good sleep hygiene and behavioural therapy (including sleep diary).
Methods. Nice guideline CG170 provides guidance on Autism management. BNFC states that melatonin therapy should be reviewed every 6 months. Records of children currently prescribed modified release melatonin were checked to see if they met the inclusion criteria. Data were collected retrospectively from clinical case files and pharmacy records (December 2020- February 2021).
Results. The results showed 18 young persons received melatonin for insomnia with ASD, 26 for insomnia without ASD, 3 for likely ASD and none for Smith Magenis syndrome. 36 received Specialist CAMHS review, 9 received Community Pediatrics review and 2 GP review. All patients received melatonin as per dose recommendations with 6 monthly reviews. Documentation on sleep hygiene was unclear.
Conclusion. We concluded that Melatonin prescribing in community CAMHS tends to be high and discussion on sleep hygiene measures must be given importance.

An Audit on the Adherence to Antipsychotic Prescription Policy for the Management of Delirium in the Medical Wards

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Aims. This audit aimed to assess the adherence to the antipsychotic policy for delirium in the medical wards. It aimed to assess compliance with each of the guidelines mentioned in the health board's policy which is based on the National Institute for Health and Cares Excellence (NICE) guidelines.
Methods. After registering the audit, the Acute medical ward was approached for the hospital numbers of all the patients admitted in the months between January and March 2021, and 70 case records were screened. Case notes of patients above 18 years who were diagnosed with delirium including those after managing alcohol withdrawal were included. Those who were admitted only with alcohol withdrawal delirium were excluded. 47 case records were selected for data collection. A proforma was prepared based on the policy available in the intranet and data were entered.
Results. Retrospective data of 47 patients who had delirium were analysed which included 18 males and 29 females. The mean age of the participants was 80.7 years (range 40–101; SD + 30). The mean days of referral after admission were 28(+7.07). 34%were diagnosed to have delirium by the treating team,8.5% were diagnosed by the Emergency Department (ED) team and 57.4% were diagnosed by the liaison psychiatric team. 57% had another psychiatric diagnosis. The cause for delirium was mentioned in 55% of the records and the most common cause was urinary tract infection (31%) followed by multifactorial delirium (27%). Antipsychotics were prescribed for 57% and among those who received 74% received risperidone, 15% received olanzapine, and 11% haloperidol. Compliance was 100% in prescribing appropriate antipsychotics, maximum dose, investigations (expect x-ray chest and CT scan), only 54% compliance was observed with regards to stopping the antipsychotic before discharge and in 23% it was mentioned to be monitored by the GP and another 23% by the treating team.
Conclusion. This audit has displayed the lacuna in the prescription of antipsychotics for patients diagnosed with delirium. Periodic programs will be planned and executed for training the liaison practitioners and the staff in the medical wards regarding the diagnosis and management of delirium especially the prescription of antipsychotics. A re-audit will be conducted after 6 months.

A Snapshot of Prescribing in Intellectual Disability CAMHS

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Aims. There is increasing recognition of the use of psychotropic medication in young people with intellectual disability (ID) at a population level but little is known about day-to-day prescribing practice. This project aimed to characterise medication use in this group and assess standards of prescribing practice with reference to RCPsych guidelines.
Methods. Data werecollected by case note review of young people prescribed psychotropic medication within a community ID CAMHS Service. An index prescription was assessed against standards of prescribing - this was the longest standing script for each young person in the study.
Results. 73 young people were recruited, aged 7–20 years, predominantly with moderate or severe ID. There was a high degree of comorbidity predominantly with autistic spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) and anxiety presentations. Diagnoses did not differ by sex ($p > 0.05$) however behaviours that challenge were proportionately higher in females ($p = 0.014$). A high proportion of youngsters displayed behaviours that challenge (68.5%, n = 50) and almost all of these young people (96%, n = 48) had an additional diagnosis. ADHD presentations were negatively associated with behaviours that challenge ($p = 0.047$).

The hypnotic melatonin was most frequently used medication (56.2%, n = 41) followed by SSRI's (49.3%, n = 36) and antipsychotics (20.5%, n = 15). It was common for use of multiple medications (67.1%, n = 49), typically combining melatonin with a stimulant, SSRI or antipsychotic medication (61%, n = 31). Medications were generally used at modest doses.

The index prescription was in place for a median of 25 months (IQR 28.5, Range 1–108). The indication for prescribing was well documented (98.6%, n = 72) however severity (67.1%, n = 49) and frequency (56.2%, n = 41) recording was poorer. 6-monthly review rate was relatively low (62.5%, n = 40) but the likelihood of review did not reduce with increasing prescription length ($p > 0.05$). Review of medication response (94.2%, n = 65) and side-effects (73.9%, n = 51) was good. Overall there was poor documentation around consent-to-treatment procedures for young people over 16 years of age with only 17.2% (n = 5) having valid authorisation for medication in their case notes.
Conclusion. This study provides rich clinical data about current clinical practice around prescribing in youngsters with ID. Comorbidity is common and results suggest there may be a bias in labelling behaviours that challenge in males as ADHD-related. A range of (multiple) psychotropic medications are used, often for long-periods despite a lack of evidence base. Clinicians are encouraged to ensure rigorous review and consent-to-treatment processes to minimise harms and over-prescribing in this vulnerable population.