

Staffordshire and Stoke on Trent: Adult ADHD Assessment, Treatment & Intervention

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1 Introduction

- 1.1 The paper provides an updated response to NSCHT and MPFT position of not providing new assessments for Adult ADHD or prescribing from November 2021 and the patient choice costs the ICB continues to incur as a result.

2 Policy Context

- 2.1 NICE Guidelines (NG87) recommend a provision of ADHD services to offer diagnosis and treatment for adults. There is a recognised commissioning gap across the ICB. There is evidence to demonstrate that undiagnosed ADHD can have a negative impact on the person's life, this could include lower educational attainment, higher levels of criminal behaviour and adding challenges into daily routines (NICE, 2019). ADHD as a neurodevelopmental condition is not a deliverable under the Mental Health LTP programme (and is excluded from MHIS), or Learning, Disability and Autism programme but the interdependencies are significant. ADHD assessment and diagnosis falls under the Patient Choice guidance therefore the ICB has to fund a request for assessment approved by a GP as long as the provider has an NHS contract with and ICB or NHS Trust in England.

3 ADHD Patients fall into 5 broad categories:

- 3.1 Graduates from CAMHS. These patients have a confirmed diagnosis (made by CAMHS services) and are stable on treatment. Medication for ADHD can only be prescribed under Secondary Care supervision so that prescriptions are provided by Primary Care under shared care protocols (it should be acknowledged that a significant number of GPs will not prescribe even under shared care). Patients are transferred to Adult CMHTs in the normal way, generally under Standard Care arrangements and receive required follow up in Outpatient Clinics.
- 3.2 Patients who received a diagnosis in CAMHS and have, for a variety of reasons, dropped out of follow up. These patients may have been treated in CAMHS and discontinued treatment but wish to have their treatment reinstituted or may have been discharged due to non-attendance.

- 3.3 Patients who have not been diagnosed with ADHD in childhood but who wish to be assessed in adulthood.
- 3.4 Patients with an NHS diagnosis who have moved from another area with shared care in primary care into our ICB and primary care will not prescribe, nor will MPFT or NSCHT unless they have transferred into secondary care Mental Health or Learning Disability and Autism services.
- 3.5 Patients who have secured a private diagnosis through self funding or patient choice and primary care will not prescribe, nor will MPFT or NSCHT unless they have transferred into secondary care Mental Health or Learning Disability and Autism services with evidence of a NICE compliant assessment

4 Components of a high-quality neurodevelopmental assessments:

- 4.1 Having a streamlined referral process i.e. clarity about what's required from referrers before new referrals are accepted. A pre-assessment / screening process in place. The purpose of this is two-fold: To ascertain that - there are enough clinical indicators that a full diagnostic assessment is indicated i.e. that there are several features suggestive of Autism (e.g. as social difficulties, rigidity of thought, sensory issues) or ADHD (e.g. difficulties with attention, hyperactivity, or impulsivity) - these difficulties have a sufficient impact on their level of functioning.
- 4.2 Obtaining relevant informant information/managing absence of informant information (essential, not optional) and providing sufficient direct clinical time with the patient to obtain detailed developmental information and make in-consultation observations. Following a semi-structured interview process (detailed in section 6) which avoids closed questioning.
- 4.3 Establishing whether at least a moderate level of impairment is present
- 4.4 Providing a clear formulation and reason for the diagnostic outcome and providing sufficient time for the patient to reflect on diagnostic outcome (prior to treatment/support). Providing essential psychoeducation (prior to treatment/support) and clarifying all the treatment/support options that are available

5 Who can diagnose adult Autism and/or ADHD?

- 5.1 The accurate diagnosis of Autism and ADHD in adulthood requires a skilled and experienced practitioner with the relevant qualifications and additional training in the assessment of Autism and/or ADHD in adulthood. Perhaps more accurate is the idea that the real skill is knowing when not to diagnose the condition. The diagnosis is highly dependent on clinical judgement as to the presence or absence of certain symptoms, and of impairment. It is therefore critically important that clinicians have the relevant training, skills and experience to capture the necessary information to ensure an informed clinical judgement. All established adult neurodevelopmental services provide high levels of supervision for new staff and ongoing supervision for all staff.

