

Those with and without emotional instability as a primary diagnosis or significant problem were dichotomised to facilitate identification of statistically significant factors specific to these symptoms.

**Result.** There were 35 completed suicides including three inpatients. Suicide was most common in the 25-29 and 45-54 age ranges, and over 68.6% were male. Hanging accounted for 60.0% of deaths, and self-poisoning for 8.6%. Up to 62.9% of patients did not appear to have ongoing scheduled appointments on a regular basis. Diagnoses were difficult to identify – 48.6% had no clear primary diagnosis specified in the reviews, and features of depressive, anxiety, psychotic, substance misuse and personality disorders frequently overlapped and co-occurred. 22.9% had problems with emotional instability; their median age was 14 years younger, and 87.5% were female.

**Conclusion.** Small sample size precluded detailed analysis. The traditional risk profile remains relevant. However, almost 25% of those completing suicide were younger females with emotional instability, despite frequent contact with services. Given the challenges in predicting suicide, we should continue to consider how best to prevent this tragic outcome in all service users, especially in younger females with emotional instability; middle-aged males who misuse alcohol, and those with ill-defined diffuse psychological difficulties who do not fit into discrete categories or are reviewed infrequently.

### Experiences of people seen in an acute hospital setting by liaison mental health services: responses from an online survey

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**Aims.** Recently the NHS has expanded the provision of liaison mental health services (LMHS) to ensure that every acute hospital with an emergency department in England has a liaison psychiatry service. Little work has been undertaken to explore firsthand experiences of these services. The aim of this study was to capture service users' experiences of LMHS in both emergency departments and acute inpatient wards in the UK, with a view to adapt services to better meet the needs of its users.

**Method.** This cross-sectional internet survey was initially advertised from May-July 2017 using the social media platform Facebook. Due to a paucity of male respondents, it was re-run from November 2017-February 2018, specifically targeting this demographic group. 184 people responded to the survey, of which 147 were service users and 37 were service users' accompanying partners, friends or family members. The survey featured a structured questionnaire divided into three categories: the profile of the respondent, perceived professionalism of LMHS, and overall opinion of the service. Space was available for free-text

comments in each section. Descriptive analysis of quantitative data was undertaken with R statistical software V.3.2.2. Qualitative data from free-text comments were transcribed and interpreted independently by three researchers using framework analysis; familiarisation with the data was followed by identification of a thematic framework, indexing, charting, mapping and interpretation.

**Result.** Opinions of the service were mixed but predominantly negative. 31% of service users and 27% of their loved ones found their overall contact with LMHS useful. Features most frequently identified as important were the provision of a 24/7 service, assessment by a variety of healthcare professionals and national standardisation of services. Respondents indicated that the least important feature was the provision of a separate service for older people. They also expressed that a desirable LMHS would include faster assessments following referral from the parent team, clearer communication about next steps and greater knowledge of local services and third sector organisations.

**Conclusion.** Our survey identified mixed responses, however service users and their loved ones perceived LMHS more frequently as negative than positive. This may be attributed to the recent governmental drive to assess, treat and discharge 95% of all patients seen in emergency departments within four hours of initial attendance. Additionally, dissatisfied service users are more likely to volunteer their opinions. The evaluation and adaptation of LMHS should be prioritised to enhance their inherent therapeutic value and improve engagement with treatment and future psychiatric care.

### Priority clinic access or outreach to provide Sexual and Reproductive healthcare for people with mental illness?

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**Aims.** To compare two sexual and reproductive health (SRH) clinical pathways (a priority appointment at a mainstream SRH clinic versus assertive community outreach), and to explore how each improves access to care for people with psychotic mental illness, severe addictions and/or learning disability.

**Method.** Observational, descriptive study of two clinical access pathways within SHRINE (Sexual and Reproductive Health Rights, Inclusion and Empowerment), a specialist SRH programme to improve SRH care for severely marginalised people.

The SHRINE programme delivers effective, ethical, accessible and user-centred SRH care for people with severe addiction, serious mental illness and/or learning disability in the deprived inner London boroughs of Lambeth and Southwark. These individuals often find accessing conventional SRH clinics very difficult. SHRINE clients can self-refer but most of them are referred by their health or social worker.

Clients or referrers indicate their preferred pathway: priority appointment at the mainstream clinic or assertive community outreach. The priority appointment pathway at Camberwell Sexual Health Centre (CSHC) is as flexible as possible, with minimal waiting times, reminders, invitation to bring a friend or care worker and active follow-up of non-attenders via key workers.

Assertive community outreach can be in an addiction clinic, post-natal ward, mental health centre, psychiatric ward, outpatient clinic, homeless hostel or the client's home.

