and the working environment. It impacts on length of stay, staffing and morale, families and carers, and hospital finances. The ELFT FVRC (East London NHS Foundation Trust forensic violence reduction collaborative) aimed to reduce incidents of inpatient violence and aggression across two secure hospital sites by at least 30% between July 2016 and June 2018.

Background: Reducing incidents of ward-based physical violence was identified as a major quality improvement (QI) priority for ELFT. It is its most significant cause of harm associated with safety incidents. The contributing factors are complex. Several factors differentiate the forensic inpatient setting. Methods: A QI methodology was applied across medium and low secure hospital sites i.e., John Howard Centre and Wolfson House. The change ideas were safety huddles, safety crosses and safety discussions in weekly community meetings. Agreed operational definitions for non-physical violence, physical violence and sexual harassment were developed and applied with the change ideas to capture incidents. The FVRC launched on the four medium secure wards with the highest incident rates. It later expanded to five wards and finally to a total eight by July 2017. The latter three sought to join of their own initiative.

Results: The FVRC achieved and sustained a reduction of 8% and 16.6% in physical violence and non-physical violence incidents per 1000 occupied bed days, respectively. On a weekly average, there was one less incident of physical violence, and 17 less of non-physical violence across seven wards, compared to baseline. On a ward level, three achieved at least a 30% reduction in physical violence and five attained the same reduction in non-physical violence incidents each week. Conclusions: At ELFT, QI has become integrated into the lives of staff and patients alike. Each project sits within a framework ensuring support, advice, supervision and coaching. In developing change ideas, a key emphasis is placed on service user involvement and staff input. Despite not meeting its aim, the FVRC brought significant improvements and a cultural shift towards openness and collaborative working around the issues of ward-based violence, aggression and sexual harassment. This fostered staff and service users to take ownership in tackling the issues together. In order to progress to lasting transformational change, broad support from across an organisation is vital. Financial sponsorship: None.
Development of Ligature Assessment Tool

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Aims & Hypothesis: To devise a risk assessment tool specific to describing how a patient has engaged in the act of tying a ligature. To see whether use of this tool influences reporting, risk assessment and risk management. To seek nursing staff opinion on its use. Background: There is a lack of literature on the act of strangulation by ligature, despite it being a common occurrence in inpatient wards. Tying a ligature can be done in multiple ways with significant variability in method and complexity; and hence a comprehensive approach to describing such events is required, to allow for greater understanding of risk posed and to enable effective risk management plans. There is no universal tool to assist clinicians in describing ligature events currently available. Methods: A Ligature Assessment Tool devised by the authors was used to retrospectively review ligature incidents that had occurred in a female psychiatric hospital. The tool consisted of 15 criteria. Entries were taken from electronic incident reporting system, Datix. Opinion of staff and MDT was sought on its use. Subsequent ligature incident reports were analysed, with discussion as to whether the new style of reporting resulted in improved knowledge of an individual’s risk and risk management. Results: A total of 51 ligature reports were analysed against the Ligature Assessment Tool criteria; 39 entries mentioned less than or equal to 5 criteria and 12 entries included 6 – 10. There were 0 entries that had more than or equal to 10 criteria. In order of highest frequency, Criteria 1, 11, 2, 3 and 4 were mentioned the most in entries. Criteria 5, 6, 13 and 15 had no or just one entry including them. Opinion of the tool was that it was easy to use, improved communication of risk, allowed profiling of patient’s ligature behaviour and informed risk management. There are case examples where risk assessment and risk management has changed with use of the tool. Conclusions: The Ligature Assessment Tool provides a template to record ligature incidents accurately and include relevant information for the MDT to make risk management decisions. It is also an effective way of communicating risk. Strangulation by ligature can be done in a variety of ways, can change over time and serve different functions – the tool is able to capture this. The tool has prospects in a variety of initiatives and settings, including risk incident recording, self harm in female patient population and restrictive practice.
An evaluation of referrals to Youth FIRST, a community forensic health service for young people

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Aims and Hypothesis  To examine the complexity of referrals into Youth FIRST, and to evaluate service delivery.  

Background  Youth FIRST is a community forensic mental health service for young people in the United Kingdom who present a significant risk of harm to others in the context of complex mental health difficulties. Young people referred to the service typically present with severe psychosocial problems, and are either currently involved with the criminal justice system or at risk of being in the future. Youth FIRST receives referrals from various sources across the UK.

Methods  A retrospective case note review of all patients referred to Youth FIRST between 2010 and 2017 (214 patients).

Results  Key findings included:

• Annual referral rates have steadily increased (range 4-41).
• Referrals have come from over 40 areas of England, often from Community CAMHS teams (64.5%).
• Referrers were generally seeking specialist risk assessment and management advice (74.5%). In a further 15.7% of instances, referrers also requested second opinion about primary diagnosis. There were 5 requests for the young people to be admitted to Ardenleigh FCAMHS inpatient services.
• In 2011, 54.6% were assessed within 8 weeks; in 2015, this fell to 35.1% and in 2017 to 22.0%.
• 7.5% of all referrals were not assessed.
• The majority of young people were male (86.6%), Caucasian (80.9%) and aged 15 or over (70.1%) (range 10-20).
• Almost two fifths (39.4%) of young people were in the care system and a quarter (24.2%) were not in receipt of education.
• At least 43.6% patients had a history of being excluded from an educational setting (data not available for 2016).
• Risks were various and multiple, including violence (82.9%), sexually harmful behaviour (45.7%), fire-setting (25.7%) and extremism (11.4%).
• The most common psychiatric diagnoses included Attention-Deficit Hyperactivity Disorder (34.3%), autistic spectrum disorder (33.3%) and conduct disorder (25.3%). 9.1% had a learning disability.

Conclusions  Youth FIRST is an expanding community forensic mental health service for vulnerable and challenging young people, who present with a multitude of significant risks on a background of complex psychiatric co-morbidity. Increasing demand has led to assessment delays, suggesting a need for the service to adapt in order to continue to meet this demand and grow further. From 2018, Youth FIRST is commissioned for specialist assessment of young people in the West Midlands.
Audit of delays in diversion of mentally disordered defendants under the Mental Health Act 1983/2007 (MHA) at Westminster Magistrates’ Court

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AIMS AND HYPOTHESIS  This is a retrospective audit to establish the length of delays in diverting defendants from Westminster Magistrates’ Court (WMC) under Part 2 of the Mental Health Act (MHA) 1983/2007.  BACKGROUND  Defendants who appear at WMC often require a Mental Health Act assessment (MHAA) and/or warrant detention to hospital; delays have been noticed in both stages of their diversion from court. This audit establishes whether the delays were within the Code of Practice timeframes and highlights they potentially resulted in increased periods of remand in custody for defendants irrespective of the seriousness of their charges.  METHOD  The Code of Practice states the following for MHAAAs and subsequent admission to hospital:  • The patient must be conveyed to hospital within 14 days beginning with the date on which the patient was last examined by a registered medical practitioner before giving a medical recommendation.  • There must be no more than five clear days between the two medical examinations.  • The applicant [Approved Mental Health Practitioner (AMHP) or Nearest Relative] must have personally seen the patient within the period of 14 days ending with the date of the application.  Mentally disordered defendants would require remand in custody until a bed is available which would prevent them from receiving the assessment and care they need. Therefore, we consider that all defendants found to be liable to detention under the MHA should be admitted to a hospital bed on the same day.  The Consultant Activity database, the MHA assessment database and information on defendants’ files were used to identify those who had been referred for a MHAA by Section 12 Approved Psychiatrist working at Court Diversion for West London Mental Health NHS Trust, and the dates of the MHAA and the admission to hospital (if applicable.  RESULTS  • In 4 out of 23 cases (17%) the MHAA took longer than 5 clear days to complete rendering the 1st Medical Recommendation invalid. The average delay for MHAAAs was 3.9 days.  • All admissions were completed within the timeframe set by the Code of Practice. However, on 10 out of 18 cases (55%) there was a delay of at least 1 day necessitating the remand of the defendant in custody.  CONCLUSION  Close liaison with AMHP Services and Hospital Bed Managers is required to address the delays. Permission to fund admission in private hospitals is worth considering. The audit will be made available to NHS England to this effect.
Growing older in secure mental health services: the user experience

Dr Renske Visser, Oxleas NHSFT, Project worker. Dr Janet Parrott, Oxleas NHSFT, Consultant Dr Fiona Houben, Senior Lecturer, Canterbury Christchurch University Prof Douglas Macinnes, Canterbury Christchurch University

Aims: To explore user experiences of being an older adult in secure forensic services and examine how far needs and concerns are addressed by service provision. Background: Providing good mental and physical health care for older people is important in all in-patient settings and can require being able to meet complex needs. 25% of all service users in the secure wards participating in the study were aged 50 or over indicating that meeting such needs is now a mainstream challenge. Little is known about the experience of being an older person in secure services and age related assumptions can be made by staff which may not reflect the views of service users.

Method: Thematic analysis of interviews and observations of weekly routines conducted with 15 service users aged 50 or more in a low and medium secure service in the UK. Older service users resided on each ward in the service and no one ward specialised as an 'older adult' ward. Results: User experiences are reported using 5 themes: ward environments; participation in activities; management of physical health needs; age-related identities and ageing futures. Older people living on wards with people of similar age reported more social integration than those on wards dominated by younger adults. Many across all wards participated in the activity programme which was predominantly age inclusive. Older service users appreciated learning new skills and being challenged by the group programme although some long-stay participants made comments such as "I have done them all". Physical health needs had a significant impact on service users everyday lives. Most wished to self manage their physical health needs with the support of primary care staff. There was a reluctance to identify as 'old' or 'older' although participants reported feeling 'mature' or 'experienced' as an older person particularly in being able to manage their mental illness. The stigma of identifying as 'old' and 'vulnerable' could lead older adults to downplay changing care needs. Conclusions: An awareness of the age balance of the ward is important in supporting the care of older forensic service users although there was variability as to whether service users felt they would wish to reside on a ward specifically for older people. Transitions to other care settings were experienced as particularly difficult. A culture of inclusivity, sensitivity and respect for older persons' agency is key to collaboratively meeting additional care needs and discharge planning.
How much is your ward round worth? A time cost analysis of computer functionality at Wathwood Hospital

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Aims and hypothesis  Despite the large headline figure for new IT investment, we ask if the efficiency costs of time lost to poorly functioning IT systems is actually greater.  

Background  The use of IT (information technology) has been widely implemented within healthcare services with the view to improve patient care and efficiency. The maintenance of IT systems is an often-neglected area, with expense often cited as a reason.  

Wathwood Hospital is a paper-free medium secure forensic unit. Each ward has a limited supply of laptops for use by all clinical staff. Staff report frustration with IT systems. The impact of this is most acutely felt during multi-disciplinary ward rounds. Large numbers of staff attend, each requiring a working laptop, often resulting in numerous pauses due to slow IT systems.  

Methods  At the start of each ward round over two weeks, attendees were recorded, along with their salary. A stopwatch was used to record stoppages due to IT systems. Timings were started once all attendees had gathered and stopped when every user had accessed the electronic patient record. Minute based salary costs were calculated for all attendees and used to determine the time cost of each ward round.  

Results  There was a wide range of timings recorded from 4 minutes 49 seconds to 17 minutes 51 seconds. When converted to time cost per ward round there is a mean of £22.53. If this figure is applied to the 20 ward rounds a week, it equates to an annual cost of £23,431.20. This is equivalent to 34 laptops, priced at the NHS average price per PC of £678.  

Conclusions  This service evaluation demonstrates in real terms the massive costs of inefficient IT systems. Whilst the annual time cost in ward rounds is £23,431.20, the overall cost across the hospital is likely far greater. It is hoped that this service evaluation will prove a business case to invest in more efficient IT systems, which in turn could be evaluated. In today’s public sector financial climate all team members must be aware of costs in order to maximise the care potential to service users. Indeed, clinical staff are often best placed to identify and evaluate clinical systems.
Aims and hypothesis  To explore if voting trends for our inpatients at Wathwood reflect local and national results for the 2017 General Election.  

Background  Article 3 of Protocol 1 of the European Convention on Human Rights states that “The High Contracting Parties undertake to hold free elections at reasonable intervals by secret ballot, under conditions which will ensure the free expression of the opinion of the people in the choice of the legislature.” The right to vote has been a long fought battle in the UK and often a symbol of your inclusion or exclusion from society.  

A number of studies have demonstrated the marginalisation of psychiatric patients within voting despite eligibility to vote for the majority. The current laws allow informal patients, those on a community treatment order, patients under civil sections, as well as prisoners remanded to hospital under the Mental Health Act on Sections 35, 36 or 48 can vote.  

At Wathwood we sought to see, if given the opportunity to vote regardless of section type and eligibility, the voting views of our inpatients reflected that of our neighbouring community and wider UK.  

Methods  Consultation took place with the patients and agreement gained that they would like to take part in this unofficial vote. Patients were made aware that there was no legal or official capacity to the vote, rather it was “just for fun” and for those eligible to vote in the national election they were free to also cast this additional vote. Anonymous voting boxes and slips were placed on three wards within the hospital. The voting boxes remained “open” for the duration of the voting time of the national election.  

Results  Voting trends at Wathwood were similar to those for South Yorkshire; Labour secured around one-third of the vote both at the hospital and across the region. Over 50% of patients either did not or actively chose not to vote at Wathwood, a higher proportion than both nationally and in South Yorkshire. The remaining parties secured a much lower vote share compared to national results.  

Conclusions    The patients were also given the opportunity to provide a free text response if they wished to their vote. This provided an insight into the knowledge the patients had on each parties politics and issues such as tuition fees appeared key. Although a fun exercise for the hospital it brought to light the lack of knowledge many had about their voting rights and also allowed the inclusion of more OT activities around politics, as it is an overlooked area that a number of patients are in fact interested in.
Internet use for in-patients in two secure hospital settings: A study from Broadmoor Hospital UK and Dundrum Hospital Ireland.