6 Duration of diagnostic assessments

- 6.1 Well established adult Autism services indicate that at least a minimum of 3 hours of direct clinical time is required to conduct a thorough diagnostic assessment for Autism. This could take the form of a single 3- hour consultation, two 90-minute consultations, or one 30-minute screening appointment followed by a 90-minute consultation and 60-minute feedback (if the ADOS are being used, this time will be significantly longer, approximately another 2-2.5 hours). All approaches are acceptable.
- 6.2 Well established adult ADHD services indicate that around 2.5 to 3 hours direct clinical time is required to complete a thorough ADHD diagnostic assessment. This could take the form of a single or two session consultation.
- 6.3 In both instances, additional time will be required to review previous clinical records, self-report, or informant-completed questionnaires (with scoring), clinical notetaking/report writing, feeding back the outcome, and discussing management and follow up options.
- 6.4 Additional time may be required for liaison or more detailed history taking in cases with complexity, such as those with comorbid mental or neurodevelopmental conditions.

7 Content of adult ADHD diagnostic assessments: direct clinical time:

- 7.1 Orientation to process
- 7.2 General HISTORY TAKING including:
 - a) Presenting problem
 - b) Developmental/personal history
Pregnancy-related detail, birth and infancy (i.e. birth complications, developmental milestones, early temperament)
Childhood and adolescence (i.e. academic progress, exclusions/expulsions, behaviour in class, peer group relationships, antisocial behaviour, personal/family relationships)
 - c) Assessment of ADHD-related impairment and the presence of ADHD in different areas of life (further education, employment, leisure/free time, relationships, self-esteem) - therefore, the presence of many ADHD symptoms are identified here through open-ended questions as opposed to following an 18-symptom list one after the other.
 - d) Health related areas (physical health, sleep, appetite) – current/past
 - e) Medication / allergies – current/past
 - f) Mental health comorbidities (mood, past/current treatment, coping strategies, etc.)
 - g) Neurodevelopmental comorbidities (e.g. ASD, Tourette's, Dyslexia, DCD)
 - h) Addiction / Drug / Alcohol history
 - i) Risk assessment
 - j) Forensic history (if relevant)

- 7.3 Review of DSM V symptoms (mainly those not addressed elsewhere in assessment) using a semistructured interview e.g. the DIVA
- 7.4 Formulation and sharing of diagnosis (clear explanation what the DSM V criteria is, why diagnosis is given/not given, subtype, level of impairment, informant information/life-long symptoms, etc.). Sufficient time for patient to reflect on diagnostic outcome
- 7.5 Structured post-diagnostic psychoeducation interview according to NICE Guidelines (not optional). Detailed discussion of all treatment options and key elements of best possible outcome
- 7.6 Following diagnosis, the initial prescribing to stabilisation requires regular review in outpatient's clinic so that most patients will be seen 2-4 weekly for no less than 6 months (and often longer in the case of suboptimal response/ emergence of side effects etc.) before prescribing is transferred. At this point, follow up can be maintained within a formatted follow up clinic.

