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ADHD Referral Toolkit and Transfer of Care Policy

Facilitating Continuity of ADHD Care Between South Africa and the United Kingdom

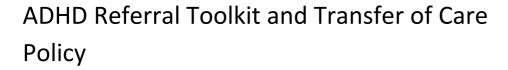
Prepared by: Prof Renata Schoeman

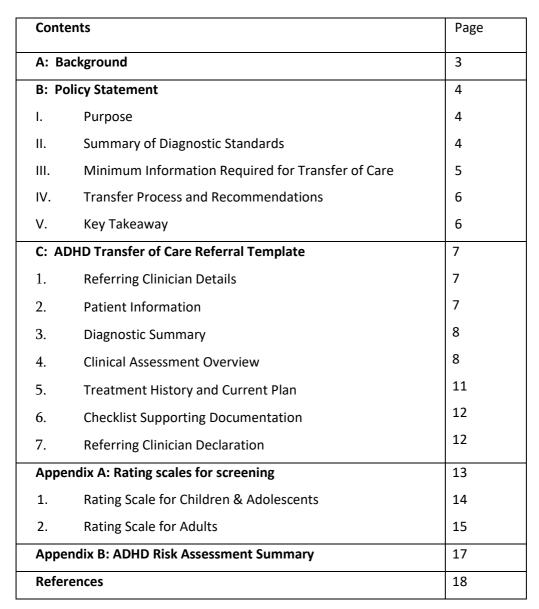
Psychiatrist | Convenor, SASOP ADHD Special Interest Group Chair, WFADHD Task Force on Cross-Border ADHD Care Transitions

July 2025

Taskforce members:

Prof Stephen Faraone (United States of America), Prof Li Yang (China),
Prof Renata Schoeman (South Africa), Dr Jack Krysztofiak (United Kingdom),
Andrew Jay (United Kingdom)







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A. <u>Background</u>

In recent years, the global movement to advance equitable access to mental health care has highlighted the urgent need to improve continuity of care for individuals with Attention-Deficit/Hyperactivity Disorder (ADHD) relocating across borders.

Recognising this, the South African Society of Psychiatrists' Special Interest Group for ADHD (SASOP ADHD SIG) submitted a formal appeal to the World Federation of ADHD (WFADHD) in January 2025, drawing attention to the barriers faced by patients emigrating from low- and middle-income countries (LMICs), particularly to high-income regions such as the United Kingdom.

Despite having received professional diagnoses and treatment from qualified specialists in South Africa, many patients find their diagnoses questioned, their treatment histories disregarded, and are subjected to redundant and costly reassessments - often with months-long waiting periods. This disruption in care during a time of major life transition can have devastating consequences for patient well-being, academic performance, occupational functioning, and overall mental health.

Following this appeal and subsequent discussions with global ADHD leaders, including formal sessions at the World Federation of ADHD (WFADHD) 10th World Congress on ADHD in Prague (8 to 11 May 2025), a Task Force was constituted on the 9th of May 2025 to address the systemic challenges in the transnational transfer of care for individuals with ADHD. I am honoured to have been appointed Chair of this international Task Force, mandated to develop practical, evidence-informed guidelines and tools that ensure diagnostic validity is respected, care transitions are clinically responsible, and patients' rights and needs are upheld.

This Referral Toolkit and Policy Framework has been developed as one of the initial outputs of the Task Force. It provides:

- A concise **policy statement** outlining minimum standards for diagnostic recognition between South Africa and the United Kingdom.
- A **referral template** to assist clinicians in transferring ADHD care with clarity and credibility.
- A **checklist** of required documentation to support medication continuation and treatment planning.
- **Appendices** including validated rating scales, and a risk assessment summary aligned with standards accepted in both countries.

This toolkit serves as both a clinical support resource and a symbol of international collaboration, underscoring the shared responsibility of global mental health professionals to reduce barriers, prevent treatment gaps, and foster mutual recognition of expertise across borders.