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Background  Paralleling the internet’s increasing presence in society, secure hospitals are increasingly concerned that refusing supervised internet access may be a restrictive practice. The internet carries obvious risks in forensic hospital settings in terms of potentially accessing illegal information such as child pornography, contacting previous links from gang or extremist associates and contacting victims. However benefits in terms of education and keeping in touch with family members must also be considered.  Aim/objectives The aim of this study was to explore staff attitudes to supervised internet access for patients in two high secure hospital settings, across two countries. Staff knowledge of internet security issues was also assessed.  Methods A confidential survey was offered to all clinical staff in Broadmoor Hospital UK and Dundrum Hospital Ireland. Questions were posed in relation to staff views regarding supervised internet access across both hospital sites and their knowledge of internet security.  Results A high number of clinicians felt that either the MDT (Multidisciplinary Team) alone (29%) or MDT in combination with a hospital safety / security committee (42%) should be permitted to approve supervised internet access. However only 14% of staff felt confident if asked to sign the approval themselves. 100% of staff stated that the patient’s index offence would at least influence their decision about offering internet access. The index offences which staff felt should merit an absolute refusal to offer internet access included terrorism related offences (100%), followed by possession of child pornography (87%) and convictions for sexual offences against children (87%). Staff had very limited knowledge about issues concerning the dark web, and the ability of sites to be used to contact the outside world. 70% were unaware of the messaging functioning of IRC (internet Relay Chat), Bitcoin and P2P (Peer to Peer) connections.  Conclusions Staff appeared to believe that MDT and hospital committees should approve internet access in some cases however there were significant gaps in knowledge around internet security. Staff were more concerned about internet use among those with terrorism offences than those with a history of sexual offending against children. This was an unexpected finding. The gaps in knowledge around security will need to be addressed as a priority if supervised internet access is to go ahead in high secure hospitals, and this will pose a challenge given the fluid nature of internet processes.
A staff attitude survey into the use of intramuscular and nasogastric clozapine in Broadmoor high secure hospital

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Background: Within Broadmoor high secure psychiatric hospital, there are a small minority of treatment resistant patients who may benefit from treatment with oral clozapine but cannot comply. Treatment with clozapine can be enforced under the Mental Health Act if it is thought to be of clinical benefit, but practical administration difficulties prevent may clozapine from being considered. Clozapine is licenced to be administered by the nasogastric route (NG) and more recently intramuscular (IM) preparations have become available. Aims: Due to the considerations taken into account when choosing and administering clozapine by such a novel method, the aims of this project were to allow clinical staff who are directly involved in the use of IM and NG clozapine to raise their opinions, establish their views and understand their concerns. Methods: A ten question Survey Monkey Questionnaire was constructed and distributed to 400 clinical staff who may have been involved in the approval, prescription and administration of IM or NG clozapine. The survey remained open for four weeks. Results: Of the 51 respondents, 32 had been directly involved in the approval, prescription or administration of IM or NG clozapine. 91% of respondents would be ‘likely’ or ‘very likely’ to consider IM clozapine if it was thought to be of benefit to their patient verses 76% ‘likely’ or ‘very likely’ to consider NG clozapine. Free text opinions on the use of these methods of administration and associated practice in enforcing treatment were assorted, in a number of themes and dependant on staff specialty. These ranged from strong opinions both for and against the use of clozapine by IM and NG routes, concerns about complications arising from siting an NG tube, concerns of limited opportunity to practice NG tube insertion and the balance between the restrictive practice a patient may endure if he remains untreated and psychotic. Discussions and conclusions: Clozapine remains an important treatment option for prescribing clinicians and the availability of means of administration by the IM and NG route increases the potential for it to be used in untreated patients who require it. Its wider use in patients who cannot initially comply with oral treatment has the potential to reduce seclusions and promote rehabilitation and recovery in unwell patients. In order for this novel means of clozapine administration to continue as a future option, the opinion of staff involved should be obtained, considered and addressed.
Changes in criminal thinking styles in secure hospital patients compared to prisoners

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Aims and hypothesis

The aim of this study is to consider the hypothesis that criminal thinking styles will change less in offenders with personality disorder undergoing hospital treatment than in offenders undergoing interventions in prison.

Background

Clinicians debate the best way to address the responsivity needs of offenders with personality disorder. Those with particularly complex needs may be transferred to hospital but this is expensive and there is limited evidence of additional benefits to remaining in prison for this group.

The Psychological Inventory of Criminal Thinking Styles (PICTS) is a self-report questionnaire that examines thinking styles thought to maintain a criminal lifestyle. It has been found to be an effective measure of change in offenders undergoing interventions.

It was envisaged that comparison of PICTS data from offenders in prison with those in hospital would show if comparable change was possible in the hospital group despite more complex needs.

Methods

Data were drawn from the case register of the personality disorder service at Arnold Lodge, a medium secure hospital in Leicester, UK. Patients completed PICTS questionnaires 3 months after admission and 12 months later. Their scores were compared with published data from a study of UK prisoners who completed the PICTS on reception to prison and prior to release.

Results

The prisoners (n=102) averaged 24 years of age and served sentences of 6 to 12 months. The patients (n=54) averaged 33 years of age and had committed more serious offences including murder, rape and arson.

Positive change of similar magnitude was seen in both groups. Confidence intervals were wider in the hospital group due to heterogeneity and sample size.

Conclusions
The hospital population are more complex and co-morbid than general prisoners. Despite this no statistically significant difference was seen in the level of positive change between the two populations.

The study underlines the heterogeneous characteristics of offenders with severe personality disorder. The hospital environment was able to meet the responsivity needs of this more complex group and achieve results comparable with a general prison population.

Despite limitations including small sample sizes, possible confounders and limited information about the prison sample, these findings contribute to the wider clinical debate regarding how to best address the needs of this group.

However, the question as to how and where offenders with severe personality disorder should be treated cannot be answered with generalisations and treatment decisions should continue to be predicated on individual need.
An audit of male inpatient medium secure and intellectual disability low secure services’ compliance with MAPPA Guidance

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Aims and hypothesis To establish the compliance of a secure hospital, including both medium and low secure wards, with relevant sections of MAPPA Guidance, and to explore how liaison with the MAPPA’s Responsible Authority could be improved.

Background Multi-Agency Public Protection Arrangements (MAPPA) were introduced by the Criminal Justice Act 2003. Close working is required between criminal justice agencies (i.e. police, prison and probation) and duty to co-operate agencies, including NHS Trusts, to protect the public from serious harm by sexual and violent offenders.

The MAPPA Guidance includes following standards of relevance to secure hospitals:

- Every MAPPA offender must be identified in one of the three categories outlined in guidance1
- Each responsible agency must identify and record MAPPA offenders under their supervision.
- The Responsible Authority should ensure that MAPPA develops effective Risk Management Plans to protect the victim. The guidance stipulates the rights of victims of mentally disordered offenders

The Hatherton Centre is a 49-bed male medium secure hospital in Stafford, West Midlands. Also included in this audit is Ellesmere House, a twelve-bed male low secure intellectual disability unit on the same grounds.

Methods An audit tool was created to capture basic demographic details. Clinical notes were reviewed to establish whether patients were MAPPA eligible. For those patients deemed eligible for identification to MAPPA, electronic clinical records of inpatients at The Hatherton Centre in the first two weeks of October 2018 were searched for the MAPPA I document. Clinical entries were also searched for keywords including ‘MAPPA’, ‘Offender Manager’, ‘Victim’, and ‘VLO’. All authors completed this stage of data collection. If there were any queries, the main author (IP) decided. All the results were collated in Microsoft Excel.

Results We are in the process of completing and collating the data. We anticipate that collated data would be available by the end of October 2018.

Conclusions The results derived from the collated data will be discussed in our local audit meeting. The action plan derived from results and subsequent discussion will be the key focus of our poster. We will also reflect on the current mechanisms for our liaison with MAPPA, and compliance of our current practice with the MAPPA Guidance. There will be a plan for re-auditing.
Response times for referrals to Medium Secure Services

Dr Andrew Porter ST5 trainee GMMH. Supervised by Dr M Sanderson, Consultant forensic psychiatrist GMMH NHS Trust

Aims and hypothesis  An audit assessing time taken from receiving initial referral to assessment of the patient by a forensic clinician and time taken to produce a written report at a Medium Secure Unit (MSU) in the North West of England.  

Background  Referrals to the MSU are managed according to trust guidelines, based on NHS England’s Low and Medium secure specification. Referrals are processed by the referrals coordinator, and assigned to an assessing clinician. Referrals are classed into 3 categories, with specific timeframes for each; Emergency (assessed within 24 hours, report within 48 hours of referral), Urgent (assessed within 72 hours, report within 2 weeks) and Routine (assessed within 2 weeks, report within 5 weeks).  

Methods  This was a retrospective review. Completed referrals received between 6/10/17 and 6/4/18 generated an initial sample size of 106. A sample of 32 referrals was then generated.  

Electronic patient records were used to review the dates the referrals were received, the date referrals were assessed and when written reports were completed. Mostly, these dates were triangulated with the dates referred to in the written assessment report. A results table was devised with patient details anonymised. The levels of urgency were also recorded, as well as dates, which breached the timeframe of the referrals guidelines.  

Results  Overall 50% of cases had a delayed assessment, with 37.5% of those severely (i.e. greater than seven days) delayed. Most urgent cases had a delayed assessment (61.5%) a majority of these were severely delayed (62.5%). A significant proportion (41.2%) of routine cases was delayed, 14.3% of which were severely delayed. Overall, 40.6% of written reports were delayed, and of those 92.3% were severely delayed. A majority of urgent assessment reports (69.2%) were delayed; all of which were severely delayed. A minority of routine assessment reports (11.8%) were delayed, all of which were severely delayed.  

Conclusions  This audit highlights the scale of the problem of delayed assessments and reports. Initial awareness is to be raised by presentation of the audit’s findings locally, and discussion at the local consultant’s meeting. This would also involve reviewing the current trust targets in line with NHS England recommendations. As an active intervention, regular progress updates on the number of outstanding assessments and reports will be sent to all involved members of staff, ensuring that staff are aware of the real-time scale of the problem, and address any current delays.
Electronic Patient Physical Activity Recording Project at High Secure Forensic Hospital in Scotland

Briju Prasad

The State Hospital has never had a robust system to monitor the amount of physical activity that patients engage. This project was designed to encourage patients and staff to routinely monitor all physical activity within the hospital and in turn feed into the two Local Delivery Plan (LDP) targets: 90 minutes of exercise per week and 150 minutes of exercise per week.

As a Hospital we could monitor patient physical activity levels whilst in the Sports and Fitness and Gardens Departments (Skye Centre), but knew there were other opportunities that were being missed e.g. Escorted walks, Ground Access, Outdoor Gym Activity and use of ward/hub fitness equipment as well as a variety of other activities.

The Physical Activity Recording Project Team (PARPT) designed a physical activity form with e-Health that is stored on Electronic Patients Record (RiO) that staff can complete following any form of physical activity is undertaken by the patient. RiO enables staff to record the time of the activity, the type of activity, the intensity and the duration of the activity in real time. Detailed collection of data gives a comprehensive picture of individual patient activities and also forms a medium to encourage patients to involve in physical activity. This has significant impact on their weight and well being.

This project has allowed us to measure the various targets within the hospital in relation to physical activity rather than what just happens within the Skye Centre (Patient Activity Centre) or the amount of fresh air the patients were getting when out on the grounds (the two can differ considerably). The data has also been used in patient CPA meetings to set individualised physical health care plan. Evidence to support that the service development is effective.

The project has been a great success and the feedback from the wards was extremely positive from both staff and patients. The poster that I propose to present is an analysis of the project in the last 12 months including the effect it has had on patients’ weight and activity.
An audit of the Section 62 paperwork against MHA Code of Practice in two male medium secure and one male low secure unit subsequent to an already completed Audit Cycle over four years and the introduction of an online S62 form integrated with RIO electron

Dr Saba Mattar, Birmingham and Solihull Mental Health NHS Foundation Trust, ST6; Dr Ramneesh Puri, Tamarind Centre Medium Secure Unit, Birmingham, Consultant; Dr Rafiq Memon, Tamarind Centre Medium Secure Unit, Birmingham, Consultant.

Aims: To audit Section 62 paperwork against MHA Code of Practice in two male medium secure and one male low secure unit, subsequent to an already completed audit cycle over four years and the introduction of an online S62 form integrated with RIO electronic medical records. Background: Part IV of Mental Health Act 1983 gives powers for patients detained under certain Sections of MHA to be given treatment without their consent. It is sometimes necessary for non-consenting patients to be treated urgently (not possible to await SOAD). The Code of Practice defines urgent treatment and the Hospital managers should monitor use by having a form (or other method) to record the details of proposed treatment; reason it was immediately necessary to give treatment and; length of time for which the treatment was given. Methods: The initial audit (January 2012 – January 2014) looked at 109 Section 62 forms (26 patients) completed at Reaside and Tamarind Medium Secure Units. For reaudit, 262 Section 62 forms (81 patients) completed at Reaside, Tamarind and Hillis Lodge (Low Secure Unit) between February 2014 and February 2016 were reviewed. Progress notes, Clinical Documentation and Consent to Treatment were explored on RiO (electronic records). The 2017-18 review is ongoing. Results: The initial Audit found that 60% identified >2 reasons for urgent treatment; 29% documented reasons for use of S62 in progress notes and decision to use S62 was not documented in progress notes >70% of time. At Reaudit, decision to use S62 form was only documented in progress notes 57% of the time; reasons for use were documented only on S62 forms only in 46.6 % cases; SOAD was not requested 24% of the time (63 cases). Reason for non-request was not documented in 18 cases. The data from current audit will be analysed and presented in Jan 2019. Conclusion: After the first audit, a checklist to assist clinicians was not deemed necessary. The reaudit highlighted an increase in the use of S62 forms. The reasons for use were appropriately identified on S62 form but it was not always clear from progress notes if the treatment was immediately necessary. It was not always made clear on S62 form if a SOAD was needed. The current audit will look at the impact of Online S.62 forms on practice and whether a T2 should be completed the following day when a S62 is used out of hours for a competent compliant patient.
Introduction Standards for Community Forensic Mental health services (FMHS), Forensic Quality network for (FMHS), RCPsych- 2013, highlight that whilst Court liaison and diversion services are recognised as important in terms of the assessment of mentally disordered offenders, these are considered as, “secondary” services. Such services screen and sign-post low risk offenders, usually to general psychiatric and related non-statutory services. It is widely accepted that all mental health teams should have some expertise in assessing offenders and that this role is not solely the remit of community forensic mental health services. NHS Lanarkshire, Forensic Community mental health service (FMHS) provides a court liaison service to three Sherriff courts, with Forensic Community psychiatric Nurses (FCPN) providing initial assessments upon offenders of potential concern. General Adult Psychiatry Approved Medical Practitioner’s (AMP’s), may subsequently be requested to provide a more detailed mental health assessment with consideration towards potential admission. Forensic psychiatrists involvement can occur within existing patient caseloads with recidivist offending or new serious offences. Relatively few requests have arisen in court diversion schemes for urgent assessments of offenders by Consultant Forensic Psychiatrist. Aim Exit pathway analysis for mentally disordered offenders within court liaison scheme, when assessed by the duty AMP, with initial assessment carried out by the FCPN. Methodology 152 court referrals to FCPN in FCMHS were identified through the NHS Lanarkshire information sharing electronic database, over one year period from September 2017 – September 2018. Information was gathered from the clinical assessment letters to the GP by the FCPN. The data collected in a spread sheet highlighted offender demographics, locality, the offence, past offences, previous and current mental health & risk, substance abuse with reason for referral to the Duty AMP or a Forensic Psychiatrist. Additional information from electronic database Trak care, indicated the use of a legal order with subsequent admission to a psychiatric unit. Analysis Qualitative analysis highlights the frequency of legal Order used by the duty AMP or a Forensic Psychiatrist to admit a mentally disordered offender to an appropriate psychiatric unit. Discussion Whilst Forensic Psychiatry clearly retains a responsibility for assessment and management of challenging mentally disordered offenders who receive final mental health disposal through forensic services, it appears appropriate for General Adult services to maintain their input for low level offenders with mental health issues, who are likely to remain in general adult setting in the longer term.
Managing Patient Pregnancy in Medium Security

