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20 August 2025

s 9(2)(a)

By email: s 9(2)(a)
Ref: H2025070364

Tēnā koe s 9(2)(a)

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to the Ministry of Health – Manatū Hauora (the Ministry) on 23 July 2025 for information regarding the Attention Deficit Hyperactivity Disorder (ADHD) clinical framework. You requested:

> *"I request all clinical advice, evidence, expert consideration, medical rationale, or other information (including correspondence) that has given rise to the recommendation that doctors should be "reviewing the need for continuing medication every two to four years" for people with ADHD. This quote comes from the clinical framework for ADHD published this week.*
>
> *Further, I also request information about how people with lived experience of ADHD were identified/recruited for the clinical reference group that informed these guidelines. I also seek any specific feedback from the 'lived experience' people in the group as it relates to the recommendation above about reviewing the need for continuing medication every two to four years (in other words, the non-medical or non-clinical feedback or consideration).*

The New Zealand Clinical Principles Framework for ADHD was developed in partnership with a Clinical Reference Group, with members including people with lived experience of ADHD, family and whānau of people with ADHD, and New Zealand clinicians with expertise and experience in assessing and treating ADHD. The Framework incorporates a range of evidence including from existing evidence-based clinical guidelines, and from the clinical expertise of professionals currently providing assessment, diagnosis, and treatment for ADHD.

Four meetings were held between October and December 2024 with the Clinical Reference Group to develop consensus on general and age-specific principles for assessing, diagnosing, and treating ADHD. Members of the Group provided input on the Framework during these meetings via email afterwards. Minutes of these meetings and email communications are provided in response to your request.

During these meetings, the Clinical Reference Group looked at international guidelines, which included recommendations reviewing the need for continuation of ADHD medications periodically. For instance, the National Institute for Health and Care Excellence (NICE) UK's guidelines for ADHD recommend reviewing the need for continuation of ADHD medications every one year: www.nice.org.uk/guidance/ng87/chapter/recommendations#review-of-medication-and-discontinuation.

While considering the international guidelines, the Clinical Reference Group drew upon their own clinical experience and expertise to recommend including the principle for reviewing continued medication every two to four years. This reflects a balanced approach, balancing the need for access to ADHD medications with quality clinical oversight of pharmacological treatment.

Lived experience representatives from ADHD New Zealand and the Young Neurodiversity Champions participated as members of the Clinical Reference Group. Lived experience representatives were recommended to the Clinical Reference Group based on the groups and networks that were actively involved in discussions with parliamentarians, government agencies, and communities, on the need for greater attention on improving availability and consistency of ADHD care in New Zealand. Feedback and contributions from lived experience representatives in the Clinical Reference Group are included in the documents released to you.

The Ministry has identified 13 documents within scope of your request. All documents are itemised in Appendix 1 and copies of the documents are enclosed. Where information is withheld under section 9 of the Act, I have considered the countervailing public interest in release in making this decision and consider that it does not outweigh the need to withhold at this time.

I trust this information fulfils your request. If you wish to discuss any aspect of your request with us, including this decision, please feel free to contact the OIA Services Team on: oiagr@health.govt.nz.

Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Ministry website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

Dr Joe Bourne
Chief Medical Officer
Strategy and Policy | Te Pou Rautaki

Appendix 1: List of documents for release

#	Date	Document details	Decision on release
1	September 2024	Draft: ADHD Clinical Reference Group Terms of Reference	Released in full.
2	September 2024	Themes from ADHD pre-meets	
3	16 October 2024	Minutes: ADHD Initial Meeting	Some information withheld under section 9(2)(a) of the Act, to protect the privacy of natural persons.
4	24 October 2024	Email correspondence: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui	Some information withheld under the following sections of the Act: • 9(2)(a); and • 9(2)(k) to prevent the disclosure or use of official information for improper gain or advantage.
5	30 October 2024	Email correspondence: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui	
6	30 October 2024	Minutes: ADHD second meeting	Some information withheld under section 9(2)(a) of the Act.
7	14 November 2024	Email correspondence: RE: Minutes and updated principles template RE: NZ ADHD consensus doc - second hui	Some information withheld under section 9(2)(a) of the Act
8	14 November 2024	Email Attachment: Draft ADHA proposed principles framework template	Section 18(d) of the Act applies as the final document is already publicly available here:www.health.govt.nz/publications/new-zealand-clinical-principles-framework-for-attention-deficit-hyperactivity-disorder.
9	20 November 2024	Minutes: ADHD third meeting	Some information withheld under section 9(2)(a) of the Act.
10	29 November 2024	Email correspondence: RE: Minutes from third ADHD hui RE: NZ ADHD consensus doc - third hui	Some information withheld under the following sections of the Act: • 9(2)(a); and • 9(2)(k).
11	4 March 2025	Email correspondence: RE: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies	Some information withheld under section 9(2)(a) of the Act.

12	4 March 2025	Email attachment: NZ ADHD clinical principles consensus framework NZCCP feedback	Section 18(d) of the Act applies as the final document is already publicly available here:www.health.govt.nz/publications/new-zealand-clinical-principles-framework-for-attention-deficit-hyperactivity-disorder.
13	29 May 2025	Email correspondence: RE: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies	Some information withheld under section 9(2)(a) of the Act.

MANATŪ HAUORA
MINISTRY OF HEALTH

ADHD Clinical Reference Group

Terms of Reference

Author	Tim Jelleyman/Kieran Moorhead, Ministry of Health ADHD project team
Status	[Draft] September 2024

1. Responsibility of this Clinical Reference Group

The purpose of this Clinical Reference Group (the Group) is to advise and support the Ministry of Health ADHD project team (Tim Jelleyman/Kieran Moorhead) on the development of a national NZ ADHD Consensus document. The document will be a guiding document based on best practice and not a mandatory directive.

The document will provide a joint understanding and agreement on identification, diagnosis, treatment, and management of ADHD across the life course. The document will clarify:

- the roles and responsibilities of the clinical workforce involved in supporting ADHD, and
- the expectations of services and supports available for people with ADHD and their whānau.

Key roles of the Group are to:

- provide expert clinical perspectives and insights on health workforce roles and responsibilities for ADHD diagnosis and treatment in New Zealand.
- provide guidance on what health-led services and supports should be expected for people with ADHD and their whānau across the life course.
- identify any workforce training requirements/gaps for ADHD.
- engage with respective colleges, professional bodies, and groups/networks to support a consensus position and understanding.
- review and comment on drafts of the Consensus document ahead of fortnightly meetings with the aim of having a final draft completed by mid-December 2024.

2. Expectations of the Group

The Clinical Reference Group will provide support and advice over a limited number of short and focussed meetings with a set deadline for delivering a final draft document (mid-December 2024). Therefore, the Group will operate as a working group and members commit to reviewing and commenting on a draft document outside of the scheduled meetings to the best of their ability.

At the conclusion of developing a final draft of the NZ ADHD Consensus document, the Group may wish to continue operating and the Terms of Reference may be reviewed at that time.

3. Guiding Principles

The Clinical Reference Group will apply the following guiding principles in how it operates. All Group members will:

1. Represent the interests of each of their respective colleges, professional bodies, and groups/networks overall, including being a voice for those who do not have a direct representative on the Clinical Reference Group.
2. Work cooperatively in a friendly and constructive manner, including encouraging open discussion with all views being fully heard.
3. Treat any information and draft documents (obtained through membership of the Group) as confidential and seek confirmation from the Group and the Ministry of Health ADHD project team before sharing anything externally or speaking to media.

4. Attempt to resolve any concerns through discussion with the Ministry of Health ADHD project team in the first instance. Following that, members can propose discussion with the wider Clinical Reference Group by requesting a specific agenda item or, if urgent, requesting a special meeting or engaging with all members via group email.

4. Decision making process

The Ministry of Health ADHD project team and the Clinical Reference Group will aim for consensus decision making to develop the draft NZ ADHD Consensus document.

The Ministry of Health holds accountability for the delivery of the project and ensuring that information and perspectives represent a consensus from the Clinical Reference Group.

5. Payment and expenses

It is not usual for the Ministry of Health to pay representatives from the publicly funded sector for meeting attendance. Lived and whānau experience members will be reimbursed as per the Cabinet Office Circular Revised Fees Framework. Ministry of Health may remunerate other parties by mutual agreement.

6. Managing conflicts of interest

Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to a conflict of interest.

From time to time, a member may find themselves in a position where they may have competing duties, responsibilities or interests to their membership of the Group. In this situation members should document their conflicts of interests and identify any conflict of interest prior to a discussion of a particular issue.

7. Project Governance

This project has governance from an ADHD Programme Oversight Group to ensure consistency across all health agency actions to improve support for ADHD.

The members of the ADHD Programme Oversight Group are:

Michael Woodside – Group Manager, Mental Health and Addiction Strategy and Policy, Ministry of Health

Joe Bourne - Chief Medical Officer, Ministry of Health

Chris James – Group Manager, Medsafe

David Hughes - Chief Medical Officer, Pharmac

Zoe Royden – Manager, Office of the Deputy Director General, Ministry of Health

Peter Dolan – Group Manager, Data Analytics and Surveys, Ministry of Health

8. Membership

Group chair and ADHD project team lead:	Tim Jelleyman
ADHD project team lead:	Kieran Moorhead

Group members:	TBC

9. Meetings

Term & Frequency	Group is expected to operate from mid-October 2024 to conclusion on development of a final draft NZ ADHD Consensus document in approximately mid-December 2024. Clinical Reference Group meetings will be held approximately fortnightly unless the ADHD project team identify a need to meet more or less often. Meetings will held online and will be one hour unless a different duration is decided by the Clinical Reference Group and/or ADHD project team.
Quorum	No requirement for a quorum. The aim of the project is to achieve consensus decision making within each meeting and over the entirety of the project.
Minutes	Minutes will be recorded by the ADHD project team and will be kept brief and focused on capturing decisions and actions.
Approach	Clinical Reference Group members will be booked into meetings through repeated calendar invitations. An agenda, previous minutes and any draft documents for discussion will be made available to Clinical Reference Group members at least two working days before each meeting. Actions from each meeting will be allocated to relevant project leads and their progress and status tracked. Action owners will be expected to report back on these actions at subsequent meetings.
Accountability	All Clinical Reference Group members must try to attend meetings to the best of their ability. Members may make delegations or apologies if necessary.
Invitations	The ADHD project team and Clinical Reference Group members may invite additional people to attend the Clinical Reference Group meetings. This will generally include clinical and subject matter experts.

ADHD CONSENSUS DOC INITIAL DISCUSSION THEMES	
Goals of the project	Purpose of the ADHD consensus document is supporting consistency across access, coverage, and quality. Needs to use a lifespan approach that covers children, young people, and adults. The consensus document will consider how to apply existing guidelines in a NZ context, and agreement on the key principles that support ADHD assessment, diagnosis, and treatment. First step can be discussion commonalities and where there are key differences and where there is a need for further work. Can explore each step of ADHD support in order from identification, assessment, diagnosis, and treatment. The document can include: • toolbox for clinicians • most valid and appropriate assessment tools, including the reasonable assessment standards we expect • flow chart for the diagnostic processes and diagnostic tools to use • outline of what you should do for each clinical session • links to high quality free to use resources. Align with the work by Pharmac and Medsafe on improving access to medications and expanding initiating prescribing criteria. These two workstreams are operating in parallel and need to inform each other. As part of this process agree a joint communication on the work that can be circulated from the group to stakeholders.
Variability / consistency	There is extreme variability in services provided, tools used, and staff available for assessments and services that are available. Where there's variation there's lack of efficiencies and effectiveness. Important to maintain and improve quality of care as well as coverage without trading off against each other. Need to consider how will we improve quality over time. Paediatric services are burdened, and there are long wait times of over a year for assessment of ADHD. Lack of agreement on assessment and diagnostic processes outside of DSM V. Insufficient access to treatment. Good examples of best practice including areas that can enable assessment, diagnosis and follow up care beginning anywhere from primary to specialist services (patient centred).

