

patients with high BP at the baseline it has improved following the intervention.

We would continue implementing healthy weight interventions on the ward and across the unit.

Diabetes care in an acute psychiatric inpatient setting: a logic model for service delivery

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Aims. To develop a logic model that illustrates the steps needed to develop an effective intervention for diabetes management in a psychiatric inpatient setting, as the point of admission to a psychiatric inpatient unit may present as an opportune time for improving diabetes care.

Method. We undertook (i) a survey of diabetes care among inpatients in a Mental Health Trust in England, comparing care to the National Health Service (NHS) Core National Diabetes Standards (ii) interviews with key clinical staff to understand challenges in delivering good diabetes care (iii) a review of current UK guidance on standards for diabetes care. On the basis of the findings we developed an initial logic model for service delivery.

Result. Among 163 inpatients reviewed, 44 (27%) had a diagnosis of diabetes, and only 3 (7%) had all three National Institute for Health and Care Excellence (NICE) treatment targets within range. Staff identified needs for regular training, better understanding of roles in shared care, and good quality IT support. We developed a logic model that illustrates the steps needed to develop an effective intervention for diabetes management in a psychiatric inpatient setting.

Conclusion. Admission to a psychiatric inpatient setting provides an opportunity in which diabetes care may be optimised. The quality and understanding of diabetes care will need to be enhanced if this opportunity is to be exploited.

Evaluation of a specialist service model for treating body dysmorphic disorder (BDD): application of National Institute for Health and Clinical Excellence Guidelines for BDD (NICE, 2006)

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Aims. Body dysmorphic disorder (BDD) is still poorly recognised with a dearth of research into treatment. The OCD/BDD Service (South West London St. George's Mental Health NHS Trust) is a specialist service offering treatment for BDD using the National Institute for Health and Clinical Excellence (NICE) stepped care model for BDD as a basis for service provision.

This is the only known study to date to evaluate the implementation of the NICE guidelines recommended treatment for BDD in clinical practice. Furthermore, a sample of patients and clinicians were interviewed to elicit their evaluation of treatment.

Method. A total of 48 patients with a primary diagnosis of BDD who were offered treatment between 2006 and 2018 were identified. Questionnaires routinely completed at time of assessment

were Yale Brown Obsessive Compulsive Scale for BDD (YBOCS-BDD); Montgomery-Asberg Depression Rating Scale (MADRS); Beck Depression Inventory (BDI) and Sheehan Disability Scale (SDS). Assessments were conducted by clinicians with expertise in BDD. Clinical data including risks and sociodemographic information were collated and analysed. Data were examined with intention to treat analysis. Thematic Analysis (TA) was used to analyse data from semi-structured interviews conducted with ten clinical staff and seven patients regarding their experiences of treatment. Qualitative data were coded and themes identified.

Result. Clinical data at assessment indicated impaired functioning plus high risks and substance misuse. There was a higher percentage of females (58%); average duration of BDD was 19.23 years. Clinical outcomes indicated significant improvements in the total sample from baseline on measures of BDD, depression and functioning ($p = 0.001$). Patients described their progress in terms of living skills, social interactions and quality of life. The main themes identified included the significance of the therapeutic relationship expressed by both patients and clinicians; the lack of early intervention and knowledge of BDD in healthcare.

Conclusion. Current recommendations for treating BDD were found to be beneficial overall. However, there are patients who are non-responders and including experiences of patients' and clinicians' perspectives provided valuable insights into other options for treatment which are lacking and could enhance current recommendations where CBT and medication have not enabled progress. The young onset age with long duration, highlights the need for developing awareness of BDD so that it is not a hidden disorder.

A service evaluation of the use and outcomes of inpatient detoxification for the treatment of alcohol and opiate dependence within a community addictions service

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Aims. The 2012 Health and Social Care Act transferred Addictions commissioning from the NHS to local authorities, leading to cuts of up to 30-50% of budgets and having the greatest impact on inpatient detox services. In a system with such limited capacity, effectively triaging access to detox services and optimising the efficacy of each detox has become increasingly important. NICE offers limited guidelines to assist with making these decisions, focused on assessing the severity of dependence and risk, but provides little detail on specific predictors of success. Our aim is to evaluate the nature of cases referred for inpatient alcohol or opiate detox and their treatment outcomes. This will help develop our understanding of the factors which influence achieving abstinence, and inform future decision-making regarding suitability for inpatient detox and post-detox planning. Conclusions will form part of a review of the local alcohol care pathway guidelines.

Method. A retrospective case note review of all inpatient detox admissions between April 2019-March 2020 ($n = 113$ patients) is being undertaken. Our data collection tool extracts quantitative and qualitative data based on criteria from Alcohol use disorders (NICE, 2017), Opiate detoxification (NICE, 2019) and local pathway guidelines.

