"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

referring to a specialist diagnostic team was about 6 months. However, after a screening questionnaire had taken place, the time to referral was only around one month. We propose that screening is considered at an earlier opportunity; ideally during (or prior to) the first appointment with the CMHT in order to reduce the time before a referral to a specialist diagnostic team is made. This would enable treatment in a care pathway which incorporates the diagnosis of ASD at an earlier stage.

Development and validation of a non-remission risk prediction model in First Episode Psychosis: An analysis of two longitudinal studies

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Aims. Psychosis is a major mental illness with first onset in young adults. The prognosis is poor in around half of the people affected, and difficult to predict. The few tools available to predict prognosis have major weaknesses which limit their use in clinical practice. We aimed to develop and validate a risk prediction model of symptom non-remission in first-episode psychosis.
Method. Our development cohort consisted of 1027 patients with first-episode psychosis recruited between 2005 to 2010 from 14 early intervention services across the National Health Service in England. Our validation cohort consisted of 399 patients with first-episode psychosis recruited between 2006 to 2009 from a further 11 English early intervention services. The one-year non-remission rate was 52% and 54% in the development and validation cohorts, respectively. Multivariable logistic regression was used to develop a risk prediction model for non-remission, which was externally validated.
Result. The prediction model showed good discrimination (C-statistic of 0.74 (0.72, 0.76) and adequate calibration with intercept alpha of 0.13 (0.03, 0.23) and slope beta of 0.99 (0.87, 1.12). Our model improved the net-benefit by 16% at a risk threshold of 50%, equivalent to 16 more detected non-remitted first-episode psychosis individuals per 100 without incorrectly classifying remitted cases.
Conclusion. Once prospectively validated, our first episode psychosis prediction model could help identify patients at increased risk of non-remission at initial clinical contact.

Audit on resuscitation equipment in Carseview Centre (NHS Tayside)

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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 furthur 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 were neccesary 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. Folloing 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 dextrotablets 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 dissemindated 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 copmlete 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

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