various non-pharmacological/psychological interventions in the management of CYP with ADHD.

Results Non-Pharmacological/psychological treatment modalities can be classified into 4 major categories including Psychosocial (eg social skills and parent training), Body-focused (eg yoga and physical exercise), Cognitive/neuro-Cognitive Therapy (CT): (eg computer attention training and Neurofeedback) and Cognitive-behavioural interventions (eg Psychoeducation and play therapy).

Published literature provides variable level of evidence for the beneficial effects of non-Pharmacological interventions on important aspects of child and parent functioning. Combination of psychological therapy (including group-based parental Psychoeducation) with psychostimulants has the greatest effect size for controlling the core and other ADHD-related symptoms compared to either psychostimulants or behavioural therapies alone. There is currently insufficient evidence to recommend standalone Behavioural therapy or Cognitive behaviour therapy, working memory or Neurocognitive training and Neurofeedback for controlling core symptoms of ADHD.

There is strong evidence for parent training and other adult/child-based behavioural interventions in controlling ADHD-related outcomes such as parenting skills, child's social skills, academic performance and challenging behaviours. Research has also proven the effectiveness of classroom-based psychosocial interventions for reducing disruptive behaviours, while use of Computer-based attention and other Neurocognitive training, as well as participation in regular Cardio exercises show moderate evidence for improving Executive skills.

On the other hand, combinations of different types of non-pharmacological modalities have disappointing low efficacy in the management of both the core symptoms and other related outcomes in ADHD.

Conclusions A wide range of non-pharmacological/behavioural interventions have been recommended as part of a Multi-modal management strategy for CYP with ADHD. The significant importance of non-pharmacological interventions for ADHD has become more relevant recently, especially during the COVID 19 pandemic crisis. All clinicians need to be familiar with the rationale and principles of different modalities of non-pharmacological interventions and be confident in offering them through 'social prescribing', by signposting to various local providers or recommending self-directed access to several free or commercial online resources.

1806

CHANGES TO THE INITIAL HEALTH ASSESSMENT (IHA) FOR CHILDREN ENTERING THE LOCAL AUTHORITY CARE SYSTEM DURING COVID-19 PANDEMIC CRISIS

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Background Covid-19 has impacted on the healthcare provision worldwide. Anecdotally, assessment and management of looked after children have been restricted, resulting in

assessment being carried out virtually by telephone or video-consultation. While changes to traditional face to face appointments were necessary enabling consultations to continue, it was unclear whether new technologies would be reliable or effective for vulnerable children.

Objectives

1. To review the decision making process which informed the method for undertaking an Initial Health Assessment (IHA) for children during the Covid-19 pandemic
2. To determine how any gaps were mitigated within the child's health care plan.

Methods Following consent from individual organisations, 5–6 anonymised IHA records were randomly selected to be reviewed against an audit template from each provider across Southend, Essex and Thurrock (SET). The timeframe for the assessment was from 1st April 2020 until 30th September 2020. The data was measured against IHA pathway standards, a guide to support decision making. A table of comparative data was mapped to provide the basis for analysis.

Results Of the five SET service providers invited to participate, four organisations provided a response within the timeframe. A total of 21 questionnaires were received. The cohort consisted of 9 females and 12 males. Ages ranged from 3 weeks to 17 years. One review was face-to-face, 4 were via video, 6 by telephone, and a further 10 recorded as virtual (unknown whether assessment was by telephone or by video-consultation). Of 11 children with no previous health review, 6 were sign-posted to the GP for a physical assessment. Similarly, 6 of the 9 children with a previous medical contact were referred to a GP. Eight children had no recorded physical follow-up.

Conclusions It is important to recognise the inclusive data provided just a snapshot of the IHAs undertaken during this period. However, it was evident that virtual assessments appeared to become the default position without always adequately reflecting the health needs, wishes and circumstances of each individual child/young person. Whilst some IHA assessments were well completed in very uncertain and challenging circumstances, others were incomplete and lacked robust arrangements for the inclusion of a physical assessment of the child. For this reason, telephone or video-consultations should not replace face-to-face consultations. Proper planning of IHA services and resourcing for recovery is of paramount importance for every professional involved. The child's individual welfare and best interests much be central to decision making.

1807

15Q11.2 MICRO-DELETION ASSOCIATED WITH ADHD: TWO CASE REPORTS AND LITERATURE REVIEW

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