The Lothian Adult AD(H)D Model

NHS Lothian AD(H)D Resource Team

11th February 2015
Edinburgh and the Lothians
A few facts

- Population c 849 000
- High student population c 50 000
- Mixed urban rural but more urban
- Prison population c 1600
- Substance use dependence

Drugs 8500
Alcohol 35 – 40 000
AD(H)D in children is 5% in UK.
Up to 60% of children with AD(H)D will continue to experience impairment in adulthood.

AD(H)D in adults:
- 2% - worldwide (NICE, 2008)
- 17,000 in Edinburgh and the Lothians

AD(H)D in Addictions
- 10-12%

AD(H)D in prison populations
- 25%
NHS Lothian Adult AD(H)D Resource Team

- Psychiatry
- Psychology
- Occupational Therapy
- Project Manager
- Admin

Service Users
NHS Lothian AD(H)D Resource Team

- Provide appropriate training in the recognition and management of AD(H)D in adults to all relevant healthcare staff in Lothian
- Provide advice on the management of adults with AD(H)D
- Provide a tertiary level assessment facility for more complex cases of AD(H)D and for second opinions
History of the Team and Journey

- Team set up in 2011.
- Building on specialist interest and clinics
- Part of a matched care model, different levels to match need of individuals
- As part of the development, developed an Integrated Care Pathway to acknowledge the different routes into care and the levels of need and treatment
What we have done..

- Building Capacity
  - Training
  - Evaluation
  - Second Opinion
- Case discussion Forum
- Speciality Pathways
  - Prisons
  - Substance Misuse
Building Capacity

Feb.12- Feb.15

- 33 Training events across Lothian
- Over 50 referrals and consultations received
- Liaison with local support groups for the creation of patient-focused resources.
Percentage of Designations trained by the AD(H)D Resource Team

% Designations trained by AD(H)D team

- Psychiatrists: 19%
- Psychologists: 10%
- GPs/Doctors: 10%
- Nurses: 10%
- Therapists (Ots/PT/SLT): 15%
- Social Workers: 3%
- Students (medical/nursing/social work): 6%
- Voluntary sector: 2%
- Student Support Workers: 6%
- Caseworkers: 11%
- Health Practitioner: 2%
Evaluation of Training

- Pre/Post questionnaires completed for each training session.

POST Training Evaluation

- Knowledge: Not at all 0.0, Neutral 10.0, Very much 40.0, N/A 50.0, Very much 80.0, N/A 90.0
- Skills: Not at all 0.0, Neutral 10.0, Very much 40.0, N/A 50.0, Very much 80.0, N/A 90.0
- Services: Not at all 0.0, Neutral 10.0, Very much 40.0, N/A 50.0, Very much 80.0, N/A 90.0
- Confidence: Not at all 0.0, Neutral 10.0, Very much 40.0, N/A 50.0, Very much 80.0, N/A 90.0
Training in Lothian (Feb 2012-Feb 2015)

Percentage Staff Trained by Locality in Lothian:
- West Lothian CHP: 20.6%
- Edinburgh CHP: 72.2%
- Midlothian CHP: 7.7%
- East Lothian CHP: 10.5%

- Edinburgh
  - 85.6%
- East Lothian
  - 0.7%
- West Lothian
  - 2.2%
- Midlothian
  - 10%
- No LHCC
  - 85.6%
Case Discussion Forum

- Piloted further to post training feedback.
- Opportunity to share challenges and best practice
- Variety of professionals attended
- Efficient use of team resource?
- Accessibility
- Future – virtual options
Developing speciality pathways
HMP Edinburgh

MH Drop In
Addictions Referral
Complete ASRS
Initial assessment Clinic Appt - WEISS

Discuss at Allocations Meeting
Joint Assessment – Forensic Consultant and SNM (NMP)

Treatment required
No Follow Up required
Medication
Small Grant for in cell activities
Hobbies Project
Liaise with PTI
Substance Misuse Directorate

- Awareness raising sessions
- “This can make your job easier”
- ASRS screening tool
- WEISS
- Review by sector consultant
- Joint work with CMHT or AD(H)D
  Resource Team
- Shared Care Protocols
Challenges and Opportunities
Costs vs Benefits - a rough estimate

Cost of assessment and follow-up  £400  
Cost of 1 year medication  £720  
Total Cost  £1120  

Assume back to work (median wage)

Saving on benefits (£138/ week)  £7,176  
Saving on 1 sheriff court case  £3,000  
(NB 6 months prison= £20,000)  
Total public savings  £10,176  
Net Savings  c.£9,000
Current state of adult psychiatrists:

1. Uncertain it exists/ it’s a diagnosis
2. Yet more work
3. Medicalising the norm/ cosmetic Rx
4. Relabelling existing conditions

Desired state:

1. I understand it
2. It’s worth the effort
3. It’s valid to offer interventions
4. Teasing out comorbidities
The service challenge

Mental, Behavioral and Neurodevelopmental disorders F01-F99

Type 2 Excludes
- symptoms, signs and abnormal clinical laboratory findings, not elsewhere classified (R00-R99)

Includes
- disorders of psychological development
  - F01-F09 Mental disorders due to known physiological conditions
  - F10-F19 Mental and behavioral disorders due to psychoactive substance use
  - F20-F29 Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
  - F30-F39 Mood [affective] disorders
  - F40-F48 Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
  - F50-F59 Behavioral syndromes associated with physiological disturbances and physical factors
  - F60-F69 Disorders of adult personality and behavior
  - F70-F79 Intellectual disabilities
  - F80-F89 Pervasive and specific developmental disorders
  - F90-F98 Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
  - F99-F99 Unspecified mental disorder

Where do these fit?

GAP services
- possibly
LD
The diagnosis challenge

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**Trait like/neurodevelopmental like (difference from norm?)**
How can ADHD be a disorder or a diagnosis?

BECAUSE

Everyone has these traits to some degree

They may be useful*

People with these traits can be very successful

Highly genetic and highly conserved**

*BMC Evol Biol. 2008; 8: 173
Medicalising normality is not new
Being normal is a risk factor
Implications

• Normal human traits bring certain risks (eg having a high BP)

• Reducing these traits reduces specific risks

• The only way to have no risk is not to have these traits at all (ie no blood pressure!)

• Whose responsibility is it to manage the risk?

**ADHD traits (NDDs in general?) could be regarded as a set of RISK FACTORS (+/- diagnosis)**
Other Challenges

- HEAT targets
- Contracting budgets
- Integration
- Burnout...
…However…

You will already be seeing patients with ADHD in daily practice

They will probably be the more challenging patients you see
Accessing Teams – different challenges

- Access to Primary Care: PLT vs one to one vs electronic
- CMHTs
- Social work provision
- Third Sector
- Service User Involvement
Future Developments
ADHD as a NDD

- ADHD is one of a number of NDDs
- They often co-exist from a young age (Gilberg)
- Often have ‘shades’ of other NDDs (like PDs)

Neurodevelopmental assessment may reveal others
Next Steps

- Review the ICP
- Links with other teams and services eg ASD Service
- Focus on Primary Care
- Build on best practice, locally and nationally
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