Conclusions The early weeks of infant existence were poorly documented prior to the nineteenth century. Neonatal tetanus was described earlier in urban and rural settings, temperate or tropical communities, Hospitals and homes. Variation in nosology was one of several factors limiting communications about this fatal illness. This deprived parents of an explanation or causation. Crucially it delayed the sharing of preventive best practices among birth assistants.

George Still Forum: ADHD Disorders (ePoster presentations only)

1804

AUTISM DIAGNOSTIC ASSESSMENT OF PRESCHOOL CHILDREN IN AN INTEGRATED MULTIDISCIPLINARY CHILD DEVELOPMENT TEAM: A QUALITY IMPROVEMENT PROJECT

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Background The ASD diagnostic process can be a source of stress for parents due to the long waits for assessment and poor understanding of the diagnostic process. The pathway should adhere to NICE guidelines, Gaining information about parent's experience of the assessment process can be used to inform adjustments to the current diagnostic pathway.

Objectives

1. To evaluate the current diagnostic pathway for preschool children in a Child Development Centre in South East Essex.
2. To gain understanding of parent's experience of the current ASD diagnostic process

Methods Eighty-four children were assessed by the integrated Child Development Multidisciplinary Team between April 2019 and March 2020. A random sample of 24 children from the cohort of 84 children was used to examine adherence to the National NICE Autism Spectrum Disorder clinical guidance. The information was obtained through clinical records from two electronic record systems used by the MSE Hospital Trust and Essex Partnership University Trust.

All families were sent questionnaires to obtain anonymised qualitative and quantitative data about their experience of assessment. Questions referred to parental understanding of the assessment process, the quality of communication and interactions between the service providers and users, information and knowledge gained through the assessment process. Parents were invited to complete and return the questionnaires by post or electronically. Ethical approval through the Trust's Quality Improvement Department was obtained. The results of the audit and parent's responses on the questionnaire were collated and reviewed.

Results Eighty-three percent of the children received a diagnosis of Autism Spectrum Disorder following assessment. The mean age at the time of diagnosis was 4 years. The mean length of time from referral to completed assessment was 20 months. Children were investigated and treated accordingly for co-morbid conditions.

Speech and language assessments were recorded on 22 of the children. Information used to complete the assessment is stored on two different electronic systems as two NHS providers are involved in the assessment of children with ASD. School information was recorded for the majority of the assessments. It is not clear whether assessment results were always shared with GP.

The response rate for the parent questionnaires was low with 9 parents out of 84 (11% of parents) returning questionnaires.

Conclusions The project revealed compliance with ASD assessment NICE guidelines in relation to collection of medical and neurodevelopmental history, direct observation and involvement of members of the Multidisciplinary team. Parents report overarching positive themes about the entire assessment and the interaction of parents with the Multidisciplinary Team clinicians.

However, areas in need of improvement such as poor recording keeping, information sharing with primary care and lack of post diagnosis training were highlighted. The results of the project has been discussed within our MDT team and resulted in establishment of adjustments to the existing evidence based autism pathway where regular monthly MDA team meetings have been initiated. Protocols for communicating with parents, health and education professionals have been established.

1805

CLINICAL RATIONALE AND EVIDENCE FOR EFFECTIVENESS OF NON-PHARMACOLOGICAL AND BEHAVIOURAL MANAGEMENT OF ADHD IN CHILDREN AND ADOLESCENTS

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Background Children and young people (CYP) with Attention deficit Hyperactivity Disorder (ADHD) often experience a wide range of multi-modal impairments often persisting into adulthood, affecting the patients, their carers and wider society. In addition to the core symptoms of age-inappropriate, persistent, and pervasive inattention and/or hyperactivity/impulsiveness that impairs daily functioning, 65–80% of patients with ADHD have conduct problems and other neurodevelopmental comorbidities, as well as poor social and organizational skills with low academic achievement. 10–30% of CYP with ADHD do not respond to psychostimulants while other children experience significant side effects that prohibit continued use. Some parents may have reservations about psychostimulant use due to concerns about potential side-effects and preference for alternative treatments.

Several national and international professional bodies have recommended that Pharmacological treatment should not be offered as the sole therapeutic intervention, especially for the preschool children.

Objectives We reviewed the extant literature to explore the rationale, principles and effectiveness of different modalities of non-pharmacological interventions for CYP with ADHD.

