A summary of an audit of young people 11 years and above, demonstrating the need to develop a robust pathway.
This document was produced by Dr Susan Ozer at East and North Hertfordshire NHS.

East and North Hertfordshire NHS
NHS Trust

Audit of young people 11 years and above referred to a UK Community Paediatric Child Development Centre with suspected ADHD

Dr Susan Yarney, Dr Vinod Tyagi - June 2013

Introduction

ADHD and Comorbidity

- ADHD is significantly associated with anxiety, mood and disruptive behavioral disorders (JAm Acad Child Adolesc Psychiatry. 2007 Dec;46(12):1575-83)
- ADHD groups were more likely to have oppositional defiant disorder (ODD), conduct disorder (CD), tics, mood disorders, past and regular use of substances, substance use disorders and sleep disorders (Aust N Z J Psychiatry. 2010 Feb;44(2):135-43)

Best Practice - ADHD NICE (UK) Guidance 2008

ADHD is pervasive, persistent and multi-faceted and therefore no one profession or discipline will be able identify, assess and treat alone (Multimodal approach).

Objectives

- To examine the profiles of children aged 11 years and above referred with suspected ADHD by identifying associated difficulties and interventions at point of referral

  And
- To determine from post-assessment outcomes whether a direct referral to specialist CAMHS services from primary care would have been a better option for the cohort

Methodology

- The database of all referrals to the North Hertfordshire Child development Centre (CDC) between February 2010 and 2011 was retrospectively examined
- 50 case notes of children aged 11 years and above with suspected ADHD were examined further for associated difficulties/co morbidities, interventions/support at pre/post assessment

Summary of difficulties listed at point of referral

- Oppositional/conduct issues
- Emotional/behavioural difficulties
- Anxiety
- Stress
- Obsession/compulsive behaviours
- Substance misuse
- Antisocial disorders
- Dyspraxia
- Learning and social difficulties

Additional difficulties/co morbidities identified/ post assessment outcomes

- Hallucinations, mental/emotional difficulties
- Oppositional/conduct problems

Drug treatment**

(12/32; 37.5%) on ADHD medication to manage symptoms.

Neurodevelopment

Speech therapy input; **(5/32; 15.6%)** Educational psychologist; **(8/32; 25%)** for learning difficulties

Discussion

Children/Young people 11 years and over referred to the ADHD team at the Child Development centre presented with multiple psychological/behavioural issues, antisocial behaviours, criminality and substance misuse.

- Further mental health and behavioural issues identified following a diagnosis of ADHD prompted referrals to tier 2 and specialist CAMHS, youth offending and behavioural services
- Only a small number of children were on ADHD medication (8/32; 25%)
- On a positive note majority of children/young people were receiving a variety of interventions within their schools and communities at point of referral

Conclusion

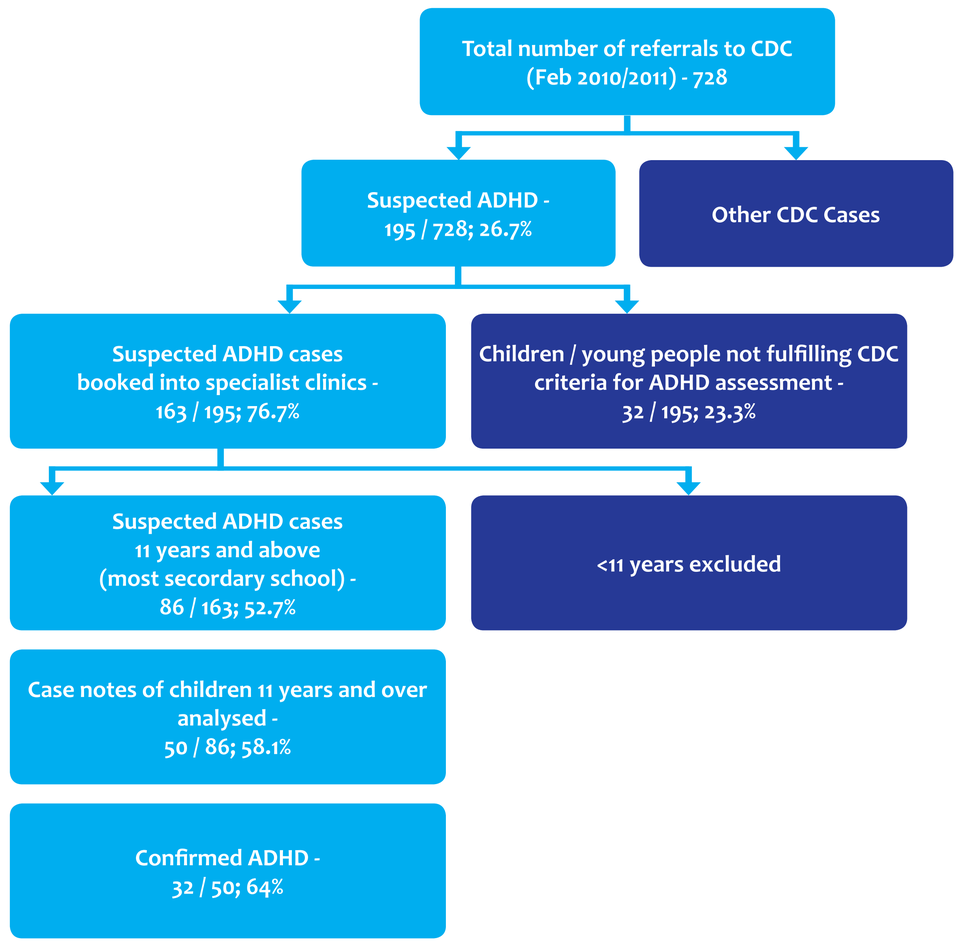
To reduce the overall patient journey for the majority of secondary school children referred with suspected ADHD, there is a strong case for cohort to receive an initial assessment/triage within Specialist CAMHS Services before a referral to the Community Paediatric Services.

