Aims. Clozapine is a well-established and widely practiced treatment for treatment-resistant schizophrenia. Due to its significant side effect profile, it requires intense monitoring, including monthly blood tests and medical reviews. A patient's attitude towards clozapine can impact compliance with treatment and its monitoring process. This survey intended to identify the community mental health patients' perception of the clozapine treatment and its monitoring process and to help improve current practices of the service.
Methods. A structured survey with 17 questions was administered to patients registered at the community clozapine clinic via face-to-face or phone conversation at an Australian Community Mental Health Service by the principal researcher and clozapine coordinators.
Results. 17 out of 25 eligible patients (68%) participated; the mean age was 39.7 years. There were nine female and eight male participants. 94% of patients were on clozapine for more than one year. 70.5% agreed that clozapine helped to improve mental health, and they understand clozapine side effects and monitoring process. 76.5% agreed that the treating team provided psychoeducation. Seven participants reported clozapine improved side effects compared with previous medications. Three disagreed that clozapine improved side effects, and six remained neutral. Hypersalivation (35.2%), constipation (23.5%) and weight gain (17.6%) were identified as the worst side effects. Nine (52.9%) participants reported that they make healthy life choices. Factors affecting motivation for a healthy lifestyle are mental health symptoms (47%), finances (47%) and physical health well-being (52.9%). Only 35% identified motivation from others as necessary for a healthy lifestyle. Fatigue/poor motivation (47%) and mental health (35.2%) prevent them from making healthy choices. Side effects and finances equally (23.5%) impact healthy choices. Eleven participants (64.7%) felt clozapine monitoring was a positive experience, and 88.2% felt they had enough support during the clozapine monitoring process and were adequately informed about their treatment plan. Two participants disagreed that they were informed of their treatment plan. The majority (82.3%) said no change was needed in the monthly medical officer-led clozapine clinic or six-monthly psychiatrist-led clozapine clinics. Text messages (88.2%) and phone conversations (47%) were the most preferred method for treating team communication about treatment.
Conclusion. The majority of patients identified that clozapine helped to improve mental health, and the monitoring process was a positive experience. Most participants were aware of clozapine and its monitoring process. Psychosocial support will be essential to improve quality of life and might improve the negative perception of clozapine's side effects.

Improving the Management of Neuropsychiatric Presentations in Early Intervention Services (EIS)

Dr Henry Finn* and Dr Emily Easter

South West London and St George's Mental Health Trust, London, United Kingdom
*Presenting author.

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Aims. Early Intervention Services (EIS) are in a unique position to assess patients presenting with their first episode of psychosis. The possibility that an organic disorder may be underlying their presentation must be ruled out, often necessitating neuroimaging and/or input from neurology and neuropsychiatry.

We aim to improve the management of neuropsychiatric presentations in EIS. We will determine the incidence of cases, from the London Boroughs of Sutton and Merton, which warrant referral to neurology, neuropsychiatry and neuroimaging. We will then review referral pathways and provide justification for community services, such as EIS, to *autonomously* request referrals and neuroimaging.
Methods. We retrospectively reviewed the complete caseloads of EIS for Sutton and Merton (n = 121). We considered the neurological comorbidities of patients to determine the incidence of cases which warranted a referral to neurology, neuropsychiatry and/or neuroimaging. We reviewed how requests were made and the subsequent results.
Results. 15% of the EIS caseload had a neurological comorbidity. Migraine was the most common condition (8.3%), followed by traumatic brain injury (3.3%), headache (2.5%), and seizure (1.7%). There was one case each of epilepsy, stroke, transient ischaemic attack, cavernoma and cerebral venous thrombosis. 83% of patients with a neurological comorbidity had received neuroimaging and all imaging results were either normal or confirmed known pre-existing neurological disease. The 17% of patients who did not receive neuroimaging had only migraine as a neurological comorbidity. One patient was reviewed by neurology and diagnosed with psychosis presumed to be secondary to paraneoplastic syndrome. All patients that fulfilled criteria for a neuropsychiatry referral had this completed electronically. However, there was no clear pathway to request a review by neurology, and Sutton EIS had difficulties autonomously requesting and accessing the results of neuroimaging, delaying provision of appropriate care.
Conclusion. There is a small but significant burden of neurological comorbidity among EIS patients. In our brief study, we found one patient whose symptoms of psychosis were likely attributable to an organic cause. Accessible pathways to refer patients for neuroimaging, and subsequently to neurology and/or neuropsychiatry if indicated, are crucial in the assessment and management of first episode psychosis where an organic cause is suspected. Access to these resources should be efficient and autonomous for EIS. We are in the process of implementing referral guidance alongside a direct electronic referral process to request neuroimaging and further input from neurology and/or neuropsychiatry, to optimise care for patients and our service.

Improving the Visibility and Accessibility of Physical Health Information in a Forensic Medium-Secure Inpatient Unit

Dr Rijul Bohra[1,2], Dr David Kelsey[1] and Dr Jon FitzGerald[1]*

[1]Oxleas NHS Foundation Trust, London, United Kingdom and [2]South London and Maudsley NHS Foundation Trust, London, United Kingdom
*Presenting author.

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Aims. To improve the visibility and accessibility of secure inpatients' physical health needs by measuring staff satisfaction levels towards physical health information and monitoring.

