

**Aims.** This audit covered 3 hospitals in Glasgow City which has 1221 beds providing inpatient healthcare for the north east region of the city. To improve the referral process, we aimed to verify adherence to existing referral pathway and adequacy of information provided by referrals. Referral characteristics including referral indication, intervention and outcomes were accounted for to identify area interest that may help improve the referral process.

**Method.** Our referral pathway involves completion of a Microsoft Word referral template subsequently sent electronically to an internal electronic mail.

Referrals in a 2 month period were included in the audit. Each referral was reviewed for adherence to the referral template, adequacy of provided information and referral indications. Intervention in the form of staff input, Mental Health Act status, psychotropic medication prescribed and given diagnosis was ascertained via staff electronic entry records.

**Result.** 139 referrals were included. 114 referrals (82%) adhered to the referral template. 72 referrals (52%) contained adequate information. Common referral indications were delirium (23%), agitation (20%), low mood (18%) and cognitive decline queries (18%). Staff input ranged from psychiatrist input (46%), liaison nurses (40%), clinical psychology (1%) and shared input (13%). 16 referrals (12%) resulted in subsequent detention under the Mental Health Act. Psychotropic medications prior to liaison assessment included antidepressants (49%), antipsychotics (29%) and benzodiazepines (16%). Liaison assessment resulted in increase use of antipsychotic (55%) and reduction of antidepressants (29%) and benzodiazepines (10%), Delirium (34%), dementia (21%), Mood & Anxiety related disorders (18%) and Query of Cognitive Impairment (14%) were recorded as the most discussed diagnosis.

**Conclusion.** Referrals with inadequate details affect the service's ability to efficiently assess for clinical urgency and matching of appropriate interventions to suit clinical needs. The percentage difference in delirium between referral indication and diagnosis highlights that delirium can be under-recognised, resulting in potentially delayed treatment. Identifying common given diagnosis and differences in psychotropic medication prescribing pattern points to the need for training and support of acute medical ward staff in utilising therapeutics for management of acute mental health disorder.

A pending electronic referral pathway with mandatory entries and linked relevant online resources can encourage early recognition of acute mental health disorder and prompt early management including the use of appropriate therapeutics. An additional feature allowing direct referrals by acute ward staff to community mental health team would support continuity of care for discharged patients needing ongoing mental health assessment.

## An audit of waiting times in the outpatient clinic in Inverness Sector A NHS Highland during the COVID-19 pandemic

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**Aims.** This audit was to assess and improve the organizational efficiency of referrals to Inverness Sector A Outpatient Service. The referrals were audited to measure the average waiting time

from referral to first offered outpatient appointment and to assess the proportion of patients waiting longer than 12 weeks.

**Method.** The audit included routine referrals to the CMHT Inverness Sector A, NHS Highland from GP practices: Kingsmills, Burnfield, Riverside, Fairfield, Foyers and Drumnadrochit Medical Practices. The number of referrals and the number and proportion of clients given appointments for assessments were calculated. Referrals were received directly from primary care and the Mental Health Liaison Team or following Out of Hours contacts at the Mental Health Assessment Team.

Data were collected retrospectively: referrals from 1 Jan 2020–31 Aug 2020. Sample size came to 160 patients aged 16–65 years. Data were collected via review of recorded documentation on the NHS electronic patient record systems (SCIstore), from 5th–25th January 2021.

**Result.** 160 patients (male 82, female 78) were referred from 1 Jan to 1 Sept 2020. Of these, 140 (87.5%) were given an appointment for an assessment. The mean waiting time was 12 weeks for 103 patients (64%), with 57 patients (36%) waiting longer than 13 weeks. The bimodal distribution of waiting times prompted an analysis of those with longer waiting times. In some instances, appointments were delayed because patients either did not attend (DNA) or cancelled their appointments. Reasons for delays included: postponement until further information was available; cancellation of meetings or patients DNA. In 20 cases (12.5%), the referrals deemed inadequate, prompting further liaison with the referrer for clarification about the nature of the problem and previous psychological interventions.

**Conclusion.** The number of transactions (any amendment to a patient record) was higher than the number of patients affected, as several transactions can relate to one patients' record.

Most referrals are vetted in advance via the daily Inverness triage huddle. Ways of improving the quality of information provided by referrers would be explored.

On receipt of each referral, the date of the 12 week deadline would be calculated and highlighted in a database.

The cross-sector (Highland wide) standardisation will add clarity about medical capacity, that does not involve use of excessive clinician time.

## Case Study

### Tics induced by promethazine in an adolescent: a case report

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**Objective.** The objective of this report is to highlight the finding of a movement disorder caused by promethazine in a 16-year-old female and to alert other clinicians to a high index of suspicion of possible movement disorders in young people on promethazine.

**Case report.** I discuss a 16-year-old female (who presented to medics at 15) with low mood, lack of motivation, self-consciousness – at 15, she was over 6 feet tall and weighed 81.2 kg. She also self-harmed by cutting her thigh with razor along with poor sleep, anxiety, and panic attacks. She took an overdose of paracetamol and ibuprofen and a strip of vitamin D and irritable bowel tablets she found at home.