	Achieving a national pathway is a good idea, but localised approaches need to be considered.
Equity	Need to include Māori and an equity lens in the work and consensus document to ensure groups with inequitable access and unmet need are addressed. Identify ongoing opportunities for bringing in the perspectives of people with lived experience of ADHD. Support is currently underserving adults with ADHD, despite greater awareness now for adults. Good evidence from the last few years that shows underdiagnosis in females, Māori, and Pacific people. Private diagnosis of ADHD which can be expensive is contributing towards inequity for people who cannot afford it.
Shift to primary care	Shifting ADHD work into primary care requires providing primary care with the tools, training, and support to provide good quality care. Ongoing frustration in general practice regarding access to ADHD assessment, therefore initiating of medication treatment. While treatment is not always about medication, often this is expected by people and can begin someone's treatment journey. There are primary care workforces with special interest in ADHD and are already doing this work. Highlight the exemplars of clinical practice across the country with the view of replicating these in more areas. Primary care in the community supports a holistic approach to treatment, lifestyle management, physical health screening, sleep, nutrition, psychological support, and habits. Need to consider potentially two camps within primary care – those weary of high demand for ADHD support without resourcing and training and the group who are keen and highly skilled in ADHD wanting to be more appropriately enabled.
Unintended consequences or risks	Potential risks of the diversion of ADHD medication from increasing supply and removing barriers to access. Clinicians report concerns regarding prescribing controlled substance and potential diversion. Diversion may be less of an issue compared with the social costs and social outcomes of unsupported ADHD. There is a gap in funding for adult ADHD in primary care as it doesn't easily fit the capitation model, and until it is resourced it remains an area for private health care to address.

	The system sets the standards of care that we expect but cannot control outcomes without the proper resourcing to implement funded ADHD assessment and diagnosis. There are known medication supply issues for ADHD stimulant medications. So expanding access might not have the level of uptake need to address unmet need. Need to identify if there are any extra people to bring into the working group to develop the consensus document. For example, WINZ is involved in funding ADHD assessments.
Workforce	There are gaps in workforce training for people doing ADHD screening and assessment. Part of this work needs to consider how to support the workforces to know how to work with ADHD. This is relevant for improving training for GPs/NPs if changes to initiating prescribing come into effect. Explore the current state of the workforce and how they are integrated and working together on ADHD. Consider what else is required to deliver on the goals to improve quality, effectiveness, coverage for ADHD support. Identify the reasonable adjustments that can be made to the system without additional resourcing. Identify where additional resource is also needed. Consider how to include ADHD coaches in this work. In Australia there are more than 100 ADHD coaches, but only a handful in NZ. The AADPA guidelines mention ADHD coaches as workforce to consider expanding. Explore different trainings overseas that may be useful. Can tap into the work by AADPA to increase training for GPs. The Goodfellow Unit are also interested in supporting ADHD training for GPs. AADPA guidelines are a good basis for training and have been endorsed for NZ. They look at symptoms, multiple environments, and co-morbidities. Micro credentialing may not be useful in this context, a better approach may be to have agreed a consensus on training requirements and have colleges endorse providers that deliver relevant courses.

NZ ADHD Consensus document initial hui minutes	
Date:	16 October 2024
Location:	Online (via Teams)
Chair:	Tim Jelleyman and Kieran Moorhead
In attendance:	**Kieran Moorhead, Ministry of Health; Tim Jelleyman, Ministry of Health; s9(2)(a) , Just a Thought; Sam Hargreaves Te Whatu Ora; David Hughes, Pharmac; David Codyre, Tamaki Health; Dr Luke Bradford, RNZCGP; Paul Skirrow, Otago University; Angus Maxwell NZCCP; Hiran Thabrew, Auckland University; Murray Patton, Health NZ; David Chinn, Health NZ; Anya Stephenson, Ministry of Health; s9(2)(a) ADHD NZ; Garth Smith, Te Whatu Ora; s9(2)(a) , Totally Psyched; s9(2)(a) , Young Neurodiversity Champions.**
Apologies:	

Item	Commentary
1	Karakia, introductions
2	**Overview (aim and project plan)** **Context:** various experiences about the limitations around diagnosis for ADHD. There is also a political interest in ADHD driven in part by communities. There are international guidelines that we can build on for the New Zealand context. There is a data context (prevalence and patterns in New Zealand) that we need to understand. **Aim:** to reduce variation across the country and improve access to diagnosis. Improving access while maintaining quality. **Deliverable:** A draft consensus by the end of the year. Won't be final but will give a framework going forward and a basis to check with the sector, with an aim to check back early next year. This will give a good framework for the primary care sector, and for Health NZ. There needs to be enough flexibility to enable flexible delivery, but also to maintain quality. This plan fits within a group of actions including access to medications, work on a prevalence study, and targeting of significant populations where rates of ADHD may be higher. There is a small oversight group in the Ministry for this group of actions, including the Chief Medical Officer of Health and Michael Woodside, GM in the Ministry. Important to focus on at-risk populations and co-morbidities; where people could benefit from ADHD diagnosis as a primary diagnosis.
3	**Summary of themes** **Agreeing the goals of the project** - Work to piece together existing information such as guidelines and evidence to apply to a NZ context. - A lot of existing info is skewed towards a young male presentation. Need to reflect on this when doing a literature review to ensure equity. - Good to have a consensus as to who/what professions can do the assessments. - Streamlined guidance needed. The question is that you can't set up a service exclusively around ADHD due to high level of co morbidity/other conditions that people present with. How do we accommodate for this?

Item	Commentary
	- Think screening tools need to be differentiated from diagnostic tools. - Align with wider work by Pharmac and Medsafe. Variability/consistency - Variability in services, tools used, staff availability and training - Importance of maintaining quality of care as coverage expands - Burden on services Equity - Including Māori and an equity lens within the work - Lived experience - How to support adult ADHD - Private diagnosis of ADHD is creating inequity Having a Māori clinical point of view will be really important. Recent work in kaupapa Māori practice, important to consider how this is perceived and focusing on a strengths-based approach to what may be seen as a "Western diagnosis". Shift to primary care - How do we resource primary care? - How do we support people to upskill for diagnoses? - Holistic approach – primary care is an appropriate setting Unintended consequences/risks - Diversion of medications as a risk - Gaps in funding for ADHD (particularly for adults) - Known issues with the supply of ADHD medications - Are we missing any groups to involve in the development of the consensus document? Workforce - Gaps in workforce - What can be done with existing resource? What needs new workforce? - Examples of ADHD coaches (overseas) - What is needed to develop training Training should be wider (neurodevelopmental/neurodiversity) not just ADHD. It's a many-layered problem; at school level, GP level. School teachers and primary care clinicians spotting it but then the next step is for the help required. Needs to be a tiered response. Sometimes is a simple ADHD diagnosis; sometimes it's a more complex diagnosis as part of a wider set. May not always require all the tools and don't need to be over-complicated for some situations. Would be helpful to get clear on the 'who' for carrying out diagnosis, as starting point depending on complexity. We need to be clear around the different levels of expertise for different scenarios. Will need to be some compromises about who is acceptable to diagnose. It's the time and expertise we're looking to get clear on. Need experience (rather than a title/specific role) with ADHD but difficult to know how to standardise this.

<table>
<tr><th>Item</th><th>Commentary</th></tr>
<tr><td></td><td>Already working in a model where General Practice is to diagnose and then refer. ADHD should not be different from the many other conditions that fall into this model.

ADHD not uni-dimensional and cannot be an ADHD-only service as needs to include co-morbidities.

Audit tool exists and could be integrated to assess rigor of practice. An 'audit' tool for qualifications/experience. Something clients could refer to as well as professionals - "does this person have the knowledge/skills."

Need agreement on people who have “assessment and diagnosis” training, and then can do additional training in ADHD. Need enough training to be able to tell the difference between ADHD and reactive attachment etc. Also need education of public on who is available to make these assessments.

Psychology Board is currently involved in a big discussion. Issue is trying to prove the harm of diagnosis, different from other conditions. The Board struggles with this. It’s not ‘apples for apples’. This is where clear guideline will be of benefit.

Agree we need a baseline for training. Some people do not currently get the training that will enable a correct diagnosis of ADHD.</td></tr>
<tr><td>4</td><td>Proposed framework for principles

Presentation of draft table – Consensus on clinical principles of ADHD care.

Support for the structure of the table, different co-morbid conditions present at different ages.

Developing table can be an iterative process, can send out questions and group can send back comments.

Further testing of the table can be done with HNZ and other providers.

Should include other agencies – education, Whaikaha etc (Neurodiversity cross-agency working group formed).

Having a direct connection to both justice/corrections and AOD areas is pretty essential giving inequity of treatment.

One additional element that might 'localise' international guidelines to the NZ context is setting out some 'organisational principles' alongside the clinical principles - such as touched on in the comments about the role of the education sector, or what might be reasonable to expect of PHO funded services, etc.

<table>
<tr><th></th><th>Assessment/Diagnosis</th><th>Treatment/management</th><th>Quality and safety</th></tr>
<tr><td>Children</td><td></td><td></td><td></td></tr>
<tr><td>Young people</td><td></td><td></td><td></td></tr>
<tr><td>Adults</td><td>Where someone has a depression that’s not resolving/treatment</td><td>Four step approach to management. Facilitated self-education for patients. Having</td><td></td></tr>
</table>
</td></tr>
</table>

Item	Commentary				
		resistance, should be considered (particularly in a Kaupapa Māori space). Most helpful, to tap into whether there were clear indications of ADHD in childhood? Seminar a couple of years ago talked about adult-onset ADHD. Huge rates of co-morbidities. These can give ADHD symptoms. Need to have a tool/approach that screens for all of these in a diagnosis. Discussion on adult onset ADHD vs. undiagnosed/treated ADHD in childhood. Would want symptoms to be pervasive across time; and co morbidity is key, as it is common for other conditions to be present. Also need to consider right treatment for these conditions in conjunction with ADHD. In private practice, you write up a large diagnosis. You begin to see patterns. Quality of the bare minimum. Who could do this? Acknowledge that GPs have the longitudinal and contextual knowledge of their patients and their information is very important when diagnosing. Particularly of co morbidities. Consider inclusion of Occupational Therapists and Social Workers doing ADHD assessments.	the tools to manage the challenging bits; coaching (less available here). Lifestyle has an important role – active lifestyle. Sleeping well. Diet high in Omega-3. Access to therapeutic intervention – psychological interventions, CBT, mindfulness practice. Pharmaceuticals; where mild to moderate, people may choose not be use medication and manage with other tools. Pointed out CBT and mindfulness tools are not available around the country. There are a growing number of ADHD coaches; an area of workforce that could be developed. Just need to be sure each discipline is regulated and under a NZ professional body - especially ADHD Coaches as this is so new in NZ. Do not want to be limited by what people can get access to (currently). Need to have aspirations to best clinical practice based on evidence (Aus and NICE guidelines). If indicated, it can allow people to advocate for the treatments. Psychological therapies are recommended first line treatments. How much should people stay in their lane when commenting on the document (e.g. psychiatrists commenting on an education)? Overall contributions/thoughts are welcomed and these can then be tested with people in the relevant field. For children and young people education supports need to be	

<table>
<tr><th>Item</th><th>Commentary</th></tr>
<tr><td></td><td>
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<tr><td></td><td></td><td>considered part of the management plan.

Peer support is such a beneficial model. The idea of being forward-thinking and building in lived experience.</td><td></td></tr>
</table>
</td></tr>
<tr><td>5</td><td>Terms of reference and project charter

Updated TOR and project charter based on feedback and will recirculate for people to check.

Action: Recirculate TOR and project charter (Ministry of Health)

Is it worthwhile for the professional groups (eg, Psychologists and Nurses) having some internal discussions ahead of further work? It might be worth doing this in parallel, but need to keep a focus on what needs to be done for the patients and family. Drafting up a short communication that can be shared by participants with their wider groups.

