curricula. Future sessions should include follow-up assessments to evaluate long-term skill retention and could expand to include other important areas of communication such as multidisciplinary team communication and conflict management.

Assessment of Impact of the ARIADNE Research: Insights Into Improving Access in Mental Health

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Aims: Enduring inequalities in mental healthcare exist between UK minority ethnic and White British groups, which were further aggravated during the pandemic. Through 2022–23 the nationally funded ARIADNE research project carried out qualitative research and co-production workshops to suggest local (in four participating sites of England) and also identified over-arching solutions to improve access and experience of care. After the ARIADNE research project ended, a further co-designed *impact analysis* initiative was carried out in 2024 in two original participating sites (Coventry/Warwickshire and East London).

Methods: Workshops were held in the two sites, attended by staff and experts by experience (carers and service users) to explore the impact and progress of the *action plans* from the ARIADNE study. Subsequently a national workshop was then held bringing together national opinion leaders and local stakeholders to identify key themes.

Results: A content analysis of the workshops and the national event minutes were carried out to identify progress, ongoing barriers and solutions to improving access:

There is a need to refine the concept of minoritised communities. Sharing experiences of racism towards individuals from *minority ethnic groups who grew up in England* and *towards immigrants* would be valuable. Care providers should arrange safe spaces for these conversations.

Pandemic and lockdown deteriorated the quality of mental health care provision and increased demand for mental health support. This disproportionately affected ethnic minorities and exacerbated their struggle in accessing mental healthcare complicated by *stigma* (both internal, in-group, external and cultural).

Professionals were in some cases experienced as being 'blind' to the issues of ethnic minorities and also impacted by institutional racism.

Education, cultural mediation and digital interventions that can offer solutions and overcome barriers to access the solutions need to be local and personalised.

Crucially, a human rights approach is required to promote integration and social cohesion. Offer of care should be diversified by including participatory culture, voluntary sector involvement and lived-experience involvement (e.g. peer work). Some potentially helpful developments and service reconfigurations were noted with population-based approach and neighbourhood models of community mental health care.

Conclusion: Locally led co-production research offer valuable intelligence and can be a resource to local health systems. It can utilised in planning of service re-design and resource allocation. Such continuous co-production increases research impact and minimises delay in putting research findings into practice. The themes raised and initiatives undertaken may be inspirational to other areas and national initiatives.

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.

Anticholinergic Burden in Older Adults Referred to Old Age Psychiatric Liaison: A Quality Improvement Project

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Aims: This quality improvement project (QIP) aims to evaluate the assessment of anticholinergic burden (ACB) of medications, using a validated tool, in patients admitted to Bristol Royal Infirmary and referred to Later Life Liaison Psychiatry, aiming to increase awareness and reduce ACB where appropriate.

Methods: The Anticholinergic burden Effect on Cognition (AEC) validated tool was selected to assess ACB. Baseline data was collected and anonymised from 20 patients via team assessments in patient records. Data included the AEC score, medications involved, prescription indication, whether ACB was considered, and if AEC score was documented.

An educational intervention involved teaching liaison psychiatry staff on ACB, AEC and strategies for deprescribing or switching medication. The team's knowledge was evaluated before and after teaching using questionnaires. An educational poster was displayed around the office.

Post-intervention data was collected from five additional patients, and the results were analysed.

Results: Baseline data showed 25% of patients (n=20) scored AEC ≥3. 30% were on multiple medications with an AEC score, 50% were prescribed antidepressants, predominantly mirtazapine and sertraline (both AEC=1). Only 15% of the assessments had a documented AEC.

Prior to the educational intervention, 71% of the team reported their ACB knowledge level as "very poor", "poor", or "average". After the teaching, 71% of the team rated their knowledge as "very good", indicating significant improvement.

Following the intervention, no patients (n=5) scored AEC ≥3, and 60% of assessments documented the AEC score.

Conclusion: The most prescribed medications contributing to ACB were, in order, cyclizine, mirtazapine and sertraline, aligning with current national literature. Most patients with AEC ≥3 were taking multiple drugs, leading to a cumulative effect. Of the assessments that did not document the AEC score after teaching, all had scores of 0, suggesting staff may not view this score as significant.

All psychiatry liaison colleagues acknowledged the importance of ACB, but had a knowledge gap prior to the educational intervention, which showed improvement following a well-received teaching session.

This QIP demonstrates patients interfacing with old age psychiatry liaison can have a high ACB. The liaison team are well-placed to acknowledge and review these medications collaboratively with medical colleagues. An education intervention shows improvements in assessing ACB in our service.

