Methods. Participants were recruited from emergency departments, primary care settings, medical units of participating hospitals and self-referral from community settings in Karachi, Lahore, Rawalpindi, Quetta and Peshawar. Eligible consented participants were assessed at baseline, 3- (end of intervention), 6-, 9- and 12-month post-randomization. Participants in the intervention arm received 6 one-to-one sessions of culturally adapted manual assisted psychological intervention (CMAP) over 3 months. The Client Service Receipt Inventory was used to record health service utilization, both formal and informal. Health related quality of life was measured using the EQ-5D-3L. The Thailand tariff value set (developed by the EuroQol Organization) was used to calculate quality-adjusted life year (QALY) because Thailand was deemed similar to Pakistan. The Incremental Cost Effectiveness Ratio (ICER) was calculated based on between arm differences in estimated cost and Quality Adjusted Life Years (QALYs) gains in the sampled population. Costs were converted to US dollars using the currency exchange rate on February 2024 (US$1 = PKR276)
Results. A total of 901 participants were randomized into either the CMAP arm (n = 440) or E-TAU arm (n = 461). Total QALY gained in the CMAP arm was 0.40 (95% CI: 0.36–0.45) and in the E-TAU arm was 0.33 (95% CI: 0.30–0.38) at 12-month post-randomization. The additional QALY gained due to CMAP intervention is 0.07. The difference in costs per participant between CMAP and TAU arms was US$59. The ICER for the CMAP versus E-TAU was US$843 per QALY gain.
Conclusion. Results revealed that the CMAP intervention is likely to be cost-effective compared with the E-TAU, given the cost-effectiveness threshold. These findings suggest that implementing culturally relevant self-harm and suicide prevention measures such as CMAP can lead to significant societal cost savings by preventing self-harm and suicides.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Longitudinal Trend Evaluation and Prescription Cost Analysis (PCA) of Clozapine in the United Kingdom

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Aims. Severe Mental Illnesses (SMI) are a group of disorders which can have a debilitating impact on an individual's daily life functioning. The National Institute for Health and Care Excellence (NICE) has set out clinical guidelines for the treatment of SMI including the use of Second Generation Antipsychotic (SGA) medication as well as psychological therapies. However, Treatment Resistant Schizophrenia (TRS) affects approximately 34% of patients with schizophrenia. Clozapine, a SGA, has shown superiority in treatment resistant schizophrenia as well as its potential benefits in reducing suicidality and improving functioning.
Methods. The following study aimed to examine the longitudinal trends in prescribing clozapine based on the NHS Digital prescription cost analysis (PCA) between 2015–2023.
Results. The results show that a number of prescriptions decrease simultaneously from the financial year 2015 (n = 5536) to 2023 (n = 3059). The cost was also found to be reducing until the financial year 2018–19 where there was an increase in costs which reached the maximum (14%) despite the number of prescriptions being lower as compared with 2015–16. In addition, it was found that clozapine prescribing trends have been reducing over time, despite a large proportion of service users with schizophrenia experiencing TRS (34%). Overall, since 2015–2023 a total of n = 34,440 items of clozapine were prescribed costing £1,252,052.27.
Conclusion. Considering clozapine's superior efficacy in the treatment of TRS, further research is required to better understand prescribing practices, monitoring compliance of clozapine and treatment adherence. Further qualitative research is needed to better understand the views and perspectives of both service users and prescribers in the clinical use of clozapine. Future research may also look at referrals of clozapine-prescribed patients to psychological services, the impact of clozapine in TRS patients who are offered psychological therapy, and the potential clinical and cost implications of not prescribing clozapine.

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Stakeholder's Views on the Development of Mobile Application (TechCare) for Patients With First Episode With Psychosis: Qualitative Study

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Aims. Psychosis is one of the leading causes of disability. First Episode Psychosis (FEP) significantly impacts the long-term course of the disorder. While a majority of FEP service users show signs of 'recovery' within 12 months of treatment, the early course involves frequent relapses, with up to 80% relapsing within five years. This elevates the risk of persistent psychotic symptoms, affecting cognitive, social, and occupational functioning. Medication, the core treatment, reduces relapse by 75%, necessitating additional psychosocial treatments. Mobile-based interventions are recognized for meeting families' needs in terms of information, guidance, and support. This paper explores stakeholder views on developing mobile interventions for those experiencing their first psychosis episode.
Methods. This qualitative paper was part of the TechCare app development process in which face-to-face interviews with patients (17), and 4 focus groups with health professionals were carried out. The qualitative interviews and focus groups explored the views of stakeholders on the need for mobile-based treatment, the structure of the application, the content of the application and barriers and challenges were also explored in detail. All the audio-recorded interviews were transcribed and analyzed through a framework approach.
Results. Qualitative analysis revealed three themes. The first theme centers on *stakeholders' views about mobile-based treatment*. Health professionals reported that app-based treatment enhances help-seeking behavior, reduces societal stigma, and aids in managing treatment and activities. The second theme

