Completion of consent form by the patient or carer.
Documentation of ongoing valid consent.
Right to withdraw consent.
The aspect of ECT administration process reviewed was the documentation of pulse, blood pressure and pulse oximetry readings.
The aspects of the monitoring process reviewed were:
Assessing and recording clinical response at baseline and between sessions.
The use of validated rating scales in assessing response.
Assessing and documenting cognitive side effects.

**Results:** Although the consent forms were completed by 100% of the patients or carers and ongoing valid consent was checked for all the patients before each ECT treatment, none of the patients were informed about the right to withdraw consent. The vital signs including the pulse, blood pressure and pulse oximetry readings were robustly documented before, during and after the administration of ECT. Unfortunately, no validated rating scale was used for assessing the symptomatic improvement during the course of ECT treatment, and the evaluation of improvement was solely based on the clinical judgement of the psychiatrist. With this reliance on clinical judgement, the clinical status of all the patients was assessed at baseline but the clinical response between each treatment session was assessed for only 45% of the patients. Regrettably, there was a lack of documentation regarding assessment and review of the cognitive side effects and no standardised cognitive assessment tool was used for this purpose.

**Conclusion:** This audit highlights several areas for improvement, including the failure to inform patients about the right to withdraw consent, irregular clinical evaluations, and the neglected use of standardised assessment tools for monitoring clinical response and cognitive side effects. We suggest updating the consent forms to include the right to withdraw consent. Culturally validated assessment tools should be designed for more structured and objective monitoring of clinical response and side effects. Finally, a re-audit should be scheduled in one year's time to assess improvement.



## High Dose Antipsychotic Therapy (HDAT) and Physical Health Monitoring for Patients Under the Liverpool Homeless Outreach Service

Dr Sibanda Shelton, Dr Monira Sharif, Dr Tom Ebbatson and Dr Kauser Tabani

Mersey Care NHS Foundation Trust, Liverpool, United Kingdom

doi: 10.1192/bjo.2025.10674

**Aims:** To assess the antipsychotic burden and adherence to the Trust policy on HDAT and physical health monitoring for patients under the Liverpool Homeless Service.

**Methods:** Patient records were assessed for a three-month period between July to September 2024 to look at the antipsychotic burden for patients under the Liverpool Homeless Service. Sources of information included patient electronic records, and General Practitioner summaries. A two-stage process was then carried out depending on the HDAT calculations. For patients found to be HDAT, records were checked to measure the adherence to the protocol. Trust Protocol would require bloods and ECG to be done, followed by repeat tests at 3 and 6 months. For the rest of the patients on the caseload we assessed whether physical health monitoring had been done per policy. Trust policy on this was yearly Body Mass Index, full blood count, Liver function tests, Renal profile, HBA1C level, lipid profile, serum prolactin. Compliance to these standards was set at 100%. A total of 40 patients were included in this audit

**Results:** We found that 2.5% of the patients in the service were receiving HDAT. HDAT protocols were not followed for these patients. With regards to physical health monitoring 62.5% of the patients had received the stipulated yearly bloods tests. 55% had Body Mass Index done. Reasons given for non-compliance to these checks included lack of engagement from service users, lack of timely reviews. 77.5% of patients assessed had ECG monitoring done, and this was on time in 60%.

**Conclusion:** Use of high-dose antipsychotics in the service was low, at 2.5%. There was low uptake of HDAT protocol in these patients. Physical health reviews were noted to be adherent to the policy in about half the caseload. To this end recommendations were made for a system to identify patients due for their physical health checks. Awareness was also to be raised in the team regarding HDAT.



## ADHD in Intellectual Disability Audit: Diagnosis, Medication and Monitoring

Dr Shoyoye Oluwadamilola Dr Iqbal Mehak Dr Bennett Sharna Dr Hemmings Colin Dr Jordanova Vesna Dr Oluwadamilola Shoyoye, Dr Mehak Iqbal, Dr Sharna Bennett, Dr Colin Hemmings, Dr Vesna Jordanova

Kent and Medway NHS and Social Care Partnership Trust, Kent, United Kingdom

doi: 10.1192/bjo.2025.10675

**Aims:** Attention Deficit Hyperactivity Disorder (ADHD) is more prevalent in adults with an intellectual disability (ID). NHS Digital reported the prevalence of ADHD in the ID population to be 9% in 2023–2024, compared with 1.2% in those without ID. Understanding the prevalence of ADHD within our Mental Health of Learning Disabilities (MHLD) team is crucial for tailoring our services accordingly and improving patient care. We decided to complete an audit across Kent and Medway to assess the degree of service demand arising from the diagnosis and treatment of ADHD in patients already open to the MHLD service, and to assess our adherence to NICE guidance for medication monitoring for ADHD medications.

**Methods:** A cross-sectional study of all patients currently open to MHLD was conducted. Total numbers across MHLD were recorded, as well as the split between the East and West Kent caseloads. All case notes, clinic letters and GP records were reviewed to identify whether a diagnosis of ADHD (or possible ADHD) was present. Once identified, a deep dive of patient records took place to check medication history and GP monitoring. Information was collated about the type of medication prescribed and length of prescription and whether monitoring had been carried out over the past 6 months in accordance with NICE guidance.