Action: To draft up a communication that people can share with their networks. Can do a more formal consultation later. (Ministry of Health)</td></tr>
<tr><td>6</td><td>Next meeting: 30 Oct 2024, 3pm (1 hour) online, already pre-booked in calendars.

Looking for any contacts people can provide to engage with Māori perspectives prior to the next meeting. Additionally, any contacts for ways of working with ADHD in different areas of NZ to increase understanding of current state and exemplars to highlight.

We will share the table template on assessment and diagnosis for the different age ranges. Further thinking will be undertaken to pre-populate the table with current recommendations from the Australasian guidelines, there may be some headings and key principles that can be used from the guidelines to stimulate discussion on application to a NZ context.

Action: Share table template with the group for feedback (Ministry of Health)</td></tr>
<tr><td colspan="2"></td></tr>
</table>

From: s9(2)(a) >
Sent: Thursday, 24 October 2024 2:16 pm
To: Garth Smith [Nelson Marlborough]; Kieran Moorhead; Tim Jelleyman; s9(2)(a) ; Sam Hargreaves (CMDHB); s9(2)(a) ; David Hughes; david.codyre@tamakihealth.co.nz; Dr Luke Bradford; s9(2)(a) @rnzcgp.org.nz; Angus Maxwell NZCCP; Hiran Thabrew; Murray Patton; Karla Bergquist; Young Neurodiversity Champions; David Chinn [CCDHB]; s9(2)(a)
Cc: s9(2)(a) Cookson; Zoe Royden; Anya Stephenson; Leeanne.Fisher@TeWhatuOra.govt.nz; Michael Woodside
Subject: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

Cheers s9(2)(a) ,

Leave it with me and I'll figure out what's paid and what's free. As a starter, I know that the ACEv and the ACE+ are freely available from Susan Young's website. Susan did some training on them in Auckland recently, through the NZCCP.

s9(2)(a)

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s9(2)(a)
Sent: Thursday, October 24, 2024 2:04 PM
To: Paul Skirrow <paul.skirrow@otago.ac.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; david.codyre@tamakihealth.co.nz; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Karla Bergquist <Karla.Bergquist@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; s9(2)(a) @psyched.org.nz>
Cc: s9(2)(a) @transport.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; Michael Woodside <Michael.Woodside@health.govt.nz>
Subject: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

Kia ora s9(2

That is a lot of work and an excellent summary, thank you.

Do you have a sense of the tools and resources mentioned that are free to use? That would be good to consider, as they are more likely to be adopted if there is no extra cost involved.

Nga mihi

s9(2)(a)

s9(2)(a)

Sent: Wednesday, 23 October 2024 2:50 PM

To: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; david.codyre@tamakihealth.co.nz; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Karla Bergquist <Karla.Bergquist@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith <Garth.Smith@nmdhb.govt.nz>; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; s9(2)(a) @psyched.org.nz>

Cc: Suzanne Cookson <S.Cookson2@transport.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; Michael Woodside <Michael.Woodside@health.govt.nz>

Subject: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

> You don't often get email from paul.skirrow@otago.ac.nz. Learn why this is important

Kia ora Kieran,

Thanks for this summary. After our meeting, I was thinking that there must already be some 'core standards' for ADHD diagnostic assessment that might give us a good place to start.

So, I took some time to an analyse/synthesise the recommendations from 6 of (arguably) the most recent/influential guideline documents that I'm aware of:

- The Australian ADHD Professional Association (AADPA, 2022),
- The UK National Institute for Health and Clinical Excellence (NICE, 2018)

- The American Academy of Pediatrics (2019)
- The Royal College of Psychiatrists in Scotland (2023)
- The Canadian ADHD Resource Alliance (CADDRA, 2020)
- The West Virginia Department of Health (2024).

There were some commonalities in both recommendations for minimum standards, as well as 'good practice' recommendations. I took the time to also include some of the recommended assessment tools that are common across several of the guidelines, although it's quite a long list of tools that 'could be' useful so this is by no means exhaustive.

I've attached the summary. Just to be clear, I'm not suggesting that I (or the NZCCP as a whole) 100% agree with these recommendations, nor am I suggesting that they cover everything, but hopefully it will give us a good start on defining what might be the 'minimum standards' that a person could expect from their assessor? We can, of course, improve them/adapt them to our own context but we know that these are the general standards internationally.

Thanks to the other members of the group (and some psychology and psychiatry colleagues in Wellington) who had a look at previous versions.

I hope that's helpful.

Ngā mihi mahana,

s9(2)(a)

From: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Sent: Wednesday, October 23, 2024 11:33 AM
To: Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; david.codyre@tamakihealth.co.nz; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Karla Bergquist <Karla.Bergquist@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; s9(2)(a) @psyched.org.nz>
Cc: s9(2)(a) @transport.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; Michael Woodside <Michael.Woodside@health.govt.nz>
Subject: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

Kia ora koutou

Thanks for the hui last week, great to have everyone's support progressing this important kaupapa! Short update on our recent actions:

- We met with the authors of the AADPA guidelines on Monday (Mark Bellgrove and David Coghill) to talk about our project and to get their thoughts on the key principles to carry over from the AADPA guidelines into our ADHD consensus document. You will be able to see these in the updated table template we send through later in the week.
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- Meeting with Māori ADHD experts later this week on some initial thoughts for including a Māori conceptualisation of ADHD within the consensus document.

Minutes from our initial hui are attached to this email. Feel free to send me through any edits/additions. We are working on the actions from the meeting and will aim to have them completed by next week's hui. Prioritising sharing a pre-populated template with the group so there is time to have a look before the next hui.

Action: *Recirculate TOR and project charter (Ministry of Health)*

Action: *To draft up a communication that people can share with their networks. Can do a more formal consultation later. (Ministry of Health)*

Action: *Share table template with the group for feedback (Ministry of Health)*

Next meeting: 30 Oct 2024, 3pm (1 hour) online, already pre-booked in calendars.

Kieran Moorhead (he/him)
Senior Policy Analyst
Mental Health and Addiction Strategy and Policy
Clinical, Community and Mental Health
s9(2)(a) | +64 4 496 2000
kieran.moorhead@health.govt.nz
Manatū Hauora, 133 Molesworth Street Thorndon, Wellington 6011

MANATŪ HAUORA
MINISTRY OF HEALTH

-----Original Appointment-----
From: Kieran Moorhead
Sent: Wednesday, October 2, 2024 8:20 AM
To: Kieran Moorhead; Tim Jelleyman; s9(2)(a) ; Sam Hargreaves (CMDHB); s9(2)(a) ; David Hughes; david.codyre@tamakihealth.co.nz; Dr Luke Bradford; s9(2)(a) @rnzcgp.org.nz; Paul Skirrow; Angus Maxwell NZCCP; Hiran Thabrew; Murray Patton; Karla Bergquist; Young Neurodiversity Champions; Garth Smith [Nelson Marlborough]; David Chinn [CCDHB]; s9(2)(
Cc: s9(2)(a) Zoe Royden; Anya Stephenson; Leeanne.Fisher@TeWhatuOra.govt.nz
Subject: NZ ADHD consensus doc - initial hui
When: Wednesday, 16 October 2024 3:00 pm-4:30 pm (UTC+12:00) Auckland, Wellington.
Where: Microsoft Teams Meeting

Added in Agenda and themes from the pre-meets
Updating to Wednesday 16 October

Agenda:

1. Karakia and introductions.	Kieran (15 min)
2. Overview – brief context, aim and project plan.	Tim (10 min)

3. Summary of themes so far – invite further responses.	Kieran (20 min)
4. Proposed framework for principles – invite discussion.	Tim (30 min) – aim to start delegate components of the work.
5. Confirm ToR and project charter.	Tim (5 min)
6. Discussion on ways to include Māori and equity perspectives going forward.	Kieran (10 min)

Kia ora koutou

Thanks for your interest in participating in the development of a NZ ADHD consensus document. We have scheduled pre-meets with the majority of people who are involved in ADHD mahi so far – we will share a summary of the themes ahead of the first meeting.

If you haven't organised a catch up with Tim and I, then please get in touch with us and we can book some time in.

Pencilling this date/time for our initial meeting, we can discuss timing and frequency for subsequent meetings. Let me know if this does not work for you - we could also look at Wednesday 16 October 2024 as an alternative.

Will send through an agenda and updated TOR/project plan closer to the date.

Thanks again, we look forward to seeing you!

Microsoft Teams Need help?

s9(2)(k)

From: s9(2)(a)
Sent: Wednesday, 30 October 2024 1:08 pm
To: Kieran Moorhead; Tim Jelleyman
Subject: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

Great, thanks Kieran and Tim

From: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Sent: Wednesday, 30 October 2024 12:48 PM
To: Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; s9(2)(a) >
Subject: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

External email - take care with links and attachments

Yep all good have sent the invite 😊

Kieran Moorhead (he/him)
Senior Policy Analyst
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Clinical, Community and Mental Health
+64 4 496 2000
kieran.moorhead@health.govt.nz
Manatū Hauora, 133 Molesworth Street Thorndon, Wellington 6011

From: Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>
Sent: Wednesday, October 30, 2024 11:55 AM
To: s9(2)(a) >; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Subject: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

Thanks s9(2)
(

Kieran, I am happy with the invitation being extended if all ok with you also.

Tim.

Dr Tim Jelleyman
Clinical Chief Advisor, Child and Youth Health
Nga Apiha Hauora : Office of Chief Clinical Officers
s9(2)(a)
timothy.jelleyman@health.govt.nz
Manatu Hauora, 133 Molesworth Street Thorndon, Wellington 6011
Auckland based. Regular MoH days: Mon – Wed;
Clinical days at Waitemata : Thurs, Fri.
Text me if your email needs priority attention.

From: s 9(2)(a)
Sent: Wednesday, October 30, 2024 11:52 AM
To: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Cc: Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>
Subject: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

Thanks Kieran and Tim

Kyra's email address is Kyra.Sycamore@cdhb.health.nz – I know she'd be interested in participating today in fact, if that might be a possibility? She's well informed re ADHD in NZ and would I think provide advice from an important sector.

Thanks for being open to this.

Best regards

s9(2)
(a)

From: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Sent: Wednesday, 30 October 2024 10:12 AM
To: s 9(2)(a)
Cc: Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>
Subject: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

External email - take care with links and attachments

Thanks s9(2) (a) for your feedback! I have started putting together the ADHD principles table and have shared it with the group ahead of today's hui to discuss and check we are going in the right direction.

I am open to Kyra being included in the group from a pharmacist perspective, Tim might have some thoughts too but send me her details and I could send her an email regarding a future hui in 3 weeks.

Cheers

Kieran Moorhead (he/him)
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Clinical, Community and Mental Health
+64 4 496 2000
kieran.moorhead@health.govt.nz
Manatū Hauora, 133 Molesworth Street Thorndon, Wellington 6011

From: s9(2)(a) >
Sent: Tuesday, October 29, 2024 5:13 PM
To: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Subject: RE: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

Hi Kieran

Thanks for this, and all the work you and Tim have completed to this point on this mammoth undertaking.
Some thoughts up to here:

- Are we planning to involve a clinical pharmacist? This would appear to be an important omission, and if it is possible to include one that would seem to fill a gap. s 9(2)(a) with Kyra Sycamore, and if she was available and keen I think she'd be an excellent addition to this group.
- Regarding the table you circulated, I have the following thoughts:
    - I wonder about collapsing the child and youth areas into one part – the Ax and Rx will be so similar I'm not sure if we need too discrete areas.
    - Regarding diagnosing ADHD I think they document that Paul Skirrow circulated had an excellent summation of the major international guidelines, and if we could pool the main thoughts from there that would help us to go a long way
    - In brief, the AADPA guidelines give a series of competencies that should be met in order for a clinician to be Ax for ADHD. They should be
        - Appropriately registered
        - Adequately trained in diagnostic Ax using the DSM or ICD
        - Experienced with conducting clinical interviews, administering and interpreting rating scales and Ax of functional impairment
        - Experienced in ADHD diagnostic Ax or undergoing ADHD-specific supervision with an experienced clinician
    - Importantly the AADPA (and other major guidelines) give primacy to the clinical interview as the chief diagnostic tool, and give domains that should be covered in this assessment. They estimate this taking 2-3 hours, often over several sessions – and although in practice some clinicians do this in less time, I do not think that should stop us from advocating for this amount of care and attention in our document.
    - I like the emphasis that the AADPA give in relation to pharmacological and non-pharmacological approaches having different treatment targets – for symptom reduction versus improved functioning and wellbeing respectively – and as such can be complementary. Stressing the potential gains of non-medication treatments will be important in this document too – as they are all too frequently insufficiently available.

