to experience barriers to accessibility to mental health services, and this was also evident from our evaluation.

Black and Asian CYP continue to be under-represented in CAMHS services as are CYP from deprived communities. However, these ethnic groups present the highest reported mental health difficulties at adulthood. More research is therefore needed in this area, to identify the specific barriers to accessing mental health care in Sheffield Community CAMHS, so as to allow the provision of culturally appropriate mental health services for the ethnic and high derivation groups.

Service Evaluation of Treatment Response in Adult ADHD Patients With Psychiatric Comorbidities

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Aims. To assess whether psychiatric comorbidities affect response to medications in adulthood ADHD.

Methods. This study included 236 subjects diagnosed with ADHD in adulthood between the ages of 18 and 65 years and receiving pharmacological treatment for the same across community treatment teams in Durham and Darlington.

Patients were identified by going through electronic case notes.

Review of SWMWEBS scores and clinic letters were carried out both prior to and following commencing medication for ADHD to assess response to treatment.

Comorbidities were recorded by reviewing clinic letters.

Results. 56% of the study subjects had no psychiatric comorbidity while 44% had at least one comorbid psychiatric diagnosis.

Both groups had a higher prevalence of males in the ratio of 1.9:1(with comorbidities) and 3:1 (without comorbidities).

Depression(56%) was noted to be the most common comorbidity followed by Autism(22%), Emotionally Unstable Personality Disorder(11%) and Bipolar Affective Disorder (10%).

94% patients without comorbidities responded favourably to treatment whereas only 56% of patients with comorbidities improved with treatment.

Conclusion. Having a comorbid psychiatric illness is likely to negatively impact both treatment response and recovery in adults with ADHD.

Both groups(with and without comorbidities) had a male predominance (2.5:1).

Higher number of patients amongst the nil comorbidities group responded favourably to treatment.

Most common psychiatric comorbidity was Depression.

Least favourable response to treatment was found among the groups of Emotionally Unstable Personality Disorder and Bipolar Affective Disorder.

No gender bias in response to treatment across both the groups.

A Descriptive Analysis of the Clinical and Demographic Features of High Intensity Users of Charing Cross Hospital Emergency Department; Utilisation of These Data to Develop Local Services

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Aims. Over recent years, there has been increasing national focus on High Intensity Users (HIU's) of Emergency Department's (ED's) and services designed to case manage and address the unmet needs of these individuals. The descriptive research literature focuses on measurable, demographic identifiers of this group, attendance trends and the presenting complaints driving attendance. There is more variable literature on the clinical profiles of these individuals, with findings describing a highly heterogeneous group. Our inner city service is well-established and staffed by a multidisciplinary team. We provide assessments and interventions to meet the needs of HIU's identified through a referral system which includes electronic flagging of cases. We aim to describe in detail the clinical and demographic features of a cohort of HIU's attending our department and demonstrate the utility of these data.

Methods. All individuals managed by the HIU service in 2022 were identified from our referral database. No individual was excluded. We undertook systematic notes reviews on each case, using medical, psychiatric and primary care records as well as interventional care plans produced by the service. Data were recorded against set domains covering socio-economic factors, demographics and clinical coding.

Results. The analysis included 98 individuals. The majority were male (59%) with 85% in receipt of government benefits and 16% of no fixed abode. A variety of psychiatric diagnoses were present with 12% diagnosed with a psychotic illness, 40% with a mood disorder, 7% with a somatoform condition and 19% with a personality disorder. 83% were diagnosed with a medical long term condition (LTC), with 32% of these being diagnosed with >3 LTC's. 81% suffered from at least 1 LTC and 1 mental disorder in combination. 40% harmfully used or were dependent on alcohol and 21% misused recreational drugs. Known or likely cognitive impairment was seen in 28% of the group and 13% were diagnosed with learning disability.

Conclusion. Our findings demonstrate the complexity of the clinical profiles of HIU's of the ED and supports service models centred on individual case management. There is a high degree of mental and physical morbidity in this group, indicating that specialist assessment and management is required. The range of unmet need covers a breadth of health and social care requiring a multi-disciplinary approach. Homelessness, cognitive impairment and learning disability are particular areas which may benefit from expertise. Our project is limited to one localised system however we recommend ED's undertake similar analyses to better design HIU services.