Dr Jeremy Rampling, Ardenleigh MSU, Birmingham & Solihull Mental Health NHS Trust, Consultant Forensic Psychiatrist  Dr John Croft, Ardenleigh MSU, Birmingham & Solihull Mental Health NHS Trust, Consultant Forensic Psychiatrist and Clinical Lead

Ardenleigh is a medium secure hospital in Birmingham and the regional NHS provider of medium secure beds for women in the West Midlands. In recent years we have managed two women through pregnancies whilst being detained in Medium Security. In both cases there were significant risks of violence justifying their placement as a least restrictive setting and in both cases seclusion facilities were used to manage risk of violence during the pregnancy. We have not heard of other pregnancies being managed in Medium Security and believe it to be a rare occurrence. This session will provide an outline of the two cases and share our experience of managing these complicated situations. We argue that our experience demonstrates that pregnancy can be safely managed within a Medium Security setting where the particular circumstances justify its use as a least restrictive setting.
Clinical and Demographic Characteristics of Patients with Neurodevelopmental Disorders in a Canadian Forensic Program

Ipsita Ray, Associate Prof. Dr Alexander I F Simpson, Psychiatrist, Centre for Addiction and Mental Health, Toronto, ON; Dr. Roland Jones, Psychiatrist, Centre for Addiction and Mental Health, Toronto ON; Kristina Shatokhina, Research assistant, Centre for Addiction and Mental Health, Toronto; Anupam Thakur Psychiatrist, Centre for Addiction and Mental Health, Toronto; Prof. Dr. Benoit H. Mulsant Psychiatrist, Centre for Addiction and Mental Health and Chair, Department of Psychiatry, University of Toronto

Aims and hypothesis: The study was conducted to assess the socio-demographic, clinical and forensic characteristics of patients in a large hospital-based forensic service. Group differences between patients with Neurodevelopmental Disorders (NDD) and a non-NDD control group were observed. We hypothesised that the NDD group would present with more aggressive behaviours and conflicts with peers and staff than the non-NDD group. Background: People with NDD Intellectual Disability (ID), Autism-Spectrum Disorder (ASD) and forensic issues constitute a challenging clinical group that has been understudied in forensic settings. Methods: We assessed the characteristics of patients with NDD under the authority of the Ontario Review Board (ORB) in a large Toronto hospital (excluding those with a cognitive disorder) and compared their characteristics with those of a non-NDD control group. Results: Among 510 adult ORB patients, 50 had a NDD diagnosis. NDD patients were: younger; with a lower level of education; less likely to have been married or employed, less likely to have a diagnosis of psychosis, less likely to be ‘not criminally responsible’; more likely to have committed a sexual offence, more likely to have a diagnosis of paraphilia, and more likely to be ‘unfit to stand trial’. They were also more likely to be treated in a secure unit, to have conflicts with co-patients, or to be involved in physical or verbal assault incidents. Conclusion: Our findings have major implications for clinicians, clinical leaders, and policymakers about the specific needs of patients with NDD presenting with forensic issues. In particular, their higher level of conflict suggests a need for higher levels of, or different, clinical support and risk management.
**Video Link Court Report Pilot**

*Dr Saduf Riaz, Independent Psychiatry, NHS Lothian & Disabilities Trust, Consultant*

Aims and hypothesis The pilot is being undertaken with the Scottish Prison Service (SPS), Scottish Legal Aid Board (SLAB) and Independent Psychiatry (IP) to explore whether Video Link (VL) technology can be used to provide safe, cost effective as well as fit for purpose psychiatric examinations and expert opinions to the courts. Background VL technology has been used for medical applications for decades. The literature is burgeoning with studies showing this technology can be used to accurately diagnose mental disorders, to administer validated rating scales and to deliver psychotherapy. Producing equivalent clinical outcomes, patient satisfaction levels and is more cost effective than face to face (F2F) psychiatric consultations. This pilot was commenced to test the viability of producing court reports through a VL, potentially delivering substantial savings to the public purse in terms of reduced travel costs. Methods Secure SPS software was used to establish an internet based VL between our office to the Agent’s Area of the prisons throughout Scotland and a protocol devised to safely manage the examination. This involved a risk assessment of the prisoner by prison staff before as well as after the consultation and guidance on managing the logistics as well as communicating any concerns or issues. IP offered VL court reports to solicitors as a more cost effective alternative solution to a F2F examination and with education as well as direction from SLAB there was an increase in demand for VL court reports. Following the instruction to provide the report the prisoners underwent a full psychiatric examination and a report was provided setting out the expert opinion requested. Results Thus far 20 court reports have been completed and the first 13 instructions analysed. The majority of prisoners consented to the VL examination. They were mostly male, aged 30 - 39, and had a range of charges as well as mental health diagnoses. 3 out of 11 were unfit for trial and 2 lacked criminal responsibility. 2 were diverted from prison to hospital and 1 was referred to local services. One of the diversions was under an Assessment Order, with a court granting the order on the basis of a VL report. All reports were cheaper than the F2F alternative due to savings on travel and a total of £1278.86 was saved over 11 reports. Conclusion Preliminary data is suggesting that VL court reports are safe, feasible, cost effective and fit for purpose.
The Southend Domestic Violence Perpetrator Pilot: a multiagency project on domestic abuse risk

Dr Graziella Romano ST4, Essex Partnership University NHS Foundation Trust; Dr David Ho, Consultant Psychiatrist, Essex Partnership University NHS Foundation Trust; Dr Antoinette Kotze, Essex Partnership NHS Foundation Trust, Ms Sarah Jones, Essex Partnership University NHS Foundation Trust, Criminal Justice-South Essex; Mr J. Williams, Southend-on-Sea Borough Council, Essex, United Kingdom.

Background: Domestic violence (DV) is a public health concern associated with mental health morbidity and societal burden. It is defined as ‘any incident of threatening behaviour, violence or abuse between adults who are or have been intimate partners of family members, regardless of gender of sexuality’ (Home Office 2010). In the UK, high risk DV offenders are managed by a multiagency panel, but there is no similar provision for low to medium DV risk offenders. In an attempt to deliver early intervention, the Southend Domestic Abuse Strategy Group brought together a number of stakeholder organisations including Southend Borough Council, Essex Partnership University NHS Foundation Trust (EPUT), Southend Clinical Commissioning Group, National Probation Service, Sodexo Justice, Essex Police, and Children and Families Social Services to develop a joint strategy for managing domestic abuse in the area. Objectives: To reduce the risk of reoffending in perpetrators of DV by identifying and addressing mental health, substance use and associated social needs. Methods: The project took place between 1st February and 31st July 2017 in Southend, Essex. The Criminal Justice Liaison and Diversion Team (CJLTD) screened adult arrestees with social and mental health needs identified as requiring mental health assessment in police custody. CJLTD clinicians referred appropriate perpetrators to the project psychiatrist. At the first appointment, the nature and purpose of the project were discussed; questionnaires were used to measure mental health symptoms and individual well-being. The follow-up contacts did not involve initiation of any treatment or case management, but simply reviewing the progress and engagement of individuals who had been sign-posted or referred to various statutory and/or non-statutory services. Results: A total of 7 referrals were received, 12 appointments were booked however only one appointment was attended over the course of 6 months. Conclusions: Significant difficulties were encountered in the recruitment and retention of individuals identified as posing a risk of DV. Arrestees screened appeared reluctant to engage likely due to the impression that participation with the project may imply guilt especially in cases where no further legal action was taken. Moreover, there appears to be a heterogeneous group of individuals with multiple needs which appear to increase the risk of DV, including substance misuse, socio-economic pressures, mental health disturbances, and criminogenic behaviours. It may be that without statutory measures, early intervention in this group of individuals is difficult to achieve.
When a patient kills; a survey of the impact on forensic psychiatrists of homicides by patients under their care.

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Aims The aim of this survey was to explore and analyse the experiences of consultant forensic psychiatrists, whose patient has committed a homicide while under their care.

Background Around 50 homicides a year are committed by individuals who are, at the time of the homicide, under the care of mental health services. Little is known about the impact of such homicides on the health, personal life and career of the Responsible Clinician, or their support needs.

Method In 2017 we conducted an online survey of Consultant Forensic Psychiatrists, through the Forensic Faculty of the Royal College of Psychiatrists, to explore the impact of having a patient who had committed a homicide whilst under their care. We asked about their experience of the event itself and its aftermath, including investigations, any support they had received and what had been helpful or less helpful. A subgroup of psychiatrists agreed to be interviewed in greater depth. Material from their interviews was recorded and analysed using qualitative methods to identify themes and subthemes. Quotations are presented that illustrate the themes identified.

Results Quantitative We present quantitative data from the online survey of 86 psychiatrists; 26 of whom (male 74%, female 26%) had experienced one or more homicides by a patient. 93% patients were male and only 15% of their victims were strangers. Just over three quarters (78%) reported that the homicide and its consequences had affected their mental health; which was very significant in 16%. 77% reported an impact on their personal life. Qualitative results Material from 8 interviews generated themes relating to affective distress, isolation, unfairness and loss of professional identity and competence. Participants reported little or no formal support or advice. A further theme was the confusing and stressful nature of the Inquiry/investigation process; and the impact of negative media reports. All reported still working but also reported costs for career progression. Little or no formal support or advice was provided afterwards.

Conclusion The experience of having a patient who then commits a homicide has a significant impact on the Responsible Clinician’s mental health; personal life and career, which can be long lasting. More recognition of the impact of such events and more research and support from the College, including in other Faculties, is required.
Aims and hypothesis  We aim to understand the similarities and differences in the ways low secure units are commissioned and function across the country. This we hoped would help us to share the knowledge of our strengths and help us to identify and address any areas of development.

Background: There is some diversity in how forensic low secure units are considered to be a step-down service from a medium secure unit with greater emphasis on longer term rehabilitation of patients as compared to an acute or enhanced low secure units that are geared to manage acutely unwell patients that require an escalation of security from a PICU (psychiatric intensive care unit). This scoping exercise is also intending to look at practice in light of the developments of new care models by NHS England.

Methods  A thirteen-question survey (Survey Monkey) was distributed to all Low Secure Units via the Royal College of Psychiatrists Quality Network LSU forum. In addition to increase the sample size regional representatives of the forensic faculty other pathways via Royal College of Psychiatrists have been utilised.

Findings  25 responses have been obtained thus far. Average scores show 20% were stand-alone units, 24% in the vicinity of a general psychiatric hospital, 28% were near medium secure, none were near a high secure and 16% were near another type of hospital. Majority of the hospitals received referrals (72%) from medium secure services with 68% from prison, 56% from other low secure services, 52% from PICU, 28% from court and 20% from the community. Only 16% of hospitals had a designated seclusion room and 96% of the discharges were to community-supported accommodation. 32% also discharged to other low secure hospitals and 28% of the hospitals discharged to community independent living. Although 60% of the sites arranged follow-ups by visiting the service users in their new accommodation and 36% following up via phone calls, 72% of them were not directly working with their outpatients.

