Department of Psychiatry. The department has 9 specialists, 4 to 5 Junior doctors and is supported by Allied Health Professionals like Psychologists, Occupational Therapists, Medical Social Workers and Nursing Professionals. All the above-named professionals work together as a well-oiled unit caring for the mental health needs of the patients mainly in the North East of Singapore. Ward 45 in SGH where the psychiatric unit is located houses inpatients who are 18 years and above. The patients have varied diagnosis, present with different risk profiles and as expected in any inpatient unit have varied lengths of stay. The aim was to start an inpatient programme which would benefit the patients during their stay and help in their recovery as well as equip them to build on their recovery and get back to successfully living in the community.

Methods: At the outset a few sessions were arranged involving all the professionals to discuss the therapeutic needs of the inpatients and how they could be addressed. The main aim of the programme was to help in recovery and relapse prevention. A list was compiled and in subsequent sessions the different health professionals who could deliver that was then mapped out. Once this was clear the individuals took it back to their respective departments to finalise on the deliverables and scheduling. This whole process took about a month. Once we were clear on the individual roles, we submitted the manpower requirement and time requirement for the Hospital Finance to generate a service code based on which the charges could be implemented. In subsequent meetings with all the professionals the different dates on which each professional could deliver the inpatient activity was finalised. The programme went live in February 2024. After a 3 month period feedback was obtained from patients and also the professional;s involved and some minor changes were made. We have now completed a year of the programme. A sample of type of activity is given below:

Psychology:

My distraction plan (pleasurable activities + thinking of someone patient cares about).

Self-soothing plan (self-compassion).

Un/helpful thinking styles.

Sleep hygiene + plan.

Values + action plan.

Self-esteem (kindness meditation).

Coping statements.

Relaxation (deep breathing + PMR).

Occupational Therapist:

Painting.

Collage.

Craft.

Drawing.

Medical Social Worker:

Generic activities to improve interpersonal skills and functioning.

Therapeutic approaches like IPT and DBT.

Nursing:

Psychoeducation activities about their condition.

Psychoeducation around the medications the patient is on.

Personal care advice and training.

Results: The Programme was accepted and appreciated by majority of the patients. The healthcare professionals also enjoyed delivering various therapeutic aspects to the patients and took an active role to improve care of the patients. A survey was done which captures the patients' views on some aspects of the programme by different professionals. The results have been overwhelming and a high percentage of patients have rated the programme as appropriate, useful and recommendable to others. A brief tabulation of the survey has been posted below:

Psychology: 76% of the participants found the programme useful in their treatment journey; 73% of the participants would recommend the programme to other service users.

Occupational Therapist: 89% of the participants found the programme useful in their treatment journey; 93% of the participants would recommend the programme to other service users.

Medical Social Workers: 75% of the participants found the programme useful in their treatment journey; 75% of the participants would recommend the programme to other service users.

Nursing: 63% of the participants found the programme useful in their treatment journey; 69% of the participants would recommend the programme to other service users.

Conclusion: The response to the initiative and encouragement has been overwhelming. We would like to enhance and build on the progress. Another regional hospital in Singapore has expressed interest in learning from our model and we intend to assist them in any way and collaborate and build on what we have gained. We are in the process of collecting data to see if we have made any progress on relapse prevention. Some of the things we can improve on:

The duration of the sessions as some patients stay short periods hence miss out.

Some patients who are high risk are excluded and we need to devise ways to include them.

Increasing awareness and also devise means of reducing the financial burden for participation in the programme.

Constantly look at what is delivered and how a varied and broad category of interventions can be provided (prevent repetition).

Clinician Perspectives and Practices in Addressing Substance Use Among Children and Adolescents in NHS Grampian CAMHS

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Aims: This study examines the perspectives, practices, and training needs of NHS Grampian CAMHS clinicians in addressing substance use among children and adolescents. The primary objectives are to:

Evaluate clinicians' attitudes towards adolescent substance use.

Identify perceived barriers to effective assessment and intervention.

Inform the development of an integrated substance use pathway within CAMHS.

Methods: A cross-sectional survey was conducted between September and November 2023 using SNAP software. The survey was distributed to 48 CAMHS clinicians across NHS Grampian and included structured and free-text questions on demographics, clinical practices, perceived challenges, and training needs. Quantitative data were analysed in Microsoft Excel, while qualitative responses underwent thematic analysis.

Results: The survey captured diverse professional representation: 50% psychologists, 25% nurses, and 14.5% medical staff. While clinicians acknowledged substance use experimentation as part of normal adolescent development, they emphasized that persistent or problematic use requires structured intervention. The majority supported a multidisciplinary, multi-agency approach for better integration between mental health and substance use services.