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focuses on *suggestions for the Techcare application,* emphasizing logical and easy-to-understand content, with a major focus on crisis management, hallucinations, and psycho-education about symptoms. Participants also highlighted the need for a section providing psycho-education for families. Carers emphasized the necessity of an activity plan in the app, including an activity log for medication management and activities. The third theme delves into *barriers and challenges in app-based treatment*, including difficulty levels and privacy concerns. Stakeholders stressed the importance of content in simple Urdu language for broader understanding.

Conclusion. In conclusion, mobile-based treatment contributes to reducing stigma, increasing awareness about the illness in its early stages, and facilitating the management of functional activities for patients. The insights gathered from stakeholders provide valuable guidance for the development of an effective and culturally sensitive mobile-based intervention for individuals experiencing FEP.

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Exploring the Attribution of Responsibility to Patients Diagnosed With Personality Disorders

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Aims. This interdisciplinary research explored how responsibility is attributed to patients with personality disorders (PDs). The attribution of responsibility to this group has been extensively discussed by philosophers, and appears to be associated with negative attitudes towards the diagnosis amongst clinicians. This research aimed to both examine the philosophical literature available on this topic, and to explore how future clinicians make judgements of these patients' responsibility.

A qualitative study was conducted to answer the following four research questions:

1. What do medical students think responsibility means in the context of healthcare?
2. What factors influence when medical students consider patients with mental health disorders, in particular PDs, responsible for their behaviours?
3. How responsible do medical students consider patients with PDs for their behaviours in comparison to patients with other mental health conditions?
4. Do medical students think that responsibility attributions could affect the stigmatisation of the condition and patient care?

Methods. Seven in-depth semi-structured interviews were conducted, involving the discussion of a case report. Interviews had a mean length of 53 minutes. They were then transcribed, coded, and thematic analysis of the data was undertaken. Four main themes were identified: understanding of responsibility, the factors affecting responsibility attribution, stigma and responsibility attribution, and the role of the clinician and the healthcare service.

Results. It was found that medical students considered similar conditions and factors in attributing responsibility to those identified in the philosophical literature. However, several important practical concerns about responsibility attribution in practice were raised, including the possible impact on the therapeutic relationship, difficulties in separating responsibility and blame, and the impact comorbidities and misdiagnoses can have on attributions. Participants believed that stigma towards the diagnosis remains prevalent amongst healthcare professionals, due to stereotypes of these patients being manipulative, and insufficient education about the condition. Additionally, participants highlighted that patient responsibility may be reduced when clinicians and the healthcare service fail to meet their own responsibilities to these patients.

Conclusion. Future research into how other groups of healthcare professionals attribute responsibility is recommended, alongside research into how improved education could reduce stigma and inform responsibility attribution. It is suggested that further education is provided to healthcare professionals about the condition, and more support is offered to those working with patients with PDs to reduce stigma and make the attribution of responsibility fairer to these patients.

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Disparities in Access to Group Parenting Training Programmes: A Cross-Sectional Analysis of Local Authorities Across England

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Aims. To compare the funding, courses and delivery modalities of parenting training delivered across London borough councils, metropolitan district councils, and county councils in England.

Methods. Freedom of Information requests were piloted on 5 local authorities. Following optimisation, requests were sent out to 74 local authorities across England requesting information on funding for parenting training programmes (26 London Borough Councils, 16 County Councils, and 29 Metropolitan Borough Councils). 26/32 London Boroughs, 16/21 County Councils, and 29/36 Metropolitan Boroughs were sent requests. No follow-up emails were sent chasing responses; however, clarification was provided where necessary. Data were analysed on Excel to observe patterns and disparities.

Results. We received responses from 74 local authorities, and 50 were usable. The mean amount of funding spent across local authorities was £881,254 (standard deviation 1,627,921). There were 18 parenting programmes used, the most common was Triple-P. The average number of parents supported by parenting programmes per local authority was 949 (standard deviation 1410). Local authorities reported spending an average of £27,430 (standard deviation 41005) on digital parenting programmes. The mean number of parenting staff was 36 (standard deviation 59).

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