supports, structured pacing, family involvement) when neurodevelopmental conditions are recognized.

(4) **Guideline gap:** Although guidelines recommend adaptations, they rarely require clinicians to systematically rule out neurodevelopmental conditions prior to starting standard therapy.

**Conclusions:** The failure to detect neurodevelopmental disorders early partly explains why many adolescents show poor response to conventional, symptom-focused treatments. Unless mental health services incorporate routine cognitive and adaptive screening before pychotherapy or pharmacotherapy, treatments risk addressing symptoms while ignoring root causes. This raises a necessary debate: should adolescent mental health care continue to apply one-size-fits-all protocols, or move toward precision psychotherapy tailored to each individual's neurodevelopmental profile?

**Disclosure of Interest:** None Declared

## EPP055

## Utilizing Evoked Response Potentials to predict clinical outcomes to Methylphenidate in children with Attention Deficit Hyperactivity Disorder

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**Introduction:** Attention Deficit/ Hyperactivity disorder is a neurodevelopmental disorder characterised by persistent pattern of hyperactivity, impaired attention and poor organization. ADHD is associated with multiple neurophysiological deficits leading to impairment in sustaining attention, reward processing and regulation of behavior. There is marked intra- individual variation in presentation due to the diagnostic, developmental and neurobiological heterogeneity which can make treatment challenging. Identifying biological predictors of treatment response becomes imperative to develop personalized regimens for the various subsets. Evoked response potentials (ERP) allow the assessment of sensory and cognitive processes and can be potentially useful.

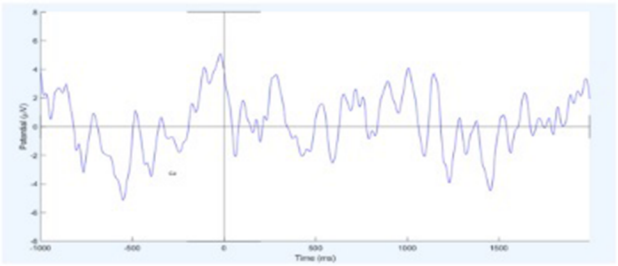
**Objectives:** This study endeavors to explore the potential Evoked response potentials in predicting medication response.

**Methods:** Longitudinal observational study, with sample size of 30 male cases of ADHD aged between 8-16 years who were planned to be started on Methylphenidate by their treating psychiatrist. Informed consent from parents and assent from the study participants were taken. Severity of ADHD was assessed using Conner's parent rating scale (CPRS). Prior to starting treatment, a 32 channel electroencephalograph (EEG) recording was taken while the participants were performing an auditory oddball task. Amplitude and latencies of P300 and N200 (evoked potentials) were extracted from the EEG data for 3 central channels (Cz, Oz, Pz) . Participants were divided into good and poor responders following 4 weeks of treatment and baseline ERP data was compared between both groups.

**Results:** P300 amplitude and latency across Auditory Oddball task did not reveal significant differences between Good and Poor Responders except P300 latency of the target stimuli over Cz channel location, participants who responded better to medication had significantly lesser latency as compared to the other group. P300 amplitude at Cz and Pz of non target stimuli correlated negatively with improvement in hyperactivity and total symptom score on CPRS- lower P300 amplitude predicted better improvement (p=0.02, 0.04 at Cz and Pz respectively).

N200 of non target stimuli had a significantly smaller amplitude in good responders as compared to poor responders in our study. A significant correlation was found between the amplitude and improvement in inattention score (rho 0.45, p-0.01) on Cz location. N200 latency was also found to be significantly longer in good responders and correlated with improvement in CPRS scores at all three channel locations.

**Image 1:**



**Component ERP arrays of all channel locations, Vertical axis denotes amplitude (microvolt), horizontal axis denotes duration (-1000 to 1995 msec)**

**Image 2:**

**B.3) Comparison of ERP variables between Good and Poor responders**

| Variable | | Median | | | | Mann-Whitney U | p-value |
|---|---|---|---|---|---|---|---|
| | | Good responder | N | Poor responder | N | | |
| **Auditory Oddball Task – Non Target stimuli** | | | | | | | |
| P300 latency (msec) | Fz | 345.00 | 13 | 300.00 | 14 | 72.00 | 0.35 |
| | Cz | 297.50 | 14 | 282.50 | 14 | 91.50 | 0.76 |
| | Pz | 310.00 | 11 | 320.00 | 14 | 75.50 | 0.93 |
| P300 amplitude (microvolt) | Fz | 3.3009 | 13 | 2.8536 | 14 | 80.00 | 0.59 |
| | Cz | 3.2480 | 14 | 3.3269 | 14 | 79.00 | 0.38 |
| | Pz | 0.9455 | 11 | 3.2152 | 14 | 54.00 | 0.21 |
| N200 latency (msec) | Fz | 260.00 | 13 | 220.00 | 14 | 46.00 | **0.03** |
| | Cz | 195.00 | 14 | 220.00 | 14 | 55.50 | 0.05 |
| | Pz | 215.00 | 11 | 202.50 | 14 | 61.50 | 0.39 |
| N200 amplitude (microvolt) | Fz | 1.2101 | 13 | 2.8285 | 14 | 76.00 | 0.46 |
| | Cz | 1.6442 | 14 | 0.7339 | 14 | 56.00 | 0.05 |
| | Pz | 1.8721 | 11 | 1.2243 | 14 | 58.00 | 0.29 |
| **Auditory Oddball Task - Target Stimuli** | | | | | | | |
| P300 latency (msec) | Fz | 295.00 | 13 | 317.50 | 14 | 54.50 | 0.07 |
| | Cz | 342.50 | 14 | 387.50 | 14 | 55.00 | **0.048** |
| | Pz | 410.00 | 11 | 377.50 | 14 | 61.00 | 0.38 |
| P300 amplitude (microvolt) | Fz | 5.1875 | 13 | 5.0453 | 14 | 80.00 | 0.59 |
| | Cz | 4.7208 | 14 | 6.1514 | 14 | 63.00 | 0.11 |
| | Pz | 4.7150 | 11 | 3.5814 | 14 | 77.00 | 1.00 |
| N200 latency (msec) | Fz | 230.00 | 13 | 227.50 | 14 | 90.50 | 0.98 |
| | Cz | 227.50 | 14 | 215.00 | 14 | 70.50 | 0.20 |
| | Pz | 205.00 | 11 | 212.50 | 14 | 77.00 | 1.00 |
| N200 amplitude (microvolt) | Fz | 2.6665 | 13 | 1.3458 | 14 | 89.00 | 0.92 |
| | Cz | 3.2180 | 14 | 2.4841 | 14 | 75.00 | 0.29 |
| | Pz | 4.7352 | 11 | 3.7289 | 14 | 64.00 | 0.47 |