Methods. Through purposive sampling we conducted a five-point Likert Scale on members of the multidisciplinary team (MDT) on one medium-secure forensic ward, within Oxleas NHS Foundation Trust, which provides 124 forensic inpatient beds to southeast London. We collated physical health data from across electronic patient records to create a single-point-of-access workspace on Microsoft OneNote, accessible to all members of the MDT contemporaneously, comprising past medical history, psychotropics requiring close monitoring (e.g. lithium, clozapine, valproate), vital signs, weight, bloodwork, electrocardiogram findings, hospital appointments/results and cancer screening.

We re-sampled members of the ward MDT after the workspace had been created and implemented.

Results. Nine members of the multidisciplinary team were sampled before and after the OneNote workspace was implemented.

- Pre-intervention, 56% disagreed that they were confident in quickly viewing recent investigation results. Post-intervention, 99% of users agreed/strongly agreed, with no negative responses.
- Pre-intervention, 67% disagreed or strongly disagreed that they were confident in knowing what physical health appointments were scheduled. Post-intervention, 100% of respondents agreed/strongly agreed.
- Pre-intervention, 78% disagreed or strongly disagreed that they were happy with the availability of past medical history information. Post-intervention, this increased to 99% agreed/strongly agreed.
- Pre-intervention, 89% disagreed/strongly disagreed that they knew where to see patients on psychotropics requiring close monitoring. Post-intervention, this increased to 100% strongly agreed.
- Pre-intervention, 66% disagreed/strongly disagreed being able to see single-point, up-to-date physical health information, at baseline. This increased to 99% agreed/strongly agreed post-intervention.

Overall, 89% agreed/strongly agreed the workspace would allow them to better understand the physical health and monitoring needs of patients, whilst 78% agreed/strongly agreed it allows for more effective work across wards/sites in the Oxleas forensic directorate.

Conclusion. Physical health information is often overlooked in secure inpatient settings. Due to the limitations of the electronic patient record, it can be difficult to find relevant physical health information quickly. This can lead to dissatisfaction and a lack of confidence in the MDT, as shown in the baseline data.

After the Microsoft OneNote dashboard was introduced, there was a marked improvement in staff confidence, happiness, and awareness of physical health requirements for each patient.

Further data needs to be collected to assess for sustainability of these improvements. We intend to expand the scope of this system across the secure inpatient units in the Trust.

The Impact on Inpatient Stays, Crisis and Emergency Department Assessments In Patients With Emotionally Unstable Personality Disorder Who Complete an 18-Month Mentalization-Based Therapy Programme in a Tertiary Personality Disorder Service in Northern Ireland

Dr Adam Flynn[1]*, Dr Owen McNeill[2], Dr Chris Walsh[1] and Dr Cedar Andress[1]

[1]NIMDTA, Belfast, United Kingdom. and [2]Northern Health & Social Care Trust, Antrim, United Kingdom
*Presenting author.

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Aims. The Personality Disorder Service in the Northern Health & Social Care Trust was originally set up to deliver evidence-based treatment for people with the diagnosis of personality disorder. This group of people historically have been stigmatised, excluded and let down by services, despite their complex needs and frequent history of childhood trauma. The team developed a Mentalization Based Therapy (MBT) programme originally commencing in 2013.

To identify recent completers of the MBT 2 18 month programme and to assess whether there was any reduction or change in pattern to the number of days spent as inpatient both during and after having completed the programme, whether there was a reduction in the frequency of same day assessments with community mental health teams or unscheduled care and finally whether there was any reduction in terms of volume of crisis assessments and presentations to Emergency Department.

Methods. Using validated Quality Improvement Methods, a Plan Do Study Act Cycle was commenced which involved identifying patients who had begun and finished the MBT programme and minimum of 12 months had passed since completion in order to follow-up.

We then broke down this data into 3 domains. By using EPEX, Paris and Electronic Care Record computer systems, it was possible to analyse days spent as inpatient, same day assessments and crisis assessments as well as Emergency Department attendance.

For these periods of time, they were split into pre-commencement of programme (18 months), during programme (18 months) and post-completion of programme (12 months) to see if there was any tangible decrease in these numbers.

19 service users were identified that had initially been referred to Personality Disorder Service between 2016 and 2018 and who subsequently began MBT2 programme between 2017 and 2019. Given the length of completion of the programme, this allowed us to gather a full set of data with regard to these patients up to completion of programme in 2021. Subsequent period of 12 months was then analysed post-completion of treatment taking us up to 2022.

Results. The average time spent in inpatient admission days prior to starting therapy for 18 months (n = 19) was 21.74 days, this decreased to 6.53 during therapy and 3.68 post-therapy (12 month follow-up) = 5.52 adjusted for 18 months. This represents a reduction of 74.61%.

The average number of same day assessments and unscheduled care (n = 8) seeking prior to admission was 1.38. This decreased to 0.75 during therapy and 0.88 post-therapy adjusted to 1.32 for 18 months, which represents a small decline of 4.35%.

Finally, the average number of Crisis contacts and Emergency Department assessments were 2.63 in the 18 months before commencing therapy, 1.26 during therapy and 0.58 in the 12 months post-therapy, 0.87 adjusted for 18 months. This represents a reduction of 66.92%

Conclusion. It is clear from analysis of the data that there has been a substantial decrease in time spent as admitted inpatient as well as number of contacts with Crisis Assessors and Emergency Departments in association with completion of the MBT 18 month programme.

This demonstrates that, by using an evidence-based and well-established programme, which carries a high time commitment for both service users and practitioners, it is possible to