A clinical impression of moderate depression with anxiety and panic attacks and possible emerging emotionally unstable personality traits was made and she had begun psychological sessions with the therapist before referral to the medics. Fluoxetine 20 mg OD increased to 40 mg and Circadin 2 mg ON was commenced. Fluoxetine was later tapered off and Circadin stopped. Sertraline 100 mg OD increased to 200 mg was commenced and Promethazine 25 mg ON to improve sleep.

Within a month of commencement of promethazine, a sudden onset of extension of neck, blowing through lips and a high-pitched sound occurred whilst experiencing a panic attack and hyperventilating. She also stuttered and had difficulty in speaking, and her vision would go blurry. She initially refused to come off promethazine as it had helped her sleep. An impression of a tic disorder characterised by motor and vocal tics was made. There had been no recent infections or previous history or family history of tics. However, at this point, sertraline had helped with her motivation and she was able to come off promethazine and her sleep was improved by practising sleep hygiene with an accompanied cessation of tics.

**Discussion.** Young person is currently on 150 mg of Sertraline.

The rationale behind reporting this case is that previous studies have pointed at SSRIs, as causes of tics disorders, but promethazine is one that does a good job in improving sleep and has a side effects of movement disorder.

**Conclusion.** Promethazine is one medication that can cause movement disorder and a high index of suspicion coupled with a prompt cessation of medication will reduce patient's distress and improve the therapeutic relationship between health professional and young person.

Written informed consent from patient and guardian was got.

Author declares that there is no conflicting interest, financial or otherwise.

## A case of pervasive refusal syndrome related to COVID19

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**Objective.** To highlight the importance of appropriate diagnosis and management of severe mental illness in children. Awareness of rare diagnoses such as this will reduce the delay to treatment. A challenge in Ireland is accessing psychiatric inpatient treatment for very young children, with specialist units in Ireland designed to better cater for young people aged 12+.

**Case report.** Michael (not his real name), age 10, was always described as a happy, calm child. He enjoyed school and loved playing outdoors. He had been progressing well with his life and neither his parents nor school had any concerns for him. Following the COVID-19 pandemic and school closures, Michael began to become more conscious of daily hygiene safety advice. However, things escalated to a very difficult level. Initially, he manifested extreme levels of anxiety with heightened levels of distress. He ran away from open doors or windows for fear he would catch the virus, insisted on changing his clothes several times per day, would become distressed if anyone touched him accidentally while he was outside and could spend hours afterwards crying and screaming.

In June 2020 he showed profound refusal to engage in basic care tasks and a dramatic social withdrawal, and ultimately required admission to hospital. He refused to eat and drink, stopped

washing and toileting himself, lay in bed with the covers over this head, became non-verbal and refused to engage with any conversation or games. He showed prolonged periods of screaming. Ultimately this reached a level requiring TPN and PEG feeding and a low stimulation environment. Diagnosis of pervasive refusal disorder, secondary to severe COVID-19 related anxiety was made.

**Discussion.** Pervasive refusal disorder is a rare and potentially life threatening condition in children. It is described as a profound psychological response to uncontrollable events such as grief, abuse, parental conflict and migration. In this case, it was the threat of the global pandemic. Through treatment in low stimulation environments, with consistent communication and rehabilitation and medication, followed by individual and family therapies when patients are more able, patients show a slow, but generally complete recovery. Happily for Michael, he has now recovered and returned home to his family, where he has returned to all his previous activities.

**Conclusion.** Michael and his parents have kindly agreed to allow us to tell his story, in the hope of teaching current and future psychiatrists about this rare condition. We send them our thanks and appreciation.

## Trials and tribulations of diagnosing and managing psychosis secondary to non-convulsive epilepsy

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**Objective.** To highlight the importance of reviewing diagnosis and management of refractory psychosis and to share that with the scientific community; and to also shed some light on the dilemma and challenges that professionals may face to diagnose and treat organic psychosis. In addition, to look at the possible similarity/dissimilarity in psychopathology between organic and primary psychosis and differences in opinions through presenting the history and course of illness of this patient.

**Case report.** We present the case of a 51-year-old female who had a 28-year history of treatment-resistant schizophrenia. She did not report or display any seizure activity, and an extensive investigation was unremarkable. The unusual nature of her psychopathology, which was predominantly visual hallucinations and somatic delusions, and the difficult to treat nature of her symptoms, prompted investigation with Electroencephalograph which demonstrated bilateral temporal lobe epileptic activity.

**Discussion.** Treatment with divalproex sodium and discontinuation of antipsychotic medication achieved an excellent response, where her visual hallucinations and somatic delusions were both remarkably ameliorated.

**Conclusion.** The differentiation between organic/secondary and functional/primary psychosis is an area of contention between psychiatrists and neurologists and also within each of these specialties.

The myriad of psychopathology and associated treatment resistant psychotic symptoms that patients with non-convulsive epilepsy may experience should result in building a long desired bridge between neurology and psychiatry to collaborate in managing such cases.