(BPSD), over the same time period to evaluate whether the number of BPSD admissions has changed since the existence of the team.
Results. The number of overall admissions to Heather ward decreased from 43 to 32. The number of detained patients remained the same, 13 patients over the 5 month period. Looking more closely at the nature of some of the hospital admissions, a referral was not made to the crisis service for some of the admitted patients.
Conclusion. The team have been providing this service for just over a year, including the three month pilot. The limited data does not show enough evidence that the crisis service reduces rates of hospital admission. As this is a new service, there is much work to be done to increase the profile of the team. We would like to re-evaluate the admission data after more information has been disseminated to referrers about the service and the support they offer.

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Naltrexone Treatment for Methamphetamine Dependence – Service Evaluation Audit

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doi: 10.1192/bjo.2024.517

Aims. There is an emerging evidence base to support the benefit of naltrexone prescription in methamphetamine dependence. This audit assesses prescribing practice and benefit of naltrexone in a specialist NHS drug service based in West London. The process for initiation and monitoring of naltrexone in the service was compared with best practice recommendations.

A patient with methamphetamine dependence can be referred to a psychiatrist in order to consider naltrexone treatment. Naltrexone works by reducing cravings, thereby assisting with abstinence. Liver function is checked and then naltrexone is made available by an FP10 prescription. Follow up is then conducted in order to ascertain whether a continuation of naltrexone is indicated.
Methods. Patients prescribed naltrexone were identified using a hand-written prescription record. Each case file was audited for prescribing metrics, substance misuse pattern, diagnoses, past treatments, efficacy, tolerability and length of prescription. Information was manually collected from the SystmOne case notes and anonymously entered into a spreadsheet under headed topics.
Results. Data was collected from 1st April 2019 to 1st June 2023 which identified 28 patients. All patients had keyworker involvement and physical health checks. GHB/GBL was the most common comorbid substance. 18 of the 28 patients took naltrexone for longer than one week. 16 reported benefit with cravings. 6 were abstinent from methamphetamine and 10 were seen to have a partial response (periods of abstinence/lessened use). 9 of the 18 patients reported one or more side effects, most commonly nausea.
Conclusion. The service meets best practice guidelines with regards to keyworker involvement, physical checks and follow-up reviews. Improvements could be made with regards to accurate diagnostic coding. Given the prevalence of side effects, it would be important to discuss options to mitigate these, as well as the importance of continuation of naltrexone (if tolerated) for at least four weeks. The offer of written information should be recorded. The tolerability and efficacy of naltrexone is in keeping with data from randomised controlled trials, which helps to inform patients and clinicians that naltrexone is an effective, safe treatment for methamphetamine dependence.

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Predictors of Readmission to an Acute Psychiatric Inpatient Unit

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doi: 10.1192/bjo.2024.518

Aims. The Acute Mental Health Inpatient Centre is an 80 bed acute psychiatric inpatient unit in Belfast. The inpatient unit is frequently over capacity resulting in the use of contingency beds or delays in accessing acute inpatient care. Readmissions to hospital after discharge remain a challenge for the service. A service evaluation project was designed to quantify the number of patients being readmitted and determine demographic and diagnostic variables associated with risk of readmission.
Methods. 1084 sequential discharges were examined between Jan 2022 and Feb 2023. Age, gender and length of stay (LOS) were determined.

For each case it was determined whether or not the case was a readmission, defined as having been discharged within the previous three months.

Diagnosis was available on 1017 (94%) cases and was categorized as schizophrenia/non-affective psychosis, bipolar affective disorder, non-psychotic mental illness, personality disorder, adjustment disorder, substance misuse disorder and dementia/cognitive impairment.

Social deprivation status was determined for each case based on the address of admission and using social deprivation data from the Northern Ireland census, 2017.

Outcome of discharge was readmission at one week, one month and three months.
Results. For the entire cohort, readmission rates at one week, one month and three months were 5.1%, 13.6% and 20.7% respectively.

Risk of readmission was significantly increased in cases with a diagnosis of personality disorder, a LOS under two weeks and female gender.

Individuals who had been readmitted to hospital within three months of the index admission were significantly more likely to be readmitted in the subsequent three months.

Data on social deprivation is currently undergoing analysis and will be available in due course.

Logistic regression was performed to determine how the variables impacted on risk of readmission at 3 months. In the final model, diagnosis of personality disorder (OR 3.1; 95% CI 2.0, 4.7; $p < 0.001$), diagnosis of schizophrenia (OR 1.8; 95% CI 1.1, 2.7; $p < 0.01$), the admission being a readmission (OR 3.4; 95% CI 2.4, 5.0; $p < 0.001$), a LOS less than 2 weeks (OR 1.9; 95% CI 1.3, 2.7; $p < 0.001$) and female gender (OR 1.7; 95% CI 1.2, 2.4; $p < 0.01$) all predicted readmission within three months.
Conclusion. The service evaluation project has allowed individuals at a higher risk of readmission to be identified. This study

https://doi.org/10.1192/bjo.2024.518 Published online by Cambridge University Press

has informed local strategies now being implemented to target community care and provide timely interventions to those groups at highest risk of readmission.