Fig 1 ADHD NSCHT proposed pathway

Assessment-Inclusion-Recovery-Stability (AIRS) Model

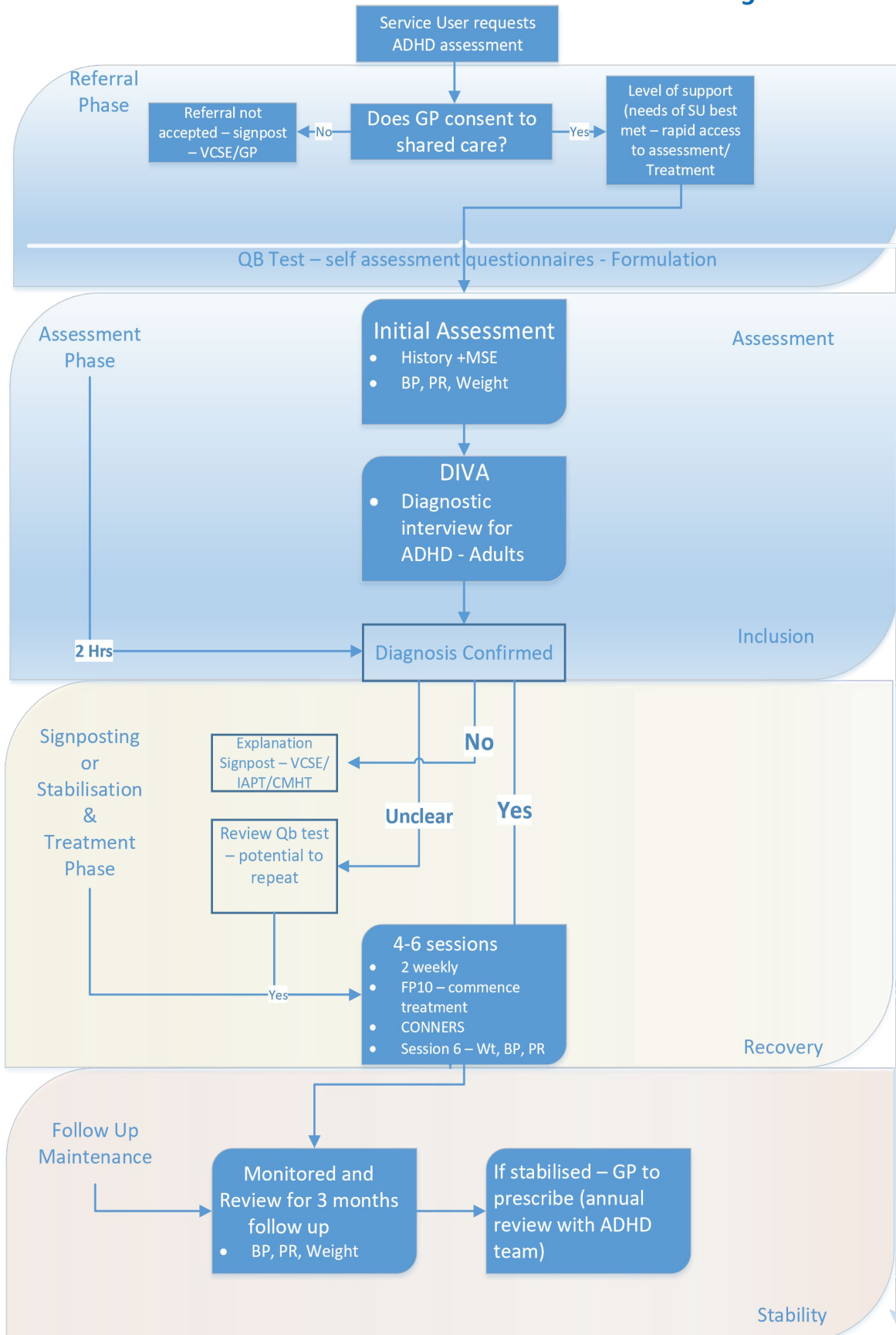
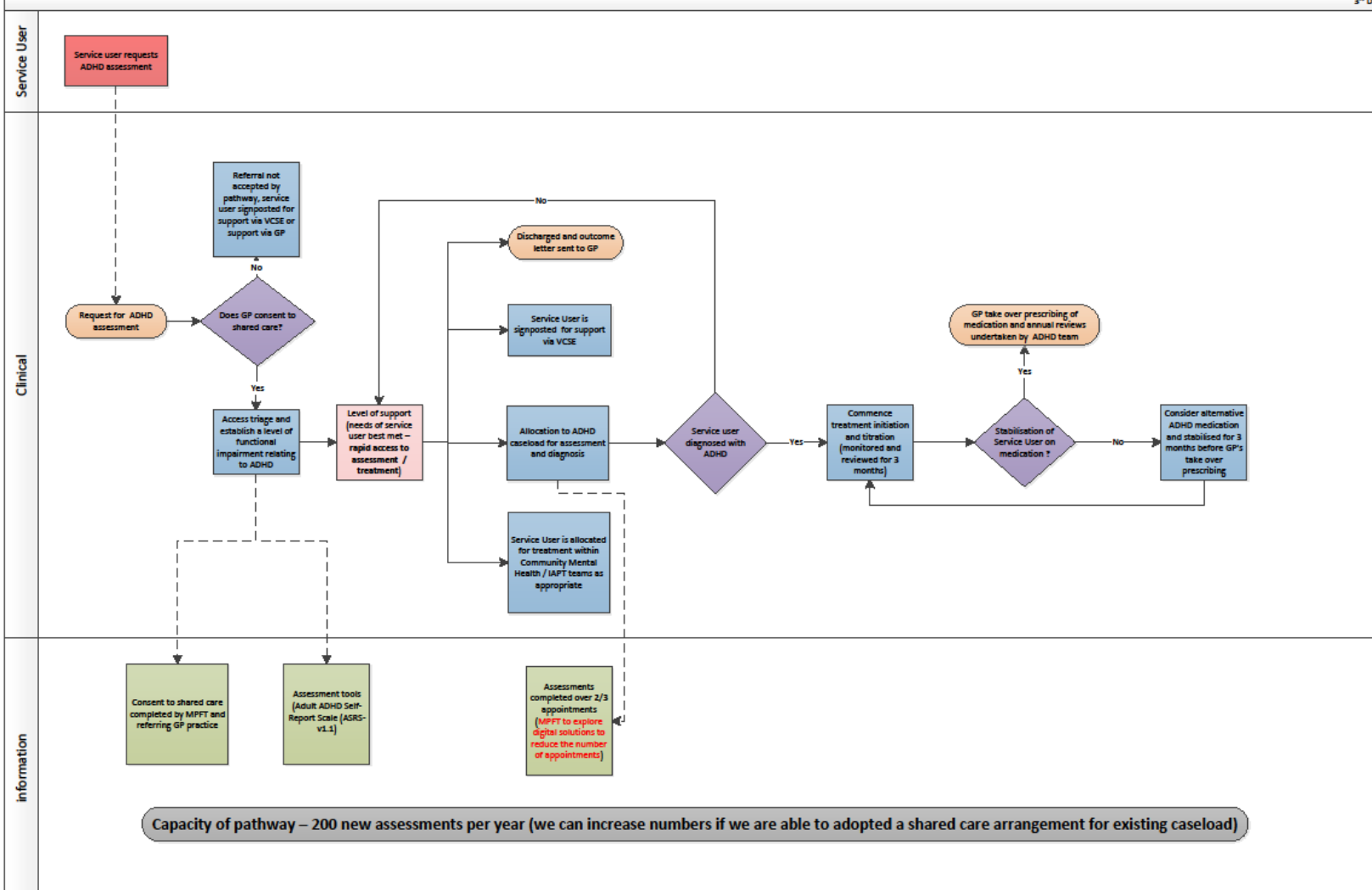