Significant training gaps emerged: 46.9% of clinicians lacked familiarity with evidence-based interventions, while 40.8% required further training to implement them effectively. Only 10.2% reported

regular use of such interventions in practice. Clinician confidence varied, with some expressing neutrality or disagreement regarding their preparedness to assess and manage problematic substance use.

Key barriers included limited resources, inadequate service integration, and challenges in engaging young people and families. Qualitative responses highlighted the need for structured training, clearer referral pathways, and enhanced service coordination. Clinicians emphasised the importance of ongoing education programmes that evolve with emerging substance use trends.

Conclusion: The findings reveal significant gaps in clinician training, confidence, and service integration. Recommendations include:

Expanding training opportunities to strengthen familiarity with evidence-based interventions.

Enhancing referral pathways to improve integration with substance use services.

Developing engagement strategies to support young people and families in accessing treatment.

These findings highlight the need to improve clinicians' awareness, confidence and training working with young people who use substances.

Improving Physical Health Monitoring in Patients Under a London Home Treatment Team

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Aims: Many of our patients have multiple co-morbidities in addition to their mental health diagnoses, with the two often impacting each other. Outcomes such as life expectancy in mental health patients also tend to be poorer compared with the general population. Therefore, it is vital to use the opportunity whilst patients are under our services to engage them in care for their physical health. Our quality improvement (QI) project began after reviewing home treatment team physical health policies across the UK to form a tailored local protocol, and was co-produced with our experts-by-experience. This project aimed to achieve 80% of patients under the Westminster Home Treatment Team (WHTT) with physical health monitoring completed (observations, bloods and ECGs) by Feb 2025.

Methods: For the 84 patients on our caseload from July–Oct 2024, data was manually collected from the electronic records for observations, blood tests and ECGs performed. Improvement strategies were implemented in 3–4 weekly cycles with input from our QI team's nurses, doctors, support workers and our experts-by-experience in monthly QI meetings to ensure a patient-centred approach.

Results: Three cycles were completed with: 1) implementing a communal monitoring spreadsheet to identify patients needing checks, 2) dedicating a section for physical health in weekly MDT meetings, and 3) the formation of equipment kits for observations. The target was met for observations (50% to 90%) and bloods (20% to 81%) by the end of cycle 3, although not for ECGs at 30% to 66%, observed to likely be due to limited ECG machines available onsite. The mean time to complete observations was 7.4 days, bloods 11.2 days and ECGs 8.0 days. No patients declined observations, only 4 declined bloods and 3 declined ECGs. GPs were informed to offer checks as follow-up for any patients who did not receive them before discharge from WHTT (observations n=18, bloods n=35 and ECG n=46).

Conclusion: Offering physical health checks was generally received well by patients and should be integrated into routine patient contact within mental health pathways. Additional training for staff (e.g. phlebotomy), access to equipment and raising patient understanding of the physical health services available would further engagement. Ongoing collaboration between WHTT and GPs is needed for timely interventions so physical health is not neglected. Forming automated processes to capture the data collected manually will be critical for sustainability and identifying further service improvements.

Protecting Lives: A Quality Improvement Project to Improve Adherence to Fitness to Drive Policy in Mental Health Setting

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Aims: Driving is a complex and rapidly evolving task that requires a high level of skill and the ability to simultaneously interact with both the vehicle and the external environment. Mental illness can impair these abilities, potentially compromising both the driver's safety and the safety of others. While individuals with mental health conditions have a legal obligation to refrain from driving if their condition renders them unfit, healthcare professionals, including doctors, have a crucial role to play. They are responsible for advising patients on the potential impact of their condition on driving ability, their legal duty to inform the Driver and Vehicle Licensing Agency (DVLA), and, in certain circumstances, directly notifying the DVLA on the patient's behalf. Unfortunately, the driving status of patients is often overlooked during both admission and inpatient stays. There is also a concerning lack of awareness among patients regarding their duty to inform the DVLA and potential driving restrictions.

To mitigate these risks, it is essential to gather relevant information about driving status on admission, during the inpatient stay, and, most importantly, to discuss this with patients and carers at the time of discharge planning. The aims and objectives of this project were to achieve a 100% rate of driving risk assessment for all patients admitted to inpatient settings and to ensure that 100% of service users receive information about DVLA guidance following a mental health illness.

Methods: This Quality Improvement (QI) project involved assessing baseline practices against the local fitness to drive policy of Leicestershire Partnership NHS Trust. Data was collected from ten inpatient wards (six general adult and four older age) for patients discharged in January 2023. Information was gathered on driving risk assessment at admission, driving status at admission, driving risk assessment during the inpatient stay, and advice on fitness to drive given at discharge. An educational training video was developed and shared with trust-wide clinicians via email in September 2024, followed by a reminder email two weeks later. Data was collected again for patients discharged in October 2024.

Results: In the first cycle (January 2023), 128 patients were included. Driving risk assessment was completed for 95% of patients at admission. Approximately 12% of patients were driving at