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Follow Up After Hospital Discharge in Older Adult Psychiatric Patients

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doi: 10.1192/bjo.2024.519

Aims. To identify if patients discharged from an older adult psychiatric ward were followed up in line with national recommended guidelines. Current National Institute for Clinical Excellence (NICE) guidelines recommend follow up and final discharge letters (FDLs) being available within 7 days of discharge.

Methods. A record search was conducted to identify all patients discharged from one ward during a one year period.

Each patient's notes were reviewed to identify what follow up they had in place and how long it took for this to be implemented. We also examined the time taken for a final discharge letter (FDL) to be made available to their General Practitioner (GP).

Results. We identified 99 patients who were discharged from the ward within the specified period.

The mean time taken for patients to be followed up after discharge was 9.72 days. In 63.16% of cases this follow up was provided by Community Psychiatric Nurses (CPNs), with 51.58% being reviewed in medical clinic. A further 9.47% had their initial follow up with an occupational therapist, 4.21% with a psychologist, 4.21% with the addictions team, 4.21% with care home liaison, 2.11% with social work, 2.11% with continuing care and 1.05% with rehab.

FDLs were sent to GPs, on average, 13.6 days after patients were discharged.

Conclusion. Within our data set a few outlier values markedly increased the mean for both outcomes. Using median figures, average follow up time fell to 6 days, meeting national guidelines, and FDL time fell to 8 days, exceeding recommendations by just 1 day.

Within our department, measures have since been put in place to ensure secretaries are reminding medical staff of the recommended time frames for final discharge letters and it should be noted that an immediate discharge letter (IDL) is routinely sent to GPs containing key clinical information prior to patients being discharged.

The results show that our current practice does fall somewhat short of matching national guidelines and further work should be done to investigate how we can improve standards.

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Treating Unmet Needs in Psychiatry (TUNE-UP): Developing a Novel Service for Individuals With Psychosis With Refractory Cognitive, Negative, and Positive Symptoms

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doi: 10.1192/bjo.2024.520

Aims. While dopamine antagonists are an effective treatment for positive psychotic symptoms, they are rarely effective when it comes to treating the cognitive (memory, learning, planning, etc.) and negative (avolition and social withdrawal) symptoms of the disorder. Furthermore, for a sizeable proportion, standard dopamine antagonists are not effective for positive symptoms either. As such, refractory symptoms are a major burden for patients, carers, and clinical services.

Methods. To address this, The TUNE-UP (Treating Unmet Needs in Psychiatry) clinic in Oxford was established in September 2023 as an innovative solution aiming to: (A) Undertake an in-depth assessment of cognitive, negative, and positive symptoms; (B) Identify potentially modifiable causative factors contributing to refractory symptoms (e.g., cholinergic burden, sleep disturbances, physical comorbidities, affective symptoms); and (C) Implement management plans including community clozapine initiation where appropriate. We have analysed data from the clinic's initial five months of operation to establish a baseline understanding of our patient population and identify trends in symptoms.

Results. In the first five months of operations, 21 referrals were accepted comprising 80.9% males (mean age 43.3 years, SD 13.7). 3 were referred for cognitive symptoms, 1 for negative and cognitive symptoms, 11 for positive symptoms, 3 for medication optimisation, and 3 for clozapine re-titration. Of those fully assessed ($N = 17$), mean total symptom scores measured using the Positive and Negative Syndrome Scale (PANSS) were of mild/moderate severity (70.5, SD 18.4). Objective cognitive testing via the Screen for Cognitive Impairment in Psychiatry (SCIP) demonstrated a total mean score of 54.1 (SD 12.1), markedly below what would be expected in a matched control population (76.3). Cognitive scores were lower in those of older age ($r = -0.62$, $p = 0.01$). Subjective experience of cognitive impairment was measured using the Subjective Scale to Investigate Cognition in Schizophrenia, poor subjective cognition was associated with more severe negative symptoms ($r = 0.57$, $p = 0.03$), but not objective SCIP results ($r = 0.12$, $p = 0.85$).

Conclusion. Refractory positive symptoms remain a priority for clinicians, but cognitive and negative symptoms are highly prevalent reinforcing the need for a comprehensive approach. Routine structured assessment of all symptom domains is feasible in clinical practice. Future work should examine the longitudinal impact of various interventions on different symptom domains.

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https://doi.org/10.1192/bjo.2024.518 Published online by Cambridge University Press