**Conclusions:** There are differences in Evoked response potentials in Cz and Pz channels between good and poor responders. This underscores the importance of further research on neurophysiological

markers as a predictive biomarker to various treatment modalities for ADHD.

**Disclosure of Interest:** None Declared

## EPP056

## A narrative systematic review of school-based screening tools to identify Autism Spectrum Disorders

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**Introduction:** Autism Spectrum Disorder (ASD) is a common neurodevelopmental condition characterized by challenges in social interaction, communication, and repetitive behaviours. Early identification through school-based screening for ASD has the potential to enhance educational and health outcomes for affected children.

**Objectives:** This review examines school-based screening tools for identifying children and young people with ASD, and assess the differences and challenges in effectiveness across various socio-demographic groups.

**Methods:** We conducted a narrative systematic review and searched EMBASE, MEDLINE, PsychINFO, Cochrane, and Scopus electronic databases (2011-2024) in October 2024 to identify studies on school-based ASD screening for children aged 4 to 16 years. Two independent researchers screened the papers and extracted the data. Data extracted included country, age, gender, socio-economic status, ethnicity, type of screening tool, informant details, and outcomes (prevalence of screen positives, sensitivity, and specificity).

**Results:** Of 7,311 eligible articles, 14 studies were included in this review. Eight different ASD school-based screening tools were identified. Study populations ranged from 103 to 16,556 participants, with varying sensitivity and specificity depending on the population age group, setting, and ASD prevalence. The prevalence of screening positive for ASD ranged from 0.7% to 8.5%. Most studies were conducted in European countries (n=6) followed by Western Pacific (n=4), Americas (n=3) and Eastern Mediterranean (n=1) countries. No studies evaluated outcomes based on ethnicity or socioeconomic status.

**Conclusions:** There is a broad range of school-based ASD screening tools available globally, but their use is inconsistent and lacks robust validation. Evidence on diagnostic accuracy remains limited, and the dearth of data on ethnicity and socio-economic status risks exacerbating health inequalities. Consensus on tool selection and validation, alongside collaboration between education systems, researchers, and policymakers, is needed to ensure ASD screening approaches are equitable and effective.

**Disclosure of Interest:** None Declared

## EPP057

## Drivers of Young People's Self-Harm Presentations to Emergency Departments: A Berkshire Service Evaluation

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**Introduction:** Epidemiological data indicate that **lifetime** self-harm is reported by approximately **16%** of adolescents (Farkas *et al.*ECAP 2023 (10):3439-3458). A proportion present to hospital emergency departments (A&E) in a crisis self-harm presentation such as overdose, attempted hanging, self-injury or jumping. These attendances are often misinterpreted as evidence of a primary mental illness; in many cases, factors other than mental illness are the drivers of crisis. Over-attributing crisis to "mental illness" can prompt reactive interventions that miss root causes, waste resources, and fail to improve emotional stability or functioning in children and young people (CYP).

**Objectives:** Evaluate crisis presentations to Berkshire Child and Adolescent Mental Health (CAMHS) Rapid Response Team (1 Feb–30 Apr 2022); describe demographics and presenting features; identify drivers of crisis; and outline implications for multi-agency responses and care to support optimal outcomes for CYP.

**Methods:** Mixed-methods retrospective case-note review of all CYP referred to Berkshire CAMHS Rapid Response from two acute hospitals after A&E mental-health presentations (Feb–Apr 2022). Data source: electronic records. Qualitative: narratives describing the main contributing factor for attendance were coded and thematically analysed to identify patterns. Quantitative data included age, sex, presenting reason, self-harm type, autism/ADHD diagnosis or waitlist, other psychiatric diagnoses, CAMHS involvement, other service input, family adversity and education. Inter-rater reliability was checked on 10 cases, with unclear cases reviewed by two clinicians to reach consensus.

**Results:** 213 self-harm crisis presentations were evaluated. Crises were largely associated with environmental factors, led by school (37.5%) and family factors (23.5%). Overall, 71% did not require ongoing CAMHS input (29% did). 55% were referred to other services, 39% were already receiving support, and 47% required multi-agency liaison. Neurodevelopmental needs were common: 22% had a diagnosis of autism or ADHD and a further 28% were awaiting assessment/referred on—indicating potentially 50% of CYP with neurodevelopmental profiles.

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