Conclusions  We have found that nationally, there is a wide variation between low secure services, regarding type of service, sources of referrals, availability of seclusion rooms and destinations of discharge. Further research is needed to identify and compare good practice along with areas of further development both locally, regionally and nationally.
The use of telepsychiatry within forensic practice: a literature review on the use of videolink – a tenyear follow-up

Christian P. Sales, Leo McSweeney, Younus Saleem & Najat Khalifa

In the last decade, telepsychiatry – the use of telecommunications technologies to deliver psychiatric services from a distance – has been increasingly utilised in many areas of mental health care. Since the review by Khalifa and colleagues in 2007 the body of literature relevant to the forensic applications of telepsychiatry has grown substantially, albeit not by much in the United Kingdom. In the current review, we aim to provide an update summary of the literature published since 2007 to determine the effectiveness and feasibility of increasing telepsychiatry utilisation in forensic practice. The literature reviewed provides some encouraging evidence that telepsychiatry is a reliable, effective and highly acceptable method for delivering mental health care in forensic settings. There are also a number of papers that indicate the use of telepsychiatry may be cost effective for health providers in the longer term. Further research is required to consider the potential legal and ethical implications of using telepsychiatry in forensic settings.
When carers need looking after: how to improve the well-being of your staff

Dr Moustafa Saoud, Sussex Partnership NHS Foundation Trust, Consultant Forensic Psychiatrist; Ms Marisa Marrocco, Sussex Partnership NHS Foundation Trust, Clinical Nurse Specialist; Dr Katie Glennon, Kent and Medway NHS Trust, ST6 Forensic Psychiatry; Mrs Karen Friel, Sussex Partnership NHS Foundation Trust, General Manager Community Forensic Services

Burnout in forensic mental health professionals is acknowledged as a major problem. This is partially due to their experience of violence and aggression at the work place. Forensic mental health services report high rate of sickness and turnover amongst their staff. This has negatively impacted recruitment, staff engagement with their services and consequently, patient care. In this session, we demonstrate various innovative measures that have been put in place by the Forensic Health Care Services in order to address this by improving the culture/organisation, improving staff wellbeing and education. This includes the use of structured tools within reflective practice where subjective experience can be codified. Through understanding of their experiences and developing an appropriate strategy of care, it is possible for staff to maintain their emotional wellbeing, thereby enhancing teamwork and patient engagement. The introduction of Restorative Justice has enabled staff and patients to come to terms with conflict in the work place. Paying special attention to the physical wellbeing of staff received positive feedback. In addition, the use of employee assistance programme, stress questionnaires, supervision, health and well-being days, discount cards and initiatives and occupational health referrals have assisted in improving the wellbeing of staff.

Session objectives

Participants will gain improved understanding of using structured approaches in:
- assessing staff wellbeing in forensic settings
- developing strategies aimed at improving staff wellbeing

Learning points

By the end of the symposium, participants will be able to:
- Use different ways in measuring the wellbeing of staff
- Describe a structured approach, which through evaluation of interpersonal dynamics can enhance staff wellbeing
- Evaluate the effectiveness of interventions aimed at improving the wellbeing of staff and their impact on the work culture
Investigating the weight gain of inpatients at a medium secure psychiatric hospital

Miss Gemma Smith1 (5th year medical student), Dr Mitesh Kasliwal (GP trainee)2 and Dr Ruth Scally (consultant forensic psychiatrist)2

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Aims and Hypotheses:

The high prevalence of physical health problems in mental health patients is well known. Obesity is linked to cardiovascular disease, type 2 diabetes mellitus, some cancers and osteoarthritis; which can all increase morbidity and decrease life expectancy. As such, this audit aimed to investigate whether female inpatients in a medium secure psychiatric unit gained weight during their admission and any pattern to the weight gain in order to inform future interventions. It was hypothesised that the amount of weight gain would be proportional to the length of stay.

Methods:

A list of all current inpatients in the female wards at a medium secure psychiatric unit was produced and their digital patient records were accessed using the computer system RiO. At the time of data collection, there were 27 inpatients. 4 patients were excluded from analysis due to having only one weight recorded, or having longer than 2 months between admission and the first recorded weight. Data on weight changes, body mass index (BMI) and also biochemistry results were collected. BMI was classified for patients as per the World Health Organisation nutritional status categories.

Results:

The data showed that none of the inpatients started or ended in the underweight BMI category. Out of the 23 patients, 1 moved down a BMI category (from obese to overweight), 11 remained in the same category (only 2 in the healthy range) and 11 moved up a category. The mean percentage weight gain was +18.4%, with the mean weight gain being 10.5kg. The mean BMI of admission weights was 29.1 which is classified as overweight, whereas the most recent mean BMI was 33.3, which is within the obese category.

There was little correlation between the length of admission and the amount of weight gained. The biochemistry data was incomplete, but the results available did not suggest a significant improvement or deterioration throughout patients’ admissions.

Conclusions:

To conclude, this study found that 16 out of 23 patients (70%) gained weight during their admission to a medium secure psychiatric hospital. There was no apparent link between amount of weight gain and length of stay. The results suggest that more proactive efforts need to be made with education about diet and exercise early in admission to try and prevent patients gaining weight and hence improving physical health outcomes.
Measurement-Based Care in Forensic Psychiatry: Coming of Age?

1) Prof Veena Kumari, Professor of Cognitive Neurosciences, King’s College, London, and Brunel University, Middlesex

2) Dr Quazi Haque, Group Medical Director, Elysium Healthcare.

3) Dr Piyal Sen, Consultant Forensic Psychiatrist and Visiting Lecturer, Chadwick Lodge, Milton Keynes and King’s College, London.

There is great variability in treatment outcomes for forensic mental health patients. To optimise treatment outcomes for these patients, we must first gain a full understanding of their psychopathology and individual needs, quantify their treatment outcomes using robust and reliable methods, and establish the moderators and mediators of good clinical outcomes. Such endeavours will not only help with formulation of effective treatment and management plans based on patients’ individual profiles, they will also enable prediction of outcome for particular patient subgroups and thus appropriate allocation of resources.

Objective and reliable predictors of good/poor outcome, if successfully developed, could highlight areas of unmet need which can be targeted through intervention (Sedgwick et al., 2016). For example, if certain cognitive deficits are related to poor outcome (Kumari et al., 2009), patients could be provided with deficit-specific cognitive remediation therapies. Similarly, if affective deficits are related to poor outcome in forensic patients, as has been suggested previously (Murphy, 2007), specific therapies could be developed to improve affective functioning. It is important to identify novel therapeutic targets in forensic mental health service patients given that the current treatments appear ineffective in a proportion of forensic patients (Coid et al., 2007).

Learning Objectives

The attendees will be able to

1. Discuss the need for objective assessments of patient characteristics and treatment outcomes

2. Review the commonly used markers of clinical success

3. Plan the most useful measures of short, medium and long-term treatment outcomes
Does using a six lead screening ECG improve outcomes within High Secure Services

Dr Saumya Madhri Senanayake, Broadmoor Hospital, West London Mental Health Trust, SHO
Dr Mary Davoren, Broadmoor Hospital, West London Mental Health Trust, Consultant Forensic Psychiatrist
Dr Callum Ross, Broadmoor Hospital, West London Mental Health Trust, Consultant Forensic Psychiatrist

A six lead screening ECG was introduced as an alternate means of performing ECG in defined circumstances, within Broadmoor Hospital, in November 2017.
Improving care of patients with diabetes in a medium secure unit.

Dr Kathleen Serracino-Inglott/Greater Manchester Mental Health NHS Foundation Trust/ST4 Dr Niamh Sweeney/Greater Manchester Mental Health NHS Foundation Trust/ST4 Dr Catarina Cardoso Rodrigues dos Santos/ Greater Manchester Mental Health NHS Foundation Trust/CT3 Dr Helen Johnson/Greater Manchester Mental Health NHS Foundation Trust/LAS Dr Hany El-Metaal/Greater Manchester Mental Health NHS Foundation Trust/Consultant Forensic Psychiatrist

Aims: We present the results of an ongoing project, in a medium/low secure unit, to improve the quality of care for patients with diabetes and severe mental illness. Background: The Edenfield unit is a 220 bed medium and low secure unit in the Northwest of England. A significant number of these inpatients also suffer from comorbid physical health conditions, including diabetes, which is estimated to be 2-3 times more frequent in patients with severe mental illness. Barriers to the management of diabetes in the secure setting include poor knowledge of management of diabetes by both patients and staff, and lack of access to structured patient education. Methods: An initial audit was carried out to evaluate current practice in four domains: 1) Identification and recording of patients with diabetes 2) Care planning and monitoring of glucose levels 3) Management of diabetic emergencies 4) Reduction of long term complications of diabetes. Following this audit a number of changes to care were made, utilizing a multidisciplinary approach. A year on, a re-audit was carried out to look at changes and further areas for improvement. Results: The initial audit showed a prevalence of 10% of patients with diabetes, with most patients having a care plan which did not include treatment targets in a majority of patients. Recording of blood glucose levels was inconsistent across the wards, and appropriate action was not taken in a majority of episodes of hypo/hyperglycaemia. A number of recommendations were made to improve practice. Following on from this audit, we created an easy to read flowchart for the management of diabetic emergencies. This was inserted in each patient’s prescription card. A monthly clinic was started, run by a physical health care nurse, to review progress with screening and identify any patients with unstable control, utilizing a custom pro-forma. She could also feedback changes in the care plan to the patient’s regular team. Any patients with unstable control were then referred on to the GP clinic/endocrinologist for specialist input. Patient education was also improved, with a dietitian clinic being started to advise and educate patients, in line with current practice in community management of patients with diabetes. A re-audit carried out a year on from the initial audit has shown encouraging results to this ongoing project, with clearer identification of patients with diabetes and an earlier input into their diabetic care. Conclusion: The multidisciplinary, targeted, approach appears to be successful in improving care of the diabetic patient. The audit has also been adapted by the mental health trust and expanded to patients outside the secure unit.
Audit regarding the transfer of patients from three Kent prisons to psychiatric hospitals

Audit completed by Dr Singh, Dr Hundal, Dr Fagbuyi, Dr Servant, Ms Eziashi.

Introduction:

The three prisons where this audit was undertaken were HMP Elmley, HMP Swaleside and HMP Rochester. As described in the Department for Health1 ‘Good Practice Procedure Guide’, transfers should be done in a timely manner, to ensure best care and minimise distress. In this re-audit, we reviewed the time taken between referral and assessment, and then between assessment and transfer. The Bradley Report2 recommended that prisoners with severe mental disorders be transferred to hospitals within 14 days of being assessed and referred.

During this audit the two main aims were (1) to reduce the time taken to transfer people with mental disorder to hospital in keeping with the Bradley recommendations and (2) to reduce the number of patients being transferred from prison to hospital.

Methods:

Clinical notes were reviewed regarding all patients who were transferred to a mental health hospital from the three Kent prisons. This included basic demographic data as well as date referred, date of assessment, date of transfer, MHA status, diagnosis, reason for referral, whether the admission unit was NHS or private and the security level of the hospital. This audit was done between Oct 2016 and Oct 2017 and then repeated for Oct 2017 to Oct 2018.

Results:

The median age of the patients was 27 years, the most common ethnicity was white British and the most common section used was section 47.

In the initial audit (2016 – 2017), 29 patients were transferred. 51% took over 10 days to be assessed and 76% took more than 14 days to be transferred.

In the repeat audit (2017 - 2018), 21 patients were transferred. 70% took over 10 days to be assessed and 90% took more than 14 days to be transferred.

There was approximately a 30% reduction in the number of patients being transferred from prison to hospital.

Conclusions:

From the re-audit above, there have been more delays in the time taken to transfer patients out from prison. We have successfully reduced the number of patients being transferred.

The possible reasons for delay in transfer include reduced number of secure beds in the UK, delays in discharges due to reduction in community resources and placements.

Initial attempts to improve the above included education and training to staff, including the Bradley Report. Future work will be focused on liaising with NHS England and the MoJ to best minimise delays.
WHAT ANTIPSYCHOTIC WOULD YOU TAKE?

Psychiatrists’ preference of antipsychotic medication if they suffered psychotic illness

Sourabh Singh

Aims: A nationwide cohort study in Finland showed that a significant proportion of patients suffering from psychosis did not continue their antipsychotic treatment after discharge from hospital and that depot formulations were associated with lower risk of rehospitalisation compared to oral formulations (Tiihonen et al, 2011). However, majority of the patients remain on oral antipsychotic medication in the community. Patients make an informed choice, but the psychiatrists’ knowledge and attitude may also play a significant role in this (Jaeger, 2010). Our aim was to understand what the clinicians prescribing these medications would prefer if they themselves suffered from a psychotic illness.

Methodology: This was cross sectional survey undertaken at Oxleas NHS Foundation Trust between May and June 2018 asking doctors for their preferred antipsychotic medication if they suffered from a psychotic illness. We asked them for their preferences in 3 different scenarios; first episode, maintenance and treatment resistant psychotic illness. The survey also included their views on duration of treatment and reasons for their preferred choice of antipsychotic medication. The online survey was anonymous and designed by Quality Assurance facilitator from Oxelas NHS Foundation Trust, who also collected and analysed the results.

Results: We sent out a survey to 70 doctors and received 51 responses. Of those who responded 21(41%) were general adult, 20 (39%) were forensic psychiatrists, and the rest were from older adults, CAMHS and prison team.

Aripiprazole was the most preferred antipsychotic medication for first episode with 53% and olanzapine was the second most preferred medication with 26% choosing that. 92% respondents chose oral formulation with only 8% choosing depot in first episode.

With regards to relapse of an established psychosis, 82% still chose oral in comparison to only 18% choosing depot formulation. For relapse, 32% chose olanzapine and 26% chose aripiprazole.

80% of the respondents said they would take medications for 2 years or longer in case of relapse in comparison with only 24% for first episode psychosis.

86% of the respondents chose clozapine if they had a treatment refractory psychosis with rest choosing high dose of single antipsychotic, combination of 2 antipsychotics or augmenting agent with antipsychotic medication.

Conclusions: Clinicians responsible for prescribing still prefer using oral antipsychotic medication despite the advantages of long acting depot medications. There is need for more work to encourage clinicians and patients to consider long acting depot antipsychotics.

Reference:

“In and out”- Transfer to hospital from prison and remission; opportunity and barriers.

Dr Hannah Slevin, Greater Manchester Mental Health NHS Foundation Trust, CT3 doctor Core Psychiatry; Dr Lucy Shaw, Lancashire Care NHS Foundation Trust, ST5 doctor Forensic Psychiatry (Joint main author); Dr Kripa Ullal, Greater Manchester Mental Health NHS Foundation Trust, Consultant Forensic Psychiatrist; Dr Sandeep Mathews, Greater Manchester Mental Health NHS Foundation Trust, Consultant Forensic Psychiatrist.

Aims and hypothesis  We aim to present an evaluation of a new pathway at our Medium Secure Forensic unit for patients transferred to hospital from prison after sentence. The aim of the pathway is to accept patients from prison, rapidly treat them, provide focused interventions and develop a risk formulation before returning them to Prison to complete their sentence. We will present the results so far and discuss our experiences of snags in the system, which prevent a rapid turnover medium secure service.  

