

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

Abstract P15 Table 1

Clinic Category	Mean age (years)	Number of Patients	Mean Index of Multiple Deprivation rank (1= most deprived, 32,844= least deprived)	Percentage of patients in least deprived quintile	Percentage of patients in most deprived quintile
Allergy	4.66	4088	10,719	3.57%	36.91%
Asthma	7.54	796	9327	2.14%	41.08%
CFS/ME	14.66	1630	18,274	26.20%	14.66%
Diabetes	11.17	663	18,369	24.13%	13.42%
Endocrine	13.61	4538	15,254	15.93%	22.17%
Epilepsy	7.92	865	10,864	4.97%	36.99%
General Paediatrics	5.73	9846	10,132	3.04%	39.15%
Rapid Access	4.05	9714	9706	2.28%	39.53%

appointment attendance. The mean Index of Multiple Deprivation rank for each postcode was obtained. The proportion of patients in the most and least deprived quintiles were also calculated. 229 postcodes were unmatched.

Results

Conclusions The socioeconomic profile of secondary care clinics for Allergy, Epilepsy and General Paediatrics broadly matched the profile of our hospital inpatient population (4.4% and 37.9% in the least and most deprived quintiles). Secondary care Asthma and Rapid Access clinics were slightly more skewed towards patients from more deprived areas. In contrast, Endocrine, Diabetes and CFS/ME clinics showed a much higher proportion of patients from more affluent backgrounds—perhaps reflecting a larger proportion of these patients who live outside our local area. Further research will now be conducted to determine the extent to which these findings may also reflect unmet need and difficulty in accessing more specialist clinics for families living in more deprived areas.

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A USEFUL TECHNIQUE FOR PATIENT ACTIVATION AND ENGAGEMENT IN YOUNG ADULTS WITH CONGENITAL HEART DISEASE: INSTRUCTIONAL CONVERSATION USING THE CONGENITAL HEART HEALTH ACTIVATION TRANSITION TOOL

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Aims Adolescents and young adults (AYA) with congenital heart disease (CHD) are a high-risk group particularly during the transition period from pediatric to adult care. We aimed to create a clinic-based tailored CHD transition program to improve adolescent knowledge and activation, increase participation in shared-decision making, and facilitate patient empowerment through Instructional Conversations (IC).

Methods We conducted a needs assessment with key stakeholders (pediatric and adult cardiologists, parents, and adolescents with CHD) to identify potential barriers to transition. A three-pronged approach was taken to spearhead transition education: (1) Streamlining dedicated transition visits; (2) Creating

individualized learning plans (ILP) to encourage shared decision making and patient engagement; and (3) Utilizing motivational interviewing (MI) and instructional conversation (IC) to administer a novel patient activation tool: CHHATT- The Congenital Heart Health Activation Transition Tool.

Results Six Plan-Do-Study-Act (PDSA) cycles were conducted and included streamlining educational/assessment materials, modifying teaching style, implementing MI and IC, and creating the CHHATT tool. During PDSA cycles, three major themes emerged regarding patient activation and engagement. First, families better received transition services if given advanced notice. Thus, we built separate clinic visits for program introduction (14 year old) and serial education/training visits (15 year old). Second, having a streamlined script for education of various CHD diagnoses and creating ILPs resulted in increased patient engagement and shared decision-making. Third, patient self-assessments poorly revealed true knowledge deficits. MI was used to reveal these deficits through creation of a CHHATT tool, which reveals knowledge/skills gaps and reinforces education through guided IC. Patients demonstrated increased confidence when using the CHHATT to teach-back to parents and ask physician questions. Parents' verbalized satisfaction in the increased empowerment teens demonstrated after serial visits using CHHATT.

Conclusion We created a CHD transition program for AYA with streamlined serial education, individualized learning plans, and motivational interviewing and instructional conversation. Patients demonstrated increased activation and engagement using our novel tool CHHATT. We strive to lead transitional clinical care and further patient success by (1) introducing additional assessment tools for health literacy and resilience and (2) guiding clinical practice by sharing our sustainable/billable program model for CHD transition programs.

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FACTORS ASSOCIATED WITH LOW PHYSICAL ACTIVITY AMONG IN-SCHOOL ADOLESCENTS

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Introduction/Aim Despite the established health benefits of physical activity, the health risks of inactivity and the various interventions to encourage physical activity, a substantial proportion of young people remain insufficiently active. Studies have attempted assessing factors associated with physical activity but do not provide explanations for the dynamics of underlying factors. Similarly, interventions do not show significant difference in control. This study therefore was undertaken to determine factors associated with physical activities among the target population using health promotion theories to provide explanations of their dynamics.

Methods The study was a community-based cross-sectional study which employed a validated instrument developed to measure level of physical activity, assess patterns of sedentary lifestyle and personal-level and environmental-level dispositions of the respondents towards physical activity. Cronbach's alpha Internal consistency measure of the instrument was 0.814 and all statistical tests were set at $p = 0.05$ level of significance as cut off.