Fig 2 ADHD MPFT proposed pathway

Proposal for ADHD Pathway across South Staffordshire (MPFT)

3rd Draft



8 The Demand:

8.1 The expected prevalence rate for ADHD is [REDACTED] of the population and demand for ADHD referrals has seen a significant increase locally, and this trend is also observed nationally.

8.2 In terms of benchmarking our population and provision Shropshire & Telford Wrekin ICS with half the population of Staffordshire & Stoke and has an ADHD service is receiving [REDACTED] referrals a year at a cost of [REDACTED]. Please see table below:

Table 1: average referrals based on 6 months Mar 21/22

April to March 22	Total pa	ave tariff	Cost
[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

TOTAL

[REDACTED]

- 8.3 ADHD assessment falls under Patient Choice guidance and the ICB's are incurring expenditure with a number of private/independent sector providers. In 2021/22 this was an estimated [REDACTED]. In 2022/23 this is now estimated at [REDACTED]

[REDACTED] The reality is referrals are continuing to increase and these figure in all likelihood will be much higher. These are the private providers where we know we have patient flow, there are likely to be others.

- 8.4 With many private providers there is no indication of quality of the assessment and diagnosis, and few provide any titration or prescribing function. Very often therefore if a patient receives a diagnosis privately the assessment has to be repeated by NHS providers unless the standards referenced above can be clearly evidenced to enable safe prescribing. This represents financial waste, but also is a poor patient experience

9 Recommendation

- 9.1 The ICB will continue to incur significant costs through patient choice for ADHD assessments many of which will require a repeat assessment via the NHS providers for safe prescribing; therefore an ICS commissioned and funded pathway [REDACTED] [REDACTED] for ADHD assessment diagnosis and treatment is recommended. The pathway with both providers has been clinically developed.
- 9.2 Essential to managing demand in the proposed model will be primary care. NSCHT and MPFT will act as a single point of access and following GP referral will determine the clinical appropriateness of the referral thus not restricting patient choice and enabling the legal right to choose.
- 9.3 Workforce model to fulfil the required functions of and Assessment, Diagnosis and Treatment ADHD pathway as described in the paper and includes a skill mix of:
- Consultant
 - Band 8a Service Lead
 - Band 8a ACP Assessments
 - Band 7 NMP – Prescribers
 - Band 3 Admin Support
- 9.4 The funding is modelled to an indicative number of assessments completed approximately 650 with shared care agreements for new and existing caseload, however providers are requested to manage demand within that resource. Essential to this will be effective triage with primary care and shared care prescribing with primary care with annual reviews by MPFT and NSCHT ADHD teams.
- 9.5 To note that Single Tender Waivers to the value of over [REDACTED] have been approved in 2022/23 in relation to patient choice and ADHD.

10 Ongoing challenges

- 10.1 Referral rates for ADHD assessment may continue to increase beyond resourced levels.
- 10.2 Patient Choice is a legal right and continues to apply to ADHD assessments where providers hold an NHS contract within England.
- 10.3 Shared Care & Prescribing remains an area requiring further agreement.