health practitioners (MHPs) has increased from 6% to 24% and from none to 16% with 13 FTE or more MHPs. For both LPSE-4 and LPSE-5, there were only two acute hospitals where both 8 FTE MHPs and 1.5 FTE consultants were present. For LPSE-4, only one site met the Core 24 criteria (for adults - there are no criteria for paediatric LPSs) of 11 FTE MHPs and 1.5 FTE consultants, and for LPSE-5, both these sites exceeded them. Other paediatric services did not meet the adult core 24 criteria for a LPS.

Acute hospitals with access to 24/7 paediatric LPSs increased from 12% to 19% between LPSE-4 and LPSE-5. In LPSE-5 68% of paediatric LPS worked to a one-hour response time target to the ED. This is an increase from 42% (14/33) in LPSE-4.

Conclusion. There are still far fewer paediatric than adult LPSs, but the provision of paediatric LPSs improved from 2015 to 2019, with more services, more staffing, and faster response times. Services need to continue to improve as few services match the adult core 24 criteria for an LPS.

A question of information mismatch in the SPC and PIL on the effect of ADHD stimulant medications on tourette's syndrome

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Aims. To assess the quality of information provided by pharmaceutical companies to patients and doctors regarding the impact of stimulant medications indicated for the treatment of Attention Deficit Hyperactive Disorder (ADHD) on Tourette's syndrome(TS) and tics in children and its implication on treatment.

Background. It is estimated that between 35% to 90% of TS patients also have ADHD. However, there remains a pervasive belief that the use of stimulants to treat ADHD symptoms in children with comorbid tic disorders is contraindicated because of concerns about possible tic exacerbation. Recent studies has disproved this, which is reflected in United Kingdom(UK) and European ADHD and TS guidelines. Pharmaceutical companies are legally required to provide a Summary of Product Characteristic (SPC) and Patient Information Leaflet (PIL) for each medicine as it is an integral part of the marketing authorisation approval. The SPC contains vital information for the usage and prescription of a drug for use by healthcare professionals. The PIL included in the medication packaging is a patient-friendly version of the SPC.

Method. The available stimulant medications licenced for use in paediatric patients with ADHD in the UK were identified through the Medicines & Healthcare products regulatory Agency (MHRA) website. The SPC and PIL were then accessed from the Electronic Medicines Compendium (EMC) website. Those not on the site were obtained directly from the marketing authorisation holder. Any direct mention of tics or Tourette's in the contraindication, warning and caution, or side effect section were documented. The information was then tabulated and compared.

Result. Of the three stimulant drug types, 17 variations are currently available for use in the UK. There were inconsistencies found between the SPC and PIC in reference to the impact of these drugs on tics and TS in all 17 licensed medication. Most discrepancy was found in regard to TS as a side effect (16/17) and also tics (15/17). TS is also listed as a contraindication in the SPC and PIL for all available variety of Dexamphetamine class drugs. This is inconsistent with current clinical evidence and guidelines.

Conclusion. The disparities in information regarding the impact of stimulant medications on tics and TS can have wide ranging effects. Outcomes could include poor patient adherence, or prevention of initiation of potentially beneficial treatment. It would benefit to standardize the information between these two documents to minimize inconsistencies in understanding between doctor and patient.

An audit into the physical health monitoring of patients who are prescribed antipsychotics in HMP Birmingham

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Aims. To assess the compliance of physical health monitoring with NICE and Maudsley prescribing guidelines for those patients prescribed antipsychotics in HMP Birmingham. To assess secondary objectives including who prescribed the antipsychotics (GP vs psychiatrist), the indication and diagnosis they are prescribed for (licensed or otherwise) and which antipsychotics were usually prescribed.

Background. Patients with psychosis or schizophrenia have a reduced life expectancy of 15-20 years when compared to the general population. The physical health effects of the medication prescribed for these conditions play a large role in this. Physical health monitoring and appropriate intervention is vital to reduce the discrepancy in life expectancy and improve the quality of life of these patients.

Method. Notes of 105 patients in total at HMP Birmingham were reviewed to assess whether the primary outcomes of weight, waist circumference, physical observations, blood tests, medical systems review and education/lifestyle advice were done at the correct times. Secondary objectives of which antipsychotics were prescribed, the profession of the prescriber and the indication for the medications (or diagnosis) were also audited.

Result. Antipsychotics were initiated by both GP's and psychiatrists. Appropriately, there were no prescriptions for clozapine. Olanzapine and quetiapine were the most common antipsychotics prescribed. Not all medications were prescribed for licensed indications and some lacked documentation of both a mental health diagnosis and indications in terms of symptoms. Average BMI of patients was overweight, with BMI ranging as high as 45. The pre-prescription, 12 weekly and annual physical health checks had poor compliance. Those that were completed in line with NICE and Maudsley guidelines were done so by coincidence at the time of diabetic reviews.

