Improving the Quality and Efficiency of Internal Referrals to Child and Adolescent Psychiatry: An Audit of Referral Standards in CAMHS

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doi: 10.1192/bjo.2025.10101

Aims: Efficient and comprehensive referral processes are essential for the timely and appropriate delivery of psychiatric care within Child and Adolescent Mental Health Services (CAMHS). Incomplete or inconsistent referral documentation can lead to delays in care, increased administrative burden, and potential risks to patient safety. This audit evaluates the quality of internal referrals to CAMHS psychiatry, focusing on the inclusion of key demographic details, documentation of consent, evidence of prior therapeutic interventions, and risk assessment.

Methods: This retrospective audit examined referral quality within Marsden House CAMHS in Cheshire and Wirral Partnership NHS Foundation Trust (CWP). The focus was on internal referrals made by therapists and other CAMHS clinicians to the Psychiatry team. Data were collected from referral emails sent to the Marsden House Doctors' email inbox between January and March 2024.The audit assessed 23 referrals against key quality indicators, including: Completeness of demographic details (name, age, gender, date of birth, NHS number).Documentation of patient consent within the referral.Evidence of prior therapy interventions (partnership work) before referral to psychiatry.Inclusion of risk assessment details.The number of emails exchanged per referral, indicating inefficiencies in the process.To ensure consistency in data extraction, a structured proforma was used to record key variables. The findings were then analysed to identify gaps in referral quality and inefficiencies in the process, with a focus on areas for improvement.

Results: The audit identified significant gaps in referral completeness, particularly in demographic documentation, consent recording, and risk assessment. The absence of a structured referral form contributes to inconsistencies and inefficiencies, increasing administrative workload and delaying access to psychiatric care. Additionally, a lack of documented prior therapy interventions suggests that referrals may not always align with NICE guidelines, which recommend therapy as the first-line treatment before psychiatric escalation.Key Findings: The mean number of demographic details included per referral was 2.7 out of 5 key identifiers. Consent was documented in only 43% (10/23) of referrals. 65% (15/23) of referrals documented prior therapy interventions, whereas 35% did not include this information. Risk was explicitly mentioned in only 39% (9/23) of referrals.On average, 2.43 emails were required per referral, highlighting inefficiencies in the process.The lack of a standardised referral form is a major contributing factor to these inefficiencies, leading to incomplete information, delays, and increased administrative workload. The findings also indicate that referrals do not always adhere to NICE guidelines, potentially leading to inappropriate psychiatric escalations when therapy should be the first-line intervention.

Conclusion: This audit highlights the need for a structured, standardised referral process to enhance efficiency, completeness, and patient safety in CAMHS psychiatry referrals. Implementing these recommendations will improve the quality of referrals, reduce delays, and ensure young people receive the most appropriate and timely psychiatric care.Recommendations: Implementation of a Standardised Referral Form with mandatory fields for demographics, consent, risk assessment, and prior therapy interventions.Training for Referrers to improve the quality and completeness of referrals in line with best clinical practice.Ensuring Compliance with NICE Guidelines by requiring documentation of prior therapy interventions before psychiatry referrals, unless clinically justified.Streamlining the referral process to improve efficiency and reduce unnecessary email correspondence.

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Functional Connectivity Patterns Associated with Inflammation in Psychosis; Results From the UK Biobank Database

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doi: 10.1192/bjo.2025.10102

Aims: Recent evidence suggests that inflammation and immune dysregulation play a role in mental health disorders, including psychosis. Research has identified grey matter volume changes, however, the relationship between inflammation and functional connectivity remains underexplored. This study investigates the impact of CRP levels on functional connectivity in psychosis.

Methods: This study used data from the UK Biobank (project 92051), an open-access resource with demographic, clinical, and neuroimaging data for over 500,000 individuals aged 40–69. We identified 91 participants with a psychotic disorder and matched 91 healthy controls (HCs). Neuroimaging data were analysed using the CONN toolbox in MATLAB, focusing on ROI-to-ROI functional connectivity, calculating Fisher z-transformed Pearson correlations, and using general linear models (GLM) for statistical comparisons. Multiple comparisons were corrected with False Discovery Rate (FDR). The interaction between functional connectivity and inflammation was examined using CRP levels as a continuous variable. Group-level analyses employed multivariate parametric statistics with random-effects modelling and Gaussian Random Field theory, with significance thresholds set at $p<0.001$ (voxel) and p-FDR<0.05 (cluster).

Results: ROI-to-ROI analysis revealed significant connectivity changes between psychosis cases and HCs, modulated by CRP. After adjusting for whole-brain connectivity, a cluster of hypoconnectivity was found between temporal regions and the language network ($F(4, 179)=4.55$, p-FDR=0.04). A second hypoconnectivity cluster involved the bilateral insular cortex and the sensory-motor cortex ($F(4, 179)=4.49$, p-FDR=0.04).

A third cluster, mostly showing hypoconnectivity, was found between the bilateral cerebellum and the right temporal gyrus ($F(4, 179)=5.23$, p-FDR=0.04), with hyperconnectivity specifically between the anterior middle temporal gyrus and cerebellum. These regions, especially the left superior temporal gyrus, left insula, and cerebellum, have previously been linked to psychosis and negative symptoms.