Result. Preliminary analysis of data from November 2019–March 2020 (43 patients) showed that a clearly documented rationale for inpatient detox was recorded in 95% of cases. 100% of cases had a recorded AUDIT score, whilst SADQ scores were recorded in 50% of cases. 33% of cases were admitted to rehab post detox, and 19% were prescribed anti-craving medication. Abstinence at one year was confirmed in 21% of cases. 28% of clients received a second detox within one year. The rationale for inpatient detoxes in this population is to be reported.

Conclusion. Preliminary data may highlight an opportunity to improve pre detox decision-making and post detox care, with confirmed abstinence in only 21% of clients at one year after detox. The low proportion of completed SADQ scores before accessing detox could offer an opportunity to improve client assessment, and the small proportion of clients prescribed anti-craving medication highlights an area of post detox care which could also be improved. The main limitation of this study is the lack of linked analysis of outcome to specific predictors, which is something that could be explored in future. It would also be valuable to gain survey data on the experience of accessing detox from a service user perspective.

A review of patients discharged from Shannon Clinic are shorter stays in secure hospitals associated with poorer patient outcomes?

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Aims. Shannon Clinic was established as the regional secure unit in Northern Ireland in 2005 and provides medium secure care to Northern Ireland's population of 1.8 million. Previous research has shown that inpatient admissions are shorter when compared to other secure units. Northern Ireland has less secure beds per population than the other UK nations, which can be a driver for shorter hospital stays. This review was undertaken to examine if shorter inpatient stays were associated with poorer outcomes.

Method. All the discharges from Shannon Clinic to the Southern Health and Social Care Trust were reviewed over a period of 10 years (2009–2019). The outcome measures examined were mortality, readmission rate and reoffending rate. Crude rates for these were calculated. To allow for comparison, these rates were compared to the systematic review findings of Fazel et al (2016), which was an international review examining patient outcomes following discharge from secure hospitals.

DUNDRUM 1 Triage Security scores for the patient group were also reviewed, to ensure a sample representative of patients needing medium secure care.

Result. 41 patients had been discharged during this period. DUNDRUM 1 Triage Security scores ranged from 2.44 to 3.2.

The average length of admission was 415.5 days. This is shorter than the average reported by Fazel et al (2016).

The crude rates for all of the variables calculated (mortality, readmission to hospital and reoffending) for patients discharged from Shannon to the trust were less of those reported in the systematic review by Fazel et al (2016).

Conclusion. This review suggests that patient outcomes are not negatively impacted by shorter inpatient stays in secure hospitals. A possible reason for this is the regional model of care approach, which helps ensure continuity and safe management of the

transition between secure care and the community. In addition, there is close multidisciplinary working with supported living providers in the trust area to ensure patients' needs are met.

Following this initial review, there are now plans to review discharge outcomes for all patients discharged during this period. There are five trust areas in total in Northern Ireland so this will allow for comparison across the region.

The review has also been used within the unit to develop information leaflets for patients at admission and posters for display in the unit. We hope this will provide clarity to patients about secure care and a sense of optimism from the start of their admission.

Audit of physical health monitoring during initiation and ongoing treatment with antipsychotic medication in a tier 3 outpatient CAMHS service, Belfast

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Aims. To evidence that physical health monitoring during antipsychotic initiation and continued treatment within the Child and Family Clinic is current, as per the agreed Antipsychotic Medication Monitoring Schedule for Belfast Trust CAMHS (2015), supporting Quality Network for Community CAMHS (QNCC) accreditation.

Background. The Antipsychotic Medication Monitoring Schedule CAMHS(2015) was agreed by a working group of consultant psychiatrists and pharmacists, based on evidence from The Canadian Alliance for Monitoring Effectiveness and Safety of Antipsychotics in Children (CAMSEA), NICE Guidelines CG 185(2014), CG155(2013) and Maudsley Guidelines, and was to be located on the electronic system (PARIS).

Method. In January 2019, a list of all children/young people on antipsychotic medication was collated (n = 12). Presence of the monitoring schedule in the clinical notes or PARIS was recorded. The Electronic Care Record was reviewed for blood results and PARIS letters for documentation of physical health parameters (heart rate, blood pressure, height, weight, BMI, extrapyramidal side effects, ECG) and to identify documentation of risk/benefit review where monitoring was declined. Re-audit January 2020 (n = 9). Criteria:

All patients commenced on antipsychotic medication will have baseline blood investigations and other physical health parameters documented as per the monitoring schedule. If monitoring was declined, the reason for this and indications for prescribing must be documented as a risk/benefit analysis.

All patients on antipsychotic medication will be current with their physical health Monitoring Schedule.

All patients will have their Monitoring Schedule completed in clinical notes or on PARIS.

Result. First cycle results (n = 12):

Baseline bloods (or documented declined) = 92%, Baseline ECG (or documented declined) = 75%

Complete monitoring bloods = 33%, Physical health monitoring parameters complete = 42%

Monitoring schedule present in the notes and current = 42% (0% on PARIS).

Initial Recommendations: Standardised recording of monitoring using PARIS clinic letters and the schedule in front of clinical notes; Baseline ECG mandatory

Second cycle results (n = 9):