

Aims. Staff mental health is a major determinant of a well-functioning health system that has become ever more important during the COVID-19 pandemic. Poor mental health is the most common reason for NHS staff sickness absences, usually accounting for 25% of all reported sick leave. At a time when the NHS most needs an available and efficient workforce, government and NHS employers lack the necessary evidence to inform decisions about how best to support the mental health needs of its staff. In this report, we share our experience and the initial figures from a newly developed multidisciplinary assessment and treatment service for NHS staff.

Method. The Staff Mental Health Service (SMHS) at the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) launched in September 2020. The SMHS is commissioned by the Cambridgeshire and Peterborough sustainability and transformation partnership and is accessible to the 25,513 staff based at five NHS trusts within the region. The service received 235 referrals within 5 months of the launch. All patients had a first clinical contact within three working days and more than 80% had their initial assessment within two weeks. The SMHS clinical team is comprised of consultant psychiatrists, senior clinical psychologists, specialist mental health nurses, and an occupational health nurse set to provide rapid access, confidential, evidence-based treatments for the NHS staff. As part of service evaluation within CPFT, we collected routine screening data (Patient Health Questionnaire-9 (PHQ-9), Generalised Anxiety Disorder-7 (GAD-7), and Posttraumatic Symptom Check List – 6 (PCL-6)) from patients completing the initial assessment (n = 130).

Result. According to the initial figures (n = 130) from a diverse group of healthcare staff, on average the patients presented with moderate level of depressive symptoms (PHQ-9: 16.22 ± 5.94). Anxiety levels were in moderate to severe range (GAD-7: 13.45 ± 4.70). Average score of PCL-6 checklist for traumatic stress symptoms was higher than the established cut-off (>14): 19.43 ± 5.65.

Conclusion. The Staff Mental Health Service offers an innovative, multi-disciplinary rapid assessment and treatment clinic for NHS staff. The demand for the service has been immense, reaching double the number of predicted referrals. Initial data suggested high rates of moderate to severe depression, anxiety, and traumatic stress symptoms in healthcare workers. Our clinical observations was that many healthcare workers have had longstanding significant mental health conditions that saw deterioration during the COVID-19 pandemic. We hope that our experience in the SMHS will help inform models across the UK to address the clear unmet need for staff mental health.

Profile of sleep pattern, psychiatric comorbidity and problematic electronic gadget use in children and adolescents with autism and ADHD

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Aims. To assess the profile of Sleep pattern, Psychiatric comorbidity and problematic electronic gadget use and explore demographic factors and correlations in children and adolescents with ADHD and Autism.

Hypothesis: There are statistically significant problems and associations across sleep pattern, psychiatric comorbidity and gadget use in children and adolescents with autism and ADHD.

Background. Literature highlights increasing global trends and emerging concerns over the problematic use of electronic gadgets and sleep related problems in children and adolescents with autism and ADHD. There is sparse literature on the profile of sleep patterns, psychiatry comorbidity and problematic gadget use in children and adolescents with autism and ADHD from developing countries.

Method. This was an observational study conducted at the Child and Adolescent Psychiatry Clinic, Department of Psychiatry at a tertiary care Institution under the STS ICMR Project 2019 with Institutional Ethics Clearance. Apriori Sample size calculated was 70. Children and adolescents diagnosed with autism or ADHD as per ICD 10 criteria, fulfilling the inclusion criteria and willing to participate in the study were included. Informed consent was obtained from caregivers. Sleep Disturbance Scale for Children, Self Designed Parent based Problematic Electronic Gadget Use Scale, Vanderbilt ADHD scale, Indian scale for Assessment of Autism and the Child and Adolescent Psychiatry Clinic structured Performa were the tools for data collection. The results were analyzed with descriptive tests, chi square test and multiple logistic regressions using SPSS.

Result. Mean age of the sample was 9.1 years and majority (57%) were boys. Forty nine patients had ADHD and 21 patients had Autism. Problematic gadget use was higher in children ranging from 6 to 15 years of age and 12.8% had severe levels of problematic gadget use. 34.3% patients experienced severe problems in initiating and maintaining sleep. Oppositional-Defiant disorder was the most common comorbidity, predominantly inattentive type (76.4%) was the most common subtype of ADHD and mild autism (54.3%) was the most common type of autism in the sample. There were statistically significant associations (p < 0.05) between age and gadget use; hyperactive subtype of ADHD and problems with initiating and maintaining sleep and ADHD subtype, sex profile and problematic gadget use.

Conclusion. We conclude that sleep problems, psychiatric comorbidity and problematic gadget use are prevalent with statistically significant associations in children and adolescents with autism and ADHD as per our study findings. Our study has relevant clinical, research and policy implications.

Pregnancy audit in the PATH (Psychosis Prevention, Assessment and Treatment in Hertfordshire) early intervention in psychosis service

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Aims. To identify whether staff from the PATH Early Intervention in Psychosis (EIP) Service routinely ask female service users of child bearing age about their plans for pregnancy, whether risks of medication in pregnancy are routinely discussed and whether contraception is routinely discussed.