Thanks again for your work on this – much appreciated

Best regards

s9(2)

From: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Sent: Wednesday, 23 October 2024 11:33 AM
To: Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; david.codyre@tamakihealth.co.nz; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Karla Bergquist <Karla.Bergquist@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith <garth.smith@nmdhb.govt.nz>; David Chinn [CCDHB]

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Subject: Minutes from initial ADHD hui RE: NZ ADHD consensus doc - initial hui

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Kia ora koutou

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Senior Policy Analyst
Mental Health and Addiction Strategy and Policy
Clinical, Community and Mental Health
s9(2)(a) | +64 4 496 2000
kieran.moorhead@health.govt.nz
Manatū Hauora, 133 Molesworth Street Thorndon, Wellington 6011

-----Original Appointment-----
From: Kieran Moorhead
Sent: Wednesday, October 2, 2024 8:20 AM
To: Kieran Moorhead; Tim Jelleyman; s9(2)(a) ; Sam Hargreaves (CMDHB); s9(2)(a) ; David Hughes; david.codyre@tamakihealth.co.nz; Dr Luke Bradford; s9(2)(a) @rnzcgp.org.nz; Paul Skirrow; Angus Maxwell NZCCP; Hiran Thabrew; Murray Patton; Karla Bergquist; Young Neurodiversity Champions; Garth Smith [Nelson

Marlborough]; David Chinn [CCDHB]; s9(2)
Cc: s9(2)(a) ; Zoe Royden; Anya Stephenson; Leeanne.Fisher@TeWhatuOra.govt.nz
Subject: NZ ADHD consensus doc - initial hui
When: Wednesday, 16 October 2024 3:00 pm-4:30 pm (UTC+12:00) Auckland, Wellington.
Where: Microsoft Teams Meeting

Added in Agenda and themes from the pre-meets
Updating to Wednesday 16 October

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Thanks again, we look forward to seeing you!

Microsoft Teams Need help?

s9(2)(k)

NZ ADHD Consensus document second hui minutes	
Date:	30 October 2024
Location:	Online (via Teams)
Chair:	Kieran Moorhead, Tim Jelleyman
In attendance:	Kieran Moorhead, Ministry of Health; Tim Jelleyman, Ministry of Health; s9(2)(a), Just a Thought ; David Hughes, Pharmac; David Codyre, Tamaki Health; Dr Luke Bradford, RNZCGP; Paul Skirrow, Otago University; Angus Maxwell NZCCP; Hiran Thabrew, Auckland University; Murray Patton, Health NZ; Garth Smith, Health NZ; David Chinn, Health NZ; s9(2)(a), ADHD NZ; s9(2)(a), Young Neurodiversity Champions; Anya Stephenson, Ministry of Health; Justine Lancaster, Health NZ; Kyra Sycamore, Health NZ.
Apologies:	Sam Hargreaves, s9(2)(a)

Item	Commentary
1	Karakia / introductions / reflections
2	General agreement with overall structure of the general principles. Various comments and thoughts on the details to be discussed. **Overall feeling that for the principles we should avoid getting really specific and point to guidance without being too prescriptive – and include a focus on quality control and audit. Need to take into account the resource constraints we have.** Getting the minimum standards right, prescriptive/directive where needed and then providing guidance on recommended practice from there. **Additional general principles to include:** Responsiveness and inclusion of tangata whenua and cultural considerations and embedding a multi-disciplinary approach. Cultural considerations need to include pacific people perspective, and in particular young Pacific females who are under-represented in ADHD diagnosis. Other important principles are approaches to screening and in particular across sectors eg, including Department of Corrections (adult/child) – this could sit in an organisational principles section which could have a focus on implementation. **Possible constraints:** It's great to see an MDT approach as a best practice, but with adults particularly it will be harder to meet this in all cases if it became a minimum standard. Workforce restraints at every level of the age-specific principles, both minimum standards and best practice. There may be additional minimum standards where there is known complexity, e.g. significant learning disabilities, developmental delay etc.

Item	Commentary
	Comprehensiveness, multi-disciplinary team, and timeframe for an ADHD assessment and diagnosis: Consider removing some of the info around specific specialties and emphasise the training and supervision element and including a whānau centred approach. Having a scope around diagnosis firstly, and then training to be able to specifically diagnose ADHD and rule out other differential conditions. **Time to get to know child is also important in diagnosis.** **Include something around the base training and scope of the clinician, i.e. training in diagnostic assessment (counselling psychologist would not have this but clinical psychologist would).** Multi-disciplinary is really just about the person not acting on their own - seeking advice/supervision/consultation with others - and considering other aspects. It doesn't necessarily mean having multiple clinicians physically seeing the person. AADPA does cover that complexity as an option to increase to multidisciplinary assessment when needed. **The time frame for assessment is important** and the overall complexity of assessment, what you cover, and the thoroughness can impact the length of assessment considerably. 2-3hours may be long for an assessment and plan. Particularly in terms of costs, resources etc. It could **create a barrier. Best practice recommendation could include access to talking therapies and time to talk through diagnosis for supportive self-management.** It can be possible to diagnose ADHD in a 90-minute assessment where other collateral info has been collected prior. 'Time' for assessment doesn't necessarily have to be just the interview/time in the room with the person, it could include school observations, discussions with others, reading background notes. Some examples: one **adult experience was with 1 hour online assessment vs a child with 3-4hr wraparound report and thorough recommendations.** There is a huge difference in quality of assessments out there across both the private and public sectors. **Australian guideline has a good section on training and assessment requirements – does not require MDT and does not require a certain time and is more realistic.** **Presence of symptoms in childhood:** Evidence of symptoms in childhood important and should be included in general principles. Rating scales already provided prior to appointments. Challenge is whether symptoms are recognised in childhood. Often first diagnosed in adulthood, but seldom onset first in adulthood.

Item	Commentary
	ADHD can follow head injury (ADHD-like syndrome, not strictly ADHD) but usually present in early childhood. Children can get missed until adulthood and can include intelligent children with good grades. Later on, the impact of adult responsibilities can really make masked symptoms come through. **Future work and implementation considerations:** ADHD NZ keen to check that all stakeholders can be included in any system/organisational principles (MSD, education sector, justice and corrections, OT and wider healthcare system). The principles will also be helpful for people to know what to expect and what good looks like. This process is as much about building trust as well as increasing quality both within our sector and confidence for the public. We've got to also be aware that professional bodies will have a role in monitoring 'compliance' with any best practice guidelines we deliver. This work is broader than helping Health NZ do its work. The issue from my perspective is what each part of a health system can/should contribute - to ensure the most efficient use of the stretched resources we are working with. This work may help reduce cost for ADHD assessment in NZ. I suggest reflecting back to the AADPA guideline for minimum standards and expectations. This does limit mandating huge prices. We must keep it real - resourcing /workforce capacity are major barriers to successful implementation of any consensus guidance. How do we as a group have a role in advocating strongly for implementation + funding support for this mahi to be done safely/equitably? Resource: ADHD Prescribing Guide For Australian Healthcare Professionals https://aadpa.com.au/product/adhd-medication-prescribing-guide/ **Next steps:** Discussion on taking this work back to respective professional bodies to identify minimum standards across the age groups and come back to the wider group to report back on what consensus within each professional body could look like. Opportunity to provide a communication for people to take to their networks to inform them of what is happening and socialise this early. Members of the group will continue to work on the principles ahead of the next meeting.

From: s9(2)(a) >
Sent: Thursday, 14 November 2024 8:18 am
To: Kieran Moorhead; Paul Skirrow; Sarah Watson; s9(2)(a) ; Dr Luke Bradford; Dr David Codyre; Tim Jelleyman; Anya Stephenson; Sam Hargreaves (CMDHB); s9(2)(a) David Hughes; s9(2)(a) Angus Maxwell NZCCP; Hiran Thabrew; Murray Patton; Young Neurodiversity Champions; Garth Smith [Nelson Marlborough]; Kyra Sycamore [Waitaha]
Cc: Zoe Royden; Justine Lancaster; s9(2)(a) ; Leeanne.Fisher@TeWhatuOra.govt.nz; Timothy Jelleyman (WDHB)
Subject: RE: Minutes and updated principles template RE: NZ ADHD consensus doc - second hui
Attachments: Draft ADHD proposed principles framework template - RANZCP feedback.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Thanks for all your work on this Kieran

As a psychiatry group David, Hiran and I have linked in with other child and adult colleagues and have adjusted the most recent edition of the template with the edits as attached

Best regards

s9(2)
(a)

From: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Sent: Tuesday, 12 November 2024 2:38 PM
To: David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Paul Skirrow <paul.skirrow@otago.ac.nz>; s9(2)(a) @psyched.org.nz>; s9(2)(a) @justathought.co.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; Dr David Codyre <david.codyre@tamakihealth.co.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; s9(2)(a) @rnzcgp.org.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith <garth.smith@nmdhb.govt.nz>; Kyra Sycamore [Waitaha] <Kyra.Sycamore@cdhb.health.nz>
Cc: Zoe Royden <Zoe.Royden@health.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>
Subject: Minutes and updated principles template RE: NZ ADHD consensus doc - second hui

External email - take care with links and attachments

Kia ora koutou

Apologies for slow response with minutes and an updated ADHD principles template, I was out all last week supporting family with sickness!

Attached are the minutes from the hui – I have also started incorporating some of the key points along with s9(2)(a) edits into the updated ADHD principles template also attached.

I know Anna and Sam have already started pulling together some thinking from NP/GP perspective for minimum/best practice standards for assessing ADHD in primary care and it looks great. We will hopefully be able to discuss it at our next hui.

I appreciate any further feedback on the template - feel free to make comments and send it through to the group.

@Angus Maxwell NZCCP @Paul Skirrow – Let me know if there's anything you need to support a discussion with the wider clinical psychologists group.

Thanks heaps!

Kieran Moorhead (he/him)
Senior Policy Analyst
Mental Health and Addiction Strategy and Policy
Clinical, Community and Mental Health
+64 4 496 2000
kieran.moorhead@health.govt.nz
Manatū Hauora, 133 Molesworth Street Thorndon, Wellington 6011

From: s9(2)(a) >
Sent: Monday, November 4, 2024 12:26 PM
To: Paul Skirrow <paul.skirrow@otago.ac.nz>; s9(2)(a) @psyched.org.nz>; s9(2)(a) @justathought.co.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; Dr David Codyre <david.codyre@tamakihealth.co.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; s9(2)(a) @rnzcgp.org.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>
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Subject: RE: NZ ADHD consensus doc - second hui

Thanks all
I've made some further edits to the document to this point – I've edited the general principles part so far, and am yet to tackle the table beneath, although I think this is where we can be more prescriptive about particular non-pharmacological approaches as they will vary by age/developmental stage.
I agree with your thoughts re AADPA guidelines Paul, and I think it's reasonable to be explicit about these expectations in this document – and there may be further discussion about the exact application of these! I think having a capacity rather than profession based approach to diagnosis makes sense, although we'd need to think about how to operationalise this.
I was an advocate for specifying the duration of time for assessment, but understand other's concerns re this too. I think an alternative is being clear about the domains to be covered in a clinical Ax, so I've listed them there (again, from the helpful synopsis from Paul).
Again, like Sarah, just wanted to echo how useful this group and discussion are.
All the best
s9(2)
(

From: s9(2)(a)
Sent: Monday, 4 November 2024 11:13 AM
To: s9(2)(a) @psyched.org.nz>; s9(2)(a) @justathought.co.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; Dr David Codyre <david.codyre@tamakihealth.co.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; s9(2)(a) @rnzcgp.org.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith <garth.smith@nmdhb.govt.nz>
Cc: Zoe Royden <Zoe.Royden@health.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>
Subject: RE: NZ ADHD consensus doc - second hui

External email - take care with links and attachments

Thanks all.

