Assertive community outreach can be in an addiction clinic, postnatal ward, mental health centre, psychiatric ward, outpatient clinic, homeless hostel or the client's home.

Time allocation for outreach and priority appointment-based care was 8 and 4 hours per week respectively. Care in both pathways was provided by senior doctors. Content of care was similar but facility for provision of gynaecological care including cervical smears and investigations for abnormal uterine bleeding e.g. pelvic ultrasound scans and endometrial biopsies were only available in the mainstream clinic setting at CSHC.

Result. From May 2016 to December 2020 SHRINE received 1367 referrals from 125+ teams. We offered 1591 first or follow-up appointments of which 1369 (86%) were attended. A total of 1153 (84%) of our patient contacts occurred in the outreach setting where 93% the appointments were attended. Of the 358 appointments at CSHC 316 (60%) were attended.

Conclusion. Making clinic access as simple and convenient as possible is not a sufficient strategy to meet the SRH needs of marginalised people. To enable them to realise their human right to sexual and reproductive health we need to leave our clinics and meet our clients where they are. A combined model of outreach and priority access clinic pathways is essential for provision of SRH care for people with mental illness.

Working with catatonia: a qualitative exploration of inpatient team emotional responses

Emma Salter[1]*, Linda Pow[1], Emma Stacey[1], Victoria Stephens[1], Paul Beckley[1], Jenna Oliphant[1], Lottie Heimes[2] and Courtney Foster[2]

[1]Somerset Partnership NHS Foundation Trust and [2]Somerset NHS Foundation Trust
*Corresponding author.

doi: 10.1192/bjo.2021.909

Aims. Child and adolescent mental health (CAMHS) wards treat patients with variable presentations. During diagnosis and treatment, psychiatric professionals use structured criteria, but also honed awareness of countertransference. Unacknowledged emotional responses can produce powerful dynamics and impact patient care.

Limited information exists on possible emotional responses and team dynamics when working with catatonia.

This project aimed to establish common themes relating to staff felt-experience of working with a specific case of catatonia on a Child and Adolescent Mental Health (CAMHS) ward. A secondary aim was to establish potential areas for future training and service improvement.

Method. Trust Research and Development department approved this work. Inpatient professionals working with the specified patient during admission were eligible. Participants were invited via email and face-face discussion with one of the authors. Participants, patient and mother provided written consent.

A questionnaire was created and disseminated via email to eligible staff (n = 33). 27 questions asked individuals to rate responses on Likert scales, plus space for further comments. Questions involved emotional responses to different catatonic states, feelings towards self, patient, colleagues and plans. Descriptive analysis was completed on this anonymised data.

Qualitative data were gathered via 1-hour recorded focus group, led by a systemic psychotherapist and psychologist. The session was transcribed anonymously. Two clinicians, using Thematic Analysis, reviewed the transcript independently.

Result. 16 (48.5%) questionnaires were completed. Participants felt negatively about themselves and colleagues more frequently than about the patient. Participants felt positively about themselves less frequently than about colleagues and the patient. Participants identified with more feelings during immobile patient states than lucid states. During immobile states, participants identified with abusive, guilt, hopeless and neglectful responses; during lucid states, with helpful, caring, happy responses

Eight (50%) participants felt they sometimes did not understand their feelings towards colleagues/plans. Nine (57%) participants felt they sometimes did not understand their feelings towards themselves. Ten (66%) participants felt they sometimes did not understand their feelings towards the patient.

Ten (62.5%) participants felt confused by their emotions at least some of the time. Two (12.5%) frequently felt confused by their emotions.

Four participants attended the focus group. Themes included confusion, internal and team conflict.

Conclusion. Working with catatonia involved confusion and team splitting. Staff conflict between plans and morals resulted in painful emotions. Prompt psycho-education within teams working with uncommon presentations was identified as a focus for improvement. The authors plan to explore possible avenues for future teaching, learning and team support.

Transition from child and adolescent mental health services to adult mental health services

Tania Saour

Central North West and West London Mental Health Trust

doi: 10.1192/bjo.2021.910

Background. The prevalence and recognition of mental health conditions in young people is growing. Around 50% of lifetime mental illness (except dementia) begins by the age of 14. Around 75% of adults requiring secondary mental health services developed problems prior to 18.

The TRACK study of young people's transitions from CAMHS to AMHS has found that up to a third of teenagers are lost from care during transition and a further third experience an interruption in their care.

A CQUIN for Transition has concluded that young children should have a transition plan 6 months before they turn 18.

Method. All young people aged 17 and a half years old were included in the data collection for this audit. Clinical information was reviewed using the West London RIO computer system. While reviewing the clinical documentation I was recording whether:

Transitional plans had been discussed with the young person.

If yes, what were they?

Had a referral been made to the appropriate service?

Result. There were 180 open cases to the Hounslow Adolescent Team. 35 cases were over 18:

At least 16 of these cases needed to be closed as no intervention was being provided.

14 cases had an unclear plan.

Of the 25 cases aged between 17.5 and 18 years of age transitional plans were:

Transition was discussed in 11 cases (44%). This meant that transitional plans were not discussed in 56% of young people.

Of these 11 cases 7 referrals were completed. (28%)

Conclusion. The lack of consistent protocols for transition remains a significant barrier to health care provided to young people.

Transitional planning needs to take place in an effective and timely manner to ensure continued patient centred care.

https://doi.org/10.1192/bjo.2021.909 Published online by Cambridge University Press