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We trust that this document will contribute meaningfully to patient-centered, stigma-free, and uninterrupted ADHD care - regardless of geography.

With appreciation,

Prof. Renata Schoeman

Psychiatrist | Convenor, SASOP ADHD Special Interest Group

Chair, WFADHD Task Force on Cross-Border ADHD Care Transitions

B. Policy statement

I. Purpose

This document outlines the minimum accepted quality of information and standards to support safe, credible, and efficient transfer of ADHD care between South Africa and the United Kingdom. It aims to:

- Promote mutual recognition of diagnostic assessments.
- Reduce duplicate or unnecessary reassessments.
- Ensure continuity of evidence-based care for patients with a confirmed ADHD diagnosis.

II. Summary of Diagnostic Standards

Element	South Africa (SASOP Guidelines)	United Kingdom (NICE, AQAS, CAAQAS)
Diagnostic Criteria	DSM-5	DSM-5 and/or ICD-11
Diagnosing Professional	Psychiatrist, Paediatric Neurologist, Neurodevelopmental Paediatrician	Psychiatrist, Psychologist with ADHD training, Paediatricians (children), UKAAN/CAAQAS trained clinicians
Clinical Interview	Required, in-depth with collateral info	Required, ≥2 hrs including open-ended questioning, family/school input
Use of Rating Scales	Conners, SNAP-IV, Vanderbilt, clinical interviews	Conners, SNAP-IV, ASRS, DIVA/ACE, collateral info required



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Collateral Information	School reports, parent/teacher ratings, therapist reports	Mandatory, includes development, family, education, risk profile
Comorbidity Evaluation	Mandatory	Mandatory, includes neurodevelopmental and psychiatric comorbidity
Assessment Report	Detailed narrative with history, diagnosis, and plan	Structured report including rationale, tools used, corroborative evidence, risk assessment



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III. Minimum Information Required for Transfer of Care

To facilitate acceptance of an existing ADHD diagnosis between the UK and SA, with transfer of care and ongoing treatment, the following minimum dataset should be provided:

1. Diagnostic Report (Structured Letter)

- Name, qualifications, and registration of diagnosing clinician.
- Confirmation of training/experience in ADHD diagnosis.
- Date of assessment and setting.

2. Diagnostic Criteria Used

- DSM-5 or ICD-11-based diagnosis.
- Subtype and severity (e.g. combined, inattentive, mild/moderate/severe).

3. Clinical Assessment Summary

- Developmental history (pregnancy, birth, milestones).
- School performance, social/emotional functioning, and home environment.
- Current presenting difficulties and goals for diagnosis.

4. Tools and Rating Scales Used

- Names and results of validated scales (e.g., Conners, SNAP-IV, ASRS).
- Methods of obtaining collateral information (e.g., interviews, reports).

5. Differential Diagnosis and Comorbidities

- Summary of ruled-out differential diagnoses.
- Any co-existing mental health or neurodevelopmental conditions.

6. Physical and Mental State Examination

- Summary of relevant findings (e.g., BP/HR for stimulants).
- Mental health history and current risk profile.

7. Treatment Plan

- Medications tried (names, dosages, response, side effects).
- Non-pharmacological interventions (e.g., psychoeducation, therapy).
- Follow-up plan and prescribing arrangements (if applicable).

IV. Transfer Process and Recommendations

- 1. Patient consent must be documented to share and use prior reports.
- 2. Reports must be available in English (on request)
- 3. Receiving providers should:
 - Review the report against NICE and AQAS/CAAQAS benchmarks.
 - Review the need for ongoing treatment (i.e. symptoms severity and functional impairment)
 - Review medical status, all medications and risks
 - Offer continuity of care, with additional brief assessment only if needed.
- 4. Where gaps exist, patients may undergo a bridging reassessment, **not full rediagnosis**.