For qualifications, I wondered about this quote from the AADPA guidelines (S2.1.1):

Clinicians conducting diagnostic assessments should be:

- *appropriately registered*
- *adequately trained in diagnostic assessment using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or International Classification of Diseases (ICD)*
- *experienced with conducting clinical interviews, administering and interpreting standardised rating scales, and assessment of functional impairment*
- *experienced in ADHD diagnostic assessment or undergoing ADHD-specific supervision with an experienced clinician."*

I'd prefer some more parameters around what 'adequately trained' in DSM/ICD might mean though!

Cheers,

s9(2)(a)

From: s9(2)(a) @psyched.org.nz>
Sent: Friday, November 1, 2024 11:36 AM
To: s9(2)(a) @justathought.co.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; Dr David Codyre <david.codyre@tamakihealth.co.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; Sam Hargreaves

(CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; s9(2)(a) @rnzcgp.org.nz>; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>
Cc: Zoe Royden <Zoe.Royden@health.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>
Subject: Re: NZ ADHD consensus doc - second hui

Agreed s9(2) .

My two cents:

I would think that should also go for Clinical Psychologists too. Having too binary an approach (e.g., specialist vs non-specialist with training) may run the risk of reproducing a "medical doctor" vs "allied health" type divide that historically doesn't reflect the varying professions specialities or skills.

That notwithstanding, agreed having a clear escalation process to a specialist (especially around any complex mental health/medical differentials) is important. For example, as an MDT team we have assessed a number of children with coexisting medical conditions that our medical staff have contributed so much knowledge to, and vice versa with Psychologists around young ones with complex psychological/mental health issues that need more in-depth understanding/formulation, especially around discerning trauma, attachment anxieties, dissociative disorders, ASD vs ADHD.

So loving this discussion!

Ngā mihi / Kind regards,

s9(2)(a)

Totally Psyched

From: s9(2)(a) @justathought.co.nz>
Sent: Thursday, October 31, 2024 9:08 PM
To: Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; Dr David Codyre <david.codyre@tamakihealth.co.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; s9(2)(a) s9(2)(a) @rnzcgp.org.nz>; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson

Marlborough] <Garth.Smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>
Cc: Zoe Royden <Zoe.Royden@health.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz <Leeanne.Fisher@TeWhatuOra.govt.nz>; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>
Subject: Re: NZ ADHD consensus doc - second hui

Just a short but important two cents from me. We need to be clear that we don't lump all NPs together as non-specialists for the sake of any guidelines or documents we produce as that would be misleading.

Will take a look soon but thanks s9(2)(a) for the starter.

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From: s9(2)(a) >
Sent: Thursday, October 31, 2024 12:05:41 pm
To: Dr David Codyre <david.codyre@tamakihealth.co.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; s9(2)(a) @rnzcgp.org.nz>; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>
Cc: Zoe Royden <Zoe.Royden@health.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz <Leeanne.Fisher@TeWhatuOra.govt.nz>; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>
Subject: RE: NZ ADHD consensus doc - second hui

CAUTION: This email originated from outside of the organisation.

Yes, but that our Colleges and registration already require us to be clear on when escalation is necessary, we just need to state as a principle that this will happen in the case of ADHD also

s9(2)(a)

From: s9(2)(a)
Sent: Thursday, 31 October 2024 11:58 am
To: Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; Anya

Stephenson <Anya.Stephenson@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; s9(2)(a) @rnzcgp.org.nz>; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>
Cc: Zoe Royden <Zoe.Royden@health.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>
Subject: RE: NZ ADHD consensus doc - second hui

Thanks s9(2)(– and yes agree totally that it will be important and helpful to include – in essence I think you are saying to broadly define a scope for the "non-specialist" practitioners with training, and escalation processes to a "specialist"??

From: s9(2)(a) >
Sent: Thursday, 31 October 2024 11:15 AM
To: Dr David Codyre <david.codyre@tamakihealth.co.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; s9(2)(a) @rnzcgp.org.nz>; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>
Cc: Zoe Royden <Zoe.Royden@health.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>
Subject: RE: NZ ADHD consensus doc - second hui

Thank you s9(2)(. I think these are really helpful edits.

I would like to have added principles around escalation and collaboration in areas of complexity or uncertainty. This recognises the fashion in which GPs and NPs work across all specialties ie managing that within their training and ability and referring and coordinating for those that need it. It likely fits in both young persons and adults

s9(2)(a)

From: s9(2)(a)
Sent: Wednesday, 30 October 2024 4:01 pm
To: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz>; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>
Cc: Zoe Royden <Zoe.Royden@health.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>
Subject: RE: NZ ADHD consensus doc - second hui

Edits from me as a starter for five.

Happy to contribute further Kieran

Crafting to link to AADPA g/line and inserting hyperlinks to the related sections would be helpful, so we can have a succinct helpful guideline BUT strong connection to the bigger “mothership” guideline.

Ngā mihi,

s9(2)(a)

s9(2)(a) [redacted]

From: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Sent: Wednesday, October 30, 2024 10:09 AM
To: Tim Jelleyman <Timothy.Jelleyman@health.govt.nz>; Anya Stephenson <Anya.Stephenson@health.govt.nz>; s9(2)(a) [redacted] @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) [redacted] @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; Dr David Codyre <david.codyre@tamakihealth.co.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) [redacted] @rnzcgp.org.nz; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>; s9(2)(a) [redacted] @psyched.org.nz>
Cc: Zoe Royden <Zoe.Royden@health.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; s9(2)(a) [redacted] transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>
Subject: NZ ADHD consensus doc - second hui

Kia ora koutou

Firstly, apologies for the lateness in sending out the draft ADHD principles template, some competing demands and the long weekend got in the way!

We have had a go at populating the table with some initial thoughts based on our first hui and the existing guidelines and documents. We will go through this at today's hui to get your feedback and steer on the overall direction so far.

I have re-attached the previous minutes, and the draft ADHD principles template, and a rough agenda is below. Will see you this afternoon.

Agenda for 30.10.24

Open meeting – karakia, welcome/apologies • Update from last meeting/minutes/actions etc.	Kieran
Work on the principles • Indicative template • Initial content • General and age-specific principles	Tim
Plan for further work over next three weeks Close meeting	Kieran

Thanks!

Kieran Moorhead (he/him)
Senior Policy Analyst
Mental Health and Addiction Strategy and Policy
Clinical, Community and Mental Health
+64 4 496 2000
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Manatū Hauora, 133 Molesworth Street Thorndon, Wellington 6011

s9(2)(a)
Clinical Lead

M: s9(2)(a)
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NZ ADHD Consensus document second hui minutes	
Date:	20 November 2024
Location:	Online (via Teams)
Chair:	Kieran Moorhead, Anna Skinner
In attendance:	Kieran Moorhead, Ministry of Health; Tim Jellevman, Ministry of Health; Anna Skinner, Ministry of Health; Zoe Royden, Ministry of Health; s9(2)(a), Just a Thought ; Eric Matthews, Pharmac; Robyn Harris, Pharmac; Rubashnee Naidoo, Health NZ; Jenae Valk, Health NZ; Dianne Davis, Health NZ; David Chinn, Health NZ; s9(2)(a), ADHD NZ; s9(2)(a), Young Neurodiversity Champions;. Sam Hargreaves, Health NZ; s9(2)(a), Totally Psyched
Apologies:	Dr Luke Bradford, RNZCGP; Paul Skirrow, Otago University; Angus Maxwell NZCCP; Hiran Thabrew, Auckland University; Murray Patton, Health NZ; Garth Smith, Health NZ; David Codyre, Tamaki Health; Anya Stephenson, Ministry of Health; Justine Lancaster, Health NZ; Kyra Sycamore, Health NZ

Item	Commentary
1	Karakia / introductions / reflections
2	Update from NPs that there is support from a wider group of NPs for the ADHD principles. Update from GPs that the principles are sitting well with a wider group of GPs too. Opportunity to do further consultation more widely with professional groups on the principles once the final draft is completed. There may be an engagement phase with additional stakeholders to consult with. General agreement from the group on the ADHD principles and the next step will be to update the formatting and circulate them as a final draft. Discussion and agreement on including a stronger cultural perspective and in particular the views of ADHD for Māori and Pacific. **Pharmac provided an update on changes to stimulant medications – removal of requirement for two yearly special authority renewal once the initial special authority is obtained, and funding of a new medicine lisdexamfetamine. These changes are expected to come into effect from 1 December 2024.** **Discussion on communicating these changes to the workforces who are involved in prescribing ADHD medications. This includes training through Goodfellow, and other opportunities to put out updates through newsletters/publications.** **Healthpathways is being updated for the Auckland/Northland region to include the new changes to ADHD special authority renewal requirements. Opportunity to align the ADHD principles with the Healthpathways guidance with the aim of providing high quality guidance and support for the health workforce who are supporting people with ADHD.** **There is general consensus that Healthpathways guidance, and the work on the ADHD principles need to tie into any changes for prescribing of ADHD medication. This includes upcoming work by Pharmac and Medsafe to consult on expanding the workforces who can initiate prescribing of stimulant medications for ADHD.**

Item	Commentary
	Agreement to have a final meeting of the ADHD Clinical Reference Group in December for any who can make it. **Next steps:** Final meeting to be put into people's calendars for early-mid December. Final draft of the ADHD principles to be shared with the group before the meeting. Healthpathways have asked to speak to the updated ADHD pathway at the next meeting.

From: s9(2)(a)
Sent: Friday, 29 November 2024 2:13 pm
To: Dr David Codyre; Kieran Moorhead; s9(2)(a) ; Sam Hargreaves (CMDHB); s9(2)(a) ; David Hughes; Dr Luke Bradford; s9(2)(a) @rnzcgp.org.nz; Angus Maxwell NZCCP; Hiran Thabrew; Young Neurodiversity Champions; Garth Smith [Nelson Marlborough]; s9(2)(a)
Cc: Anya Stephenson; Timothy Jelleyman (WDHB); Justine Lancaster; Murray Patton; Zoe Royden; s9(2)(a) Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB]; Justine Lancaster; Jenae Valk (NDHB); Rubashnee Naidoo (CMDHB); Kyra Sycamore [Waitaha]; Anna Skinner; Robyn Harris; Dianne Davis (NDHB); Eric Matthews; Robyn Harris
Subject: RE: Minutes from third ADHD hui RE: NZ ADHD consensus doc - third hui

Thanks s9(2) ,

That's really helpful feedback. I've had some other good suggestions from other members of the group. I'll have the opportunity to make some changes when it comes back from reviewers. I should probably have put in an acknowledgement of this group already, so I'll make sure that goes in as well.

Best wishes,

s9(2)(a)

From: s9(2)(a)
Sent: Thursday, November 28, 2024 10:24 AM
To: Paul Skirrow <paul.skirrow@otago.ac.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>
Cc: Anya Stephenson <Anya.Stephenson@health.govt.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; jenae.valk@northlanddhb.org.nz; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore [Waitaha] <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB) <Dianne.Davis@northlanddhb.org.nz>; Eric Matthews <eric.matthews@pharmac.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>
Subject: RE: Minutes from third ADHD hui RE: NZ ADHD consensus doc - third hui

Kia ora s9(2 – as others have said this is a fantastic article – in many ways you have done the job of the working group so THANKS!

My only comment is re the audit tool – I would suggest that the first item of the "High Quality Assessment" table should actually be in the "All ADHD assessments should include" table, as the analysis you have done seem to clearly indicate that thorough assessment of differential diagnoses should be core to all assessments.

