EPV0568

ACOMPANYA'M a novel multimodal intervention plan

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Introduction: The Residential Educational Therapeutic Unit Accompany from Hospital Sant Joan de Déu Barcelona, is a device integrated into the public health network, intended for the comprehensive care of **children and adolescents under 18 years of age who suffer from an illness complex mental disorder**, at serious risk of becoming chronic and generating significant disabilities at a functional, cognitive and emotional level. It was a result from a joint venture between the Department of Social Rights and the Department of Health. The device was created to respond to the increase in behavioral problems and mental health disorders of children underguardianship.

Objectives: General Objective

To improve the quality of life in the physical, mental and social spheres of vulnerable children and adolescents with serious complex mental pathology through a biopsychosocial and community care model that integrates health, social, family and educational care and which is aimed at the recovery of the person's life project.

Specific Objectives

To offer intensive intervention, personalized and in a co-responsible manner, that is to say, that integrates the therapeutic, education, social services and child protection teams.

Promote the community and social reintegration avoiding stigmatization and social exclusion.

Improve the intra-family relationship and the burden perceived by caregivers.

Decrease the number of renunciations of parental authority of a minor.

Methods: The unit has a capacity for **28 beds:** 23 places for children/adolescents underguardianship of the administration and 5 places for cases that are at risk of family claudication due to their therapeutic and educational needs.

There are 5 coexisting therapeutic units. The apartments are referred as 'homes' and their organization is designed to encourage the active participation of residents with the professionals who attend them.

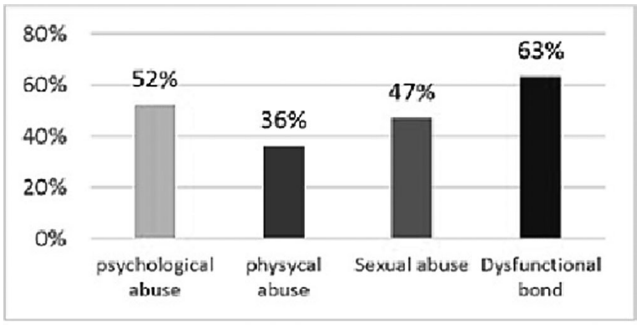
The Unit has a multidisciplinary team made up of the following professionals: Psychyatrists, Nurses, clinical psychologists, Social Workers, Educational worker, nursing assistants, administrative.

Results: - **110 children and adolescents have been taken care**, with an **average cumulative stay of 13 months**. In all cases in which the family had the guardianship of the patient, family claudication has been avoided There is a 36% discharge of those patients under guardian that have returned to their original family home 100% of the cases have been linked to an educational center adapted to their needs or to a training project

Image:

DSM-V	2018	2019	2020	2021	2022
Neurodevelopmental Disorders					
Intelectual Disability non specified	13	9	15	5	1
Austism Spectrum Disorder	5	8	19	15	6
Attention Deficit Hyperactivity Disorder	11	3	14	8	4
Gilles de la Tarette Syndrome		2	3	1	
Fetal alcohol syndrome			3	1	1
Eating Disorder					
Ingestion avoidance/restriction disorder	2	1	1	1	1
Impulse and behavior control disorder					
Conduct Disorder	7			2	2
Oppositional defiant disorder	3	2	7		1
Affective disorder					
Bipolar Disorder	1			1	
Major Depressive Disorder		2	5	1	3
Personality Disorder					
Limit Personality Disorder	2			1	
Unspecified Personality Disorder	3	1	2	1	2
Dissocial disorder	3			2	
Substance use disorder					
Cannabis use disorder	10	1	7	1	1
Cocaine use disorder	1				
Alcohol use disorder					1
Anxiety disorder					
Anxiety disorder	1			3	
Social phobia	1	2	1		
Obsessive compulsive disorder			2		
Disorder related to trauma and stress					
Post traumatic stress disorder	2	2	10	8	4
Adaptive disorder	3	2		1	1
Reactive attachment disorder	1	2	1	1	1
Disinhibited attachment disorder		1	2		
Schizophrenia and other disorders, Psychotic	3	5	5		1

Image 2:



Graphic 1. Percentage and type of family neglect

Conclusions: Overall, the care model implemented by the population served in the Acompanya'm unit is positively evaluated. Since it provides an intensive and personalized care, treatment and intervention for children suffering from a serious mental disorder

of high complexity. A comprehensive, personalized, interdisciplinary approach is offered, coordinated and co-responsible with educational, protection and social services.