V. Key Takeaway

This document advocates for a harmonised cross-border approach to ADHD care. Valid diagnoses made in one country should be respected and upheld in the other when minimum quality standards are met. This protects patients from gaps in care, unnecessary costs, and the loss of therapeutic momentum during vulnerable life transitions.



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ADHD Transfer of Care Referral Template

1. Referring Clinicia	an Details
Name and surname	
Academic qualifications	
Practice number	
Registration number	
Contact number	
Email	
Practice address	
2. Patient Informat	tion
Full Name	
Date of Birth	
Gender	
ID/Passport Number	
Contact Number	
Email	
Preferred Language	

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Did the patient sign consent to share information as per the POPI Act (Section 11(1)(a) and Section 26) and transfer of care?

☐ Yes □ No

3. Diagnostic Summary

Date of first consultation with current				
Date of most recent consultation with				
Date of initial ADHD diagnosis				
Age at the initial diagnosis				
Diagnosing Criteria Used:	□ DSM	-5	☐ ICD-11	
ADHD Subtype:	☐ Com	bined	☐ Inattentive	
,,			-Impulsive	
Current severity:	☐ Mild		-	□ Severe
as determined by		*refer	to appendix	
Comorbid diagnoses:				
comorbid diagnoses.				
Diely rating (aliaisian judgamant) *rafar	to annor			
Risk rating (clinician judgement) *refer ☐ ☐ Low	то арреі	luix		
□ Moderate				
□ High				
☐ Critical (requires urgent intervention)			
Brief narrative of the risk formulation: _				
	_			
4. Clinical Assessment Ove	rview			
Summary of Family History:				



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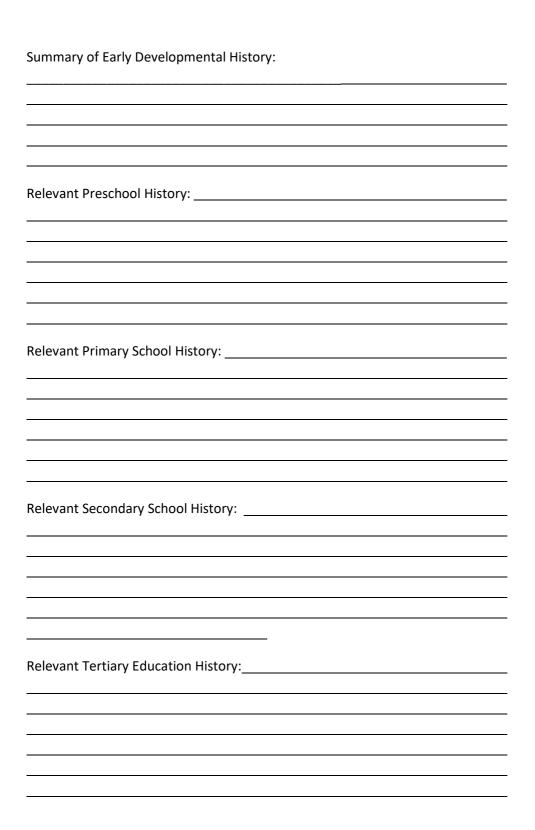
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Relevant Occupational History:			WORLD FEDERATION ADHD
			PRESIDENT Prof. Dr. Stephen Faraone Department of Psychiatry SUNY Upstate Medical University 750 East Adams Street Syracuse, NY 13210, USA
Substance Use History:			VICE-PRESIDENTS Prof. Jan Buitelaar Radboud University Medical Center Postbus 9102, 6500 Nijmegen The Netherlands
			Prof. Dr. Li Yang Child Mental Health Research Unit Peking University Sixth Hospital 51, Huayuan Bei Road, Haidian District Beijing, 100191, People's Republic of China
Relevant Medical History (including	g allergies and	chronic treatment):	SECRETARY GENERAL Prof. Dr. Mark Bellgrove School of Psychological Sciences Monash University Clayton 3800 VIC, Australia
			TREASURER Prof. Dr. Manfred Gerlach Department of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy University of Würzburg Margarete-Höppel-Platz 1 97080 Würzburg, Germany
Corroborative Information/ Rating Findings *refer to appendix	Scales/Tools u	sed in Diagnosis of ADHD and	WORLD FEDERATION OF ADHD Global Head Office Zum Ehrenhain 34 22885 Barsbüttel, Germany Phone: 449 – 40 – 670 88 20 Fax: +49 – 40 – 670 32 83 Email: adhd@cpo-hanser.de
Who	What	Summary of findings	
Parents/ primary caregivers			
School/educators			
Psychometric/psychoeducational			
Occupational therapy, speech			
Current Mental State Examination	Summary:		
			_

