improvements to the sleep education they currently provide, and keen to use additional resources. Examples of good practice exist already, with one school offering an optional 30 hour sleep medicine module annually to 12 students.

Conclusions Little has changed since Stores' previous survey 20 years ago: sleep medicine remains a neglected topic despite agreement on the importance of sleep for general health. Sleep research is the exception rather than the rule. Obstacles to change are akin to those noted by Stores, including the views that 'sleep is not a core topic', or the 'curriculum is too crowded'. However, there is some enthusiasm for improving sleep education. Given its broad importance to health, and the existence of effective therapies, we recommend that medical schools should implement a sleep medicine curriculum.

REFERENCE

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28 USING EXPERIMENTAL SIMULATION OF DEMENTIA TO UNDERSTAND FUNCTIONAL COGNITIVE DISORDERS

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Objectives/Aims Symptoms and signs of functional (psycho-genic) motor and sensory disorder often depend on the individual's ideas about symptoms rather than on the rules of anatomy and physiology. The possibility that functional cognitive symptoms might similarly reflect beliefs about cognitive disorders such as dementia has not been widely explored. We aimed to assess the ideas and beliefs of healthy non-medical adults about symptoms of mild dementia.

Methods Healthy adult volunteers aged 18-27, without medical training, underwent a 25 minute assessment during which they were asked to imagine that they in fact had symptoms of 'mild or early stage dementia'. The assessment included the Montreal Cognitive Examination (MOCA), examination of gait, digit span, the Luria 3-step test, interlocking finger test of parietal function, and the 'coin in hand' forced-choice test. Close family history of dementia and specific perceptions about dementia were recorded.

Results In 50 participants, mean age 22, mean MOCA score was 16 (SD 5.5, range 5 – 26). Summed responsetime ranged from 5 minutes 13 seconds to 14 minutes 12 seconds (mean 8 minutes 4 seconds, SD 1 minute 59 seconds). Delayed recall was the most frequently failed item (100%) followed by letter vigilance (86%), forward 5-digit span (82%) and clock-drawing (82%). Cube drawing was the least frequently failed item (42%). 26% failed forward 3-digit span and 36% failed reverse 2-digit span. On the 'coin in hand' test, 30% scored at (22%) or below (8%) the level of chance. 18% successfully completed the Luria 3-step test. 76% successfully copied 3 or 4 interlocking finger positions. 48% had abnormal gait. Inconsistent response patterns and difficulty following and remembering instructions was common. There were no significant differences between those with and without a family history of dementia.

Conclusions Cognitively healthy young adults simulating mild dementia perform similarly to older adults with mild dementia, demonstrating beliefs that dementia is associated with significant global impairment, including of attention and motor function, with relatively poor performance on letter vigilance, but preservation of cube drawing. Inconsistent response patterns were common. Contrary to expectation, family history of dementia did not influence performance. Digit span showed particular promise as a bedside test. Further investigation will establish whether similar patterns of results are produced in individuals with functional cognitive symptoms.

29 ASSESSING POINT-PREVALENCE AND DOCUMENTATION OF HEAD INJURY IN THE NORTH LONDON FORENSIC SERVICE

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Objectives/Aims Traumatic brain injury (TBI) is highly prevalent in prison populations, but little is known about TBI prevalence amongst mentally disordered offenders in secure settings. The North London Forensic Service (NLFS) is a tertiary forensic secure psychiatric service, serving a catchment population of over 1.4 million. We aimed to estimate the point-prevalence of head injury amongst inpatients at NLFS, and audit the quality of documentation of head injury.

Method We performed a retrospective case note review of the NLFS electronic records system to identify all documented head injuries in all NLFS inpatients on a selected day. To increase detection, we reviewed neuroradiology reports, and medical records were electronically screened for the following text-strings: 'brain injury', 'TBI', 'head injury', 'road traffic accident', 'loss of consciousness', 'LOC', 'concussion', 'MRI', 'GCS' and 'boxing'. For each injury identified, we assessed whether amnesia and altered consciousness at the time of the injury were documented, in line with established criteria for assessing severity of TBI (Department of Veterans Affairs/Department of Defence criteria). Injury mechanism and date, patient age, and admission length were recorded. Authors AJB and RM co-rated the findings, and disagreements were resolved by consulting a third party.