Background  In light of our bid to be a new care model site and Manchester devolution, we looked at existing pathways within our secure service and looked at ways of realising benefits including reducing prolonged stays in secure services. An identified pathway which we could streamline was that for patients transferred from prisons for treatment and stabilisation. Whilst acknowledging that some would need to remain in hospital and get discharged from hospital, there would be a cohort who got lost in a big secure service without doing much, in terms of engaging in therapies or could not progress in other ways. It was decided to group all the sentenced prisoners who required transfer under section 47/49 in one stream, admit them under a pair of Consultants who would work together and facilitate their early return to prison, after treating the acute phase of their illness and stabilising them. The other driver for this was to enable faster transfer from prison of identified prisoners who required hospital treatment and the emerging new national guidance on prison transfers and remission.  

Methods  Patient records will be retrospectively analysed for the period 1st April 2018 (when the stream went live) to 1st October 2018 (a six month period), to identify times from referral to assessment and to admission, time spent on establishing treatment and stabilising and length of stay. We will also look at time taken from identification that they were ready to return to prison, to actual return and any barriers encountered. We will discuss barriers to the smooth functioning of this pathway in established secure services and barriers to remission.  

Results  Data collection to take place in October/November 2018, will be presented.  

Conclusions  The conclusions are pending as data collection will be in October 2018. The early indications are that there are systemic barriers, which will be discussed.
5 Minutes and Counting Observation Quality Improvement Project

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Aims and hypothesis  This Quality Improvement (QI) project aimed to reduce the frequency and duration of Enhanced Observations on a mixed purpose (acute and rehabilitation) female forensic psychiatric ward by 50% within 12 months using a QI Plan Do Study Act (PDSA) approach. We sought to reduce the frequency and duration of enhanced observations on a mixed purpose (acute and rehabilitation) female ward in a medium secure unit by 50%, using a quality improvement approach, over a 12 month period. Background  This QI project was part of East London NHS Foundation Trust (ELFT) QI Wave 7, a drive to increase awareness of QI and the utilisation of QI within ELFT. Enhanced observations represent a mechanism for supporting patients facing increased needs, usually an increased risk to themselves or others. Whilst of a supportive nature, enhanced observations are also a restrictive practice. As such their use should be carefully monitored, appraised, and their use minimised in order to provide essential support whilst avoiding unnecessary deprivations of liberty and maximising patient autonomy. Methods  We utilised a QI PDSA approach, as taught during the ELFT QI Wave 7, was utilised over the course of a year in order to assess the level of enhanced observations, assess clinical need, and subsequently to refine ward practices in order to seek to support staff and patients in maintaining a safe environment whilst minimising unnecessary observations. Multi-disciplinary QI team meetings, including medical, nursing, managerial and administrative staff under the guidance of a local QI coach were used to guide and refine ward practices using the PDSA approach. Results  Our results are pending. A reduction in the level of enhanced observations has been observed, as has an increased level of staff satisfaction. Conclusions  A reduction in restrictive practices (unnecessary enhanced observations) was possible using a QI approach. Changes implemented as part of the PDSA cycles have facilitated improved and easily auditable documentation of enhanced observations/restrictive practices. Changes to staff practices in conducting enhanced observations, their review, addressing staff training needs during the QI cycle and reassessment of their purpose have resulted in a reduction of this restrictive practice. Financial Sponsorship  This QI project was endorsed and supported by East London NHS Foundation Trust.
A study of the use and misuse of Gabapentinoids in prison

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Abstract  Aims The aim of this study was to establish the prevalence of the prescription of gabapentinoids in a category B men’s prison in London and to establish the prevalence of gabapentinoids co-prescription with opioid substitutes and antidepressants. In the light of this study it was hoped to establish the standards for the prescription for gabapentinoids in prison.

Background There is now recognition that the gabapentinoids are being increasingly misused and are associated with drug-related deaths especially when combined with opiates and that gabapentinoids are sought after and misused in secure settings, including prisons.

Method Electronic medical case files of male prisoners in category B prison was studied to establish the prevalence during an 8 month period of gabapentinoid prescribing in the prison, the documented indications for their use, whether licensed or off label and the level of co-prescribing with opioid substitutes and antidepressants.

Results 109 cases were identified of prisoners having been prescribed gabapentinoids. Pregabalin was prescribed in 66 cases (61%) and gabapentin in 43 (39%). In 72 cases (66%) the indication for the use of gabapentinoids was documented. In 30 of the cases (27%), gabapentinoids were prescribed for the licensed indication for neuropathic pain, but for a further 36 cases (33 %) prescriptions were for unlicensed(off-label) indications, mainly for non-neuropathic pain. In 51 cases (47%), gabapentinoids were prescribed with opioid substitutes such as methadone or buprenorphine and in 19 cases (17%) with antidepressants. In 38 of these cases (75%), there was no documentation in the records of the risks of such co-prescribing nor that such risks had been discussed with the prisoners. In 13 cases (12%), there was documented evidence of prescribed gabapentinoids being concealed, or being diverted to the other prisoners.

Conclusions For those prescribed gabapentinoids in prison, the indications for such use especially if off label should be reviewed, their use minimised and where relevant and available compared to NICE guidelines. Less harmful alternative drugs are often available. Initiation of gabapentinoids in prison should be avoided unless recommended by a specialist. For patients who are also receiving opioid substitutes or are abusing opiates, consideration should be given as to whether it is safe to continue on gabapentinoids, given the risks of misuse and death. Issues raised by the study are likely to apply to other prisons and secure forensic psychiatric facilities.
Learning for Recovery: Implementing a Recovery College in Medium and Low Secure Services

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Aims and Objectives Learning for Recovery is a Recovery College co-developed and co-delivered in forensic inpatient services of Midlands Partnership Foundation Trust (MPFT). Defining features of Recovery Colleges have been set out by Perkins and colleagues (Perkins, Repper, Rinaldi & Brown; 2012). This paper illustrates how MPFT have adhered to Perkins principles of Recovery Colleges, using innovative ways to ensure Learning for Recovery is widely accessible to service users.

Background Government’s Mental Health Strategy ‘No Health without Mental Health’ (2011) set an objective for more people with mental health problems to achieve recovery. It is intended that a recovery-based approach will increase positive clinical outcomes and improvements in service user experience.

Methods Service user involvement has been central to developing Learning for Recovery with involvement from existing and former service users and Peer Recovery Workers to coproduce and co-deliver courses. The prospectus was designed following a needs analysis completed by holding Focus groups to seek patient views about different kinds of activities and courses they would like to attend. A broad range of courses that address mental health recovery and mental wellbeing along with ‘lifestyle interests’ are delivered. A ‘Train the Trainer’ course is also offered to staff and service users.

Results Since its inception in 2017, Learning for Recovery’s prospectuses have continuously improved in style and design, with increasing involvement and collaboration between service users and staff. During 2017, number of service users enrolling in Learning for Recovery increased from 26 (28.9%) in Q2 of 2017-2018 to 51 (62.2%) in Q2 of 2018-2019. Number of service users actively participating in Learning for Recovery courses has also grown steadily. In Q2 of 2017-2018 21 (23.3%) service users participated in at least one course, while in Q2 of 2018-2019 this figure was 28 (34.1%). In 2018, all service users were individually engaged in discussion about Learning for Recovery. 88 service users (100.0%) said they had been offered a prospectus and 45 service users (51.1%) accepted a copy of the prospectus. 35 service users (39.8%) said they had identified a future course they wished to attend and many service users suggested ideas for future courses.

Conclusions A Recovery College is an important and exciting way of promoting change. This can mean change for individuals, helping them in their personal and collective journeys of recovery. This can also mean change for the organisation itself; becoming more recovery-focused will change the focus of the services.
Reaching Every Secure Care Service User from the West Midlands and creating Hope, Opportunities, Understanding and Trust (REACH OUT) - A New Care Model

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Aims and hypothesis  To provide care closer to home  To reduce the rate of readmission by providing wraparound care and support in the community  To support individual recovery and re-enablement.

Background  West Midlands has a population of 5.6m with areas of high social deprivation and poverty. It has circa 560 patients with severe and enduring mental health problems & high risk of offending who are placed in medium or low secure care.  West Midlands has around 440 inpatient secure beds across three providers  with around 35% of its patients placed in secure units outside Westmidlands away from their communities .  Methods REACH OUT is a wave 1 New Care Model commissioned by NHSE as part of the Five Year Forward view. It is a partnership between 3 core partners including Birmingham and Solihull Healthcare NHS Foundation, Midland Partnership NHS Foundation Trust and St Andrews Hospital, supported by a range of NHS, charitable and private sector providers working in partnership with NHSE.  This clinical model is delivered via an Accountable care function and involves the Forensic Intensive Recovery and Support Team (FIRST), a multidisciplinary team providing repatriation services, intensive wrap around community care and guiding patients in their recovery with help of peer support workers. Other developments include joint bed management and robust governance arrangements.  Results Reach Out has empowered clinicians and service users/carers to redesign pathways to better suit the needs of patients. It has resulted in increased discharges via an enlarged FIRST outreach service. There has been a reduction of inpatient population by 13 in 2017/18, with increase of 27 in the FIRST caseload. It has also resulted in 20 - 24 less Out of Area patients since April 2017 and a reduction in delayed discharges due to improved partnership working with stakeholders. The partnership has also achieved improved efficiency with £0.5m savings in 2017/18 which has been reinvested in new services. Better data collection and sharing has led to improved understanding of patient need and outcomes across the partnership. There is a strong service user focus with recruitment of Peer support workers with lived experience and setting up of Recovery arm and coproduction workshops, cochaired by service users. REACH OUT has also been chosen by NHSE for pilots to improve the experience and outcomes of Black men in secure care.  Conclusions REACH OUT has improved partnership working among stakeholders whilst developing a cohesive care pathway for service users in secure care.
Distribution of ethnicity among admissions and discharges from Ashworth Hospital

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Aims

To understand the distribution of ethnicity among admissions and discharges from Ashworth High Secure Forensic Psychiatric Hospital over a 10 year period between 2006 and 2016

Background

An article on ‘Detentions under the Mental Health Act’ published by NHS Digital highlighted that among broad ethnic groups, people in Black ethnic group were most likely and people in the White ethnic group were the least likely to be detained under the MHA in 2016/2017. There has been no recent study into the ethnicity of admissions into high secure psychiatric services and specifically Ashworth Hospital.

Method

The service evaluation explored to understand the ethnic composition of patients admitted to Ashworth Hospital between 2007 and 2016. The catchment area of Ashworth Hospital includes North West, West Midlands and Wales. The ethnic composition of its catchment area population shows that 89.5% are of White ethnicity, 6.43% are Asians and 1.76% is Blacks. The total BAME (Black, Asian and Minority Ethnic) population is 10.5%. The hospital admission data was collated from the electronic patient record system.

Results

There were 334 admissions at Ashworth hospital between February 2007 and December 2016. The admission rate of White ethnic group was 80.2% and BAME was 18.9% (Black -17.06% and Asian -2.69% - the corresponding population ethnicity is Black 1.76% and Asian 6.43%). The youngest admission age in both groups was at the age of 17 years. 44% of White ethnic patients presented in their 20s and 39.3% of BAME patients were in their 30s. The total time of inpatient stay ranged from 15 days to more than 10 years in both groups. The discharge figures showed that 58.3% of white ethnic group and 67% of BAME had been discharged from hospital. The rate of discharge in BAME was higher than in the white ethnic group in the study period.

Conclusion

People in the Black ethnic group were more likely to be detained under Mental Health Act at Ashworth hospital over the last 10 years. They are over-represented in Ashworth High Secure hospital, reflecting the national picture when it comes to detentions under the Act. However, the rates of discharge for those of the BAME appear to be higher than those of White ethnicity.
Quality of referral received from prison at Edenfield centre

Dr Ssidhu, ST5 & Dr S. Plunkett, Consultant Forensic Psychiatrist

Aims

The aim of the audit was to look at the quality of referral received at Edenfield centre from prison services. The objective was to streamline this process for referrers and assessors, resulting in improvement of patient care.

Background

The Adult Forensic mental health service is responsible for undertaking access assessments of prisoners who are referred for a secure bed and are residents of Greater Manchester.

They are assessed for admission to medium security in accordance with NHS England’s Medium Secure Mental Health Services (Adults) Service. The information requested on referral form for admission includes basic demographic details and following:

1. Reason for referral/presenting problem
2. Offending history
3. Risk issues
4. Any other relevant information
5. Supporting documents

Method

Data - The data was collected from referral log kept by the referral coordinator. A performa for data collection was prepared and information was transferred for analysis to Microsoft Excel sheet.

Peer review - As the process involved qualitative checking of information in the referrals, ST peers were asked to check whether information provided on the performa and letter was sufficient or not. 30 forms were given to 4 STs (3 – ST4 & 1 – ST6). After forms were returned, few disagreements were identified and resolved by discussion about the information. These disagreements were resolved by taking a joint decision.

Results

N=51

Time = March 2016 to July 2017 (17 months)

Quality of information in 23 nursing referrals

Sufficient = 13 (56%)
Insufficient = 10 (44%)

Quality of information in 29 Doctor’s referrals

Sufficient = 22 (76%)

Insufficient = 7 (24%)
Quality of 28 Doctor’s supporting letters
Sufficient = 19 (68%)
Insufficient = 9 (32%)
Supporting information provided in form of Court reports, Psychology reports, PNC, IMR, Tribunal reports = 15/51 (30%)

Conclusions

1. In the case of urgent referrals, the methods of submission of the referral or the provision by the referrer of incomplete demographic or clinical information should not delay the assessment and such information can be obtained subsequently.

2. The audit findings were disseminated to all Inreach teams through ST’s at respective prisons to improve quality of information in the referral letters.