Recommendation

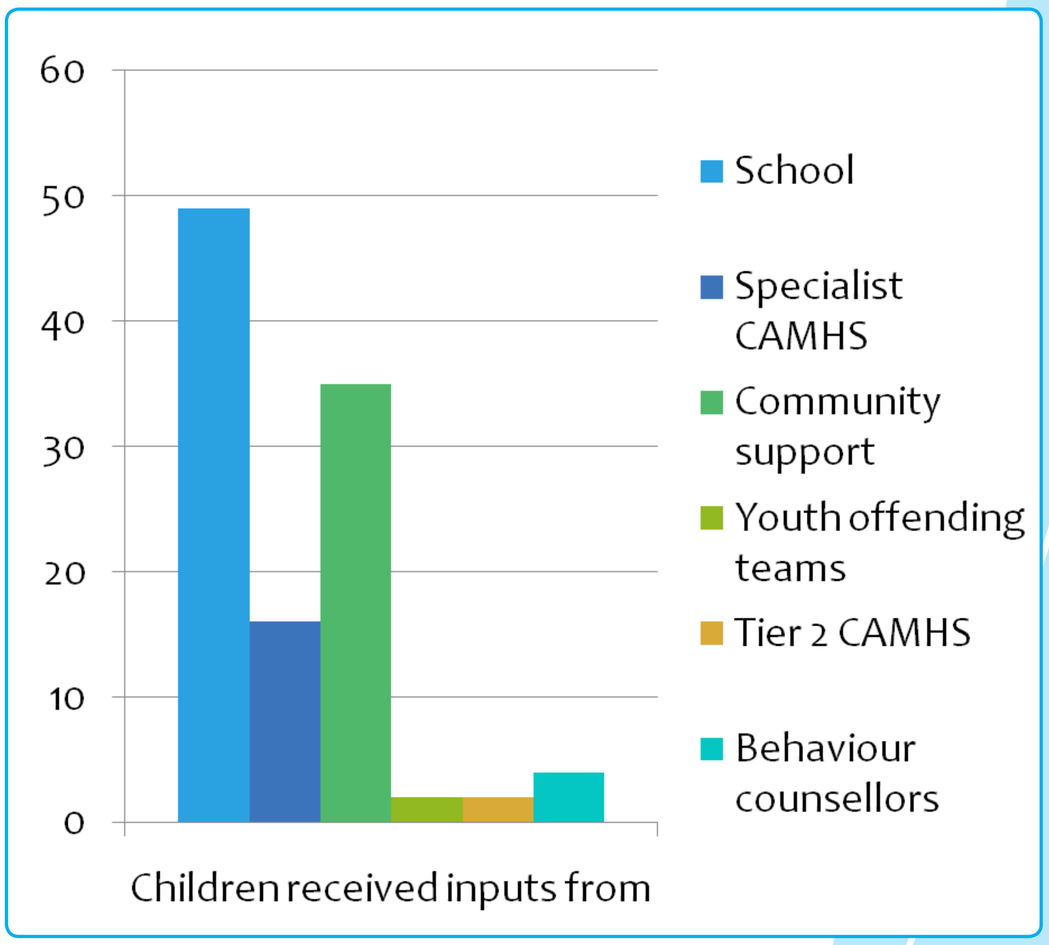
This audit has shown the need for ADHD teams within (Paediatrics/Child/Adolescent Mental Health Services-CAMHS) to develop robust pathways/single access referral points for identification of vulnerable children/young people with suspected ADHD from primary care requiring early specialist CAMHS intervention.