Ngā mihi,

s9(2)(a)

From: s9(2)(a) >
Sent: Wednesday, November 27, 2024 8:49 AM
To: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; Dr David Codyre <david.codyre@tamakihealth.co.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>
Cc: Anya Stephenson <Anya.Stephenson@health.govt.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; jenae.valk@northlanddhb.org.nz; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore [Waitaha] <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB) <Dianne.Davis@northlanddhb.org.nz>; Eric Matthews <eric.matthews@pharmac.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>
Subject: RE: Minutes from third ADHD hui RE: NZ ADHD consensus doc - third hui

Kia ora koutou,

Sorry I didn't make the last meeting, as I was away. I thought it might be useful to circulate the attached. After my initial review of the international standards for diagnosis, I decided to do it properly and undertake a proper review for publication.

Attached is a manuscript that I've submitted to the Journal of the NZCCP for review. Obviously, it's not published yet, but is hopefully of interest.

As an appendix to the paper (the last two pages of the pdf) I've created an audit tool for consumers and families to review the quality of their assessment. It's not perfect and may change following review but hopefully it's a useful checklist.

Ngā mihi mahana,

s9(2)(a)

From: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Sent: Tuesday, November 26, 2024 3:50 PM
To: s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; david.codyre@tamakihealth.co.nz; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz>; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <Garth.Smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>
Cc: Anya Stephenson <Anya.Stephenson@health.govt.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Murray Patton <Murray.Patton@tewhatuora.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; jenae.valk@northlanddhb.org.nz; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore [Waitaha] <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB) <Dianne.Davis@northlanddhb.org.nz>; Eric Matthews <eric.matthews@pharmac.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>
Subject: Minutes from third ADHD hui RE: NZ ADHD consensus doc - third hui

Kia ora koutou

Thanks everyone for the discussion on ADHD last Wednesday - was great to hear from our colleagues at Pharmac on the changes to ADHD medications. I have attached the minutes from the meeting, hopefully they reflect the discussion.

Next steps for the ADHD principles work:

- I will put a fourth and final ADHD meeting in people's calendars for early-mid December recognising that this is a tricky time of year but good to make the space for those who can attend.
- I am planning to update the final draft of the ADHD principles and will circulate them ahead of that meeting.
- I have also discussed with my Group Manager and Chief Medical Officer Joe Bourne to prepare some advice to go to the Minister for Mental Health, Hon Matt Doocey to update him on our ADHD principles work. This

advice will highlight where we are at with the wider ADHD actions, what we plan to do next, and some indicative potential funding implications and opportunities.

Thanks again for your support and insights, feel free to reach out to me to discuss anything.

Kieran Moorhead (he/him)
Senior Policy Analyst
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Clinical, Community and Mental Health
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kieran.moorhead@health.govt.nz
Manatū Hauora, 133 Molesworth Street Thorndon, Wellington 6011

MANATŪ HAUORA
MINISTRY OF HEALTH

-----Original Appointment-----
From: Kieran Moorhead
Sent: Monday, October 14, 2024 3:30 PM
To: Kieran Moorhead; s9(2)(a) ; Sam Hargreaves (CMDHB); s9(2)(a) ; David Hughes; david.codyre@tamakihealth.co.nz; Dr Luke Bradford; s9(2)(a) @nzcgp.org.nz; Paul Skirrow; Angus Maxwell NZCCP; Hiran Thabrew; Young Neurodiversity Champions; Garth Smith [Nelson Marlborough]; s9(2)
Cc: Anya Stephenson; Timothy Jelleyman (WDHB); Justine Lancaster; Murray Patton; Zoe Royden; s9(2)(a) ; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB]; Justine Lancaster; Jenae Valk (NDHB); Rubashnee Naidoo (CMDHB); Kyra Sycamore [Waitaha]; Anna Skinner; Robyn Harris; Dianne Davis (NDHB)
Subject: NZ ADHD consensus doc - third hui
When: Wednesday, 20 November 2024 3:00 pm-4:00 pm (UTC+12:00) Auckland, Wellington.
Where: Microsoft Teams Meeting

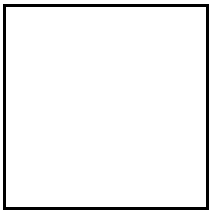
Updated – added agenda and the latest version of the principles template

Open meeting – karakia, welcome/apologies - Update from last meeting	5 mins	Kieran
Updates on discussion with wider professional bodies on ADHD principles consensus	10 mins	s9(2)(a) /others
Discussion on changes to ADHD stimulant medications	40 mins	Eric (Pharmac)
Next steps – plan for final meeting if needed	5 mins	Kieran

Microsoft Teams Need help?

s9(2)(k)

s9(2)(k)



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****

From: s9(2)(a) >
Sent: Tuesday, 4 March 2025 3:34 pm
To: Presidents NZCCP; Kieran Moorhead
Cc: s9(2)(a) ; Sam Hargreaves (CMDHB); s9(2)(a) ; David Hughes; david.codyre@tamakihealth.co.nz; Dr Luke Bradford; s9(2)(a) @rnzcgp.org.nz; Hiran Thabrew; Young Neurodiversity Champions; Garth Smith [Nelson Marlborough]; s9(2)(a) ; Timothy Jelleyman (WDHB); Justine Lancaster; Zoe Royden; s9(2)(a) ; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB]; Justine Lancaster; Jenae Valk (NDHB); Rubashnee Naidoo (CMDHB); Kyra Sycamore [Waitaha]; Anna Skinner; Robyn Harris; Dianne Davis (NDHB); Jin Russell; Chair
Subject: RE: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies
Attachments: NZ ADHD clinical principles consensus framework NZCCP feedback.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Thanks for this Kieran,

I've added some additional comments to those sent by s9(2)(a) (attached).

As an aside, the paper that I previously circulated on assessment standards has been accepted to the Journal of the NZ College of Clinical Psychologists, with a few minor additions. I'll circulate the final version when I get a proof copy but the reference will be:

s9(2)(a) . (in press). Practice Standards for the Assessment of ADHD: A Synthesis of Recommendations from Eight International Guidelines. Journal of the New Zealand College of Clinical Psychologists.

Noho ora mai,

s9(2)(a)

From: s 9(2)(a) @nzccp.co.nz>
Sent: Friday, 28 February 2025 2:47 pm
To: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Cc: s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; david.codyre@tamakihealth.co.nz; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Paul Skirrow <paul.skirrow@otago.ac.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson

Marlborough] <Garth.Smith@nmdhb.govt.nz>; s 9(2)(a) psyched.org.nz>; Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; jenae.valk@northlanddhb.org.nz; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore [Waitaha] <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB) <Dianne.Davis@northlanddhb.org.nz>; Jin Russell <Jin.Russell@health.govt.nz>; s 9(2)(a) @adhd.org.nz>
Subject: Re: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Kia ora koutou,

I discussed this with our exec today and had some minor pieces of feedback. I have added them as a track changes.

Overall looking great though, good work!

Ngā mihi nui
s9(2)(a)

On 26 Feb 2025, at 1:10 PM, Kieran Moorhead <Kieran.Moorhead@health.govt.nz> wrote:

Kia ora koutou

Hope you are all going well!

As you may remember last year we met four times to develop an ADHD clinical principles consensus framework. The framework describes the general principles and minimum standards and best practice recommendations for ADHD assessment, treatment, and management.

I have finalised the attached ADHD framework and we (the Ministry of Health) are keen to socialise the framework with your respective workforce bodies, with the intention of publishing the framework on the Ministry of Health's website (or wherever is appropriate) noting that this is collaborative piece of work.

There is some urgency to publishing a clinical consensus framework, as you are aware the Medsafe and Pharmac consultation on updating the ADHD stimulant medication prescribing criteria has recently ended and we expect that any changes will follow this year.

There is a risk that when these changes come into effect there will be a lack of clarity for both clinicians and the public on the minimum standards for assessment and treatment for ADHD in NZ. I.e. you wont simply be able to go to your local GP for an ADHD diagnosis and receive stimulant medications in a 15min co-pay appointment.

Note that the proposed framework will not address the resourcing and workforce pressures that exist for ADHD and that will likely continue following the prescribing changes. But we are keen to continue exploring what we can do to address them.

Could you please get back to us (Kieran, Jin Russell, Anna Skinner) about the best process for getting agreement from your respective workforce bodies to finalise the framework? Happy to organise some individual or group catch ups as required.

Thanks!

Kieran Moorhead (he/him)
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Clinical, Community and Mental Health
+64 4 496 2000
kieran.moorhead@health.govt.nz
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<image001.png>

<image002.png> <image003.png> <image004.png> <image005.png> **<image006.png>**

<ADHD clinical principles consensus framework.docx>

From: s 9(2)(a) @otago.ac.nz>
Sent: Thursday, 29 May 2025 9:58 am
To: Dr David Codyre; Chair; Jin Russell; Kieran Moorhead; s9(2)(a) ; Matt Eggleston; Sam Hargreaves (CMDHB; s9(2)(a) David Hughes; Dr Luke Bradford; s9(2)(a) @rnzcgp.org.nz; Angus Maxwell NZCCP; Hiran Thabrew; Young Neurodiversity Champions; Garth Smith [Nelson Marlborough]; s9(2)(a) Cc: Timothy Jelleyman (WDHB; Justine Lancaster; Zoe Royden s9(2)(a) ; Leeanne Fisher; David Chinn [CCDHB; Justine Lancaster; jenae.valk@northlanddhb.org.nz; Rubashnee Naidoo (CMDHB); Kyra Sycamore; Anna Skinner; Robyn Harris; Dianne Davis (NDHB
Cc: CAF SMO's
Subject: RE: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Kia ora s9(2)(a) ,

Thank you so much for this. I think you're completely right. We talk frequently to our students about the *process* of assessment as much as the assessment questions themselves.

In neuropsychology in particular, we frequently come across kiritaki who feel like they have not really been taken seriously in their journey- frequently feeliing 'fobbed off' by professionals and others around them. A thorough assessment, where you look broadly at the person and their context is often extremely validating and can be very therapeutic.

I completely appreciate the time demands and that many people would like to keep assessments shorter and I'm not necessarily disagreeing with the suggested minimum. However, I would personally take a lot longer than an hour (even though I am very experienced) and that's certainly what we teach in clinical and neuropsychology training.

I often make the comparison with things like COVID tests- RATs are good and quick but they are much less accurate than their more in-depth brother the PCR test. Ultimately, the more thorough the assessment, the longer it will take and the more likely it is to get the right answer.

That doesn't necessarily mean that the quick assessment is the wrong way to go- it will be right more often than not, particularly if an experienced person is doing it, and that's what we've done with RATs- but I don't think we should pretend that the shorter assessments are as accurate.

If we are going down the route of minimum time frames then I think we should acknowledge that most assessments will take much longer. Maybe better to talk mean/mode length, or a range (1-5 hours), rather than a minimum?

Noho ora mai,

s9(2)(a)

s9(2)(a)

From: s 9(2)(a) @tamakihealth.co.nz>
Sent: Thursday, 29 May 2025 8:19 am
To: s 9(2)(a) @adhd.org.nz>; Jin Russell <Jin.Russell@health.govt.nz>; Paul Skirrow <paul.skirrow@otago.ac.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; s9(2)(a) @justathought.co.nz>; Matt Eggleston <Matt.Eggleston@cdhb.health.nz>; Sam Hargreaves (CMDHB <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <garth.smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>; Cc: Timothy Jelleyman (WDHB <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne Fisher <Leeanne.Fisher@TeWhatuOra.govt.nz>; David Chinn [CCDHB <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; jenae.valk@northlanddhb.org.nz; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB <Dianne.Davis@northlanddhb.org.nz>
Cc: CAF SMO's <CAFSMO@cdhb.health.nz>
Subject: RE: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Mōrena koutou

Yes that is a really important point - in practice I do see that a lot in those diagnosed later s9(2)(a) – it tends to not come up in the first appt, but afterwards when they experience the benefits of treatment, so I do as part of the psychoed at that first session, tell people that they may have all sorts of emotional reactions when they experience the impact of treatment, and encourage referral for therapy/CBT as part of the process – one of many reasons why a multidisciplinary approach to care is critical.