3. IMR should be sent with all referrals from prison.

4. Current medication and compliance should be clearly mentioned in the forms.
Aims To improve the physical health monitoring of male low secure inpatients on antipsychotics. Background Life expectancy for adults with schizophrenia spectrum disorder is approximately 15 years less than for the general population. Physical health problems have been cited as a causative factor; individuals with severe mental illness have double the risk of obesity and diabetes and five times the risk of dyslipidaemia. Guidelines for monitoring physical health of patients on antipsychotics are available to help healthcare practitioners identify and manage physical health. Consent to engage with and compliance with physical health monitoring can also be an issue. Methods A service evaluation was completed to assess the performance of a male low secure unit against the following antipsychotic monitoring standards: • NICE Clinical guideline [CG178]: psychosis and schizophrenia in adults • Antipsychotic monitoring guidelines in the Maudsley Prescribing Guidelines • Local Trust policy The clinical notes of fifteen male inpatients were analysed to complete the study. Only compliance with blood test monitoring was included in this study. Results 87% (13/15) of patients had FBC, U&E, LFT and TFT measured within 30 days of admission. Lipids, Hba1c, glucose and prolactin were measured 73% (11/15), 53% (8/15), 67% (10/15) and 53% (8/10) respectively in patients following admission. No patient had creatine kinase measure following admission. 14% (2/14) had lipids and Hba1c monitored at 3 month; 18% (2/11) had prolactin and Hba1c measured at 6 months post admission. 29% (2/7) of patients had FBC, U&E, LFT and lipids measured at 12 months post admission; 14% (1/7) had Hba1c monitored at 12 months. No patient had prolactin measured at 12 months post admission as set out in the standards. Patient refusal was identified as a cause of missed blood tests. Conclusions Improvements have been made to clinical practice to ensure that physical health monitoring is completed and patient capacity assessed in the event of patient refusal: 1. Improved education for practitioners administering the investigations includes the production of posters and flowcharts which now populate clinical areas. 2. A flow chart is used to ensure patients’ capacity to decide to agree to blood tests is assessed in a timely fashion. Further education is offered if the patient refuses; if the patient lacks capacity, tests may be carried out in their best interests. 3. We have devised ‘easier to read’ leaflets which explain the need for blood tests for use with our patients to assist with the capacity assessments.
A mentalisation based therapy group for female prisoners: a pilot study

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Background: People with personality disorders can benefit from a range of psychological interventions, including Mentalisation based therapy (MBT). MBT is an intervention based on attachment theory which enhances self-reflective function and perspective taking. It has been shown to be effective in reducing the symptoms of severe borderline personality disorder (BPD), such as self-harming behaviours and affect dysregulation (Bateman & Fonagy 2013). MBT is recommended as an intervention for BPD (NICE 2014). MBT is also considered to be potentially effective for people with antisocial personality disorder (Bateman & Fonagy 2008); and is currently under test in a randomised controlled trial with male offenders with an ASPD diagnosis. The current MBT treatment trial for ASPD does not include female offenders; many of whom are known to have co-morbid BPD and ASPD.

Method: A pilot study using MBT was initiated by Professor Gill McGauley using a convenience sample of female prisoners with BPD who were seeking treatment for repeated self-harm in prison and persistent feelings of distress. The group consisted of a modified MBT model of 10 weekly group meetings without individual support.

Results: Pre- and post-treatment scores on the CORE are presented (both raw scores and after reliable change index analysis). These indicate improvement in well-being and reduction in risk.

Conclusion: MBT may be a useful addition to interventions offered in women’s prisons for prisoners with co-morbid BPD and ASPD. Such an approach would be consistent with the NOMS Offenders with Personality Disorder (OPD) pathway, which utilises MBT principles with staff in relation to offenders with PD. Further, group interventions like MBT make efficient use of limited manpower resources and have the potential to enable participants to develop pro-social skills. More formal studies are needed to evaluate the use of MBT with female prisoners who have personality disorders.
The sequelae of suspected novel psychoactive substance use in a medium secure forensic unit; is an ion tracker the answer?

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Aims and Hypothesis The use of an ion-tracker to screen for substance misuse in patients in a medium secure forensic facility was compared to local guidelines. Our aims were to assess whether the ion-tracker supports clinical suspicion of substance misuse and whether appropriate consequences of suspected use were enacted. Background The use of an ion-tracker has recently been adopted by one medium secure forensic facility to detect substances including cocaine and the novel psychoactive substance “spice”. The latter cannot be detected by a standard urine drug screen, but its use and associated physical health complications are becoming increasingly common in such forensic facilities. Local guidelines dictate that clinical suspicion should be confirmed with use of the ion-tracker and that leave should be suspended pending repeat negative ion-tracker result. Methods Datix data over 6 months, for patients on 7 medium secure forensic inpatient wards, was analysed, targeting the descriptors “patient unwell” and “substance use”. This data was further filtered by analysis of computerised clinical records to identify patients who clearly presented as physically unwell secondary to illicit substances. The records were then compared to guidelines in terms of: 1). Documented result of ion-tracker. 2). Repeat test in the proceeding 5 days. 3). Suspension of leave in cases of a positive result. Results 21 instances of patients presenting as physically unwell in the context of substance misuse were identified. 1.) Of these 21 incidents, only 9 patient records (43%) indicated intent to use the ion-tracker. Only 7 records (30%) had an ion-tracker result documented. 2 of the 7 documented results were positive for illicit substances. 2.) For the 9 incidents with intent to use the ion-tracker documented, 1 had a repeat test documented. 3.) Of the 21 incidents of suspected substance misuse, there were 15 cases of leave suspension. Conclusions There were 21 incidents over a 6-month period of patients displaying serious physical health symptoms suggestive of illicit substance use. Only a third of these patients had ion-tracker results documented in their clinical records and only 1 patient had a documented repeat of this test. Despite this, 71% of incidents resulted in a leave suspension, indicating an emphasis on clinical observations driving decision making. We suggest that a lack of positive results from the ion-tracker is suggestive of poor sensitivity to rapidly evolving novel psychoactive substances. Further staff education both on ion-tracker use and guidelines would likely improve adherence to local policies.
A CASE OF UNDIAGNOSED AND UNTREATED NEUROSYPHILIS WITHIN THE SECURE SERVICE

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Aim and Hypothesis

We aim to present the case report of an interesting foreign national who presented in prison with psychotic symptoms. The importance of keeping a wide spectrum of disorders in mind and investigating thoroughly is discussed.

Background

A rare manifestation of Central Nervous System infections include a multitude of psychiatric symptoms. Clinical presentations of Neurosyphilis vary depending on whether the Central Nervous System is involved early or late in the disease. A number of patients will remain asymptomatic despite positive serology; this is termed latent syphilis. Early Neurosyphilis presents with meningitis and acute vascular events. Late Neurosyphilis has a wide range of neuropsychiatric symptoms including dementia, mood disturbances and psychosis.

This is the case of a failed asylum seeker who was an inpatient at a Medium Secure Hospital. The patient was facing further charges for sexual offending and was a registered high risk sex offender. There was a change in his presentation over the last five years. In the UK there were documented psychiatric inpatient admissions. During these admissions he presented with bizarre and sexually disinhibited behaviour.

The patient was undergoing an assessment to determine whether his behaviour is the result of a mental disorder. When transferred to hospital he displayed significant sexual disinhibition, thought disorder, disturbed behaviour and was responding to psychotic stimuli.

Methods

The initial approach was to rule out an organic cause for the patient’s presentation. These included series of blood tests for autoimmune and infective markers and a CT brain scan.

Results

The work-up revealed positive syphilis serology raising the question of a possible central nervous system infection. The CT brain scan showed mild generalised atrophy, disproportionate to his age.

A subsequent neuropsychiatric opinion was sought. Further Magnetic Resonance imaging of the brain was normal. A Lumbar Puncture was requested to confirm the presence of active Treponemal infection.

However, the patient was remanded back to custody following a court hearing leaving diagnostic uncertainties and the patient partially treated.

Conclusion

There needs to be a high index of suspicion for organic causes of psychosis in prisoners from other countries who may be exposed to central nervous system infections and who may have been sub-optimally treated.
Obtaining collateral history and medical records is a challenge. There will be a reluctance to engage due to immigration consequences and the history is often patchy.

Forensic by Any Other Name: Violence, Aggression and Risk on General Adult Wards

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AIMS AND HYPOTHESIS: AIMS: To assess the impact patients with forensic histories have on general adult services, the frequency of violence on an acute male inpatient ward, and how this violence is managed. HYPOTHESIS: More than half of adult patients admitted to acute wards will have forensic histories, but less than half will be known to forensic services. More than 20% of inpatients will commit at least one act of violence whilst on the ward. Violence will be managed using 1:1 or 2:1 observations with verbal de-escalation, restraint, intramuscular (IM) medication, and Psychiatric Intensive Care Unit (PICU) referrals.

BACKGROUND Evidence shows that 20%-33% of patients admitted to acute psychiatric units commit an act of violence, but doctors working in inner city male acute wards may feel the figure is higher. This may be because patients with forensic histories are no longer the sole remit of forensic teams. They are often cared for by general services, who are not always adequately equipped to manage this client caseload. In turn, this may affect the standard of care provided.

METHODS Electronic records were reviewed for a sample of patients (n=55) who were admitted to, or present on, an inner London, all male, 20-bed acute inpatient ward between 01/08/18 and 01/10/18. We assessed several domains, including forensic history, nature of offences, previous contact with forensic teams, incidents of violence on the ward, and management strategies used.

RESULTS 65% of patients had a forensic history, 56% of whom served prison sentences. Only 11% of whom were known to forensic services. 24 patients (44%) committed at least one act of violence on the ward, some of which were very severe. 1:1/2:1 observations were used 12 times, and restraint only 9. IM medication was given to 7 patients. Only 5 referrals to PICU were made. 6 patients were referred to forensic services, and only 3 were accepted for assessment. None were accepted for case load management.

CONCLUSIONS Patients with forensic histories represent a large proportion of the adult inpatient caseload. These histories often involve violence and risk, which frequently translates into violence and aggression on the ward. Acute wards seem to have evolved to cope with this increasing burden, but serious incidents can occur if staff are not trained or supported. General adult teams may benefit from closer liaison with forensic services and additional training on how to risk assess and manage forensic patients.
The Bodyguard: Did the characterisation of David Budd trivialise or raise awareness of PTSD in military personnel amongst viewers?

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Background: The BBC aired The Bodyguard which amassed 10.4 million viewers; the highest ratings since 2008. The drama follows the character, David Budd, a British Army veteran who had served in Afghanistan, now employed in close protection. Viewers see David’s relationship breakdown, his suicidality and symptoms of PTSD. Aim: To observe whether the portrayal of David Budd raised awareness of PTSD in military personnel amongst viewers or whether the series in fact trivialised or romanticised mental health conditions. Methods: 100 members of the public who have watched BBC’s The Bodyguard were asked to complete a questionnaire survey on their opinions of the mental health condition (PTSD) as portrayed in David Budd’s character. Inclusion criteria: watched all episodes of The Bodyguard sequentially, Not a mental health professional, Exclusion criteria: Under 18

Results to follow  Conclusion to follow
Early evaluation of REACH OUT: A New Care Model for Adult Low and Medium Secure Services.

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Background:

REACH OUT (Reach Out to Everyone And Create Hope, Opportunities, Understanding and Trust) constitutes a new care model for Adult Low and Medium Secure Psychiatric Services for all service users of the West Midlands Clinical Commissioning Groups. REACH OUT aims to reduce length of stay in inpatient secure care by moving care into the community. The main objectives of the new care model are to provide care closer to home, reduce the length of inpatient stay, achieve earlier discharge into the community, prevent admission and readmission into secure care, enable patient recovery and to work in partnership with criminal justice system and other stakeholders.

Aims:

The main aim of the evaluation is to examine whether the desired outcomes of the new care model have been achieved.

Method:

REACH OUT was implemented in April 2017. The evaluation initially gathered quantitative data confirming the number of service users residing in secure care outside of the West Midlands. Baseline characteristics were collected for all service users in the cohort. Data was then gathered on the number of service users repatriated to the area over the duration of the evaluation and the number of referrals and discharges to the newly developed Forensic Intensive Recovery Support Teams (FIRST) community team.

Results:

There were approximately 600 adults from the West Midlands in medium and low secure care (excluding people with learning difficulties) before REACH OUT implementation. Approximately 40% (n = 240) were receiving care outside of the region. We will report the number of service users that have been repatriated to the West Midlands and numbers referred or discharged to the FIRST community teams. Findings will also report the number of new referrals to services, along with the number of admissions and readmissions. Data on length of time between assessment and repatriation for service users moving back to the region will be reported.
Service description of REACH OUT: a New Care Model for Adult Low and Medium Secure Services.

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Background:

REACH OUT (Reach Out to Everyone And Create Hope, Opportunities, Understanding and Trust) constitutes a new care model for Adult Low and Medium Secure Psychiatric Services for patients of the West Midlands Clinical Commissioning Groups. Prior to the new care model implementation, Birmingham and Solihull Mental Health NHS Foundation Trust worked with 89 service users to understand what the partnership needed to provide within the new care model. Service users were asked to collate their views of what “good community service provision” look like, based on what had worked in the past or they thought would work better for them. This service user engagement, as well as listening to families and stakeholders and building on established best practice and evidence led to the REACHOUT model.

Aims:

The main objectives of the novel service model are to provide care closer to home, reduce length of inpatient stay, achieve earlier discharge into the community, prevent admission and readmission into secure care, enable patient recovery and work in partnership with the criminal justice system and other stakeholders.

Method:

A service detailed description including service users; pathways and service components.

Results: The REACHOUT model

Having applied successfully to be a wave one pilot, as a partnership of three secure care providers in the West Midlands, the model was implemented in April 2017.

The new model of care was developed to reduce reliance on inpatient care and strengthen the whole pathway, to prevent numbers of West Midlands service users requiring secure services from rising. In order to support individuals at risk and so reduce the total required numbers and length of time individuals require secure care, an infrastructure was developed providing intensive intervention and preventative work.

This new care model aims to reduce reliance on secure care inpatient provision, improve the efficiency of inpatient bed usage and invest in a preventative and stabilising model of care through a unique collaboration of providers across the West Midlands.