For sustainability, further service level interventions have been implemented, including bookmarking the AEC calculator on staff computers (medichec.com) and adding a prompt to the team's initial assessment template to check AEC. These measures aim to continue improving patient outcomes.

Assessing Documentation of Analgesic Prescribing in a Medium Secure Forensic Psychiatric Setting

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Aims: This service evaluation sought to assess the consistency of documentation in 5 key areas of analgesic prescribing in a medium secure forensic unit in South Wales.
Methods: Five key areas which are important to document when prescribing analgesia were defined as follows: 1) Indication, 2) Prescription Review, 3) Risk, 4) Discontinuation Guidance and 5) Patient Counselling on Analgesic Choice. Data was collated on these 5 key areas for opioid and pregabalin prescriptions between 1 November 2023 and 1 April 2024. Using Hospital Electronic Prescribing and Medicines Administration (HEPMA), it was possible to establish prescription data. Information on each prescription was then collated from: clinical team meeting (CTM) notes, nursing notes, GP contact records and tribunal reports for each patient.
Results: There were 18 analgesic prescriptions which fitted project criteria. 11% prescriptions were for morphine, 17% for co-codamol, 39% for codeine and 33% for pregabalin. Documentation across the 5 key areas was deficient, with 0% patients with documentation in all 5 key areas, 14% patients with documentation in 4 areas, 36% patients with documentation in 3 areas and 50% patients with documentation in <2 areas. Indications were better recorded in CTM notes than on HEPMA. On HEPMA, only 50% prescriptions had an indication, and of those only 6% had a specific indication with the remainder noted as "pain" (33%) or "pain team advice" (11%). In comparison, 90% prescriptions from CTM notes had an indication; the most common indication being leg pain (40%). In terms of prescription reviews, only 56% prescriptions were reviewed. No patients had any documented consideration of the risk of prescribing analgesia based on their substance misuse history despite 93% patients included having a recorded substance misuse history. 57% patients were prescribed the drug they have a recorded history of addiction to. Only 36% prescriptions documented the physical health risks of prescribing analgesia. Similarly, there was no documented guidance for any patient on circumstances to discontinue analgesia. In regard to patient counselling, only 50% patients were counselled on the choice of analgesia.
Conclusion: Multiple sources of information made it time consuming to get a holistic view of each prescription. Some of the key areas such as discontinuation guidance and substance misuse risk were not documented at all, with other areas having sporadic documentation depending on the prescriber. To improve future practice, changing HEPMA to have mandatory fields to record 5 key areas when prescribing analgesia would ensure consistency of documentation.

Healthcare Contacts Prior to Suicide by Those in Contact With Mental Health Services

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Aims: People under mental health (MH) services' care are at increased risk of suicide. We aimed to identify opportunities for suicide prevention and underpinning data enhancement in people with recent contact with MH services.
Methods: A population-based study of all who died by suicide in the year following an MH services contact in Wales, 2001–2015 (cases), paired with similar patients, with the same mental health diagnoses, who did not die by suicide (controls). We linked the National Confidential Inquiry into Suicide and Safety in Mental Health and the Suicide Information Database – Cymru with primary and secondary healthcare records. We present odds ratios and 95% confidence intervals (OR [95% CI]) of conditional logistic regression.
Results: We matched 1,031 cases with 5,155 controls. In the year before their death, 98.3% of cases were in contact with healthcare services, and 28.5% presented with self-harm.

A high proportion (98.3%) of cases were in contact with primary and secondary healthcare services in the year before their death. Compared with controls, cases were more likely to attend emergency departments (OR 2.4 [2.1–2.7]) and have emergency hospital admissions (OR 1.5 [1.4–1.7]); but less likely to have primary care contacts (OR 0.7 [0.6–0.9]), out-patient attendances (OR 0.2 [0.2–0.3]) and missed/cancelled out-patient appointments (OR 0.9 [0.8–1.0]).

A high proportion of cases presented to primary and secondary healthcare services with accidents, injury and poisoning, and especially self-harm – more so than controls (for self-harm, 28.5% of cases compared with 8.5% of controls; OR 3.6 [2.8–4.5]). This was particularly true for female patients admitted to hospital with injury and poisoning (OR 3.3 [2.5–4.5] in females compared with 2.6 [2.1–3.1] in males).
Conclusion: We may be missing existing opportunities to intervene across all settings, particularly when people present to emergency departments and hospitals, especially with self-harm. Intent underlying injury and poisoning events may be undisclosed, or recorded as undetermined or without specifying intent when they may in fact be self-harm, particularly in females. Efforts should be made to appropriately identify those who are self-harming, including by direct and non-judgmental questioning on presentation underpinned by staff training and awareness. Prevention efforts should focus on strengthening non-urgent and routine contacts (primary