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 symptoms along with a scoring system ensuring 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 system 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.

REFERENCES
2. Effective management of attention deficit/hyperactivity disorder ADHD through structured re-assessment: the Dundee ADHD Clinical Care Pathway, Coghill and Sethi.

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 FRSH4 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.