Methods We conducted a search of electronic database including the OVID, EMBASE, CINHAL and Cochrane's Databases for publications regarding the principles and effectiveness of

various non-pharmacological/psychological interventions in the management of CYP with ADHD.

Results Non-Pharmacological/psychological treatment modalities can be classified into 4 major categories including Psychosocial (eg social skills and parent training), Body-focused (eg yoga and physical exercise), Cognitive/neuro-Cognitive Therapy (CT): (eg computer attention training and Neurofeedback) and Cognitive-behavioural interventions (eg Psychoeducation and play therapy).

Published literature provides variable level of evidence for the beneficial effects of non-Pharmacological interventions on important aspects of child and parent functioning. Combination of psychological therapy (including group-based parental Psychoeducation) with psychostimulants has the greatest effect size for controlling the core and other ADHD-related symptoms compared to either psychostimulants or behavioural therapies alone. There is currently insufficient evidence to recommend standalone Behavioural therapy or Cognitive behaviour therapy, working memory or Neurocognitive training and Neurofeedback for controlling core symptoms of ADHD.

There is strong evidence for parent training and other adult/child-based behavioural interventions in controlling ADHD-related outcomes such as parenting skills, child's social skills, academic performance and challenging behaviours. Research has also proven the effectiveness of classroom-based psychosocial interventions for reducing disruptive behaviours, while use of Computer-based attention and other Neurocognitive training, as well as participation in regular Cardio exercises show moderate evidence for improving Executive skills.

On the other hand, combinations of different types of non-pharmacological modalities have disappointing low efficacy in the management of both the core symptoms and other related outcomes in ADHD.

Conclusions A wide range of non-pharmacological/behavioural interventions have been recommended as part of a Multi-modal management strategy for CYP with ADHD. The significant importance of non-pharmacological interventions for ADHD has become more relevant recently, especially during the COVID 19 pandemic crisis. All clinicians need to be familiar with the rationale and principles of different modalities of non-pharmacological interventions and be confident in offering them through 'social prescribing', by signposting to various local providers or recommending self-directed access to several free or commercial online resources.

1806

CHANGES TO THE INITIAL HEALTH ASSESSMENT (IHA) FOR CHILDREN ENTERING THE LOCAL AUTHORITY CARE SYSTEM DURING COVID-19 PANDEMIC CRISIS

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Background Covid-19 has impacted on the healthcare provision worldwide. Anecdotally, assessment and management of looked after children have been restricted, resulting in

assessment being carried out virtually by telephone or video-consultation. While changes to traditional face to face appointments were necessary enabling consultations to continue, it was unclear whether new technologies would be reliable or effective for vulnerable children.

Objectives

1. To review the decision making process which informed the method for undertaking an Initial Health Assessment (IHA) for children during the Covid-19 pandemic
2. To determine how any gaps were mitigated within the child's health care plan.

Methods Following consent from individual organisations, 5–6 anonymised IHA records were randomly selected to be reviewed against an audit template from each provider across Southend, Essex and Thurrock (SET). The timeframe for the assessment was from 1st April 2020 until 30th September 2020. The data was measured against IHA pathway standards, a guide to support decision making. A table of comparative data was mapped to provide the basis for analysis.

Results Of the five SET service providers invited to participate, four organisations provided a response within the timeframe. A total of 21 questionnaires were received. The cohort consisted of 9 females and 12 males. Ages ranged from 3 weeks to 17 years. One review was face-to-face, 4 were via video, 6 by telephone, and a further 10 recorded as virtual (unknown whether assessment was by telephone or by video-consultation). Of 11 children with no previous health review, 6 were sign-posted to the GP for a physical assessment. Similarly, 6 of the 9 children with a previous medical contact were referred to a GP. Eight children had no recorded physical follow-up.

Conclusions It is important to recognise the inclusive data provided just a snapshot of the IHAs undertaken during this period. However, it was evident that virtual assessments appeared to become the default position without always adequately reflecting the health needs, wishes and circumstances of each individual child/young person. Whilst some IHA assessments were well completed in very uncertain and challenging circumstances, others were incomplete and lacked robust arrangements for the inclusion of a physical assessment of the child. For this reason, telephone or video-consultations should not replace face-to-face consultations. Proper planning of IHA services and resourcing for recovery is of paramount importance for every professional involved. The child's individual welfare and best interests much be central to decision making.

1807

15Q11.2 MICRO-DELETION ASSOCIATED WITH ADHD: TWO CASE REPORTS AND LITERATURE REVIEW

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