And it does inevitably come up in follow-up not infrequently. GPs and NPs are well experienced in supporting people to process emotions as part of their every day work, BUT yes we have been concerned re the ASSESSMENT process, perhaps we need to be clear that having capacity to provide follow-up sessions with in a reasonable timeframe is also important??

Ngā mihi,

s9(2)(a)

From: s9 @adhd.org.nz>
Sent: Thursday, May 29, 2025 6:22 AM
To: Dr David Codyre <david.codyre@tamakihealth.co.nz>; Jin Russell <Jin.Russell@health.govt.nz>; Paul Skirrow <paul.skirrow@otago.ac nz>; Kieran Moorhead <Kieran Moorhead@health govt.nz>; s9(2)(a) s9(2)(a) @justathought.co.nz>; Matt Eggleston <Matt.Eggleston@cdhb.health.nz>; Sam Hargreaves (CMDHB <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <garth.smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>; Cc: Timothy Jelleyman (WDHB <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne Fisher <Leeanne.Fisher@TeWhatuOra.govt.nz>; David Chinn [CCDHB <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; jenae.valk@northlanddhb.org.nz; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB <Dianne.Davis@northlanddhb.org.nz>
Cc: CAF SMO's <CAFSMO@cdhb.health.nz>
Subject: Re: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Kia ora koutou

I'd like to offer a view from the ADHD community perspective. Any less than 60 minutes for an assessment would be insufficient to cover all the ground and differentiate ADHD from other symptom causes. Any more than one hour for a single appointment would be difficult I think for many people with ADHD to sustain attention (or anyone for that matter) but perhaps this assumes more than one appointment.

I also know from many many conversations with late diagnosed people with ADHD that there is a lot to process when receiving a diagnosis – anger that their school years and friendships were so fraught, that they have struggled to hold down a job etc etc. Grief that life might have been different if they had known and others had known they had a brain difference etc etc. Relief that maybe life might become easier. So although the assessment might be able to be completed in 60 minutes if the forms have been completed prior and the medical history is known…I believe another appointment should be booked quite close to the first to check in and discuss treatment options so a person is not left wondering "what now". They may also not want to make a decision about medication on the spot but to discuss other options first.

What I would like to convey is that the assessment is a very emotional experience for the person who is diagnosed with ADHD and for this to considered. Getting the medication type and amount right for the individual if that is the path they choose to pursue takes months and I think this needs to be clear to everyone from the outset….including the "consumer".

Perhaps these comments relate more to training than the guideline…but I feel very strongly that those assessing need to be aware that the assessment process is a very emotional moment for many – both the person and their whanau. I believe that the living experience view should be included in the training and ADHD NZ is keen to help with this.

s9(2)(a)

From: s 9(2)(a) @tamakihealth.co.nz>
Date: Wednesday, 28 May 2025 at 8:14 AM
To: Jin Russell <Jin.Russell@health.govt.nz>, Paul Skirrow <paul.skirrow@otago.ac.nz>, Kieran Moorhead <Kieran.Moorhead@health.govt.nz>, s 9(2)(a) @adhd.org.nz>, s9(2)(a) @justathought.co.nz>, Matt Eggleston <Matt.Eggleston@cdhb.health.nz>, Sam Hargreaves (CMDHB <Sam.Hargreaves@middlemore.co.nz>, s9(2)(a) @adhd.org.nz>, David Hughes <david.hughes@pharmac.govt.nz>, Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>, s9(2)(a) @rnzcgp.org.nz <s9(2)(a) @rnzcgp.org.nz>, Angus Maxwell NZCCP <presidents@nzccp.co.nz>, Hiran Thabrew <h.thabrew@auckland.ac.nz>, Young Neurodiversity Champions <ceo@ync.org.nz>, Garth Smith [Nelson Marlborough] <garth.smith@nmdhb.govt.nz>, s9(2)(a) psyched.org.nz>, Cc: Timothy Jelleyman (WDHB <Timothy.Jelleyman@waitematadhb.govt.nz>, Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>, Zoe Royden <Zoe.Royden@health.govt.nz>, s9(2)(a) @transport.govt.nz>, Leeanne Fisher <Leeanne.Fisher@TeWhatuOra.govt.nz>, David Chinn [CCDHB <David.Chinn@mhaids.health.nz>, Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>, jenae.valk@northlanddhb.org.nz <Jenae.Valk@northlanddhb.org.nz>, Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>, Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>, Anna Skinner <Anna.Skinner@health.govt.nz>, Robyn Harris <robyn.harris@pharmac.govt.nz>, Dianne Davis (NDHB <Dianne.Davis@northlanddhb.org.nz>, Matt Eggleston <Matt.Eggleston@cdhb.health.nz>
Cc: CAF SMO's <CAFSMO@cdhb.health.nz>
Subject: RE: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Kia ora Paul and Jin – finally got a moment to review the paper in detail.

The overall approach and content of assessment is broadly in line with what we had agreed.

In particular in this era of AI tools to transcribe an interview and then summarise it into a structured note, I do not agree that setting a minimum time of 2 hours for assessment is required or helpful. The issue here is more having the flexibility to take the time required in a given case, and I think we had agreed the expectation was that this would be AT LEAST 60 min.

In my context – myself and a team of GPwSIs and NPs seeing the full range of complex MH&A presentations seen in primary care – we have 60 min initial assessment slots booked, with the person providing a set of screening tools filled in by themselves and at least one source of collateral, before the appointment is booked. Where the diagnosis is straight forward with no complications, and using Heidi for note writing, 60 min is plenty of time to do all that the guideline outlines. However where the presentation is more complex (other neurodevelopmental differentials, complex co-morbidities etc) then a following of 30 or 60 min is booked to complete the assessment. This follow up may also include getting in person collateral.

I should add that we have access to the GP record so can see all classifications, records of BP, pulse etc, current medications etc so this does save time in taking a full history of those elements – but if these assessments are being provided in primary care then presumably that will often be the case for other GPs and PNs undertaking these assessments.

There are also clinics where other disciplines are trained in and completing the DIVA interview prior to a psychiatrist/GP/NP assessment, so whatever guidance we provide for NZ has to accommodate that reality.

So overall the approach we agreed would seem far more practical and to accommodate the necessary flexibility to ensure the time needed is taken.

Ngā mihi,

s9(2)(a)

From: Jin Russell <Jin.Russell@health.govt.nz>
Sent: Friday, May 23, 2025 8:43 AM
To: Paul Skirrow <paul.skirrow@otago.ac.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; s 9(2)(a) @adhd.org.nz>; s9(2)(a) @justathought.co.nz>; Matt Eggleston <Matt.Eggleston@cdhb.health.nz>; Sam Hargreaves (CMDHB <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; Dr David Codyre <david.codyre@tamakihealth.co.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <garth.smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>; Cc: Timothy Jelleyman (WDHB <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne Fisher <Leeanne.Fisher@TeWhatuOra.govt.nz>; David Chinn [CCDHB <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; jenae.valk@northlanddhb.org.nz; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB <Dianne.Davis@northlanddhb.org.nz>; Matt Eggleston <Matt.Eggleston@cdhb.health.nz>
Cc: CAF SMO's <CAFSMO@cdhb.health.nz>
Subject: Re: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Kia Ora s9(2) ,

Thanks for sending this around. Hiran Thabrew also forwarded this to me when it came out. It is a very clearly written summary statement. I was most interested in the consensus statements around the time taken to assess. The statement is for total assessment time to take at least 2 hrs, acknowledging it may take longer for less experienced clinicians and shorter for more experienced clinicians. This would have implications for implementation of the regulatory changes.

I'm keen to hear other's thoughts!

Ngā mihi
Jin

From: s9(2)(a) @otago.ac.nz>
Sent: Friday, May 23, 2025 12:10 AM
To: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>; s 9(2)(a) @adhd.org.nz>; s9(2)(a) @justathought.co.nz>; Matt Eggleston <Matt.Eggleston@cdhb.health.nz>; Sam Hargreaves (CMDHB <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; david.codyre@tamakihealth.co.nz <david.codyre@tamakihealth.co.nz>; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz <s9(2)(a) @rnzcgp.org.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <garth.smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>; Cc: Timothy Jelleyman (WDHB <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) <s9(2)(a) @transport.govt.nz>; Leeanne Fisher <Leeanne.Fisher@TeWhatuOra.govt.nz>; David Chinn [CCDHB <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; jenae.valk@northlanddhb.org.nz <Jenae.Valk@northlanddhb.org.nz>; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB <Dianne.Davis@northlanddhb.org.nz>; Jin Russell <Jin.Russell@health.govt.nz>; Matt Eggleston <Matt.Eggleston@cdhb.health.nz>
Cc: CAF SMO's <CAFSMO@cdhb.health.nz>
Subject: RE: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Kia ora koutou,

I thought this might be an interesting paper to circulate, in case it hadn't crossed your desk. These are some new consensus guidelines from the UK Adult ADHD Network (UKAAN) entitled "the adult ADHD assessment quality assurance standards". These were not included in the review that we did last year (published after that was accepted) but it includes some excellent and very fine-grained recommendations for assessment of adults. I haven't fully scrutinised them myself yet but I thought they looked really good at first glance.

Ngā mihi mahana,
s9(2)(a)

From: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Sent: Wednesday, 16 April 2025 1:43 pm
To: s 9(2)(a) @adhd.org.nz>; s9(2)(a) @justathought.co.nz>; Matt Eggleston <Matt.Eggleston@cdhb.health.nz>; Sam Hargreaves (CMDHB <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a)

s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; david.codyre@tamakihealth.co.nz; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <garth.smith@nmdhb.govt.nz>; s9(2)(a) psyched.org.nz>; Cc: Timothy Jelleyman (WDHB <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne Fisher <Leeanne.Fisher@TeWhatuOra.govt.nz>; David Chinn [CCDHB <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; jenae.valk@northlanddhb.org.nz; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB <Dianne.Davis@northlanddhb.org.nz>; Jin Russell <Jin.Russell@health.govt.nz>; Matt Eggleston <Matt.Eggleston@cdhb.health.nz>
Cc: CAF SMO's <CAFSMO@cdhb.health.nz>
Subject: RE: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies
Importance: High

Kia ora koutou

Thank you all for taking the time to provide comprehensive feedback on the ADHD clinical principles framework. This update is to let you know that we have closed off feedback for now and we are updating the framework with your suggested changes to prepare for publishing.

We are accepting all suggested edits in the spirit of this framework being developed by the sector and by the people who know what is needed to provide support for people with ADHD in New Zealand.

Where there are issues around evidence base for approaches to support for people with ADHD, as this framework is not a meant to be a full clinical guideline based on tightly controlled evidence, we are going with the principle of including approaches that we know are showing benefits and that are working for people with caveats that the evidence may be from overseas or is emerging.

To make this clear, we are drafting a new section that explains the methods and evidence base for the framework. This highlights that it is grounded in the existing guidelines and available evidence but is also a practical document created by people with lived experience of ADHD and our local experts in assessing and treating ADHD in NZ.

We acknowledge that there are real limitations for our health system, including primary care, to deliver on the framework particularly funding for the ADHD assessment pathways, and for the workforce training. The framework is not meant to place unrealistic expectations on services but act more as a yardstick for understanding what good quality ADHD assessment and treatment looks like for New Zealanders. We may change the language a little to reflect this (i.e. changing best practice recommendations).

Additionally, we expect that the upcoming changes to prescribing ADHD stimulant medications for GPs and NPs will reveal and potentially exacerbate these funding and training issues. Publishing the clinical principles framework is one step we are taking to support the health sector and the public when these changes come into effect in July.

We are also continuing to work with Health NZ on how we can implement the ADHD prescribing changes and provide good guidance to the health sector. And we are advising Ministers on the issues and risks and high public expectations that the changes may bring.

