

Methods Telephone interviews with focused questions on transition experience was used to obtain the data. The sample contained patients with IBD that had already been transitioned from 2020 onwards. The questions that were used was derived from the ready steady go criteria (Nagra, 2015)¹ and NICE guidance (NICE, 2016)² but condensed to 11 questions for the child and 3 for the parent/guardian. Qualitative data was obtained to understand more about the transition process.

Results 10 patients and 10 carers were contacted, of those people 6 patients and 3 carers responded. 4 patients remembered transition being introduced at the age of 15–16 years old and 2 by 17–18 years. 5 patients had a face to face consultation, 1 had a telephone call due to COVID-19 restrictions. 5 could name a healthcare professional they could contact for transition support, one person who did not. All 6 were confident on their knowledge about the condition and also to be seen independently in clinic. Only 1 patient stated to not lead a healthy lifestyle but everyone understood the risks of drugs, alcohol and smoking on their health and their condition. All 6 reported a happy mood. 2 patients rated their overall experience as very good, 2 rated their experience as good and 2 rated their experience as neither good or bad.

The qualitative data reflected positive feedback from both parties. COVID restrictions was the main cause of complaint.

Conclusions Overall, this study shows an overwhelming satisfaction in the transition services offered. NICE guidance was met in providing a named service provider for all and building confidence in patients. All patients were introduced to transition much later than 13–14 years of age recommended by NICE (NICE, 2016).² We need to start early with preparation for transition. In some cases pandemic disruptions have effected transition due to the reduced availability of face to face appointments. Coincidentally, 2 of the 4 patients who did not answer when contacted came from South Asian backgrounds, both with a longstanding history of missed appointments. A look into ethnic backgrounds and transition needs and attitudes may help improve the process for ethnic minorities.

REFERENCES

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1834

YOURSTANCE: TEACHING YOUNG PEOPLE AT RISK OF SERIOUS YOUTH VIOLENCE BASIC LIFE SUPPORT AND HAEMORRHAGE CONTROL

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Objectives Serious youth violence (SYV) is a significant cause of injury and death among young people. YourStance is a preventative education project which endeavours to minimise morbidity and mortality caused by SYV by teaching basic life support and haemorrhage control to young people. The objectives of this evaluation are to identify characteristics of young people that attend YourStance sessions, to understand their reasons for attending, and to assess whether training sessions are beneficial for participants.

Methods Healthcare professionals delivered interactive teaching sessions to young people in prisons, pupil referral units and youth hubs in London boroughs with high rates of SYV. Participants completed feedback surveys at the end of each session. Data from completed surveys from June 2019 until December 2021 were analysed.

Results 197 participants completed feedback forms. The majority were male (75%) and black, Asian, and minority ethnic (78%). Whilst the average age was 21 years, two thirds were <15 years old (61%). Over a quarter had experienced SYV (29%) and the majority of participants in prison were SYV victims (79%). The predominant reason for attending was to gain medical skills (63%), and over half (58%) had previously been in situations where YourStance training would have been useful. Benefits of the sessions included: medical training (81%), feeling better prepared to respond to emergencies (80%), and 83% would recommend the sessions.

Conclusions The results provide useful information about participant demographics and motivation for attending YourStance teaching, which will help tailor future sessions towards those most at risk of SYV. YourStance is successfully preparing young people to be emergency responders in their communities, and participants find the sessions beneficial. Further research is required to investigate whether these skills are retained, and whether morbidity and mortality from SYV is affected.

1835

TRENDS IN MENTAL HEALTH PRESENTATIONS OF ADOLESCENTS TO A PAEDIATRIC EMERGENCY DEPARTMENT OVER THE COVID-19 PANDEMIC

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Objectives The aim of this study is to observe the trends in the mental health presentations of 10 to 16-year-olds to the paediatric emergency department (ED) in Belfast over a two year period, capturing the onset and peak of the COVID-19 pandemic.

Methods Data was gathered on attendances to a paediatric ED between October 2019, prior to the announcement of the COVID-19 pandemic, until October 2021. Data was collected on demographics including postcode, as well as trends of the presentations including reasons for presentation, timing of presentations, and outcomes following emergency department attendance.

Results There were 488 presentations between the start of October 2019 and the end of October 2021, of which the ratio of male-to-female was 19.7%:80.3%. A majority (76.0%) of cases presented out-of-hours. The peak number of admissions were in May 2021 with a total of 33. The overall admission rate was 26.8% of overall presentations. Of the 131 cases which resulted in admission, 3 patients (2.3%) were referred directly to the paediatric intensive care unit (PICU). The most common cause of presentation and admission was overdose which made up 40.0% of cases.

