100 Heads Road, Private Bag 3003
Whanganui 4540, New Zealand

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Anusha Bradley
RNZ

Via email: anusha.bradley@rnz.co.nz

Tēnā koe Anusha

Official Information Act Request – OIA 13908 ADHD Diagnosis and Services

On 8 November 2021, under section 12 of the Official Information Act, you requested the following information from Whanganui District Health Board (WDHB):

1. Do you diagnose ADHD for those under the age of 18, and for those over 18? If so, what is the process to getting a diagnosis, and who does the diagnosis? If not, please explain why not.
2. What is the waiting list/average time frame to be diagnosed over the last 12 months? (for under and over 18)
3. What support do you provide once they are diagnosed?
4. Do you have the ability to cope with an ADHD person in crisis? What care is provided?

Whanganui District Health Boards response:

1. Do you diagnose ADHD for those under the age of 18, and for those over 18? If so, what is the process to getting a diagnosis, and who does the diagnosis? If not, please explain why not.

a) Paediatrics

Non-complex ADHD in those under age 15 years is diagnosed by the Paediatric Service

It was identified by the WDHB Paediatric service that there was an increased demand on services. To ensure that children presenting with behaviour and learning difficulties were seen in a timely manner with a full, evidenced based, whanau centred assessment in place, a Behaviour and Development coordinator role was established for 24 hrs a week in July 2019 and a Registered Nurse with experience in behavioural and developmental conditions was appointed into the role.

Referrals are received via GP with information attached from school and family to clearly identify the behaviours and learning concerns. Referrals are triaged by a Paediatrician and a Behaviour and Development Assessment is completed.

The assessment contains information gathered from family around concerning behaviours using DSM 5 criteria for ADHD, a general health screen, history, social situation and other agencies involved. A school observation is completed where information is also gathered from the teacher. Conners' forms are completed by both school and family and child (if this is indicated.) The process is evidenced based and whanau centred. Referrals to other agencies are made as required to support the family. The assessment places the child at the centre of our thinking and the outcomes reflect a model that builds positive relationships with families, schools and agencies in the Whanganui District Health Board.

Following a Behaviour and Development Assessment, the family and child are invited to meet with the Consultant Paediatrician or Nurse Practitioner to review the assessment for diagnosis. This is a

coordinated approach by the Behaviour and Development Coordinator leading the process and supporting the family around the diagnosis pathway.

b) **MICAMHAS - Maternal Infant Child and Adolescent Service**

Where there are other behavioural or mental health conditions, or other neurodevelopmental conditions suspected alongside ADHD, the young person may be referred to MICAMHAS, which follows young people through to the age of 18 years.

MICAMHAS operates the Choice and Partnership approach, CAPPA, where a young person and whanau will be offered an initial, "Choice" appointment within a 3 -week timeframe. If they are understood to be requiring assessment for a condition such as ADHD then this commences with clinical interviewing and assessment, taking into account the full developmental history and whanau background; supplemented by instruments such as Conners' suite of testing (Conners' Comparative, CPT-3 and CATA, the latter of which are computerised tests). School observations are usually carried out. A referral is then made within the team for a psychiatrist to conduct further clinical assessment, including determining whether other differential diagnoses (look-alike conditions) or coexisting conditions may be present. The diagnosis is confirmed by the psychiatrist. Access to psychological testing, for example for assessment of learning difficulties, is requested on a case by case basis.

c) **For those over 18 years of age**, the diagnosis is usually made by a psychologist in private practice using psychometric testing instruments.

The Whanganui DHB Community Mental Health and Addiction services currently do not have ability to offer assessment for ADHD diagnosis for people over the age of 18, due to constraints on psychology and psychiatry workforce resources. However the service does assist with treatment planning as noted in the response to Question 3. below.

2. **What is the waiting list/average time frame to be diagnosed over the last 12 months? (for under and over 18)**

a) Under 15 – Paediatric department

The above diagnosis pathway for ADHD has significantly reduced DNAs and timeframes for children presenting with ADHD. Prior to the appointment of the Behaviour and Development Coordinator role, a child would wait on average for 3-6 months for a 1st appointment and up to 12 months for diagnosis and a plan (Stats as per 2019). Approximately 75 children were seen in the first year of the role.