Conclusion. The physical health monitoring of patients on antipsychotics in HMP Birmingham is not currently compliant with clinical guidelines. There needs to be improved systems in place for the monitoring of physical health both before prescriptions are initiated and after at the NICE recommended intervals. Amongst other actions, improved computer reminders and training of existing and new team members will be done. The monitoring requirements will be re-audited in 6 months following immediate implementation of the recommendations outlined below.

An evaluation of the incorporation of psychological interventions into the care of patients with a diagnosis of emotionally unstable personality disorder following admission to the general adult inpatient setting

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Aims. To assess incorporation of and access to psychological therapies for patients with a diagnosis of emotionally unstable personality (EUPD) who were discharged from the inpatient wards at Clock View Hospital, an inpatient unit in Mersey Care NHS Foundation Trust.
Method. A retrospective analysis of the electronic record of 50 patients discharged from Clock View Hospital between 1st of January 2020 and 1st of November 2020 was performed to assess whether patients were engaged with psychotherapy and whether they had an extended care plan in place.

25 patients with EUPD and no associated psychiatric comorbidities were included in the sample, as well as 25 patients with EUPD and associated psychiatric comorbidities.
Result. Those EUPD patients with no psychiatric comorbidities were more likely to be under the care of the Liverpool Personality Disorder (PD) Hub compared to those with psychiatric comorbidities (12 vs seven patients). Of the 19 patients under the PD Hub, 11 had a Case Manager, four were engaged with the PD Hub's day services / safe service and one with a PD Hub readiness group. Six of the 50 patients had a documented refusal to engage with the PD Hub.

Only 27 of the patients had either received psychological intervention, were on a waiting list, or had a referral in place. 16% of patients refused a psychotherapy referral. Of the 20 patients who received psychological treatment, eight completed a form of psychotherapy (cognitive analytic therapy, dialectical behaviour therapy, cognitive behavioural therapy, eye movement desensitisation and reprocessing) and 12 psychological intervention (either structured case management, psychoeducation or emotional coping skills).

Only 28 of 50 patients had an extended care plan and 28 had a collaborative risk management plan in place.
Conclusion. There was no obvious correlation between previous completion of psychological therapy and degree of polypharmacy. Median admission time was reduced for patients under the PD Hub (six vs 14 days). This was also reduced for patients who accessed psychotherapy or psychotherapeutic interventions (nine vs 10 days).

This audit coincided with the COVID-19 pandemic and subsequent reduced access to the PD Hub and psychotherapy service. There is a need to consider barriers to EUPD patients receiving psychotherapy.

EUPD patients may have numerous hospital admissions and frequently present in crisis. Given the iatrogenic harm from prolonged hospital admission, there is a need to consider incorporating a collaborative extended care plan and risk management plan as part of discharge planning, following admission to hospital.

Suicides in Barnsley – an IHBTT project

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Aims. We wanted to see whether an increase in IHBTT(Intensive Home based treatment team) case load correlated with the recent increase in suicides. We also wanted to investigate the common factors between patients who died by suicide.
Background. This was a study completed by IHBTT in Barnsley (South Yorkshire), looking into recent suicides with the caseload from April 2009 to November 2019. There were a total of six suicides.
Method. We Calculated mean IHBTT caseload size from November 2008 to November 2019 . There were 6 suicides in this period. We plotted this against caseload, investigating if increase in caseload correlated with these. We also analysed the common themes and trends associates with these patients who died by suicide. We compared the trends we found locally against a National Survey. (National Confidential Inquiry into Suicide and Safety in Mental Health; Annual Report: England, Northern Ireland, Scotland, Wales October 2018 University of Manchester).
Result. We found that four out of six suicides occurred during periods of high activity.. Common themes we found around patients who had died by suicide included middle aged men who lived alone, with a diagnosis of adjustment disorder, recent financial stress and relationship breakdown, upcoming court case, abusing drugs or alcohol. This does compare somewhat to national trends, however alcohol and drug misuse, upcoming court case and financial stressors and relationship breakdown are higher in our patients who died by suicide compared to nationally.
Conclusion. We acknowledge the small sample size and hence the need to take results cautiously. However there is a clear increase in suicides as caseload increases, we hypothesised this was due to the same levels of staff despite increase in caseload. We were also able to conclude the factors our patients who died by suicide had in common locally, and how this compared to national data. We wondered if this could be used to guide resource allocation, i.e. interventions to help patient manage their finances, accommodation and substance misuse. Consideration may need to be given to reviewing IHBTT staffing levels, given the significant decrease in inpatient bed numbers.

Suburban vs urban: do the attendee's demographic profile influence the emergency department's mental health characteristics presentation?

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