Conclusions During the pandemic, the hospital saw an increase in the number of young people with mental health difficulties in ED. Peaks in presentations were noted initially at the easing of restrictions around 5 months following onset of lockdown. The data also allowed us to look at demographic

presentation areas using post codes which could potentially be targeted by community teams. The literature acknowledges notable variations in the specific types of presentations, with an increased proportion being due to self-harm and eating disorders. There may be a link between the environmental factors of being under lockdown with limited social contact and increased online media consumption causing adolescent health to deteriorate in specific ways.

1836

ADHD TREATMENT RESPONSE FORM – FOR YOUNG PEOPLE BY YOUNG PEOPLE; EMPOWERING YOUNG PEOPLE TO BE ACTIVE PARTICIPANTS IN THEIR OWN ADHD MANAGEMENT AND HEALTHCARE

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Objectives Historically, ADHD medication efficacy and symptom improvement has been monitored for young people by parents/carers and teachers completing rating scales, which are evaluated by the paediatrician.

In our service, young people felt it was important that they were involved and contributing to the management of their own ADHD treatment. The aim was to co-produce an ADHD treatment response tool for young people to complete.

Methods A project group was held with four young people aged 13 – 17 years (boys and girls) who have ADHD and two clinicians.

The group worked together to co-produce a ‘Treatment Response Form’, adapted from DSM 5 ADHD symptoms¹ along with a scoring system,² ensuring that the form was easy to use and understand, that the questions were asked in first person, and that the language was suitable and positive, whilst also being clinically accurate as an effective assessment tool.

The group of young people involved in the project group were equal partners in designing the form and were engaged and proactive from the beginning. As well as designing the form, the group discussed the value and benefit of being able to actively contribute to, and participate with their own healthcare, as well as health service improvements more widely.

Results The Treatment Response Form is now being used by young people and the community paediatrics service in Bedfordshire and Luton. Young people are able to input their perspective into the monitoring and efficacy of their ADHD treatment and intervention by completing this questionnaire.

The questionnaire is a word document, therefore accessible for free, online electronically or on a printed paper version and is quick to complete.

The Treatment Response Form has a simple scoring system² which means the individual responses indicating progress to treatment and interventions of their ADHD condition can be self-monitored by the young person. The form not only encompasses questions relating to ADHD symptoms and behaviour, but also compliance with medication, side effects, and sleep difficulties. It also asks the young person to talk about the positives and things they enjoy doing to offer a holistic perspective.

Conclusions When using the Treatment Response Form as an assessment tool in clinic, the paediatrician evaluates the completed form with the young person, thus generating an informed discussion on areas of strength and challenge, to

together agree treatment, interventions and set goals. It has enabled both the young person and clinician to better understand how the young person is feeling and managing ADHD from their perspective. Positive feedback has been received from the young people.

The Treatment Response Form is empowering young people to be actively involved in their treatment, also supporting positive transitions into adulthood. For clinicians, it reinforces the value of patient centred care, and the voice of the young person being central to their treatment and care plan.

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1840

EATING DISORDERS IN ADOLESCENTS AND THEIR RELATION TO CONTRACEPTIVE DECISION MAKING

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Objectives These findings are part of a wider study designed to assess clinicians’ contraceptive provision for patients with eating disorders. Contraception provision for patients is a vital role of sexual health clinics across the country. Certain patient groups may have additional factors, symptoms or behaviours that make different contraceptive choices safer or preferable. Adolescents with eating disorders are one such group. Research shows that behaviours such as laxative use or the induction of vomiting alongside pre-existing risk factors can affect contraceptive choice efficacy and safety. Patients with eating disorders have been demonstrated to have a greater number of new sexual partners and decreased condom use.¹ Eating disorders most commonly start in adolescence, with studies estimating the mean age of incidence for anorexia nervosa as 14.6 years² and have a much higher prevalence in females.³ Current advice from the FRS⁴ is for clinicians to ask about eating disorders when providing contraception and the recommended contraception for this group is long-acting-reversible contraception (IUS/implants).

Methods 25 females aged 15-18 were randomly selected who had come to a regional sexual health centre from October 2021 - May 2022 seeking contraception. Patient records were reviewed to assess the use of the box for history of eating disorders on the ‘new family planning’ history form (this box was not mandatory for clinicians to complete but they were advised to). If an eating disorder was identified, information was then collected on what further history was documented (e.g. classification of eating disorder, relevant behaviours and risk factors). Data was collected on what contraceptive was then given to each patient with/without the eating disorder box completed. Data was collected on recorded BMIs.

Results In the age group 15-18 only 76% of the patients were asked about eating disorders. Of these patients, 5 had notes detailing problems relating to eating. The average number of words in the notes on eating disorders was 10.4, with the least being 5. The contraceptive choices given were varied (figure 1). Only 10 of the patients had their BMIs measured, of these 3 were low (<18.5). Only 1 of these 3 had notes detailing eating problems.