CAMHS (Child and Adolescent Mental Health Service) to Adult MHLD (Mental Health of Learning Disability) services in North Kent. It examines the reasons for psychotropic medication use, assesses medication burden, and evaluates MHLD's effectiveness in reducing or discontinuing unnecessary prescriptions.

Methods: A retrospective review was conducted by searching the records of patients registered with MHLD North Kent between 2011 and 2022. The study included individuals aged between 17–24 years at their first MHLD assessment, either referred from CAMHS or via GP, Community Learning Disability Team, or Community Mental Health Team. Those first seen after age 24 were excluded. Data analysis covered referral sources, demographics, co-morbidities, prescribing patterns, and treatment outcomes.

Results: Seventy-one patients were identified, with an average referral age of 19. Males comprised 65%. 82% were White British. Learning disabilities were classified as mild (38%), moderate (39%) or severe (23%), with 87% having autism and 32% diagnosed with ADHD. Epilepsy was noted in 25%. Psychotropics were primarily prescribed for behavioural challenges, with risperidone being most common (32%), followed by promethazine (30%), melatonin (23%), and aripiprazole (15%). Medication reduction was attempted in 27% of cases, with 18% achieving successful dose reduction or discontinuation. Psychological interventions were provided to 55% of patients, with 36% having a diagnosis of challenging behaviour. Importantly, no patient exceeded a psychotropic load of 100%.

Conclusion: The main reason for referral was challenging behaviour. Psychotropic prescribing was frequent, yet no direct link was found between prescribing patterns and demographic factors. The MHLD team successfully maintained psychotropic loads within safe limits and engaged over half of the patients in psychological therapies. While medication reduction efforts were undertaken, success rates remained modest.

Recommendations:

Strengthen medication monitoring systems to enhance reduction efforts.

Develop a structured STOMP/STAMP plan and share it with GPs and carers.

Regularly review care plans, particularly when side effects arise.

Improve access to MHLD services for GPs and carers to build confidence in medication management.

Work closely with psychological services to address challenging behaviour at its source.

Implement a clear medication review flowchart, incorporating it into patient records and communication with primary care.

These steps aim to enhance care for individuals with intellectual disabilities and refine medication management within MHLD services.

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A Service Evaluation Exploring Referrals Made From Primary Care to CAMHS in Children With a Potential Diagnosis of ADHD, Autism and Other Mental Health Conditions in a South London Based GP Practice

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doi: 10.1192/bjo.2025.10514

Aims: This service evaluation aims to identify and assess referrals made to CAMHS at a south London based GP practice. The focus of this evaluation will be on referrals for Attention Deficit hyperactivity Disorder (ADHD), autism, anxiety and other mental health conditions such as depression and suicidal ideation. It will also aim to assess if the support available to parents and children is sufficient and if the long waiting times creates pressure on the practice.

Methods: This service evaluation has a cohort of 50 patients who were randomly selected through the EMIS database and had referrals to CAMHS from the practice for autism, ADHD, anxiety and other mental health conditions. The eight parameters that are being measured in this study are:

Age.

The type of mental health support that is offered in the community for the child, e.g. counselling.

The date of first referral from the GP practice.

The date whereby the referral was accepted or rejected.

If the referral was rejected, were there any more referrals?

If the referral was accepted, the number of appointments between referral and diagnosis at A&E.

If the referral was accepted, the number of appointments between referral and diagnosis at the GP.

The type of information and support given to the parents.

Results: In this study a total of 88 extra consultations were made at the practice or A&E with 84% of these consultations made at the GP. Many extra consultations were made at the general practice due to the long waiting times and worsening mental health whilst waiting for CAMHS input. 59% of referrals were rejected or put on a waiting list after the first referral was made. After the initial referral, 32 % of patients made extra referrals, the majority being for ADHD and autism. Rejected referrals for ADHD were the highest at 14% of the total cohort and rejections for other mental health conditions were the lowest at 4%. Some patients received support in the community before or whilst waiting for a referral such as occupational therapy, counselling and school support.

Conclusion: This retrospective study highlights the need for more clarity in referral criteria for GPs and in signposting support services during initial referral and diagnosis to prevent the condition of the patient getting worse.

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Readmission Patterns to KMPT Acute Wards

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doi: 10.1192/bjo.2025.10515

Aims: To identify patterns of readmission to acute wards and look for specific themes associated with readmissions – discharge planning, diagnosis, gender, social support, accommodation issues and any other associations.

To Identify improvement opportunities to align with the patient flow programme.

Methods: Data was gathered from KMPT Electronic patient record system. A total number of 12,602 admissions to all wards across KMPT between July 2019 and August 2024. The number of readmissions were extracted from this data.

https://doi.org/10.1192/bjo.2025.10515 Published online by Cambridge University Press

12.4% of admissions were readmissions within 30 days following discharge. 95.38% of these 30-day readmissions were to Acute MH wards.

