

An Evaluation of Referrals and Attendance at a Perinatal Specialist Mental Health Service

Miss Francesca Best^{1*} and Dr Mennatullah Dakroury²

¹Newcastle University, Newcastle, United Kingdom and ²Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Newcastle, United Kingdom

*Presenting author.

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Aims. This service evaluation had four aims:

1. Breakdown the sources of referrals to one Perinatal Specialist Mental Health Service.
2. Calculate the average waiting time from referral to an initial assessment.
3. Analyse the Did Not Attend (DNA) rate for initial assessments.
4. Suggest possible service improvements to reduce waiting times and DNA rates.

Methods. Referrals made in the period May–July 2023 to the Cumbria, Northumberland, Tyne and Wear (CNTW) Perinatal Specialist Mental Health Service were collated. Data regarding the source of referral, demographic details of the patient, whether they were accepted for assessment and whether they did or did not attend their assessment and the outcome of the case was analysed.

Results. Midwives and GPs made the greatest number of referrals (37% and 26% respectively). Out of 263 referrals, 47 did not meet the criteria for an initial assessment – the largest single contributor to this number being referrals from GPs. Just under 16% of referrals made by GPs were found more suited to primary care services after initial assessment compared with 11% amongst referrals from midwives.

The average waiting time from an accepted referral to assessment was 29.85 days. This is higher than the CNTW two-week wait target.

Of the 203 patients offered assessments, there were 20 occasions on which patients DNA. Those who DNA were more likely to have history of domestic abuse (55% compared with 48% amongst those who attended their assessment first-time). Of the patients who DNA their first appointment, 1/3 attended future appointments.

Text reminders about appointments proved extremely popular; where there was information available, 98% of patients were agreeable to text reminders about their appointments.

Conclusion. Waiting times could be reduced by implementing tighter guidelines for referrals and further educating referrers on the specific role of the perinatal service in contrast to primary psychological services, thus reducing unnecessary assessments.

Text reminders should continue to be used in addition to offering assessments at home where suitable. In several cases, patients who had forgotten about their appointment were still agreeable to assessment when met at home.

Future research could be carried out in collaboration with patients who DNA to better understand the barriers they face to attendance.

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Over-Referred and Badly Served – Patient Journeys in Attention Deficit Hyperactivity Disorder at a Community Mental Health Team

Dr Samuel Brooks* and Dr Delia Annear

Cardiff and Vale Trust, Cardiff, United Kingdom

*Presenting author.

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Aims. To measure the proportion of Attention Deficit Hyperactivity Disorder (ADHD) referrals that result in a positive diagnosis and medication prescription at a community mental health team (CMHT) in Cardiff.

To compare patient journeys from referral to diagnosis – documenting the use of GP mental health liaison, private psychiatrists, questionnaires and CMHT appointments.

To measure the proportion of patients with a pre-existing private diagnosis of ADHD that subsequently received a positive diagnosis by the CMHT.

Methods. 230 referrals were made to Pendine CMHT in 2022 for consideration of ADHD. Patient e-records were manually reviewed over a 12-month period following initial referral.

We recorded whether a patient had a pre-existing private diagnosis and whether they were subsequently diagnosed with ADHD by the CMHT. It was also recorded if medication was prescribed or if an alternative diagnosis was suggested.

We recorded whether the patient was asked to see GP mental health liaison team, fulfil an ADHD questionnaire, or attend a doctor appointment before a diagnosis of ADHD was made or refused.

For positive diagnoses, patient records were reviewed to record whether this diagnosis was later changed on subsequent appointments.

Results. Of 230 referrals, 32 received a CMHT diagnosis of ADHD (14%) and 25 were prescribed medication for ADHD (11%).

Of the 25 patients who received a positive diagnosis and medication, 4 had the diagnosis changed on a subsequent appointment and medication stopped.

21 patients had a pre-existing private sector diagnosis of ADHD, of which 9 (43%) were given a positive diagnosis by CMHT and 8 (38%) were prescribed medication.

Of 230 total referrals, 33 were asked to see their GP mental health liaison team for information gathering before re-referral to the CMHT. 112 were asked to complete a questionnaire before an appointment would be considered. 87 were given a consultant psychiatrist appointment at CMHT.

When ADHD was not diagnosed, the most common alternative diagnoses suggested by the CMHT were anxiety, substance misuse or emotional dysregulation (36, 23 and 9 patients respectively).

Conclusion. Referrals to the CMHT for ADHD assessment result in a low rate of positive diagnosis and even lower rates of medication prescription, even for those with an existing private diagnosis.

Patient journeys vary markedly, which we propose reflects the variable quality of referrals and pressure on the CMHT to protect clinic time.

Future work to create ADHD referral guidance is needed to ensure better patient experience and proper utilisation of secondary mental health resource.

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Pilot Study of Community Group Mindfulness Training

Ms Alexandra Cornwall¹, Ms Naz Sergison¹ and Dr Peter L Cornwall^{2*}

¹Bestill for mind and body, Redcar, United Kingdom and ²Tees, Esk and Wear Valleys NHS Trust, Middlesbrough, United Kingdom

*Presenting author.