In addition, approximately 40% of West Midlands adults (excluding people with a Learning Disability) who are detained in medium or low secure care are placed out of area and at greater distances from their homes, family and friends than they should be, which is often not conducive to their recovery. A further aim of the model was to repatriate these service users.
Prior to REACHOUT implementation, the three providers in the region all had similar goals but were working separately with minimal integration, however now work in partnership with a shared goal which is supported by senior clinicians and leaders across the West Midlands.
Development of protocols for high dose antipsychotic prescribing in a secure setting

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Aims and hypothesis: To develop a standardized protocol for monitoring patients on high dose antipsychotics through the completion of an audit cycle. The first audit aimed to: Identify the prescribing trends for all patients prescribed high dose antipsychotics across the hospital. Review the process of ongoing monitoring for benefits and side effects. Recommend changes in line with existing best practice guidelines. The second audit aimed to: Monitor whether the changes made following the first audit were implemented. Identify any trends and opportunities for further improvement. Formalise the protocol for high dose antipsychotic treatment. Background: Kemple View hospital is a 90 bedded low secure and locked rehabilitation psychiatric facility for men with mental disorder. A significant proportion of patients have treatment resistant psychosis, requiring antipsychotics above BNF licensed doses. The quality of prescribing and monitoring needed to be standardised in line with best practice guidelines. Methods: From medication charts we developed a database of all patients on high dose antipsychotics. Data on physical health monitoring and dosing regimens were compared with recommended guidelines. We developed a pilot protocol for specific care plans, which involved a multidisciplinary approach to reviewing efficacy, physical health monitoring, and peer reviews every 3 months. A re-audit after a year led to fine tuning of the protocol and its implementation. Results: The first audit revealed that 21% of all inpatients were on high dose antipsychotics. Appropriate investigations were not offered as frequently as required. No reasons were documented for refusals. Patients on the highest doses were the least compliant with monitoring. No outcome measures were used to monitor efficacy. We recommended 3 monthly completion of BPRS, LUNSERS and LESTER tools; MDT and peer reviews; physical observations, blood tests and ECGs. The re-audit revealed that the overall doses of antipsychotics had reduced, although a similar number of patients were above BNF limits. The choice of drugs had changed. Olanzapine was the most prescribed antipsychotic. None of the high dose combinations included clozapine in the re-audit, possibly because the hospital became smoke-free. Three monthly monitoring was being completed, but just over half had specific care plans, and even fewer had specific outcome measures/peer reviews. Conclusions: There was improved site-wide awareness about the implications of high dose antipsychotic treatment and physical health monitoring recommendations were followed. Further training and resources were allocated to optimise implementations of care plans, outcome measures and peer reviews.
Physician suicide is a growing epidemic worldwide. In the USA alone, around 400 doctors die every year by suicide. Similar numbers are seen worldwide. Yet, instead of addressing the problem, it is often hushed up. No study has been done on physician suicide in the Indian subcontinent. A few studies assessing stress among medical students report severe stress in around 25%-40% and suicidal attempts in 2-5% of them. The aim of this paper is to find out what leads doctors into taking a final step of suicide. The technique of psychological autopsy was used to interview at least 2 close friends/relatives of the deceased. 46 semi structured interviews were conducted over the period of one year to probe details of 23 doctors who died by completed suicide. The interview was divided into three parts, the first part included basic demographic and personal details of the victim. The second part of the interview aimed at collecting information regarding the professional life of the deceased. The third part aimed at delineating strategies that could have prevented the death. Mean age at death was 28 years. Majority of the sample were females (61%). Only 17% of those who died had a previously diagnosed psychiatric disorder. Substance use disorder was a co morbidity in 23% of the sample. 43% of the doctors who died were married or in stable relationships. Only in 2 cases (8%) was there a previous history of intentional self harm. In 91% of the cases the stressor that led to the fatal event was known to the family or friend. The most common stress (70%) was stress at the workplace. Most of the respondents felt that the death of the victim could have been prevented had some intervention been done.
Background: A ‘delayed transfer of care’ occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. Delayed transfers – also referred to as ‘DTOCs’ or sometimes, often in the media, described as ‘bed-blocking’ – can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients. Here we look at how delayed transfers of care are measured, why they occur, and what impact they have.  

Aim: To audit the number of patients with delayed discharges from a low secure forensic ward between April 2017 and April 2018. To tabulate the reasons for delayed discharges. 

Methodology: To calculate the number of days for the Rio electronic systems discharge alert to the point of discharge. To go through patients case notes, specifically social work and tribunal reports, and identify attributable reasons for delayed discharges. 

Results: Total number of patients on the ward: 18 Total number of identified discharges during the review period: 8 Number of patients discharged: 6 

Conclusion: It is noteworthy that despite significant efforts from the clinical team, CTR recommendations, Tribunal recommendations/ directions and extensive negotiations/ conferences between teams the vast majority of patients have significant delayed discharges. The average number of delayed discharge days is running at 426.
Implementation of Mentalization-based Treatment Introductory (MBTi) Group in a Remand Prison Setting in Ireland

Dr Kezanne Tong, Central Mental Hospital, Registrar; Dr Niamh Joyce, Irish Prison Service Psychology, Clinical Psychologist

Aims  We aim to describe the implementation of a Mentalization-based treatment introductory (MBTi) group in Cloverhill Prison, challenges posed to the introduction of MBTi group in a remand setting and adaptations made to the established MBT for antisocial personality disorder (ASPD) model according to the needs and abilities of prisoners in Cloverhill Prison.  

Background  Psychotherapy is the recommended treatment for persons with borderline personality disorder (BPD), one of the therapies is MBT. MBT is an evidence-based psychodynamic-oriented psychotherapy. Recently, MBT has been adapted for the treatment of persons with ASPD. Persons with antisocial characteristics have fixed perspective about themselves. They seek confirmation from others of their world view. When challenged, they regulate their internal affect states by over-controlling their emotions, leading to violence to regain control. MBT aims to help these persons to maintain their mentalizing ability when their views are challenged.  

Cloverhill Prison is the main remand prison in Ireland, taking in 60% of remand prisoners. The remand status of inmates means they do not remain in the prison for a fixed period. This posed challenges to the setting up of an MBT programme in the prison. To our best knowledge, this is the first time an MBTi programme is introduced in a remand prison.  

Methods  The MBTi group was introduced for the first time in Cloverhill Prison in April 2018. Clinical characteristics of inmates were screened to identify suitable candidates. Selected inmates were invited to “welcome” sessions where an overview of MBT was presented to them. Inmates who were enrolled into the group may not have a diagnosis of BPD or ASPD. Participation was entirely voluntary. The programme was delivered by a Clinical Psychologist and Psychiatric Registrar in Cloverhill Prison with supervision by an MBT supervisor based in England.  

Results  Ten inmates participated in the MBTi group. Only half completed the ten-week programme. The high drop-out rates were due to a change in the remand status of participants during the therapy. Other challenges include the need to use simple language and visual representations during sessions as well as setting boundaries among prisoners outside treatment sessions.  

Conclusion  We described the first pilot MBTi group in the main remand prison in Ireland. Due to the remand nature of the prisoners, several challenges arose from the setting up of the programme. Consequently, the programme was adapted to suit the needs and abilities of the group participants within the available resources in the prison.
Audit of psychiatric court reports from a male remand prison over three years. Are they timely and clinically indicated?

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Aims  To determine, for all psychiatric reports requested for inmates in Cloverhill Prison from 2015-2017: Which court request most reports, Mean time to provide reports, Whether requests related to persons with mental illness, The proportions assessed as needing mental health admission or other follow-up.  

Background Prevalence rates for severe mental illness are higher in prison than in community settings. 7.6% of male remands have a psychotic condition. Criminal justice staff perform poorly in differentiating between persons with severe mental illness and persons with more minor conditions, or purely substance misuse problems. This may translate into inappropriate requests for psychiatric reports. Judges have complained of long delays in obtaining reports, particularly in District Court settings or for High Court bail applications.  

Method A record was kept of all reports completed at Cloverhill Prison from 2015-2017. Clinical variables included history of mental illness, current psychotic symptoms and ICD-10 diagnosis. Outcomes were grouped into admissions, community treatment and prison treatment. Only court-requested reports were included in the analysis (n=288).  

Results  Of 423 reports, 356 were to District Courts and 69% were to Courts in Dublin. Cloverhill District Court requested more reports than all other courts combined (220/423= 52%). 120/253 (47%) District/High Court reports (DHCR) related to persons with active psychotic symptoms, compared with 8/35 (23%) for reports for other higher courts (Chi-Square 7.520, df1, p=0.006). 136/253 (54%) DHCR related to persons with lifetime history of psychosis, compared with 14/35 (40%) for reports for other higher courts. 78% DHCR related to persons with lifetime history of contact with psychiatric services, compared with 74% for reports for other higher courts.  

Four grouped mental health outcomes for reports from DHCR differed significantly from higher court reports (Chi-Square 14.72, df3, p=0.002). 87/253 (34%) DHCR resulted in psychiatric admissions compared with 4/35 (11%) for reports for other higher courts. 74/253 (29%) DHCR resulted in discharge to prison primary care and/or addiction services compared with 18/35 (51%) for reports for other higher courts. 40% related to persons diagnosed with ICD-10 F20-29: Schizophreniform disorders. 17% had no mental illness. Over 90% had histories of substance misuse. Mean time from request to report provision was 14.9 days for District and High Courts (95% CI 13.3-16.38), and 50 days (95% CI 35.13-64.93) for other Higher courts.  

Conclusion This is the first large scale study of psychiatric reports over an extended timeframe in Ireland’s main prison and may help inform criminal justice services and mental health services.
Does live update of Structured Clinical Risk Assessment in a multidisciplinary risk review improve staff experience of the risk assessment process?

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Aims and Hypothesis

To determine whether changing risk assessment policy to allow Structured Clinical Risk assessments to be updated as a “live” document projected on to a screen within the risk review meeting would allow for improvement in staff experience and in the document being viewed as more multidisciplinary in nature.

Background

Current risk policy in NHS Lanarkshire focuses on an individual staff member, with appropriate training, completing a draft update to the risk assessment which then would either be circulated or discussed at a risk review meeting before finalisation. Informal feedback from those involved revealed that they often felt unsupported in this process and that they struggled to get timely feedback to complete the review. It was considered that many of the difficulties raised could be addressed by making the risk review meeting mandatory and updating annual reviews of existing assessments as a “live” document projected onto the screen during the meeting.

Methods

Prior to the implementation of the new system of reviewing structured clinical risk assessments allocated assessors were issued with a simple likert scale questionnaire seeking their views as to the current policy in relevant areas. The questions focussed on whether the assessor felt they had the necessary skills and their confidence in undertaking the report, how supported they felt while completing the risk assessment, and whether they considered the final report to be a multidisciplinary effort. A final question at the end allowed for general comments on the process or how satisfactory or unsatisfactory it was deemed to be. After the instigation of the new system of live updates the questionnaire was re-sent to the primary updating staff member to see if their views and experience of the process of risk assessment updates had changed.

Results

Eight of the ten questionnaires sent to risk assessors were returned. Results indicated that staff members found the new process of live updates to be less stressful, less time consuming, and more multidisciplinary in its completion. All staff found that they had greater confidence in the process and its conclusions. Seven of the staff group strongly agreed with the notion that live updates were an improvement, one agreed and no staff member disagreed.

Conclusion

Completion of annual risk assessment updates as a live document within the risk review meeting appears to improve staff experience and engagement. Additional benefits in reduction of staff time appear also to be present.
Incorporating quality improvement processes into normal clinical practice: A quality improvement project to create a system that supports sustained and repeated measurement of treatment in the medium and low secure unit, Rohallion Clinic, Murray Royal Hos

Dr David Walsh, NHS Tayside, ST6 Forensic Psychiatry  Dr Gordon Cowan, NHS Tayside, ST6 Forensic Psychiatry

Aims of project  To use the existing system of collecting information via CPA processes to support sustained practice of 6 monthly audit cycles to ensure ongoing improvements in clinical practice.

Background to project  Inpatients in our unit have Care Program Approach (CPA) meetings at set intervals; 6-8 weeks following admission, at 6-month intervals and in the weeks prior to discharge  At each meeting, each discipline is required to complete a ‘checklist’ [Variance Analysis Tool (VAT)] confirming that a number of interventions have been completed  The information currently collected by the VAT, although important, does not measure completion of interventions that would indicate whether certain standards of care, as measured by commonly used local and national guidelines, are met.

Method of project  An ‘Audit working group’ within the clinic was formed.  The aim of the group was to redevelop the VAT document, changing the information to be recorded by every discipline. It soon became clear that to make such a substantial change to the VAT document, possibly requiring collection of notably different or additional information, without first testing the changes would be unwise.   The focus of the working group became to review the VAT section completed by medical staff to collect additional information to support the completion of a limited number of audits.   A subgroup of the working group was formed and agreed that completion of 8 audits would be supported by the revised VAT document.  Audits were chosen on the basis of what was considered the most commonly occurring clinical practice situations within the clinic.

Guidelines were identified for each area of practice to be audited. National guidelines, if available, were used in each case. Adjustments to the Variance Analysis Tool (VAT) were made to support additional interventions to be measured that would allow the identified audits to be carried out.

