any preparation or dosing schedule, compared to a control such as sublingual buprenorphine or placebo.

The primary outcome measure was treatment efficacy, specifically treatment retention and negative urine drug screen results. The secondary outcomes measures were drug related adverse events, severe adverse events, nonfatal serious adverse events, mortality, discontinuation, and drug overdose.

Six articles were selected for inclusion following assessment using our exclusion criteria. Study quality was assessed using the CASP tool and Cochrane Risk of Bias 2. Review Manager 5.4.1 was used for data synthesis.

Results. Our primary endpoint was efficacy, using treatment retention and negative urine samples as surrogate markers. Regarding treatment retention there was a statistically significant increase in the 'Buvidal' group compared to the control group (OR = 1.46, 95% CI = 1.12 to 1.89, P = 0.005). There was also a statistically significant increase in negative urine samples in the 'Buvidal' group compared to the control group (OR = 1.38, 95% CI = 1.26 to 1.52, P < 0.00001).

We examined a number of secondary outcomes which focussed on safety and tolerability data. These showed no statistically significant differences between the two groups (drug overdose (OR = 0.09), drug related adverse events (OR = 1.75), severe adverse events (OR = 0.93), nonfatal serious effects (OR = 0.65), mortality (OR = 1.63) and discontinuation (OR = 1.52)).

Conclusion. The studies have shown the efficacy of 'Buvidal' was statistically significant in comparison to the control groups, with no difference in their side effect profiles.

To our knowledge, this is the first systematic review and meta-analysis of its kind, and our results support the hypothesis that 'Buvidal' is an effective and safe treatment for opioid use disorder.

Esketamine Nasal Spray Improves Rate and Time to Remission Versus Quetiapine Extended Release in Subgroups of Patients With Treatment Resistant Depression and Two or Three Plus Prior Treatment Failures: Results From ESCAPE-TRD, a Randomised Phase IIIb Trial

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doi: 10.1192/bjo.2023.245

Aims. For patients with depression, the likelihood of remission decreases with each subsequent treatment failure. Per European Medicines Agency guidance, treatment resistant depression (TRD) is defined as nonresponse to ≥2 consecutive treatments at adequate dosage and duration in the current depressive episode. In ESCAPE-TRD (NCT04338321), esketamine nasal spray (NS) increased the probability of achieving remission and remaining relapsefree, compared with quetiapine extended release (QXR) in patients with TRD. Here, we report the efficacy of esketamine NS vs QXR in patient subgroups with 2 or ≥3 consecutive prior treatment failures (PTFs).

Methods. ESCAPETRD was a phase IIIb trial comparing the efficacy of esketamine NS with QXR in patients with TRD. Patients (N = 676) were randomised 1:1 to esketamine NS (n = 336; 56/84 mg; twice weekly, weekly, or every 2 weeks [wks]) or QXR (n = 340; 150–300 mg daily, both in combination with an ongoing selective serotonin reuptake inhibitor/serotonin norepinephrine reuptake inhibitor. Randomisation was stratified by age (18-64 years; 65–74 years) and PTFs (2; ≥3).

The primary endpoint of remission (Montgomery-Åsberg Depression Rating Scale total score ≤10) at Wk8 and the secondary endpoint of remaining relapse-free through Wk32 after remission at Wk8, were analysed in PTF patient subgroups and compared between study arms, with treatment discontinuation considered as a negative outcome. The effect on time to remission was assessed using hazard ratios (HR) from a Cox regression model.

Results. Of the randomised patients, 415 (61.4%; esketamine NS: 204, QXR: 211) had experienced 2 PTFs and 261 (38.6%; esketamine NS: 132, QXR: 129) had experienced ≥3.

Of patients with 2 PTFs, 54/204 (26.5%) esketamine NS-treated patients and 46/211 (21.8%) Q-XR-treated patients achieved remission at Wk8 (p = 0.267). Of patients with ≥3 PTFs, 37/132 (28.0%) and 14/129 (10.9%) patients achieved remission at Wk8 in esketamine NS and Q-XR arms, respectively (p < 0.001). Of patients with 2 and ≥3 PTFs, 49/204 (24.0%) and 24/132 (18.2%) of esketamine NS-treated patients and 38/211 (18.0%) and 10/129 (7.8%) of Q-XR-treated patients achieved remission at Wk8 without relapse to Wk32 (p = 0.133 and p = 0.013), respectively.

Esketamine NS significantly improved time to remission, with a greater effect in the ≥3 PTF subgroup (2 PTFs: HR = 1.547 [95% confidence interval (CI) 1.210–1.976]; p < 0.001 vs ≥3 PTFs: HR = 2.066 [95% CI 1.469–2.907]; p < 0.001).

Conclusion. Esketamine NS demonstrated a significantly superior remission rate versus QXR at Wk8 in patients with ≥3 PTFs, and significantly shorter time to remission versus Q-XR in both subgroups.

ACKNOWLEDGMENTS. Study funded by Janssen, medical writing by Costello Medical, UK.