Disclosure of Interest: None Declared

EPV0569

Implementation of a peer support intervention for family members of involuntarily hospitalised patients

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Introduction: Peer support has been identified as successful in improving patient wellbeing and empowerment and there is evidence that peer support can also help their family members (FMs). A peer support programme for FMs, developed in Germany, significantly improved FMs' quality of life. We have worked to adapt this support programme for delivery in England. We will report the results of this adaptation process and of the implementation of peer support for FMs.
Objectives: To examine the feasibility of the peer support programme developed and assess whether it can be delivered using a "train-the-trainer" approach.
Methods: The peer support programme is being implemented in two stages. In stage one, FMs with experience of supporting an involuntarily hospitalised patient (family peer supporters (FPSs)) receive an online training programme consisting of four sessions. These sessions, provided by the research team and FMs with lived experience of caring for an involuntarily hospitalised patient, teach FPSs skills in communication, reflection, coping and trialogue (promotion of equal communication between FMs, professionals and patients). FPSs then use these skills to deliver support to FMs of patients who are currently involuntarily hospitalised. This support is delivered for up to three months. The impact of this programme is assessed through one-to-one interviews with FPSs and FMs. Questionnaires are also provided to FMs measuring their quality of life, caregiving burden and psychological wellbeing before and after receiving support from FPSs.
In stage two, a modified version of the training programme (based on FPS feedback) is provided to a new group of FPSs. This training will be delivered by FPSs from stage one. After receiving the training programme, stage two FPSs will deliver support to other FMs as described for stage one. Assessment of the modified programme will mirror stage one.
Results: Provision of the stage one training programme is complete, and delivery of support is in progress with modifications being made for stage two. Eight FPSs and six out of a target of 12 FMs have been recruited for stage one. FPSs reported the training programme to be a positive experience, highlighting that it was engaging, easy to understand and gave them the confidence to support other FMs. Technical difficulties and an overload of information were cited as areas to improve for the next stage.
Conclusions: FPSs described the peer support training programme as a positive experience overall. However, improvements need to be made for stage two which is in progress. A more comprehensive report of our findings, including the impact of this peer support programme and the feasibility of implementing it in England, will be provided as the programme progresses.

Disclosure of Interest: None Declared

EPV0570

Exploring The Impact of Positive Behaviour Support Plans on Adult Acute Mental Health Staff Practice

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Introduction: There is a national movement to reduce restrictive interventions due to the harm and distress they can cause which has been reflected in NHS trust policies and practices. NHS trust policies state that all in-patients who may require restrictive interventions must have a Positive Behaviour Support Plan (PBSP) based on a functional analysis of what drives and triggers their behaviour. A PBSP is intended to facilitate understanding and help manage behaviours that challenge by teaching new skills and ways to communicate a person's needs. Previous research on the use of PBSPs on adult acute mental health wards is limited but research on PICU wards has shown PBSPs have not been implemented into mental health care as intended.
Objectives: Trust policies identify that PBSPs should be implemented to reduce the use of restrictive interventions. However, it is unknown whether PBSPs are being used as part of routine practice on the acute mental health ward. The degree to which staff are aware of patients PBSPs and how they use them to guide their practice is unclear. The service evaluation aims to understand the perspectives, attitudes, and experiences of staff who are responsible for using and implementing PBSPs on the ward. The evaluation aims to investigate how PBSP informs practice and to identify the barriers and facilitators to implementing PBSPs on the ward.
Methods: A volunteer sample of clinical staff members (including Doctors, Nurses, Psychotherapists, Occupational Therapists, and Clinical Support Workers) who are responsible for implementing PBSPs on an acute mental health ward in the East of England took part in a focus group which lasted up to an hour. There were four focus groups with between two and four participants per group. A total of thirteen staff members participated in the focus groups. The focus groups lasted up to one hour and were guided by a topic guide. Two members of the project team facilitated the group. Focus groups were audio recorded.
Results: Thematic synthesis will be the overarching approach used to synthesise the qualitative data from the focus groups. The audio recordings will be transcribed. Analysis will be conducted on a within-case basis prior to cross-case analysis aimed to identify common themes. Two evaluators will work together to code, analyse, and synthesise the extracted data.
Conclusions: Based on the results, training may be developed to improve the understanding and implementation of the PBSPs on the ward. The findings may also result in changes to the way PBSPs are used. The results will be presented to the trust chief executives

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