. Treatment Histor	y and Current Pl	an	
Current medication			
Trading name Active	Dose and	Treatment	Adverse
substance	and instructions	response	effects
formulation	on		
Previous medication			
Trading name Active	Dose and	Treatment	Adverse
substance	and instructions	response	effects
formulati	on		
Non- Please			
pharmacological elaborate			
and complementary			
interventions			
used			



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Signature: ___

Current follow- up plan	Please elaborate		WORLD FEDERATION ADHD
6. Checklist	t. Sunnorting [Documentation	PRESIDENT Prof. Dr. Stephen Fara Department of Psychia SUNY Upstate Medica 750 East Adams Stree Syracuse, NY 13210, U
☐ This referral temp	plate has been con	npleted accurately and in full	VICE-PRESIDENTS Prof. Jan Buitelaar Radboud University M Postbus 9102, 6500 N
	scales and collate	ransfer care eral reports are available on further written with written consent from the patient/ legal	The Netherlands Prof. Dr. Li Yang Child Mental Health R Peking University Sixth 51, Huayuan Bei Road Beijing, 100191, Peop
☐ Collateral reports	s (school, therapist	ss, medical professionals)	SECRETARY GENERA Prof. Dr. Mark Bellgrov School of Psychologica Monash University Clayton 3800 VIC, Au
□ Copy of the most7. Referring	recent script issue		TREASURER Prof. Dr. Manfred Gerl Department of Child and Adolescent Psychi Psychosomatics and Psychosomatics
I confirm that the ak	oove information i	s accurate to the best of my knowledge.	WORLD FEDERATION
		rt continuity of ADHD care for the above-named	Global Head Office Zum Ehrenhain 34 22885 Barsbüttel, Ger Phone: +49 – 40 – 67 Fax: +49 – 40 – 67 Email: adhd@cpo-har

Date: __



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These rating scales are accepted in both South Africa and the United Kingdom for the diagnosis and management of ADHD.

Recommended combination by country:

South Africa	SNAP-IV or Vanderbilt + WFIRS-P/S +
	Clinical Interview
United Kingdom (NHS)	DIVA-5 (or CAAQAS for youth) + ASRS +
	WFIRS-S + Vanderbilt or Conners

Key clinical notes:

- Severity is not only based on symptom count, but on functional impact across settings (home, school/work, social).
- DSM-5 guides classification into:
 - Mild: Few symptoms beyond the diagnostic threshold; minor functional impairment.
 - Moderate: Between mild and severe.
 - Severe: Many symptoms in excess; marked impairment.