Results: Although KMPT has an improving picture in the number of 30-day readmissions compared with previous years, it is still 3% above the national average.

The 30-day readmissions have reduced over time from September 2019 to August 2024, an improving trend.

On an average KMPT currently has 24 readmissions per month. In order to achieve the national average, KMPT would have to reduce this from 24 per month to approximately 16 per month.

Patients aged between 25–35 had the highest 30-day readmission rate in the last year's data.

There was a higher rate of readmissions for female patients.

The majority of 30-day readmissions have either not had their referral reason recorded but secondly indicate 'In crisis' as the reason for readmission.

Patients readmitted within 30 days of previous discharge were predominantly of cluster 8. They were also predominantly of ICD–10 code F603 at 18.75%.

Conclusion: This project is progressing under the Re-admissions pillar of the Patient Flow Improvement Project looking at both avoidable readmissions and high intensity user readmissions.

The Improvement project will look at data in greater detail and identify avoidable readmissions and high intensity users.

The purposeful admission pillar of the Improvement project will address the need to explicitly state what inpatient admission can achieve and the expected outcome from the admission.

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Ultra-Processed Food in an Inpatient Mental Health Setting

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doi: 10.1192/bjo.2025.10516

Aims: The consumption of ultra-processed food (UPF) is associated with many adverse health outcomes including cardiometabolic disorders, mental health disorders and mortality.

The aim of the service evaluation project is to assess the menu items of a 32-beded low secure forensic mental health hospital against the NOVA criteria for ultra-processed food. All the inpatients have a variety of severe mental health illnesses such as schizophrenia or bipolar. All are treated with antipsychotics and rates of complex physical health comorbidity are high.

Methods: 14 different menu items available from the catering department were analysed and the NOVA classification was assigned by reference to the ingredient list. The percentage of ultra-processed food in each menu item was calculated based on amount of NOVA 4 (ultra-processed food) items contained in relations to the total number of each food composition.

Results: Analysis of all 14 menu items, using the NOVA criteria, showed they contained about 68% of ultra-processed food material. This included unexpected items such as roast potatoes and omelettes. Each menu item was wrapped in plastic and had significant amount of processed material, artificial flavouring, colouring and other preservatives sufficient to be classed as ultra-processed food.

Conclusion: 'Don't just screen, intervene' is the motto used to try and improve the physical health of people with severe mental illness. The Lester tool used to assess the cardiometabolic health of people with severe mental health disorder, focuses on the individual person but without the consideration of the institutional context that surrounds those detained in the forensic mental health unit for many years. The interventions all include advice to eat healthily which is impossible if all the food provided is ultra-processed. Whilst individual organisations might be able to change their catering standards to remove ultra-processed food from their menus, a systemic change to nutritional standards for mental health inpatients may be more effective.

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Developing Integrated Old Age Psychiatry and Care of the Elderly Medicine Services for People With Parkinson's Disease: Service Development and Evaluation

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doi: 10.1192/bjo.2025.10517

Aims: Parkinson's disease is a neurodegenerative condition with a lifetime risk of 2.7%, with a rise in prevalence expected in line with an ageing population. Whilst characteristically associated with motor symptoms, it is a multi-system disease with neuropsychiatric sequelae which are frequently missed by non-psychiatric specialists. Patients face barriers to access psychiatric services.

We describe a 15-month pilot of a novel integrated service for people with Parkinson's disease in the Bristol Royal Infirmary. A monthly joint outpatient clinic was established whereby old age psychiatrists from the later life liaison psychiatry team and geriatricians saw patients within the same appointment. Additionally, we collaborated for weekly multidisciplinary team (MDT) meetings, inpatient reviews and wider liaison. Our aim was to develop a holistic integrated service with the hypothesis that this would offer value to our joint patient cohort and the wider healthcare service.

Methods: Patients were identified through triage of outpatient referrals, as inpatients and at MDT meetings. Clinical outcomes from the integrated clinic were measured using the Clinical Global Impressions (CGI) scale. Patient and professional quantitative feedback was gathered. Hospital admission data was measured against baseline admission rates for similar outpatient groups.

Results: Between November 2023 and January 2025, eleven integrated clinics were run and 33 patients attended; some patients were seen on multiple dates. The rationale for integrated working included new psychiatric symptoms (17%), pre-existing psychiatric diagnosis complicated by dopamine treatment (28%), cognitive conditions (39%) and complex psychotropic prescribing (33%). Major treatment outcomes included medication adjustment (78%), diagnostic reformulation and psychological therapy provision. There was a clear positive trend in CGI data showing benefit to patients, with overwhelmingly positive patient and professional feedback. Formal analysis of data looking at hospital admissions was

https://doi.org/10.1192/bjo.2025.10515 Published online by Cambridge University Press