Method. In May 2019, a report was run capturing all female PATH service users of child bearing age (16-50 years) who were on the pathway at this time. This totalled 177 service users, all of whom were included in the sample. We used the search terms “pregnant”, “pregnancy”, “having children”, “contraception”, “conceive”, “baby”, “conception”, “miscarriage”, “abortion”,

“IVF”, “still born” to interrogate the patient records. Auditors searched case notes, clinic letters, recent physical health assessment and recent wellbeing plan for evidence as to whether staff had asked about pregnancy plans, contraception, offered a referral to the Community Perinatal Team, and discussed risks about medication in pregnancy.

Result. Of the 177 service users, 34 were asked whether they had plans for pregnancy (19%). Of the 177 service users, 28 were given advice regarding contraception (16%). Of the 34 service users who were asked about pregnancy plans, 27 did have plans for pregnancy. Of these 27 service users, 15 were offered a referral to the Community Perinatal Team (56%). Of the 27 service users who did have plans for pregnancy, 12 received advice and or information about risks of antipsychotic medication in pregnancy (44%).

Conclusion. It is clear that PATH staff are not routinely having discussions with female service users of child bearing age about their plans for pregnancy or contraception; this audit has identified that this occurs in less than 20% of cases. Of service users that did have plans for pregnancy, only 56% were offered a referral to the Community Perinatal Team; we should strive for this to be 100% so service users can access specialist support and advice. Work is underway to include information on pregnancy in the PATH service information leaflet to ensure women referred to PATH expect staff to ask them about their plans for pregnancy and contraception. Questions about pregnancy planning and contraception are to be embedded in the Trust's Physical Health Assessment care document to act as a prompt for staff. Finally, the topics of pregnancy and contraception in women with psychosis have been incorporated into the PATH physical health training programme which will be delivered with support from the Community Perinatal Team.

Non-attendance at psychiatric outpatient clinics: comparison of clinical, risk and demographic factors between attenders and non-attenders

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Aims. With an overarching aim of decreasing the incidence of non-attendance in psychiatric outpatient clinics, this service evaluation was intended to explore the profile of non-attenders. Specifically, the clinical, risk and demographic features of patients who did not attend their psychiatric outpatient appointments were compared with those of attenders. The outcome of patients who did not attend was also studied.

Method. All the consecutive non-attenders ($n = 32$) in November 2020 in a psychiatric outpatient clinic were compared with 32 consecutive attenders. The groups were compared based on clinical features (diagnosis, medical treatment, psychological treatment, care programme approach, first contact), risk profile (self or others) and demographic features (age, gender, ethnicity, accommodation, occupation, benefits). The non-attender sample was also analysed to consider the outcome after their missed appointment, following local Trust protocols.

Result. The overall rate of patients who did not attend their appointment was 22%. There was a statistically significant difference between the age and gender of non-attenders. Males were less likely to attend their appointment than females ($p = 0.024$). The mean age of patients who did not attend their appointment was 36.4 compared with 44.8 years in the attenders ($p = 0.005$).

There were a few clinically relevant findings. Around one third (34%) of patients who did not attend their appointments had a history of risk of self-harm noted in previous appointments. The results also showed that 75% of individuals who did not attend their outpatient appointments were unemployed. There were no significant differences based on the type of treatments (depot injections, lithium, clozapine, antipsychotics or antidepressants) patients received. Patients who did not attend were more likely to have a mood disorder (59% compared with 40%), and less likely to have a psychotic disorder (25% compared with 44%). Of the patients who did not attend, all were appropriately contacted as per the local Trust guidelines via a letter, and were provided with appointments where appropriate; 34% of non-attenders were discharged from services.

Conclusion. Non-attendance at psychiatric outpatient appointments is a concern, particularly for younger and male patients. Considering the clinical risks associated with this patient population, efforts need to be taken to improve their engagement with mental health services. Future studies may explore patients' perspectives of non-attendance and how to ameliorate any hindrances to attending.

How long does it take community mental health team staff to suspect autistic spectrum disorder?

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Aims. We wanted to discover the time delay between the initial assessment of service users referred to a Community Mental Health Team (CMHT) and suspicion that they had an Autistic Spectrum Disorder (ASD). We wanted to know whether early use of a screening questionnaire could significantly reduce this delay.

Background. About 1% of the UK population have ASD and the rate is higher among service users within CMHTs. Although CMHT staff are trained to recognize service users with ASD, often the diagnosis is only suspected when service users do not make progress with standard treatment. Early recognition of ASD informs a treatment pathway individualised for people with ASD. Brief screening instruments for ASD can help clinicians decide whether to refer someone for a full diagnostic assessment. The fifty question Autism Questionnaire (AQ50) and ten question Autism Questionnaire (AQ10) both perform well as a screen for ASD.

Method. All referrals from two adult CMHTs to a specialist Wiltshire Autism Diagnostic service (WADS) over a 2.5 year period were ascertained from a referral database. 24 service users referred from the CMHTs were identified. We determined from their records: (A) overall time between initial CMHT appointment and referral to WADS, (B) time between initial CMHT appointment and screening test (when used), (C) time between screening test and referral to WADS.

Result. For all 24 cases, the average time between initial CMHT appointment and referral to WADS was 186 days. 18 of the 24 service users completed a screening questionnaire prior to WADS referral (AQ10 or AQ50 or both); 16 of these had positive screening tests. The average time between initial CMHT appointment and use of screening test was 164 days. The average time between screening test use and referral to WADS was 32 days.

Conclusion. Our results demonstrated the average time taken from CMHT staff first seeing a patient to suspecting ASD and