between a referral being made and the assessment taking placed varied between 1.5 hours and 22 hours. Two defendants were remanded overnight in prison as the MHAA could not take place on the same day as the referral.

In the 25 cases where an application for detention under Section 2 of the MHA was made, beds were not available on the same day in 7 cases. In 4 cases defendants required remand in prison custody due to beds not being available.

**Conclusion.** There were some limitations to this audit as data were not available for all 42 individuals referred for a MHAA.

Individuals referred for MHAA by the Service had both medical recommendations completed within 5 days and those who required admission to hospital were admitted within 14 days of the recommendations being completed.

Whilst these standards are being met, individuals referred for MHAA and those requiring admission to hospital are still facing remand to custody.

## Handcuff use on forensic psychiatry wards

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**Aims.** This project aimed to assess the use of handcuffs in a secure forensic mental health hospital.

**Background.** Handcuffs are used by secure forensic psychiatric wards where patients need to leave the ward and require added restrictive measures for their own or other's safety. The decision to use handcuffs is made by the multi-disciplinary team, with the input of the unit's clinical security team and is assessed based on individual risk and need. This study investigated the frequency, duration and purpose of handcuff use in one secure forensic mental health unit, encompassing 8 male medium secure wards, 5 male low secure wards, 1 adolescent secure ward,1 female low secure ward and 5 female medium secure wards.

**Method.** Handcuff use was recorded contemporaneously by ward staff in a specialised handcuff proforma. This data were then compiled to assess the number of instances of use, the mental health section applicable to the patient, the reason the patient needed to leave the unit, and the duration of use (including the time period for which the handcuffs were removed during the visit, if applicable.) Data from these forms over an 18 month period were analysed.

**Result.** Over the 18 months, there were a total of 347 uses of handcuffs, with an average of 18.3 occurrences per month. In 55 cases, the patients were detained under a civil section, with the remaining instances occurring in patients detained under forensic section. 47% were unsentenced prisoners.

The most common destination for patients was the general medical hospital, which accounted for 49% of all visits. Court was the second most common destination, with 39% of uses.

The average duration spent in handcuffs was 3.3 hours. The average time that the handcuffs were taken off during the transfer was 1.2 hours.

**Conclusion.** Through ongoing education and supervision by the clinical security team, handcuff use in this forensic service was limited to essential situations, most often to allow treatment of physical health issues off-site. A large proportion of instances involved unsentenced prisoners and court attendances, where the risk of absconsion might be particularly high. Duration spent in handcuffs was kept to a minimum, with cuffs being removed where possible. The service strives to continue such good practices and to identify further ways to reduce handcuff use, such as using video-conferencing as an alternative court attendance.

## Assessment and management of patients detained under Section 136 in Northwick Park Hospital emergency department

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**Aims.** To evaluate the role of the Emergency Medicine team (EM) within a London Emergency Department (ED) in assessing and managing patients detained under Section 136 of the Mental Health Act, 1983 (S136).

**Background.** S136 allows detention and transfer of people to ED and psychiatric hospitals for further assessment. EDs are optimised for the investigation and management of the medically unwell, but attending ED may also delay access to psychiatric services if required. Minimal research has been performed to investigate the relative benefits of transferring people under S136 to ED versus psychiatric hospitals.

**Method.** Electronic notes were searched to identify those attending under S136 between 01/04/2017 and 31/03/2018. Scanned medical notes were reviewed and data extracted regarding patient demographics, length of ED stay, reason for S136 use, investigations and interventions undertaken by EM.

**Result.** This identified 95 attendances by 87 patients. The mean age was 35 years (range 15-75) and 59% of attenders were male. The mean duration of stay was 7 hours 34 minutes (range 6 minutes - 25 hours 50 minutes).

Reasons for S136 use were abnormal behaviour (32), expressed suicidal ideation (29), overdose (15), self-harm (13), overdose plus self-harm (4), being found wandering (1) and was unclear for 1 presentation.

In 39 attendances no investigations beyond history and examination were performed by EM. Only 6 patients had investigations that were not bloods, electrocardiogram or urinalysis. These included X-radiograph trunk (4), computed tomography (CT) head (3), X-radiograph limb (3), CT cervical spine (1), Focused Assessment with Sonography for Trauma (1).

No interventions were given by EM in 55 attendances. Twenty-nine different medications were prescribed and 18 patients were prescribed intravenous fluids. Three had wounds dressed, 3 glued, 3 sutured and 1 stapled.

**Conclusion.** There were difficulties categorising the reason for S136 use, as clear documentation was often unavailable, but the vast majority of patients were detained due to abnormal behaviour, expressed suicidal ideation and self-harm.

Few attending ED under S136 received investigations or interventions that could not be offered within a psychiatric hospital. There was a wide range in duration of stay within ED, however 65% of attendances were longer than the standard 4 hour target.