Quality Improvement

Compliance With Nice Policy on Ecg in Patients on Psychotropic Medications: Frays Ward August 2020 to January 2021

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doi: 10.1192/bjo.2023.246

Aims. 1. The need to ensure ECG is done before commencing Psychotropic medications. 2. The need to ensure both medical

and non-medical staff cooperate in ensuring ECG monitoring is done according to guidelines. 3. The need to help Nurses acquire competence in performing ECG

Methods. A total of 101 patients were reviewed, all with various diagnoses, cardiovascular risks, and on different medications. Of these, 61 were included while 40 were excluded.

The exclusion criteria include:

1. Transfer from another trust to Frays ward
2. Transfer or step down from ICU to Frays ward
3. Transfer from frays ward on the day of admission
4. Patients who are already on treatment and recently had physical health assessments.
5. Admitted before August and after January

Some of the patients were already known to mental health services and had been on medications. While others were having contact with mental health services for the first time.

After the exclusion, only about 61 patients were included in the study over the 5-month period.

Data were collected on the following:

1. Date of admission
2. Date ECG was done.
3. Date medication was commenced.
4. QTc readings
5. Type of medication commenced.
6. Days between admission and completion of ECG were extrapolated.
7. Days between admission and commencement of medication were also extrapolated.

All the above data were analysed and presented in charts, tables, and graphs.

Some Limitations identified:

Lack of standard admission register

Lack of discharge register

Missing ECG reports

Recruitment and participation of team members due to multiple training activities on Frays

Results.

1. A total number of 48 patients had ECG while 13 of them did not. Some refused to give consent or were not mentally/clinically stable.
2. A total of patients that had Baseline ECG before the commencement of medications on admission was 22(36%), while 39(64%) had ECG after the commencement of medications. The vast majority of the non-compliant patients were due to failure to consent at the time of admission.
3. Timeline for Baseline ECG vs commencement of medications: 16 patients had within 24 hours, 10 patients had after 24 hours, 16 patients had within one week and 4 patients had after one week.
4. Concerning QTc pattern; A total of 37 patients had normal, 10 patients had borderline and 1 had prolonged
5. Patients with other ECG abnormalities: Out of the 48 patients that had ECG at one point during the admission, about 44 of them had a Normal sinus rhythm while 4 were abnormal. However, all the abnormal ECGs were asymptomatic

Conclusion. Although the vast majority of service users in this study had normal ECG readings and overall low cardiovascular risk, the compliance rate with Trust/NICE guidelines are significantly low. Apart from falling short of Trust and NICE policies, this increases the chances of missed diagnosis, especially in people with pre-existing cardiac conditions.

Efforts must be intensified to ensure the vast majority of service users get thorough physical health assessments including ECG before psychotropic medications are commenced.

Quality Improvement Project: Referral Process for Adults With Suspected ADHD

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doi: 10.1192/bjo.2023.247

Aims. Twelve GP surgeries refer adults with suspected ADHD to Horsham Assessment and Treatment Service (ATS). Patients are referred by GPs via letter and an adult ADHD self-report scale (ASRS). Letter contents are variable and some referrals are rejected. There is no gold standard or national guideline for what referral information is required. We used a combination of guidelines and advice from The Royal College of Psychiatrists, The National Institute for Health and Care Excellence, and ADHD UK. Aims: to evaluate the current quality of the referrals, to obtain GP" views on the referral process, to make the process more efficient and clearer, and with that improve patient experience.

Methods. A retrospective data collection method was used. 57 patients were referred between 31^{s}t August 2021 and 1^{s}t April 2022. We reviewed 54 referral letters (3 were excluded). Main information looked for: presenting difficulties, resultant impairments, confirmation some symptoms present in childhood, past medical history, family history and if an ASRS was attached. We sent a questionnaire to obtain GPs' opinions on the referral process and how to improve this.

Results. Results of reviewing referral letters:

- 89% of referrals explained the current difficulties
- 52% described the resultant impairments
- 61% of referrals mentioned if symptoms had been present in childhood
- 91% of referrals contained past medical history and current medication
- No referrals mentioned family history
- 6% of referrals contained some physical health data
- 85% of referrals to ATS were accepted; 13% rejected as ASRS not attached.

Results from GP questionnaires: 11 surveys were returned. Most GPs were not confident in making a referral or what information is required, and did not understand the referral process. GPs would like a referral form, a flowchart outlining the referral process and information for patients about ADHD assessment.

Conclusion. 89% of referrals explained current difficulties. Just over half described the resultant impairments, and confirmed if there were symptoms in childhood. Most referrals contained past medical history. 6% contained some physical health data. Only 85% of referrals were accepted. GPs would like a referral form, a flowchart and information for patients.

Results were distributed to staff in ATS and we will distribute results to GPs. We have created a referral form and flowchart to make the referral process more efficient and clearer, and to improve patient experience. We will re-evaluate this after a few weeks, so we can compare with previous data collected.

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.