curricula. Future sessions should include follow-up assessments to evaluate long-term skill retention and could expand to include other important areas of communication such as multidisciplinary team communication and conflict management.

Assessment of Impact of the ARIADNE Research: Insights Into Improving Access in Mental Health

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Aims: Enduring inequalities in mental healthcare exist between UK minority ethnic and White British groups, which were further aggravated during the pandemic. Through 2022–23 the nationally funded ARIADNE research project carried out qualitative research and co-production workshops to suggest local (in four participating sites of England) and also identified over-arching solutions to improve access and experience of care. After the ARIADNE research project ended, a further co-designed *impact analysis* initiative was carried out in 2024 in two original participating sites (Coventry/Warwickshire and East London).

Methods: Workshops were held in the two sites, attended by staff and experts by experience (carers and service users) to explore the impact and progress of the *action plans* from the ARIADNE study. Subsequently a national workshop was then held bringing together national opinion leaders and local stakeholders to identify key themes.

Results: A content analysis of the workshops and the national event minutes were carried out to identify progress, ongoing barriers and solutions to improving access:

There is a need to refine the concept of minoritised communities. Sharing experiences of racism towards individuals from *minority ethnic groups who grew up in England* and *towards immigrants* would be valuable. Care providers should arrange safe spaces for these conversations.

Pandemic and lockdown deteriorated the quality of mental health care provision and increased demand for mental health support. This disproportionately affected ethnic minorities and exacerbated their struggle in accessing mental healthcare complicated by *stigma* (both internal, in-group, external and cultural).

Professionals were in some cases experienced as being 'blind' to the issues of ethnic minorities and also impacted by institutional racism.

Education, cultural mediation and digital interventions that can offer solutions and overcome barriers to access the solutions need to be local and personalised.

Crucially, a human rights approach is required to promote integration and social cohesion. Offer of care should be diversified by including participatory culture, voluntary sector involvement and lived-experience involvement (e.g. peer work). Some potentially helpful developments and service reconfigurations were noted with population-based approach and neighbourhood models of community mental health care.

Conclusion: Locally led co-production research offer valuable intelligence and can be a resource to local health systems. It can utilised in planning of service re-design and resource allocation. Such continuous co-production increases research impact and minimises delay in putting research findings into practice. The themes raised and initiatives undertaken may be inspirational to other areas and national initiatives.

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.

Anticholinergic Burden in Older Adults Referred to Old Age Psychiatric Liaison: A Quality Improvement Project

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Aims: This quality improvement project (QIP) aims to evaluate the assessment of anticholinergic burden (ACB) of medications, using a validated tool, in patients admitted to Bristol Royal Infirmary and referred to Later Life Liaison Psychiatry, aiming to increase awareness and reduce ACB where appropriate.

Methods: The Anticholinergic burden Effect on Cognition (AEC) validated tool was selected to assess ACB. Baseline data was collected and anonymised from 20 patients via team assessments in patient records. Data included the AEC score, medications involved, prescription indication, whether ACB was considered, and if AEC score was documented.

An educational intervention involved teaching liaison psychiatry staff on ACB, AEC and strategies for deprescribing or switching medication. The team's knowledge was evaluated before and after teaching using questionnaires. An educational poster was displayed around the office.

Post-intervention data was collected from five additional patients, and the results were analysed.

Results: Baseline data showed 25% of patients (n=20) scored AEC ≥3. 30% were on multiple medications with an AEC score, 50% were prescribed antidepressants, predominantly mirtazapine and sertraline (both AEC=1). Only 15% of the assessments had a documented AEC.

Prior to the educational intervention, 71% of the team reported their ACB knowledge level as "very poor", "poor", or "average". After the teaching, 71% of the team rated their knowledge as "very good", indicating significant improvement.

Following the intervention, no patients (n=5) scored AEC ≥3, and 60% of assessments documented the AEC score.

Conclusion: The most prescribed medications contributing to ACB were, in order, cyclizine, mirtazapine and sertraline, aligning with current national literature. Most patients with AEC ≥3 were taking multiple drugs, leading to a cumulative effect. Of the assessments that did not document the AEC score after teaching, all had scores of 0, suggesting staff may not view this score as significant.

All psychiatry liaison colleagues acknowledged the importance of ACB, but had a knowledge gap prior to the educational intervention, which showed improvement following a well-received teaching session.

This QIP demonstrates patients interfacing with old age psychiatry liaison can have a high ACB. The liaison team are well-placed to acknowledge and review these medications collaboratively with medical colleagues. An education intervention shows improvements in assessing ACB in our service.