care have been taken up in forensic mental health settings. However, the introduction of lived experience workers is arguably significantly more difficult when the dual vulnerabilities of forensic mental health services users are considered (Drennan & Alred, 2012). This paper will describe a multi-layered approach to the introduction of lived experience roles in a forensic in-patient unit. Roles have developed from being solely ward-based, to service-wide roles that include participation in management and service development, the creation of a Recovery College Forensic Campus, and to co-production and co-delivery of the psychological therapies programme. In addition to 'mapping' these developments in co-production, this paper will also describe the development of the governance structures that have been necessary to support this infrastructure. Lived experience workers require recruitment, vetting, placement, and aftercare, when they engage in the activities available. On-going mental health and risk stability cannot be assumed, and so regular formal and informal psychosocial support is required to ensure that workload pressures do not negatively impact on other service users and staff. The paper will suggest that much more attention needs to be paid to the development of organisational infrastructure to sustain and manage the growth of lived experience roles in forensic mental health settings than is currently in place.

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Keywords: Lived experience; co-production; Forensic; governance

S0066

Implementation of a peer support worker in a forensic hospital in germany

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Experienced Involvement (also called Peer Support Work, PSW) has existed in mental health care in Germany since 2005 though its implementation lags behind, compared to other countries. Due to the unique challenges of forensic-psychiatric settings, implementation of PSW in these settings is even less developed. We prepared the implementation of a peer support worker in our forensic hospital for addicted offenders in Germany in several steps: A survey amongst the 75 forensic hospitals in Germany was conducted to evaluate the prevalence of PSW in these settings. Individual interviews were conducted with directors and peer support workers of forensic clinics nation-wide to investigate their facilities' experiences with PSW. Focus groups with several occupational groups of the clinic in Rostock addressed staffs opinions, expectations and reservations regarding peer support work. These were recorded and transcribed for thematic analysis.
Results: revealed that the majority of forensic hospitals (83.6%) has no experience with peer support work. Interviews with external clinic directors revealed similar concerns and expectations among the employees as our focus groups did. Staff at the clinics expected the peer support worker to offer useful experiences and new perspectives. Concerns occurred about stability of health condition of the peer support worker, trust issues because of former criminal behavior and attitudes towards psychiatric treatment that might interfere with professional treatment negatively. Furthermore the clinic directors stressed the importance of a well prepared implementation and a good "fit" of the peer support workers background to the patients (e.g. regarding diagnosis).

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Keywords: forensic mental health; peer support work; recovery

S0067

Oh what a tangled web we weave when first we practice to deceive…

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'Oh what a tangled web we weave when first we practice to deceive'. Marmion, Sir Walter Scott 1808. Conflict is unpleasant, it is aversive, we tend to avoid it. Yet inevitably tension between individuals or between individuals and society is inevitable as the wants of one collide with the purpose of the other. Most of these tensions resolved peacefully but a societal level aggression can sometimes spill out. In the hinterlands between individuals and larger groups these can play out more safely through the courts or sometimes the avoidance of conflict can be the only tactic that the individual can use. As doctors we are used to sing medical problems with patients have true disease believe they have two disease and want to get well-the standard social model of medicine. But sometimes this plays out differently there are those who may fabricate symptoms to avoid punishment or for reward: malingering. There are those who believe they have a disease but the distress is disproportionate to any possible recognised component; somatic symptom disorder. There are those whose anxiety about whether they have a disease or not is paralysing and perhaps most distressing for all of the groups who self-harm or malinger with authentic illness or disease. In this talk Dr Wise will, using case examples, look at a couple of the tools that exist to assist psychiatrists in piloting a pathway through the stormy waters of abnormal illness in litigation.

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S0068

Prison psychiatry and faking symptoms

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Faking symptoms is not an unusual finding in psychiatry; As a such is not a symptoms o sign of mental disorder; we could say that lying is frequent in the normal life of people. In psychiatry, in the community has been widely reported (), mainly related to legal psychiatry (getting some social benefits, avoiding legal obligations, etc). From forensic psychiatry, this topic have a special relevance as they have more serious consequences (to avoid prison, child custody, etc) (Resnick 2003, Gunn 2014). Another topic of paramount importance is that in psychiatry we have not complementary examinations (RMN, TAC, blood tests, etc) that help to discard some symptoms. Some test are used for detecting feigned symptoms as SIMS, The most important psychological episodes in prison are those related to disruptive / bizarre behaviour, suicide ideation and psychotic symptoms that create a great nuisance to Prison Governors. To get an accurate diagnosis is very important because this could have a