Progress

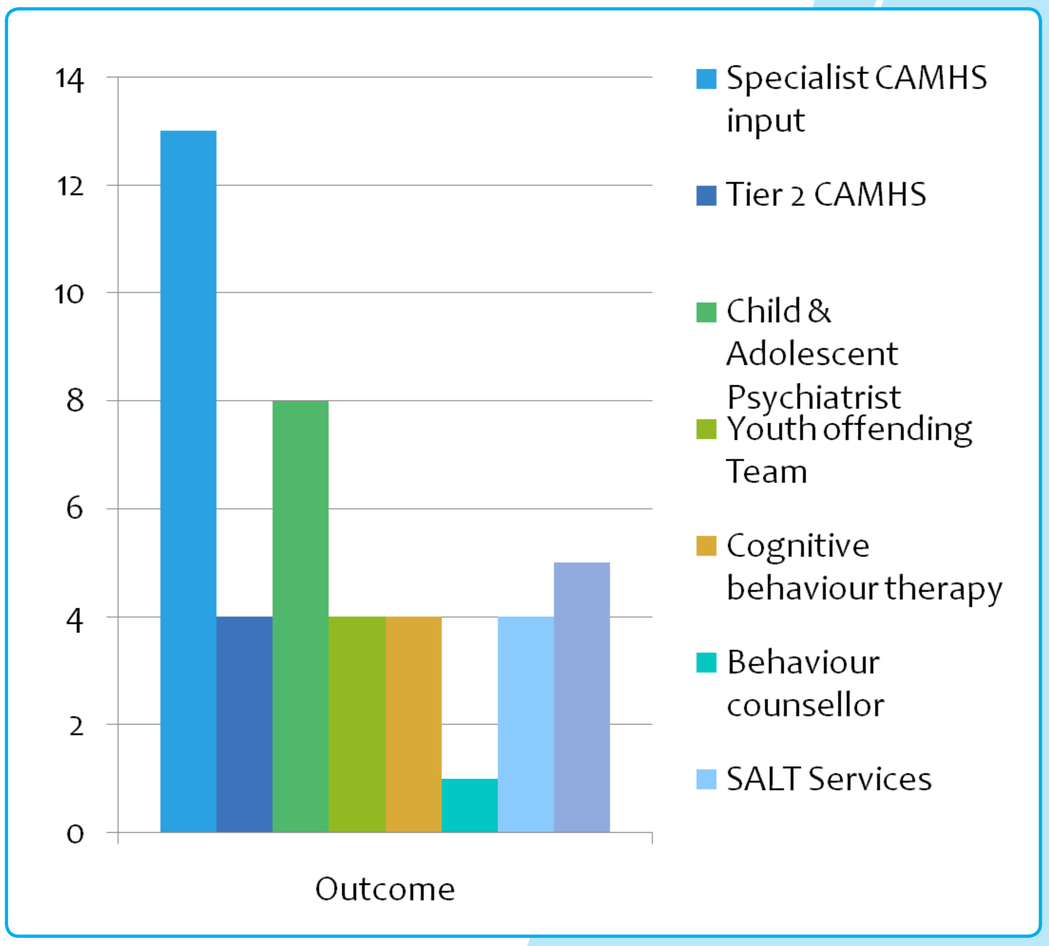
- There is now a Hertfordshire wide single point of access (SPA) for all ADHD and other mental health referrals from primary care and universal services to specialist services - launched in 2012
- ADHD referrals are triaged at SPA and distributed to the appropriate specialist service CAMHS/ Paediatrics) as per Service referral criteria
- ADHD referrals to the CDC are screened further by the ADHD nurse specialist team



Interventions at referral



Assessment Outcomes



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