Time allocation for outreach and priority appointment-based care was 8 and 4 hours per week respectively. Care in both pathways was provided by senior doctors. Content of care was similar but facility for provision of gynaecological care including cervical smears and investigations for abnormal uterine bleeding e.g. pelvic ultrasound scans and endometrial biopsies were only available in the mainstream clinic setting at CSHC.

**Result.** From May 2016 to December 2020 SHRINE received 1367 referrals from 125+ teams. We offered 1591 first or follow-up appointments of which 1369 (86%) were attended. A total of 1153 (84%) of our patient contacts occurred in the outreach setting where 93% the appointments were attended. Of the 358 appointments at CSHC 316 (60%) were attended.

**Conclusion.** Making clinic access as simple and convenient as possible is not a sufficient strategy to meet the SRH needs of marginalised people. To enable them to realise their human right to sexual and reproductive health we need to leave our clinics and meet our clients where they are. A combined model of outreach and priority access clinic pathways is essential for provision of SRH care for people with mental illness.

### Working with catatonia: a qualitative exploration of inpatient team emotional responses

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**Aims.** Child and adolescent mental health (CAMHS) wards treat patients with variable presentations. During diagnosis and treatment, psychiatric professionals use structured criteria, but also honed awareness of countertransference. Unacknowledged emotional responses can produce powerful dynamics and impact patient care.

Limited information exists on possible emotional responses and team dynamics when working with catatonia.

This project aimed to establish common themes relating to staff felt-experience of working with a specific case of catatonia on a Child and Adolescent Mental Health (CAMHS) ward. A secondary aim was to establish potential areas for future training and service improvement.

**Method.** Trust Research and Development department approved this work. Inpatient professionals working with the specified patient during admission were eligible. Participants were invited via email and face-face discussion with one of the authors. Participants, patient and mother provided written consent.

A questionnaire was created and disseminated via email to eligible staff (n = 33). 27 questions asked individuals to rate responses on Likert scales, plus space for further comments. Questions involved emotional responses to different catatonic states, feelings towards self, patient, colleagues and plans. Descriptive analysis was completed on this anonymised data.

Qualitative data were gathered via 1-hour recorded focus group, led by a systemic psychotherapist and psychologist. The session was transcribed anonymously. Two clinicians, using Thematic Analysis, reviewed the transcript independently.

**Result.** 16 (48.5%) questionnaires were completed. Participants felt negatively about themselves and colleagues more frequently than about the patient. Participants felt positively about themselves less frequently than about colleagues and the patient. Participants identified with more feelings during immobile patient states than lucid states. During immobile states, participants identified with abusive, guilt, hopeless and neglectful responses; during lucid states, with helpful, caring, happy responses

Eight (50%) participants felt they sometimes did not understand their feelings towards colleagues/plans. Nine (57%) participants felt they sometimes did not understand their feelings towards themselves. Ten (66%) participants felt they sometimes did not understand their feelings towards the patient.

Ten (62.5%) participants felt confused by their emotions at least some of the time. Two (12.5%) frequently felt confused by their emotions.

Four participants attended the focus group. Themes included confusion, internal and team conflict.

**Conclusion.** Working with catatonia involved confusion and team splitting. Staff conflict between plans and morals resulted in painful emotions. Prompt psycho-education within teams working with uncommon presentations was identified as a focus for improvement. The authors plan to explore possible avenues for future teaching, learning and team support.

### Transition from child and adolescent mental health services to adult mental health services

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**Background.** The prevalence and recognition of mental health conditions in young people is growing. Around 50% of lifetime mental illness (except dementia) begins by the age of 14. Around 75% of adults requiring secondary mental health services developed problems prior to 18.

The TRACK study of young people's transitions from CAMHS to AMHS has found that up to a third of teenagers are lost from care during transition and a further third experience an interruption in their care.

A CQUIN for Transition has concluded that young children should have a transition plan 6 months before they turn 18.

**Method.** All young people aged 17 and a half years old were included in the data collection for this audit. Clinical information was reviewed using the West London RIO computer system. While reviewing the clinical documentation I was recording whether:

Transitional plans had been discussed with the young person.

If yes, what were they?

Had a referral been made to the appropriate service?

**Result.** There were 180 open cases to the Hounslow Adolescent Team. 35 cases were over 18:

At least 16 of these cases needed to be closed as no intervention was being provided.

14 cases had an unclear plan.

Of the 25 cases aged between 17.5 and 18 years of age transitional plans were:

Transition was discussed in 11 cases (44%). This meant that transitional plans were not discussed in 56% of young people.

Of these 11 cases 7 referrals were completed. (28%)

**Conclusion.** The lack of consistent protocols for transition remains a significant barrier to health care provided to young people.

Transitional planning needs to take place in an effective and timely manner to ensure continued patient centred care.