

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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doi: 10.1192/bjo.2021.907

**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 first-hand 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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doi: 10.1192/bjo.2021.908

**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.