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Aims. Community mental health transformation relies on the integration of NHS, local authority, and voluntary agencies to deliver mental health care and support where and when people need it. There is a concern that resources may be diverted to services focused on those with less severe problems and without robust outcome data. We plan to develop a network of self-sustaining mindfulness support groups in a disadvantaged locality with very limited community resources. We provided a pilot mindfulness programme to a group of mothers of primary school age children in East Cleveland.

Methods. Participants were recruited through poster adverts at a primary school. The programme was delivered through 12 weekly hour-long sessions at the school. The group facilitators had basic training in mindfulness. The aim was to teach basic mindfulness practices that could be used in everyday life, including breath work, meditation, and journalling. Mental health status at baseline, mid-point (week 6) and end point (week 12) was measured using the GHQ-12 (score 0–36 and a threshold for likely psychiatric disorder). Data was analysed using *t* test for continuous scores and χ^2 test for caseness.

Results. 14 women responded to the invitation and 9 completed the programme attending a mean of 11.2 sessions. The mean age of participants was 37.4 years and 8 reported previous mental health treatment with medication or psychological therapy, with 4 currently taking medication, but none were known to secondary mental health care services. GHQ-12 scores at baseline indicated significant levels of mental health distress (mean score = 24.1, caseness = 100%). At the midpoint there was a 56.2% reduction in GHQ-12 scores, and this increased to 62.0% at the endpoint. 2 participants remained GHQ cases at both follow-up assessments. The improvement was highly significant (baseline mean score (SD) = 24.1 (2.71); final mean score (SD) = 9.11 (6.15); paired *t* test: *t* = 7.23, *df* = 8, *P* = 0.0001).

Conclusion. This was a novel programme where participants gained access through being parents of primary school aged children. Despite being an unselected community sample, the participants reported significant levels of psychological distress. This highlights both that most people with mental health problems have no contact with psychiatric services and that there remains a high level of unmet need in the community. In this sample, a remarkable level of improvement was demonstrated from a relatively simple and straightforward intervention. Clearly, this will benefit from replication in greater numbers in more diverse samples and settings and with follow-up to see if the benefits persist beyond the intervention phase.

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Review of Equity of Access to Treatment for Gambling Harms in Racial and Ethnic Minority Populations: A Mixed Methods Study

Mrs Deborah Davidson-Hine^{1,2*}, Dr Helen Lloyd², Dr James Close², Dr Konstantinos Ioannidis¹ and Dr Mat King¹

¹Southern Health Foundation Trust - Southern Gambling Service, Southampton, United Kingdom and ²School of Psychology,

University of Plymouth, Plymouth, United Kingdom

*Presenting author.

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Aims. The NHS Southern Gambling Service (SGS) is a service providing evidence-based assessment and treatment for people affected by Gambling Disorder (GD) across the South-East of England. This service evaluation aimed to ascertain whether SGS was offering equality of access to treatment and suitable provision of treatment to ethnic minority communities, and whether there were barriers making it difficult for people from ethnic minority communities to access and engage in treatment for gambling harms.

Methods. Quantitative ethnic origin demographic data was obtained from 120 referrals to SGS between September 2022 and October 2023. These were statistically compared with the ethnic origin demographics of the general population in the same geographical area, as identified by Office of National Statistics (ONS) Census 2021 data. Qualitative data was collected through interviews with three participants from ethnic minority populations who were engaged in treatment with the service. Relevant themes in the qualitative data were identified using thematic analysis.

Results. Quantitative data results indicated no significant statistical differences in most ethnic origin categories between the proportion of referrals to SGS from the ethnic origin and the recorded proportion of this ethnic origin in the general population. There was a greater difference for the “other ethnic group” category (chi square *p*, 0.05, uncorrected), which was likely due to a difference in categorisation of ethnicity between SGS and ONS in 2021 Census.

The qualitative review identified themes of value of money, stigmatisation, different cultural attitudes towards gambling, and experiences of healthcare. GPs were identified as the first step towards seeking help for gambling.

Conclusion. These results suggested that SGS was offering equality of access to treatment for people from ethnic minority populations and that there were not significant barriers preventing people from ethnic minority populations accessing treatment. The reported positive experiences of participants’ referral to and treatment with SGS indicates that for these participants suitable provision of treatment had been offered by our service.

With the thematic analysis identifying GPs as the first step towards seeking help for their gambling, this study indicates the importance of the gambling service working closely with primary care for the equitable access to treatment from gambling harms on a regional level.

These preliminary findings are based on a limited, small sample. Further research using a larger, more diverse sample to gain a deeper knowledge would be advised to further shape the service offer to ensure equity of access.

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“It’s Changed My Mind-Set About the Idea of Motherhood”: An Online Perinatal CFT Group Service Evaluation

Ms Joanna Douzenis* and Ms Mahnoor Lashari

West London NHS, London, United Kingdom

*Presenting author.

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