**Results:** We found that 15% (N=97) of all MHLD patients (N=629) had a confirmed diagnosis of ADHD, with 65.5% male and 34.5% female. The mean age of these patients was 24.6. Of those with confirmed diagnoses of ADHD, 43% (N=42) were prescribed medication. The most commonly prescribed medication was methylphenidate (62%), followed by atomoxetine (14%) and lisdexamfetamine (9.5%). Most patients had been on ADHD medication for less than 1 year (31%), with only 7% of patients being prescribed ADHD medication for over 10 years. With regards to medication monitoring, for those prescribed ADHD medication,

83% had their weight measured in the last 6 months, 76.5% had their pulse measured and 64% had their blood pressure measured.
**Conclusion:** This audit suggests that the rate of ID and ADHD in our clinical sample is higher than the estimated population prevalence. This will have implications for service development and training requirements, meaning that clear pathways will need to be established, with available resources and adequate monitoring in place to ensure the needs of our patient group are being met, and current NICE guidance is adhered to.



## Bridging the Gap: Early Identification of Mental Health Needs in Paediatric Inpatients

Ms Sivakami Sibi[1], Dr Sophie Marin[2] and Dr Birgit Westphal[2]

1Queen Mary University of London, London, United Kingdom and 2Royal London Hospital, London, United Kingdom

doi: 10.1192/bjo.2025.10676

**Aims:** Paediatric inpatients often face both physical and mental health challenges, yet the extent of their mental health needs may not always be recognised. At the Royal London Hospital (RLH), we observed a high prevalence of mental health distress among paediatric inpatients, with many scoring above the distress threshold on the Strengths and Difficulties Questionnaire (SDQ), a validated screening tool for emotional and behavioural difficulties. We aimed to assess the prevalence of undiagnosed mental health concerns in paediatric inpatients using the SDQ, hypothesising that 80% would exhibit elevated distress scores, indicating potential unmet mental health needs.
**Methods:** Between 25 November and 22 December 2024, SDQs were administered to all paediatric inpatients across four wards, using parent or self-rated formats (depending on the child's age and ability). Exclusion criteria included children already receiving mental health support or those not fluent in English or Tamil. Of 62 families approached, 49 (79%) participated, with 43 included in the analysis after excluding incomplete forms. Reasons for declining participation included language barriers (5), fatigue/stress (7), and perceived irrelevance of the study (1).
**Results:** Of the completed SDQs, 74% of children showed elevated scores in one or more categories, with 28% having a high Total Difficulties Score. Parent-reported data identified emotional (39.3%) and peer difficulties (39.5%) as the most prevalent concerns, while self-reports revealed that 59.9% of children reported greater difficulty in prosocial behaviour. Notably, discrepancies were observed in seven children, who reported higher difficulty scores than their parents.
**Conclusion:** The high prevalence of elevated scores across multiple domains suggests that a significant proportion of paediatric inpatients at RLH have unmet mental health needs. Discrepancies between parent and child reports highlight the value of incorporating multiple perspectives in assessments. The proportion of families declining participation underscores barriers to engaging in mental health screening. Routine, systematic screening during admissions could help normalise assessments and improve access to timely support.



## Paper in an Electronic World – the Utility of an Integrated Treatment Booklet for the Safe Provision of Electroconvulsive Therapy (ECT) in a Regional Australian Mental Health Service (MHS)

Dr Leo Smith and Mr Andrew Robertson

South West Healthcare, Warrnambool, Australia

doi: 10.1192/bjo.2025.10677

**Aims:** It is incumbent upon psychiatrists to manage cognitive and physical health sequelae during a course of ECT. Monitoring post-seizure orientation and the stability of Montreal Cognitive Assessments (MoCAs) over time allows for dynamic changes to modality, frequency and energy settings in order to minimise side effects. Our service hypothesised that disparate electronic forms actually hindered this process and therefore conducted an audit.

An integrated paper-based treatment booklet for use within the ECT suite, with all forms bound together, was piloted as the quality improvement intervention. A new post-seizure orientation tool was also used.
**Methods:** The setting was South West Healthcare (SWH), Warrnambool, Australia. Standards were set a priori according to ECT guidelines from the Victorian Office of the Chief Psychiatrist and the Royal Australian and New Zealand College of Psychiatrists, with 80% compliance targeted. At a minimum, patients needed baseline bloods (full blood count; urea/electrolytes/creatinine), electrocardiograph, physical examination and MoCA, then physical/MoCA after every third treatment. Furthermore, a comment on orientation in the recovery suite after each treatment was required to meet standard.

Files were selected by 26/06/23 (cut-off date), capturing all ECT patients in the 6 months prior. 15 patients were identified, a combination of acute/completed and acute-continuation/maintenance ECT. Records, both paper and electronic, were audited against standards over 4 consecutive weeks by the authors. After the results were reviewed, the integrated treatment booklet (designed by the lead author) and post-ECT orientation questionnaire (licensed from the University of New South Wales) were introduced into clinical practice.

The audit cycle was completed a year later, with files selected by 30/08/24, capped at 20 patients and capturing all those who had had ECT since the pilot began.
**Results:** The baseline standard during the initial audit was generally met: bloods (79%), ECG (86%), physical (64%), MoCA (86%). However, the standard was not achieved once ECT commenced: physicals every 3rd treatment (60%), MoCAs (49%). Orientation status was documented in 90% of treatments.

During the post-intervention re-audit, compliance had vastly improved: baseline bloods, ECG, physical and MoCAs (100%); objective orientation scores (99%); ongoing physicals (76%)/MoCAs (72%).