2021: To date 56 referrals have been received and 55 assessments have been completed. The average timeframe is 90 days from referral to Behaviour and Development Coordinator, through to diagnosis, follow up plan and discharge. COVID19 has impacted on the stats due to accessibility of schools and families in lockdown.

There is no wait list. All referrals are seen in a timely manner (1-3 weeks) by the Behaviour and Development Coordinator to start assessment process.

b) Under 18 – MICAMHAS –

The KPI target set by the Ministry of Health for CAMHS services for those 18 and under is 80% to be seen in 3 weeks from receipt of referral. Whanganui MICAMHAS consistently meets or exceeds this target and all referrals are seen within 8 weeks. The current average rate of those seen within 3 weeks of receipt of referral is 88%.

The length of time from assessment to appointment with a Psychiatrist varies from one month to 3 months. The time has been lengthened as a result of COVID-related delays in service provision. However, during this time, the Clinician is gathering information and completing the assessment as well as meeting with the young person and whanau. The involvement with the whanau will include parenting skills and arranging supports from primary services and education.

c) Over 18 – Community Mental Health and Addictions

The timeframe for private psychology assessment is outside of the service's control. People arrange these for themselves and return to the service once the assessment is completed, as there are no private specialist psychiatrists operating in the Whanganui district at this time. A booking may then made for an appointment with a vocationally registered psychiatrist for the purpose of treatment planning (including education and prescribing). These professionals are usually booked out 8-12 weeks ahead.

3. What support do you provide once they are diagnosed?

a) Paediatrics:

Following diagnosis, a plan is put into place with the family and Behaviour and Development Coordinator for follow up. Family are given support around a trial of medication and regular contact is made both with school and family to ensure medication is effective and any side effects are managed. Families are given strategies to help manage child at home and referrals to other agencies are completed as required.

GP and family receive a clinical outcome letter following Behaviour and Development Assessment with the diagnosis and recommendations made at Paediatric Review. GPs are asked to monitor height, weight and BP every 6 months. GPs and Nurse Practitioners regularly contact Behaviour and Development Coordinator for advice around clients who have an ADHD diagnosis. A Collaborative approach is used to ensure outcomes for children with an ADHD diagnosis are monitored and supported within primary care.

b) MICAMHAS – persons under age 18 years

Assessment for treatment by a psychiatrist, (who will usually be the clinician confirming the diagnosis), including support to the family and school in management of ADHD and then transfer of care back to primary care providers when the young person has been stabilized on treatment. The network model in Whanganui means that primary care providers are able to link to the psychiatrist to discuss any required modifications to treatment. Depending on the clinical need, the psychiatrist may liaise with the primary care provider regarding testing such as ECG. If necessary, the psychiatrist and key-worker may offer a further review.

The psychiatrist and key-worker will monitor weight and height, as well as response to treatment, working alongside schools and other educational centres, until the dosage and other treatment are optimised, after which the young person can be discharged to the ongoing care of their primary care provider, with advice on continued monitoring.

Further collaboration occurs around review of the need for ongoing treatment, typically after two years. For young people this often occurs with growth spurts or at other points of transition.

Assessment for other commonly co-occurring conditions is also carried out as required. These include anxiety, low mood, other neurodevelopmental conditions such as ASD, tic disorders and learning difficulties, and trauma-related conditions which may be confused with ADHD.

c) For those over 18 years – CMHAS Adult services

Whanganui DHB CMHAS are currently short two clinical psychologists and are regrettably unable to provide full appropriate assessment and treatment for ADHD or other neurodevelopmental conditions until these vacancies can be filled.

Referrals which are accepted for ADHD treatment planning(following confirmation of diagnosis by a psychologist) require an appointment with a triage clinician to obtain consent and agree to sharing of information (such as school reports, collateral history from family members and significant others).

An appointment is then made with a vocationally registered consultant psychiatrist who will work with the person to come up with a treatment plan and may initiate prescribing of stimulant or other medication if indicated. A clinical psychologist may also be involved in sharing of information including behavioural and other non-medication strategies for management of ADHD. Once a treatment plan is agreed, ongoing monitoring and care usually reverts to the primary care practitioner. In this district most primary care practices now have Health Improvement practitioners and Health coaches who can assist with monitoring and sharing of educational materials with the person and their whanau or employers as appropriate.