Results  Initial review the first 8 completed VAT documents identified a number of difficulties. In the majority of cases, the updated document was not completed at all or not sufficiently to meet the aim of the project. The current plan is to carry out an in depth examination of why this is the case, adapt the document as necessary, and run familiarisation sessions with junior medical staff to complete the updated document. By October 2018, the plan is to have an updated document in place and have initial audit results available by February 2018 completed.
Psychiatric reports at NHS Lanarkshire: A retrospective study examining number of requests, demographic factors and diagnosis of individuals referred, and the psychiatric recommendations over a 24-month period (July 2016 to June 2018)

Dr David Walsh, NHS Tayside, ST6 Forensic Psychiatry  Dr Fiona Cooper, Consultant Forensic Psychiatrist  Dr Callum MacCall, Consultant Forensic Psychiatrist

Background  Requests for psychiatric reports from court services in Lanarkshire are sent to the NHS Lanarkshire Forensic Community Mental Health Team. Requests are then passed onto clinicians who previously indicated an interest in completing such reports. It was apparent the individuals for whom the requests are concerning are likely to reside in areas of economic deprivation. However, no data exists on their demographic details It was apparent that some of these requests for reports are not fulfilled at all or in good time, potentially to an individual’s disadvantage. However, no data exists on the response to the requests. Aim of project  Firstly, we describe demographic details, offence details, psychiatric details of individuals referred for court reports. An individual’s deprivation status is determined from an individual’s postcode using the ‘Scottish Index of Multiple Deprivation (SIMD) 2016’. Secondly, we examine the content of psychiatric reports to identify the diagnosis and recommendation made. Finally, we evaluate the service by describing the time between request and report completion, and whether a report has been requested on more than one occasion for the same matters. Method  The study population are those referred for psychiatric reports over a 24-month period; July 2016 to June 2018. The study is retrospective in design. There are approximately 200 requests for psychiatric reports over this period. 1. A database of court report requests is maintained by administration department at FCMHT 2. The study authors are in the process of contacting the individual clinicians completing the reports 3. Obtained reports are analysed to collect the data required 4. This includes cross referencing a patient’s postcode to determine the corresponding SIMD decile Results and conclusions  Preliminary results indicate that the majority of individuals referred for psychiatric assessment by the court, are unemployed males from the bottom two SIMD deciles.
Deliberate Self-Harm as the First Presentation of Attention Deficit Hyperactivity Disorder in Adolescents

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Aims and Hypotheses: The aim of this paper is to investigate the link between deliberate self-harm (DSH) and attention deficit hyperactivity disorder (ADHD) and assess its clinical implications. If this relationship is clinically identifiable, it allows for greater risk-prevention and management in both deliberate self-harm and ADHD. Background: DSH in adolescence poses significant challenges to sufferers, health carers, families and peers alike. Its aetiology has been linked to impulsivity, on a trajectory that also includes ADHD. Moreover, it has been shown that ADHD and DSH are related in multiple recent systematic reviews and studies, potentially mediated by emotional dysregulation (ED). Methods and Materials: this case-control study examined 124 cases of DSH, identified over a six-month period from electronic patient records. Strength and Difficulties Questionnaires (SDQs) are routinely completed by patients or their parents/carers at 7 days post-admission and are a screening tool for multiple psychiatric disorders, including ADHD and emotional dysregulation. The SDQ hyperactivity and dysregulation scores were calculated and compared against pre-existing reference data. Results: both the mean SDQ hyperactivity score and the proportion above threshold (a score greater or equal to 6) were significantly greater in the sample than the reference data for both parent and CYP groups (CYP: Sample Mean 6.6 versus UK Mean 3.8, Parent: Sample Mean 6.6 versus UK Mean 3.2, p<0.0001) (CYP: 72.9% sample scores≥6 versus 21% UK scores≥6, Parent: 68.5% sample scores≥6 versus 19.9% UK scores≥6, p<0.0001). In addition, there was a significantly greater proportion of people above the emotional dysregulation threshold in the sample than in the clinic sample of ADHD patients (57% vs 29%, p<0.0001). Conclusions: our findings point towards a clinically significant link between ADHD symptoms and DSH which can be assessed with SDQ screening. Our largely female sample also points towards this being an avenue of diagnosis for ADHD in girls that has not been previously recognised. Furthermore, we speculate that emotional dysregulation plays a role in the evolution of DSH in a dysregulated ADHD phenotype. We recommend that clinicians assessing presentations of DSH be aware for signs of hyperactivity/impulsivity and screen with SDQs as appropriate. The results warrant further investigation of this link in clinical practice and follow-up of patients.
Introduction to the updated ALACRITy study; a long-term follow-up of a Medium Secure Unit (MSU)

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The ALACRITy study is a follow-up project of patients admitted to Arnold Lodge MSU in Leicester, and has examined the outcomes of patients after discharge from the unit in terms of mortality, reconviction and readmission to hospital. The study cohort, of 909 patients, spans 30 years of admissions (1983 and 2013) and therefore provides important insights into how the admission characteristics of patients, and their course after discharge, has changed over time.

In this poster we provide a general theoretical and methodological foundation for the three more focused posters. We describe the background to the study, discuss the methodology used and explain how the services at Arnold Lodge have developed since 1983.

The poster aims to show MSU provision in the UK and how the Arnold Lodge service has changed over time. It will also show the methodology used to conduct this long-term follow-up study, including the ethical and legal permissions required, data sources and analysis techniques.
Secure psychiatric services are high-cost low-volume services and as such the management, care, and outcomes of individuals residing in secure care is of great public and professional interest. However, little is known about the outcomes of patients discharged from secure psychiatric care. The aim of this poster is to provide data on the outcomes of a cohort of 909 patients admitted to Arnold Lodge Medium Secure Unit in Leicester, England. This cohort represents the largest cohort and follow-up of patients discharged from a secure hospital and includes all patients admitted up to June 2013. This poster reports findings related to reconviction and readmission. It will show the risk of reconviction for the cohort, in particular the types of reconvictions patients received, time to reconviction and individuals who may remain a long term risk. The poster will also detail the likelihood of readmission for patients and those who might be more likely to be readmitted, with a particular focus on readmission to Arnold Lodge and Rampton High Secure Hospital.
Excess Mortality of Patients Admitted to Medium Secure Care: Findings from the ALACRITY Study

Dr Martin Clarke1, Ms Jodie Westhead1,2, Dr Lucy McCarthy1, Dr Ruth Hatcher2, & Dr Simon Gibbon1

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The original Arnold Lodge follow-up study spanned 20 years. It followed-up 595 first admissions to Arnold Lodge Medium Secure Unit in Leicester, England. Fifty-seven (10%) patients had died. The risk of death from any cause was six times greater than in the general population. We extended the study by 10 years to include all 909 admissions up to June 2013. We obtained mortality data from the Office for National Statistics. We report data about the risk of death, in particular deaths by suicide and from natural causes. In total, 135 patients (14.9%) died prior to the June 2013 census. The standardised mortality ratios indicated the risk of death from any cause, natural causes or suicide were 5.6 times greater, 4.0 times greater, and 22.4 times greater respectively, than that expected in the general population. Our findings highlight the need for long-term support and monitoring of the physical and mental health of this group in order to improve their health outcomes.
Changes in the Admission Characteristics of patients admitted to a MSU: Findings from the ALACRITY study

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The purpose and function of medium secure services has evolved since they were first established in the 1980s following the recommendations of the Butler report. As one of the first such services to be established, the case register at Arnold Lodge provides useful information about changes in the characteristics of patient admitted over the last 30 years. These changes reflect wider national changes in secure and general mental health service provision. Of particular note is the increasing acuity and risk profile of those admitted; the vast majority of whom are now admitted from prison. The poster will detail these changes and how they are relevant to current and future provision of secure psychiatric services.
Abstract for Poster on Development of a Dementia Pathway for Elderly prisoners suffering with Cognitive impairment or a Dementia Syndrome

Dr Rashi Negi, Dr Caroline Winkle, Dr Pallavi Chandra

Aims and Hypothesis:
To map out the need for a formal memory assessment and diagnostics services in prisons for the elderly with cognitive impairment.

Background:
There is an increasing number of elderly in prisons. Statistics reveal that about 11% of the prison population comprises of people aged 50 and over. 2 out of 203 prisoners aged over 60 have been diagnosed with dementia and this is suspected to be an under representation of the true numbers. Due to the structured regime in the prison environment, the signs and symptoms of early cognitive impairment can be overlooked. Hence, a scoping exercise was organised to map out the needs of older prisoners with cognitive impairment, which could help in the development of a formal pathway for these patients.

Method:
Research revealed that there was a high prevalence of elderly prisoners with suspected cognitive issues in two of the prisons in the Staffordshire area. The scoping exercise was initiated in the Stafford prison that had the most number of these patients, with a view to roll out to Featherstone. The time duration for this exercise was set as 2 years between 2016-2018. Patients were identified with the help of the prison doctor and were scheduled to see a specialist doctor for an initial assessment followed by subsequent appointment for diagnosis if deemed appropriate.

Results:
The majority of patients referred for assessment within the first year, were found to have a mild cognitive impairment that did not fulfil diagnostic criteria for Dementia at the time of assessment. Patients were however identified within our assessment process that had other mental health conditions that required treatment, which had not previously been identified.

Within the last year a greater number of the patients who have been referred into the service have been given a formal diagnosis of a Dementia syndrome. Possible reasons for this could include improved knowledge of the referring GP, a greater awareness amongst prison healthcare staff of the availability of the memory clinic service, or a possible demographic change in the prison population, with a greater number being elderly and having cognitive impairment or a Dementia syndrome.

Conclusion:
As a result of this scoping exercise the prison authority, in conjunction with CCG’s and the local mental health provider are looking at developing a clear lean pathway in order to assess, diagnose, treat and manage prisoners with a Dementia diagnosis, including offering post diagnostic support.
Aims  Broadmoor Hospital is committed to Quality improvement and in the spirit of promoting ‘least restrictive practice’ the Ascot (High Dependency ward) undertook a Quality Improvement (QI) project aiming to increase the association time (the mount of time patients have freedom of access to all areas and activities on the ward) for our LTS (Long Term Segregation) patients by 10% over a 6m period. Background, The process of safely terminating LTS is often lengthy and our approach to risk management can be improved. Increased LTS association hours allow us to focus on providing a range of one to one interventions with patients to reduce risk and promote recovery.

Methods, We applied QI methodology. This included a stakeholder analysis and communication, process mapping and identification of primary drivers and the development of a number of change ideas. Change ideas have been sequentially implemented and refined via PDSA (Plan, Do, Study, Act) cycles. We collected outcome measures (number of association hours), balancing measures (Maslach Staff Burnout) and ‘customer’ measures (EssenCES 2010, Beck Hopelessness Scale).

Results  We have completed a PDSA cycle on the implementation of a specific ‘LTS meeting’ where only the risk management of patient’s nursed on LTS would be discussed. Our project is not yet complete however preliminary results are as follows: An improvement on the Maslach Staff Burnout measure from ‘high’ to ‘moderate’ on the depersonalization and ‘personal accomplishment’ parameters. An improvement on the EssenCES evaluation tool, both for staff and patients on all domains. A reduction on the ‘Beck Hopelessness Scale’ for our patients. A significant increase in ‘association’ time for our LTS patients.

Conclusions  Our project is ongoing and further PDSA cycles are planned. In the time that we have been working on the QI project 3/5 of our LTS patients were successfully re-integrated onto the ward. Our work has not only benefited patients though improved risk assessment and management but also led to improved feelings of personal accomplishment. Both patients and staff noted an increased sense of safety on the ward. In our HDU (high dependency) ward ‘hope’ is now more prevalent amongst the patient group. The effort involved in working on this project has also functioned as a significant team building exercise and has led to improved communication between the disciplines and individual team members and increased staff engagement.
There is a scarcity of data on service evaluation of women’s services both in general and forensic psychiatry. Since October 2015, the secure mental health service for women within Oxleas NHS Foundation Trust adopted a pathway model with patients progressing from an assessment and treatment focussed admissions ward to a rehabilitation-focussed ward within a single treatment episode. This change is in line with what some have recommended as best practice. The pathway model was further expanded within the South London Partnership, Wave 1, New Care Models programme and has been live since April 2017. This new model of care is now well embedded within three medium secure wards and one low secure ward across the three trusts, South London and Maudsley, South West London and St Georges and Oxleas NHS Foundation Trust within South London Partnership. This pathway was developed with a view to providing patient centred care that was needs focussed and would allow transition though the system more effectively and quickly, preventing stagnation between levels of security. The aim of the project was to evaluate the new pathway model of care within the women’s secure services. The evaluation looked at outcome measures that focused on quality of life and risk assessments and compared incidents rates, use of seclusion and restraint, HCR-20 C Scores and staffing levels obtained retrospectively pre-pathway model to post transition immediately and post six months. In addition, costs of the service pre-transition was compared with outcomes and cost post-transition taking into account the change in the staffing levels as well as distribution and expertise of the staff. The results showed that the rates of violent incidents, incidents of self-harm, use of seclusion and staffing shortage reduced six months post transition on both wards. The use of restraint and HCR-20 C Scores increased on the acute admissions ward. In conclusion, the results of the evaluation supports our hypothesis that a pathway model of care is more patient centred, cost-effective and needs-focussed.
The WORDS Multi-disciplinary Handover on a Secure Unit

Dr Nuruz Zaman, Essex Partnership Trust (EPUT), Consultant Forensic Psychiatrist  Killian Matiwa, EPUT, Ward Manager  Dr Adnan Bashier, EPUT, Associate Specialist  Dr Louise Roberts, EPUT, Clinical Psychologist  Victoria Nagy, EPUT, Assistant Psychologist  Charlotte Etchells, EPUT, Occupational Therapist  David Harris, EPUT, Social Worker  Michael Benson, EPUT, Integrated Clinical Lead

Aims: To improve the quality and relevance of multi-disciplinary (MDT) handovers on a secure ward. Hypothesis: There is considerable scope to utilise daily handover meetings, to convey essential dynamic risk in a timely and relevant format. This has potential to manage emerging risks, improve concordance and support pro-active interventions. There is potential to reduce length of stay, prevent escalation of risk and improve general staff and patient satisfaction. Background: Communication with multi-disciplinary teams working across health settings can be variable and suboptimal. Miscommunication is known as one of the leading causes of adverse events leading to harm. Better communication has been demonstrated to improve patient outcomes. Traditional handovers within secure wards were considered to be hierarchical, of variable relevance, inefficient and of limited accountability. Methods: Using a Quality Improvement methodology, an initial daily multi-disciplinary handover procedure was developed on a low secure unit. Historically, multiple handovers occurred on the ward between different professional groups. Inconsistent transmission of risk and updates of progress was present. The WORDS handover framework achieved initial acceptance by the multi-disciplinary team and was embedded into the ward routine and culture. Subsequent progress was made in conveying relevant risk information and reducing the length of time required and developing appropriate accountability. The WORDS mnemonic incorporates development of a WELCOMING culture, reporting of OBSERVATIONS, encouraging appropriate RECORDING, cultivating team DISCUSSION and subsequent appropriate SHARING outside of the immediate MDT. Results: Initial feedback of staff acceptance was positive. Further data is presented in terms of staff utilisation. Measures for risk management, time to intervention and general ward and patient safety are considered. Conclusions: The WORDS multi-disciplinary daily handover has scope for wider acceptance within secure care and other healthcare settings supporting multi-disciplinary communication and potential for reducing harm to patients.