At the network level, hypoconnectivity was observed within the salience network, including between the rostral prefrontal cortex, insula, supramarginal gyrus, and anterior cingulate cortex (p-FDR=0.03–0.05). Hyperconnectivity was found between the salience network and default mode network ($F(4, 179)=3.52$, p-FDR=0.03). This pattern of hypoconnectivity within networks but increased

cross-network connectivity mirrors findings in first-episode psychosis with auditory hallucinations.
Conclusion: This study highlights significant CRP-modulated functional connectivity changes in psychosis, particularly hypoconnectivity within the temporal, insular, and motor regions, as well as the salience network. Hyperconnectivity between the salience and default mode networks was also observed. These findings suggest inflammation's role in neural dysregulation.

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Awareness of Voting Rights Among Psychiatric Inpatients – Patients Should Affect Policies

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doi: 10.1192/bjo.2025.10103

Aims: Mental health inpatients are eligible to vote, whether they are detained under the Mental Health Act or not (except for those under a forensic section). It is essential that we do everything possible to facilitate patients being able to vote. Psychiatric inpatients not exercising their democratic right due to logistical failings would further implicate our mental health services in the systemic stigma that people with mental health difficulties face.

1) Assess patient's knowledge of their voting rights
2) Assess proportion of the inpatients currently registered to vote
3) Explore any misinformation patients have been given in the past with regards to their voting rights
4) Explore patient's willingness to advocate for future mental health policy changes as someone with lived experiences of mental health services.

Methods: Type of patients: Functional psychiatric inpatients who are both informal and under section in Cardiff and Vale University health board. Data time frame: 25/06/2024 to 04/07/2024 (prior to 2024 general election in UK). We received 67 responses in total from 8 wards.

Method of collection: A proforma filled out by consenting patients in all the adult psychiatry inpatient wards and functional ward of old age Psychiatry in University Hospital Llandough, Wales and community inpatient wards under Rehabilitation Psychiatry in Cardiff.

Results: Awareness of voting rights of patients is low, among patients and staff alike, on informal interactions. 76% of the responders were aware of the upcoming election and 64% were aware of their voting rights (2024 general election). There was a mixed response in patients wanting to vote in the recent general election as only 55% shared their intention to vote. 10 patients (14%) reported being told by someone that they were ineligible to vote. 60% of the patients were aware of the need for a photo ID to vote and 53% had a photo ID. 33 patients (around 50%) expressed willingness to advocate for future changes to policies.

Conclusion:
1) While there is interest in inpatient settings to influence change in the political setting, more work must be done to educate and inform the inpatient population of their voting rights.
2) Work should be done to make the process of registration for voting streamlined for inpatients, including supporting their access to a photo ID.
3) Arrangements should be made to allow voting by the most suitable method (i.e. in person, by post or by proxy).

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Choice of Treatment Used in a Patient With Antipsychotic-Induced Rhabdomyolysis

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doi: 10.1192/bjo.2025.10179

Aims: Raised creatine kinase (CK) secondary to antipsychotics is often discussed in the context of neuroleptic malignant syndrome (NMS). However, it is documented that antipsychotic-induced CK can also result from rhabdomyolysis, with limited data available on the risk profile of specific antipsychotics.

Methods: We report the case of a 42-year-old woman with paranoid schizophrenia, maintained on olanzapine for years and recently started on a combination of olanzapine and lurasidone. She was admitted to an intensive care unit following seizures and severe hyponatraemia (sodium level 113). Both antipsychotics were stopped initially due to concerns about their role in hyponatraemia; later identified as secondary to psychogenic polydipsia. Upon olanzapine reintroduction, CK levels rose from 9,000 to 32,000 overnight, prompting immediate discontinuation. As there were no NMS symptoms, olanzapine was reintroduced but subsequently stopped again after CK levels peaked at 77,000 and liver function tests deteriorated.

The patient was reviewed by Rheumatology, who suggested olanzapine-induced eosinophilic myositis and rhabdomyolysis. This resulted in the patient developing compartment syndrome; hence a slower CK decline, and bilateral foot drop which was reflected on the nerve conduction studies.

Steroids were initiated for compartment syndrome, and antipsychotics were withheld until CK normalised. The patient was commenced on risperidone, but within a few days the CK increased to 1,000, necessitating its discontinuation. Aripiprazole was then trialled, but the CK rose to 737 after three doses and it was therefore ceased. Benzodiazepines were temporarily used to manage emerging psychotic symptoms until CK levels stabilised. The patient was then transferred to an inpatient psychiatric ward. Given CK elevation with three atypical antipsychotics, a typical antipsychotic, namely haloperidol, was cautiously introduced. It was successfully titrated to a therapeutic dose without CK elevation.

Results: The case recognises the potential occurrence of rhabdomyolysis secondary to antipsychotics and the medical complications as a result. It underscores the importance of close monitoring of CK when prescribing antipsychotics. More importantly, a pattern of atypical antipsychotics being the key factor for rhabdomyolysis was identified. Thus, trialling a typical antipsychotic could be beneficial in treating psychotic disorders in such cases.

Conclusion: This case has identified that typical antipsychotics may have a lower risk of causing rhabdomyolysis compared with atypical antipsychotics, but the mechanism behind this is unclear. This should be kept in mind, particularly in patients with a history of elevated CK who require treatment for their mental health.

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