Prescribing of a stimulant medication, such as Methylphenidate (Ritalin, Rubifen or Concerta), or Dexamphetamine, to treat ADHD, must be initiated and endorsed by a vocationally registered specialist psychiatrist for people over the age of 18 years. Treatment with the non-stimulant medication, atomoxetine can be initiated by a senior medical doctor working in psychiatry. The response to treatment is usually monitored in repeat reviews with doctor and keyworker until treatment is optimised and any side effects have been dealt with. The person can then be transferred back to the care of their primary care provider for ongoing management. This includes monitoring of physical health parameters. A psychiatrist will be required to review the management with the primary care provider at least every 2 years for continuation of endorsement of the treatment.

4. Do you have the ability to cope with an ADHD person in crisis? What care is provided?

a) Paediatrics: An on- call Paediatrician is available for any child in crisis outside working hours. Behaviour and Development Coordinator is responsive to families, GPs and agencies requiring advice for families needing to access crisis services within the WDHB during her working hours.

b) MICAMHAS – Youth to Age 18 years - Crises in people with ADHD are often due to coexisting conditions such as anxiety, mood disorder or conduct disorder. Substance use disorders may also be present and contribute to crises. It is essential to work closely with whanau and caregivers as well as educators in these situations. The SUPP (Youth alcohol and drug and coexisting disorder service) is embedded in the MICAMHAS team and can reach out to those youth who may not otherwise engage with the conventional services. These services are 8:30 am to 4:30 pm on weekdays. After hours young people with ADHD, in crisis are referred to the MHAHT team which has access to the on call medical officers in mental health.

The services work alongside other agencies, such as Kaupapa Maori youth mental health services, (Te Oranganui), JIGSAW(parenting support), educators,(including regular schools, the Central Regional Health school and Alternative education providers), police (Youth Aid and Life to the Max) and Oranga Tamariki to assess and support the young person in their environment. Frequently modification of the environment is required. For example, students with ADHD may learn better in specific settings and may require supports such as Teacher aides or reader-writers in order to be able to optimize their learning. School observations can be helpful in this case.

In older youth, crises may occur in the context of mood disorders, anxiety disorders, bullying, exclusion and other conditions common in youth, as well as conduct and substance use disorders and

these are assessed and managed as for those conditions themselves. Likewise the team will bear in mind the possibility of undiagnosed ADHD in young persons presenting with other conditions who may show an atypical response to management of other conditions, including trauma-related conditions and psychotic disorders. Suicidal behaviours may occur and are managed whilst being mindful of the neurodevelopmental condition. Suicidal behaviours may be more common in people with ADHD and coexisting autism spectrum condition. MICAMHAS also has access to youth respite facilities in Palmerston North. These are sometimes helpful in allowing young people and families to cope better.

Another form of crisis situation may arise when a young person cannot sleep well. Prescribing of melatonin by either a psychiatrist or the GP, can bring about a marked improvement in sleep, concentration and mood.

c) For people over the age of 18 years, crises are more likely to arise due to other conditions rather than the ADHD itself. Regular crisis resolution services are provided, including being aware of the potential for family/intimate partner violence. Alcohol and other substance use interventions may be linked in. Services exercise caution in regard to the potential for diversion of stimulant drugs and it is important to gather information including collateral history to ensure that people are appropriately prescribed stimulants. At times urgent demands are made to services for prescription of stimulant drugs, where the use of these cannot be substantiated by history or assessment. Assessment will take place for other similar conditions which may mimic ADHD, including bipolar disorder and emotional dysregulation or a trauma response. Appropriate treatment will be offered according to the outcome of the assessment. At times a non-stimulant medication will be offered to allow management of the condition, where there has not been a good response to other treatments or where there may be concern about the potential for diversion.

In general, secondary service providers will act as a resource to the community agencies, primary care, educators, whanau and caregivers who are managing the situation day to day.

Should you have any further queries about the above information, please contact our OIA co-ordinator Anne Phoenix at anne.phoenix@wdhb.org.nz

Ngā mihi

Graham Dyer
Kaihautū Hauora – Acting Chief Executive
Whanganui District Health Board