Once the framework is finalised, we will share it with you and ask for your thoughts on how we can reference the members of the group in the published version (by name or as representatives of workforce bodies).

Thanks again!

Kieran Moorhead (he/him)

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From: s 9(2)(a) @adhd.org.nz>
Sent: Saturday, April 12, 2025 7:24 AM
To: s9(2)(a) @justathought.co.nz>; Matt Eggleston <Matt.Eggleston@cdhb.health.nz>; Sam Hargreaves (CMDHB <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; david.codyre@tamakihealth.co.nz; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <garth.smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>; Cc: Timothy Jelleyman (WDHB <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) <s9(2)(a) @transport.govt.nz>; Leeanne Fisher <Leeanne.Fisher@TeWhatuOra.govt.nz>; David Chinn [CCDHB <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; Jenae Valk (NDHB <Jenae.Valk@northlanddhb.org.nz>; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB <Dianne.Davis@northlanddhb.org.nz>; Jin Russell <Jin.Russell@health.govt.nz>; Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Cc: CAF SMO's <CAFSMO@cdhb.health.nz>
Subject: Re: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Kia ora koutou

Thanks to everyone for their engagement on this framework.

ADHD NZ is very keen to be a channel for information out to the ADHD community. We are working closely with Pharmac on communicating the ongoing supply issues. This is working well because we have the reach but also because we are seen as a trusted source of information for people who have sometimes felt the medical community has not understood them.

On another matter, David Codyre has mentioned ADHD coaches as another form of support – wholeheartedly agree. However, not all ADHD coaches are created equal and this is an unregulated group. ADHD NZ is in the process of working on some information on the qualifications to look out for, eg ICF accreditation. We are also looking at whether we can have a group of coaches associated with ADHD NZ and bookings offered through our website.

Nga mihi
s9(2)(a)

From: s9(2)(a) @justathought.co.nz>
Date: Friday, 11 April 2025 at 10:38 AM

To: Matt Eggleston <Matt.Eggleston@cdhb.health.nz>, Sam Hargreaves (CMDHB <Sam.Hargreaves@middlemore.co.nz>, s9(2)(a) @adhd.org.nz>, David Hughes <david.hughes@pharmac.govt.nz>, david.codyre@tamakihealth.co.nz <david.codyre@tamakihealth.co.nz>, Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>, s9(2)(a) @rnzcgp.org.nz <s9(2)(a) @rnzcgp.org.nz>, Paul Skirrow <paul.skirrow@otago.ac.nz>, Angus Maxwell NZCCP <presidents@nzccp.co.nz>, Hiran Thabrew <h.thabrew@auckland.ac.nz>, Young Neurodiversity Champions <ceo@ync.org.nz>, Garth Smith [Nelson Marlborough] <garth.smith@nmdhb.govt.nz>, s9(2)(a) @psyched.org.nz>, Cc: Timothy Jelleyman (WDHB <Timothy.Jelleyman@waitematadhb.govt.nz>, Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>, Zoe Royden <Zoe.Royden@health.govt.nz>, s9(2)(a) @transport.govt.nz>, Leeanne.Fisher@TeWhatuOra.govt.nz <Leeanne.Fisher@TeWhatuOra.govt.nz>, David Chinn [CCDHB <David.Chinn@mhaids.health.nz>, Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>, Jenae Valk (NDHB <Jenae.Valk@northlanddhb.org.nz>, Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>, Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>, Anna Skinner <Anna.Skinner@health.govt.nz>, Robyn Harris <robyn.harris@pharmac.govt.nz>, Dianne Davis (NDHB <Dianne.Davis@northlanddhb.org.nz>, Jin Russell <Jin.Russell@health.govt.nz>, s 9(2)(a) @adhd.org.nz>, Kieran.Moorhead@health.govt.nz <Kieran.Moorhead@health.govt.nz>
Cc: CAF SMO's <CAFSMO@cdhb.health.nz>
Subject: Re: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Kia ora s9(2 and team

I think your points are all incredibly valid, balanced and important s9(2)(a).

A stepped approach and trying to 'formalise' or somehow support this within the framework seems very important to support 'triage' and a stepping up/down of referrals and cases. It may also help to communicate via ADHD NZ and other networks suggestions on care/dx and tx options for the public. Prescribers could also be supported to have a sense of when/who to suggest meds to as a supportive intervention based on severity of impacts. Hopefully there won't be too many people functioning well who will seek out medication, but identifying those who may jump to this conclusion would be helpful for newer prescribers.

I have long believed bolstering funding/resources to support the ADHD community will bring far reaching benefits for people outside of this population too (e.g. upskilling primary care in more 'specialist work', additional time and resources). David Codyre's model at Tāmaki is a great example of this.

I'm unsure if the framework needs to directly talk to diversion (many MH drugs get diverted, not just stimulants) but perhaps advice on what to do if this is suspected?

New prescribers/assessors will be assessing and working with comorbid substance use issues but perhaps guidance on steps where there is comorbidity (if consensus of approach can be reached given the differences going on in practice).

We do need to consider scalable EB psychological support for people too and I'm sure we can make some suggestions as a group to Health NZ of what immediate solutions they could look to offer/support (e.g. development of a digital CBT for ADHD tool, additional training resources for our Access and Choice workforce etc)

A range of Nurse Practitioners in MH, Paeds and CAMHS are included in the ADHD diagnostician group. We do need to think about creating access to support, supervision, mentoring etc and this could be done regionally perhaps with a digital group but the issues around time and cost needs to be considered.

A pilot approach is a great idea in terms of possibly trialling some of the suggestions you've raised.

What I would strongly suggest we do, is to continue to meet as a group of professional organisations so we can work together and find solutions. This is the best way to ensure our resources, experience and capabilities are maximised. We should be doing this anyway so this provides the perfect opportunity to stand up a more formal professional advisory group/think tank.

Thanks for the time you've put into this Matt.

s9(2)
(

From: Valerie Black <Valerie.Black@cdhb.health.nz>
Sent: Thursday, March 6, 2025 1:56 PM
To: Carmen McNaught <Carmen.McNaught@cdhb.health.nz>; Valerie Black <Valerie.Black@cdhb.health.nz>; Sian Gimblett <Sian.Gimblett@cdhb.health.nz>; Brandon Strange <Brandon.Strange@cdhb.health.nz>; Suzanne Sundheim <Suzanne.Sundheim@cdhb.health.nz>; Matt Eggleston <Matt.Eggleston@cdhb.health.nz>; Melissa Beatson <MelissaBeatson.Beatson@cdhb.health.nz>; Julie Potts <Julie.Potts@cdhb.health.nz>; David Thomasson <David.Thomasson@cdhb.health.nz>; Jo Dowell <Jo.Dowell@cdhb.health.nz>; Monique Malloch <Monique.Malloch@cdhb.health.nz>; Tisha Bradley <Tisha.Bradley@cdhb.health.nz>; Russell Blakelock <Russell.Blakelock@cdhb.health.nz>; Helen Mountford <Helen.Mountford@cdhb.health.nz>; Amy Hay (nee Crooks) <Amy.Hay@cdhb.health.nz>; CAF SMO's <CAFSMO@cdhb.health.nz>
Cc: Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>
Subject: FW: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Dear Team,

Please see the above document which as I understand it is aimed to give national guidance re the minimum standards for assessing, diagnosing and treating ADHD as well as best practice recommendations

I have added in a few other people to the list and feel free to send to others you think may want to comment.

Please send any feedback to Kyra

Thank you | Ngā mihi nui

Valerie

Dr Valerie Black

Clinical Director |

Child & Adolescent Psychiatrist

Child, Adolescent and Family Mental Health Service

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5th Floor, Heathcote Building at The Princess Margaret Hospital, Private Bag 800, Christchurch 8022

Hours of work: Tuesday, Wednesday, Thursday, Friday 8:30-17:00

Kia mau ki te tumanko, te whaka pono, me te aroha

Te Whatu Ora – Health New Zealand

TeWhatuOra.govt.nz

From: Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>
Sent: Monday, March 3, 2025 11:53 AM
To: Valerie Black <Valerie.Black@cdhb.health.nz>
Subject: FW: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Hi Val

Please would you circulate to anyone who might have some thoughts on the national ADHD framework?

Ngā mihi

Kyra

Kyra Sycamore FANZCAP (Mental Hlth, Lead&Mgmt)

Specialist Mental Health Pharmacist

Convenor – NZHPA Mental Health Special Interest Group

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Health New Zealand
Te Whatu Ora

From: Kieran Moorhead <Kieran.Moorhead@health.govt.nz>
Sent: Wednesday, 26 February 2025 1:10 PM
To: s9(2)(a) @justathought.co.nz>; Sam Hargreaves (CMDHB) <Sam.Hargreaves@middlemore.co.nz>; s9(2)(a) @adhd.org.nz>; David Hughes <david.hughes@pharmac.govt.nz>; david.codyre@tamakihealth.co.nz; Dr Luke Bradford <luke.bradford@rnzcgp.org.nz>; s9(2)(a) @rnzcgp.org.nz; Paul Skirrow <paul.skirrow@otago.ac.nz>; Angus Maxwell NZCCP <presidents@nzccp.co.nz>; Hiran Thabrew <h.thabrew@auckland.ac.nz>; Young Neurodiversity Champions <ceo@ync.org.nz>; Garth Smith [Nelson Marlborough] <garth.smith@nmdhb.govt.nz>; s9(2)(a) @psyched.org.nz>
Cc: Timothy Jelleyman (WDHB) <Timothy.Jelleyman@waitematadhb.govt.nz>; Justine Lancaster <Justine.Lancaster@TeWhatuOra.govt.nz>; Zoe Royden <Zoe.Royden@health.govt.nz>; s9(2)(a) @transport.govt.nz>; Leeanne.Fisher@TeWhatuOra.govt.nz; David Chinn [CCDHB] <David.Chinn@mhaids.health.nz>; Justine Lancaster <Justine.Lancaster@healthpathwayscommunity.org>; Jenae Valk (NDHB) <Jenae.Valk@northlanddhb.org.nz>; Rubashnee Naidoo (CMDHB) <Rubashnee.Naidoo@cmdhb.org.nz>; Kyra Sycamore <Kyra.Sycamore@cdhb.health.nz>; Anna Skinner <Anna.Skinner@health.govt.nz>; Robyn Harris <robyn.harris@pharmac.govt.nz>; Dianne Davis (NDHB) <Dianne.Davis@northlanddhb.org.nz>; Jin Russell <Jin.Russell@health.govt.nz>; s 9(2)(a) @adhd.org.nz>
Subject: Finalising and socialising the ADHD clinical principles consensus framework with your professional bodies

Kia ora koutou

Hope you are all going well!

As you may remember last year we met four times to develop an ADHD clinical principles consensus framework. The framework describes the general principles and minimum standards and best practice recommendations for ADHD assessment, treatment, and management.

I have finalised the attached ADHD framework and we (the Ministry of Health) are keen to socialise the framework with your respective workforce bodies, with the intention of publishing the framework on the Ministry of Health's website (or wherever is appropriate) noting that this is collaborative piece of work.

There is some urgency to publishing a clinical consensus framework, as you are aware the Medsafe and Pharmac consultation on updating the ADHD stimulant medication prescribing criteria has recently ended and we expect that any changes will follow this year.

There is a risk that when these changes come into effect there will be a lack of clarity for both clinicians and the public on the minimum standards for assessment and treatment for ADHD in NZ. I.e. you wont simply be able to go to your local GP for an ADHD diagnosis and receive stimulant medications in a 15min co-pay appointment.

Note that the proposed framework will not address the resourcing and workforce pressures that exist for ADHD and that will likely continue following the prescribing changes. But we are keen to continue exploring what we can do to address them.

Could you please get back to us (Kieran, Jin Russell, Anna Skinner) about the best process for getting agreement from your respective workforce bodies to finalise the framework? Happy to organise some individual or group catch ups as required.

Thanks!

Kieran Moorhead (he/him)

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