Results 100% of inpatient records were screened (n=194, 6% female, 94% male, mean age 40.2 years). 58 documented head injuries were identified, involving 50 patients (25.8%). 43 head injuries occurred prior to admission to NLFS. 16 patients (8.2%) had head injuries associated with clearly documented impairment of consciousness and/or amnesia, suggestive of TBI. 13.7% of all recorded head injuries included explicit documentation of both consciousness level and amnesia (33% when limited to head injuries occurring during admission to NLFS). The most common identified mechanism was assault (n=30). Mean admission length was 1306 days, and was not significantly different in patients with a history of head injury (p=0.825, *Mann-Whitney U*). 34% of inpatients had undergone neuroimaging. Abnormalities were identified in 32% of reports, with leukoaraiosis and generalised cerebral involutional changes being most frequently reported.

Conclusion These findings highlight a local need to improve quality of documentation in assessment of patients with head injuries, and provide an estimate of point-prevalence of head injury and TBI at NLFS. The high frequency of assault

observed in our sample is comparable to previously published findings in prison populations.

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BEST FOOT FORWARD? SUCCESSFUL MULTI-DISCIPLINARY NOVEL TREATMENT OF FIXED EQUINOVARUS DYSTONIA IN THREE PATIENTS WITH FUNCTIONAL NEUROLOGICAL DISORDER

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Objective/Aims Functional Neurological Disorder (FND) affects 10-30% of neurology outpatients. Symptoms commonly include sensory, motor and cognitive changes without structural nervous system damage. Fixed equinovarus dystonia (FEVD) of the foot and ankle is a common feature of FND

characterised by plantar flexion and inversion of the foot which cannot be corrected passively. This prevents weight-bearing often causing permanent wheelchair dependence. FEVD correction is necessary for patients to walk again. Consensus opinion is that invasive treatments are ill-advised and potentially detrimental in patients with FND. However, we have developed a novel approach that may challenge this opinion for a specific patient group, combining invasive treatments and neuropsychiatry interventions.

Methods A patient-led, goal oriented, multidisciplinary approach guided treatment. Treatments included functional electrical stimulation, botulinum toxin, tibial nerve block, serial casting and surgical intervention as an adjunct to specialist physiotherapy, occupational therapy, psychology. Standardised outcome measures of gait and mobility, balance, anxiety and depression were performed on admission and discharge. Patient consent was obtained for photo and video recording.

Case	19 years female dancer 5 year history symptoms 2 year FND diagnosis 19 week admission	33 years mother 12 year history symptoms 18 month FND diagnosis 12 week admission	30 years female PA 4 year history symptoms 3 year FND diagnosis 24 week admission
Wheelchair dependence	2 years	1.5 years	2.5 years
Discharge mobility	Independent walking	Supervised walking with crutches	Independent walking with frame
Pre-admission care needs	Carer QDS Hoist transfer Hospital bed Commode Downstairs living	Carer TDS Slide board transfer Downstairs living	Boyfriend full time carer Turning aid transfer
Discharge care needs	Nil	Carer BD	Nil
Six-month follow up	Dancing No care needs No recurrence of FEVD	Furniture walking Family support only No recurrence of FEVD	Returned to work Independent walking with crutches No care needs No recurrence of FEVD
Intervention 1	FES	FES	FES
Intervention 2	BoNT	TNB BoNT	TNB BoNT
Intervention 3	Not required	Ankle cast/splint	Ankle cast/splint
Intervention 4	Not required	Not required	Ankle manipulation under anaesthetic
Intervention 5	Not required	Not required	Surgical release of Achilles Tendon, Tibialis Posterior, long toe flexors

Abstract 30 Table 1 Functional Electrical Stimulation to common peroneal nerve (FES). Botulinum Toxin to posterior tibial muscles (BoNT). Tibial Nerve Block (TNB)