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George Still Forum

G507 RELATIONSHIP DEVELOPMENT INTERVENTION; A DEVELOPMENTAL PERSPECTIVE TO AUTISM MANAGEMENT

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Introduction/Aim The aim of this paper is to present the experiences of two familes of children with autism spectum disorder (ASD) using a particular intervention.

The deficits of individuals with ASDs can be divided into homogeneous "primary" deficits, which define the disorder, and heterogeneous "secondary" deficits, which may or may not be present. Primary deficits reflect poor development of dynamic neural functioning and the failure to develop dynamic intelligence.

NICE Guidelines The management and support of children and young people on the ASD(August 2013) recommends that **interventions for core ASD features** include training of parents, caregivers, and teachers to increase joint attention and reciprocal communication using video-feedback methods appropriate to the child's developmental level.

One such intervention, Relationship Development Intervention (RDI), uses the principle of typical development of Dynamic Intelligence via Guided Participation relationship, which either never gets to develop or gets disrupted early in the development of a ASD child.(development psychology research)

RDI is implemented through intensive parent education to reconstruct their natural "guide" relationship from a developmental perspective, modelling and role-playing, regular videotape review of parent-child performance, and school staff training.

Methods This intervention has been used on my own son for 3½ years and another child with an ASD for 1 year. They were followed through regular videos and Relationship Development Assessment (RDA) of the child and parents every 6 months.

RDA consists of a semi-structured observational assessment (RDA-RV) focusing on three interpersonal parent-child processes: shared attentional focus, ability to co-regulate an interaction, and ability to share emotional experiences.

Results Both families showed Improvement in their child's ability to interact and engage, accept and adjust actions with parent modelling and pace adjustment, understand changes and variations with continuity, and co-ordinate their actions with others.

After RDI for 3½ years One child was able to 1) understand and use nonverbal cues, gestures, and facial expressions; 2) explore new situations and activities, participating with other adults to learn; and 3) handle group activities/peer games like almost any normal child.

Conclusions The results show overall improvements in functioning related to ASDs. An examination of the literature reveals a growing body of empirical evidence and best practice recommendations supporting the practices embedded in RDI.

G508 ARE PAEDIATRIC SERVICES BETTER GEARED UP THAN CAMHS TO MONITOR PATIENTS ON STIMULANT MEDICATION?

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Stimulant medications are widely used to control symptoms of Attention Defict Hypercativty Disorder in children and NICE has issued comprehensive guidelines in 2008 about diagnostic criteria based on DSMIV and monitoring of patients on medication

RCPSYCH under QIP through PRESCRIBING OBSERVATORY FOR MENTAL HEALTH -UK (POMH) undertook a national audit – topic 13a "prescribing for ADHD medication" 2013.

Audit tool, sampling options poster and participation were sent to POMH lead contact. Data was collected over a period of one montha and entered on line. data was anaylysed over 6 month period and resuls were published. It measured 6 standards Heart rate, BP, Height, Weight, Cardivascular risk assessment and substance misuse risk before starting treatment, 3 months after and over a year

There were 5479 patients in 48 Trusts under 370 clinical teams. There were 429 Paediatric patients in the sample treated by paediatricians.3737 by CAMHS teams and 1313 adult patients. Children aged 13–8 were the largest group, 83% were male, 80% were caucasian. commonest co morbidities: 25% had sleep disorder, 23% pervasive developmental disoder. Adults had 25% had mood, personality and stress disorder. 30% had no co morbid disoder.

Our Trust compliance was highest in the sample with 100% in all the 6 standards before and 3 months after starting treatment and 88% over the year.

We provide ADHD service in DGH setting and treat ~ 200 patients per year. We run 4 dedicated clinics a month and have designed specific templates for initial and fup clinics to capture the data and paediatrics is more failiar in plotting growth charts, measuring BP and performing physical examination than CAMHS colleagues which has helped us to do well in this audit. A well focussed team with limited resources can provide high quality care and this has been re inforced by a recent service user survey.

It is unclear from this audit what percentage of services are provided in UK by paediatricians and CAMHS. As the project was initiated by RCPSYCH Paediatricians providing a service were probably not aware hence less data input.