P11 ADAPTING A LAY COUNSELOR MENTAL HEALTH INTERVENTION FOR ADOLESCENTS IN BOTSWANA

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Aims When implementing interventions for adolescents, specific adolescent friendly adaptation from adult interventions is vital. The Friendship Bench is a lay counselor community therapy model that has been shown to have high efficacy in adult populations with adult lay counselors in Zimbabwe and other communities. Our objective was to understand the overall mental health needs and necessary adaptations for lay counselor based work for adolescents in Botswana.

Methods We used theory of change activities during stakeholder meetings to discuss necessary elements of the Friendship Bench for use with adolescents. We held four groups sessions with stakeholders who were youth, parents, members of youth serving non-governmental organizations, members of government, and HIV clinic clinicians, and social workers. The meetings addressed root causes of poor mental health in youth in Botswana, overall structure of mental health services, ultimate outcomes we would hope to achieve with a youth mental health intervention, and action steps and assumptions necessary to implement a lay counselor intervention.

Results Root causes of mental health in youth included lack of knowledge about these issues, family problems like abuse/neglect, and poor communication, low self-esteem, rapid growth of technology, and biology/genetics. Structurally barriers included: the stigma against mental illness, lack of psychosocial support, poor follow-up for mental health services, cultural beliefs about mental illness, and fragmented mental health services available. The stakeholders seek a program that empowers adolescents and youth counselors to address mental health concerns in order to create a healthier community. The group identified several major elements of an effective lay counselor intervention including age appropriate (youth) lay counselors, broad education and screening of youth at risk, creative and fun ways of engaging and maintaining them into the intervention, flexibility with schedules, and strong lay counselors with adequate training and personalities that support thoughtful interpersonal engagement. Lay counselor pre-training qualifications were defined and included a preference for youth with similar diagnoses, a minimum of secondary school training, age of 18 to 35 and agreement to attend mandatory counseling.

Conclusion Stakeholders from multiple segments of the community can illustrate key elements of interventions being expanded to new populations and environments.

P14 BREAKING DOWN BOUNDARIES TO SUCCESSFULLY MANAGE YOUNG PEOPLE WITH EATING DISORDERS

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Aims To describe how a brief (7-10 day) medical stabilisation model was developed for young people with restrictive eating disorders through joint team building between paediatrics and Child and Adolescent Mental Health Services (CAMHS). The paper will outline development of the team across traditional mental and physical health boundaries, challenges faced, outcomes, and discuss benefits of the model for patients, families, Trusts and the wider health economy.

Methods From 2014-2015 a consultant psychiatrist and paediatrician worked to turn existing informal support into a formalised arrangement, aligning with regional CAMHS transformation. This led to development of a multidisciplinary regional Tier 3 community eating disorders service (CYP-CEDS). From 2015-2016 work began with children's nursing staff in the local paediatric unit to develop skills in managing young people with eating disorders. Concurrently, a multidisciplinary team across paediatrics and mental health worked on development of a shared protocol. From early 2016, young people were selectively admitted to the paediatric ward for medical stabilisation if required, with primarily nurse-led management and supervision and liaison from the CYP-CEDS.

Results 61 patients had a total of 72 admissions over three years. Age range 10-17 years (mean 14.8 years). Length of stay range 1-22 days, with mean of 9.7 days in year 1, 10.4 days in year 2 and 7.2 days in year 3. Of admissions from the community, 79% (50/63) were discharged back to the CYP-CEDS. 82% of admissions (59/72) were managed entirely with oral feeding on the ward. 4% (3/72) had a brief period of nasogastric (NG) feeding but were discharged orally feeding. Over the 3 years, the rate of admission to a Tier 4 eating disorders inpatient unit fell from 14% of CYP-CEDS caseload in year 1 to 4% of caseload in year 3. Challenges faced included: training, including in ethicolegal aspects; risk management; nursing rotas; avoidance of parental disempowerment.

Conclusions With effective joint working between physical and mental health and upskilling of children's nursing staff, young people with severe eating disorders can be effectively stabilised and eating established over only 7-10 days on a paediatric ward. This has led to significant reduction in admission to inpatient psychiatric units, with less time in hospital overall and reduced system costs.

P15 DOES THE NHS OFFER EQUITABLE ACCESS TO SPECIALIST PAEDIATRIC CLINICS? A STUDY OF INEQUALITIES IN OUTPATIENT REFERRALS TO EIGHT PAEDIATRIC SUBSPECIALTIES

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Aim To assess the distribution of socioeconomic status across different subspecialty outpatient clinics in a large paediatric service.

Methods 32,369 consecutive, accepted, new referrals to selected paediatric clinics at a large London hospital from April 2007 to June 2018 were reviewed (Allergy, Asthma, Chronic Fatigue Syndrome/ME, Diabetes, Endocrine, Epilepsy, General Paediatrics and Rapid Access). Data collected included age, postcode, referral date, referral source, clinic code and