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

Mahum Kiani* and Nilamadhab Kar
Black Country Healthcare NHS Foundation Trust
*Corresponding author.
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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?
Kirsty Knight* and Ian Ellison-Wright
Fountain Way Hospital
*Corresponding author.
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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...
Aims. Psychiatric hospitals are well equipped to manage patients with complex psychiatric needs, however due to their community setting when a rare medical emergency occurs it is not unusual for a small delay whilst staff search for equipment on the ward or even go to other wards for equipment. The aim of this audit is to ensure that our psychiatric wards in Carseview Centre are well equipped to respond to patients becoming medically unwell and put our nurses and doctors in a position to safely stabilise the patient until further help arrives.

Method. We collected data from 3 inpatient adult wards, 1 intensive psychiatric care unit and 1 learning disability unit and compared their resuscitation trolley equipment with local NHS Tayside Emergency Equipment Protocol in January 2020. Following data collection we fed back to the wards about our results and discussions were held between doctors, charge nurses, pharmacists and resuscitation officers to determine whether missing equipment was necessary in the community setting and to see if there were updates that required for our local protocol to better reflect current practices as it had not been reviewed since 2012. Following multiple meetings we amended our local protocol to better reflect what was. A list of recommendations was also made to improve patient safety.

We then collected data again in January 2021

Result. Following our first data collection we found that the resuscitation trolleys tended to not have ligature packs and masks were generally not by the oxygen cylinders. Hypoglycaemic dextro-tablets were also not readily available. The Learning disability units also did not have an emergency resuscitation trolley.

Following our discussions and amendment of the protocol this was finalised in November 2020 and was disseminated towards the wards and we waited 2 months for the changes to take effects and recollected our data. There continued to be equipment that was incomplete/missing on each individual ward, but none that were consistent throughout the whole hospital site. All the recommendations that were made for the 1st data collection had been done.

Conclusion. Overall we felt that the emergency trolleys were better equipped in line with the updated protocol compared to the previous audit cycle. The overall pattern of missing equipment was inconsistent and the recommendation was for staff to complete checks to address missing/incomplete items when found. Our local protocol also recommends that all ward should stock 'additional items' (nebuliser masks and non-rebreather masks), which majority had however were difficult to locate, which could delay patient care.

We will continue to repeat data collection cycles and feedback to our wards to ensure patient safety is not compromised.

Psychopathology and cognitive deficits in young people exposed to complex trauma

Stephanie J Lewis*, Karestan C Koenen2, Antony Ambler3, Louise Arseneault1, Avshalom Caspi4, Helen L Fisher3, Terrie E Moffitt4 and Andrea Danese1

1Institute of Psychiatry, Psychology & Neuroscience, King’s College London, South London and Maudsley NHS Foundation Trust; 2Harvard TH Chan School of Public Health; 3Institute of Psychiatry, Psychology and Neuroscience, King’s College London and 4Duke University, Institute of Psychiatry, Psychology and Neuroscience, King’s College London

*Corresponding author.

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Aims. Complex traumas are traumatic experiences that involve multiple interpersonal threats during childhood or adolescence,