Future research may assess the relative benefits of ED versus psychiatric hospitals in assessing those detained. This could aid services in meeting both the physical and psychiatric needs of patients whilst making efficient use of available resources.

## Audit of appropriate consideration of anti-craving medication following alcohol detoxification in a north east addictions service

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**Aims.** NICE guidelines recommend that all patients who undergo a successful alcohol detoxification programme should be considered for treatment with acamprosate or oral naltrexone. This audit studied the proportion of patients considered for acamprosate or naltrexone treatment in a North-East Addictions Service.

Primary aim

To explore whether naltrexone/acamprosate had been considered for each patient completing alcohol detoxification.

Secondary aims

what proportion of those offered agreed to be prescribed acamprosate/naltrexone

whether these patients were being adequately followed up in terms of prescription

**Background.** There is a significant evidence base for both naltrexone and acamprosate in the maintenance of abstinence in patients with alcohol addiction. NICE recommends the consideration of both medications for patients following successful alcohol detoxification from alcohol. The addictions service at Plummer Court in Newcastle upon Tyne has a comprehensive pathway for alcohol detoxification patients, which involves multiple reviews by keyworkers and medics. The attendance at these appointments is often poor, and it is often unclear whether these patients have been offered anti-craving medication.
**Method.** A list of patients referred for inpatient or outpatient alcohol detoxification between June to August 2018 (n = 23) was curated. The progress notes were reviewed for any evidence that there had been clinical consideration of acamprosate/naltrexone. If evidence was found that the discussion had taken place, the notes were further scrutinised to assess if the client had accepted a prescription. The clinical documentation was further reviewed to see if follow-up for anti-craving medication was in place.
**Result.** There was evidence that anti-craving medication had been considered in 47% of patients during the treatment process

In all but one case, acamprosate was offered rather than naltrexone

In cases where medication was offered, it was accepted in all but one case

Anti-craving medication was universally well tolerated

There was considerable difficulty with assessing who was following up the prescription. On scrutiny of the notes, several GPs had contacted addictions services stating that they would not prescribe acamprosate because of local policy prohibiting its prescription from Primary Care (this policy is in fact no longer current)
**Conclusion.** Practice changed to offer patients monthly follow-up with addictions services for six months

Template letter sent out to GPs with discharge from addictions requesting acamprosate prescription, outlining current policy and offering support if GPs not comfortable

Audit presented to medical team. Treatment pathway amended to specify medical team's role in offering anti-craving medication at initial appointment

Re-audit in six months

## Audit of high dose antipsychotic prescribing in the havering community recovery team

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**Aims.** The main aim of this audit was to determine the prevalence of HDAP in Havering Community Recovery Team (CRT). The secondary aim was to determine how well HDAP has been monitored and documented - specifically, whether discussions around the reasons for continuing and the risks and benefits have been discussed.
**Background.** There is a focus to reduce high dose antipsychotic prescribing (HDAP) due to the lack of evidence that it is efficacious and that smaller doses have an equivalent effect and are better tolerated. Similarly, the consensus by the Royal College of Psychiatrists is that any prescribing of high dose antipsychotics should be an 'explicit, time-limited individual trial' with a distinct treatment target. There should be a clear plan for regular clinical review including safety monitoring. The high-dose regimen should only be continued if the trial shows evidence of benefit that is not outweighed by tolerability or safety problems.' Following a CQC inspection in 2014 of NELFT which found that the trust was failing to comply with the relevant requirements of the Health and Social Care Act 2008 with regards to safe use of medicines, yearly audits of inpatient HDAP have been undertaken. Although improvements have been made in the inpatient setting, no such audits have been performed in the community setting and consequently there is no data in NELFT regarding community services compliance with the above regulations.
**Method.** All 349 patients in Havering CRT clinical records were screen by either using RIO or GP letters from recent CPA reviews. A data collection and analysis tool was created using Microsoft Excel. Data collection and analysis was carried out by the project lead and checked by a fellow project member.
**Result.** Of the 349 patients included for analysis:

16 (4.58%) of patients were prescribed a high-dose antipsychotic

Of the 16 prescribed high dose antipsychotics:

0 out of 16 had the high dose antipsychotic monitoring form available

12 (75%) had well documented evidence of review of HDAP.

4 (25%) had no documented evidence of review of HDAP.

**Conclusion.** There is a small group of patients receiving high dose antipsychotic therapy for which better monitoring is needed. This should include education of staff regarding HDAP, better documentation in their care plans and working with pharmacy to make HDAP monitoring forms available widely in the community.

## ELPS helps!

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**Aims.** This study aimed to identify whether contact with the Ealing Liaison Psychiatry Service (ELPS) improved patients' mental health using the Clinical Global Impressions (CGI) scale, and to understand the utility of this tool.