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Scale	Description	Purpose	Severity interpretati on	Accepted in South Africa	Accepted in United Kingdom
SNAP-IV	18-item parent/teac her report, aligned with DSM 5	Diagnostic support, progress tracking	Scores per item (0–3); total score and subscale scores used to rate severity; >1.78 average indicates clinical concern	✓ Widely used	Accepted in NHS/resea rch
Conners (CPRS/CTRS)	Detailed parent and teacher forms	Clinical, severity, and comorbidi ty assessmen t	T-scores > 60 suggest borderline to clinical; >70 = severe	✓ Frequentl y used	✓ Yes, widely accepted
Vanderbilt (VADPRS/VADT RS)	DSM-based parent and teacher tools	Symptom and performan ce ratings for diagnosis and severity classificati on	Symptom count + performanc e items (1– 5 scale); performanc e scores ≥4 indicate significant impairment	✓ Frequentl y used	Accepted in NHS



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SDQ (Strengths and Difficulties Questionnaire)	25 items scale Parent-report, teacher-report, and self-report (11–17 years)	General mental health screener (with ADHD subscale)	Sum of the first four subscales (range: 0–40). Higher scores = more difficulties.	✓ For comorbid ity	✓ Required in NHS
WFIRS-P (Weiss Functional Impairment Rating Scale – Parent)	For parent- reported impairment severity		Scores ≥1.5 on multiple domains = moderate- to-severe impairment		



Scale	Description	Purpose	Severity interpreta	Accepted in South	Accepted in United
			tion	Africa	Kingdom
ASRS (Adult	6-item	Screening	Score	√ Yes	√ Yes
ADHD Self-	screener and	and	range (0–		
Report Scale	full 18-item	symptom	72).		
v1.1)	DSM-based	tracking	Higher		
	tool		scores =		
			more		
			severe		
			symptom		
			s. No		
			fixed		
			severity		
			cutoff,		
			but		
			severity		
			interprete		
			d through		
			symptom		
			count and		
			impact.		



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DIVA-5 (Diagnostic Interview for ADHD in Adults)	Semi- structured DSM-5 based diagnostic interview	Diagnostic assessment and impairment rating	Severity rating (mild/mo derate/se vere)	√ Yes	✓ Gold standard (UKAAN/NI CE)
ACE+	Diagnostic interview covering childhood and adult symptoms	Diagnostic assessment		✓ Occasiona Ily	√ Yes
CAARS (Conners' Adult ADHD Rating Scale)	Comprehensive self/observer questionnaire	Diagnosis and monitoring	T-scores >65 = clinical significan ce, >70 = severe	✓ Specialist use	✓ Used in private and NHS
Wender Utah Rating Scale	Retrospective childhood symptom scale			√ Yes	√ Yes
WFIRS-S (Weiss Functional Impairment Rating Scale – Self)	Measures functional impairment across 7 domains	Severity of impact on daily functioning	Scores ≥1.5 on multiple domains = moderate -to-severe impairme nt		



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Appendix B: ADHD Risk Assessment Summary

To be completed by the referring clinician based on clinical evaluation, collateral history, and observation.

1. Historical Risk Factors ☐ Childhood trauma or neglect ☐ History of abuse (physical, emotional, sexual) ☐ Early substance use or exposure \square Previous suicide attempts or self-harm ☐ Family history of mental illness or suicide ☐ Academic expulsion, repeated suspensions, or early school leaving 2. Current Risk Factors ☐ Suicidal ideation or behaviour ☐ Self-harming behaviour ☐ Aggression or violent outbursts ☐ Substance misuse ☐ Significant impulsivity affecting safety (e.g., reckless driving) ☐ Poor insight into illness or behaviour ☐ Medication misuse or non-adherence ☐ Risk to others (e.g., children in care) 3. Protective Factors ☐ Supportive family or caregiving environment ☐ Engagement with school/work ☐ Insight and motivation for treatment ☐ Regular follow-up with healthcare provider ☐ Absence of comorbidities or good control thereof 4. Risk Rating (Clinician Judgement) ☐ Low ☐ Moderate ☐ High ☐ Critical (requires urgent intervention)

5. Summary Risk Formulation

Include a brief narrative.

For example: "The patient demonstrates moderate risk for academic and social impairment due to untreated ADHD symptoms. No current suicidal ideation or substance misuse is reported. Protective factors include good parental involvement and a stable home environment. Risk is manageable with appropriate ongoing treatment and monitoring."



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