



Can the “Current View” show that autistic young people referred to mental health services have more comorbidities and complex needs?

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Introduction

Autism is a neurodevelopmental disorder associated with deficits in reciprocal social interaction and communication, and restricted, stereotyped, repetitive behaviour or interests (American Psychiatric Association, 2013). Approximately one in a hundred (1%) young people in the UK have autism (BMA, 2020). Around 70% of young people with autism have at least one coexisting mental health condition and 41% have two or more (Simonoff et al., 2008).

Autism is increasingly being recognised and diagnosed in childhood, thus increasing the demand on local diagnostic and intervention services for young people. Young people with autism are more likely to be able to contribute and be affirmed in their community if they are able to access adequate support from health and care services in terms of receiving timely, proactive, and evidence-based community interventions (Council for Disabled Children, 2017).

However, in the absence of adequate support or understanding of their needs they can miss out on an education (Totiska et al., 2020), and/or fail to benefit from employment and training, and become isolated from their community (Locke et al., 2010). This can result in complex mental health difficulties (Simonoff et al., 2008), behavioural difficulties (Horner et al., 2002; Matson et al., 2008) and low self-esteem (Van der Cruijssen and Boyer, 2021). Inadequate support may also lead to increased long term costs to the National Health Service and Local Authorities (Foundation for People with Learning Disabilities, 2007), as individuals with potentially avoidable and treatable issues may show signs of deterioration and the issues become more severe and/or chronic requiring specialist interventions (Children's Commissioner, 2019; National Autistic Society, 2020).

Supporting young people with autism can be challenging, due not only to their neurodevelopmental needs, but accompanying medical diagnoses and/or other difficulties in their life (Rydzewska et al., 2018). Wee et al. (2021) suggest that a multiagency approach between mental health, neurodevelopmental, physical health, social care and education services is required for young people with autism to have the best outcomes possible.

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3 At present there is limited information available on the comorbidities, complexity,
4 contextual and educational factors of young people referred to Children and Young People's
5 Mental Health (CYPMH) services. A considerable amount of data on each young person is
6 routinely gathered via the "Current View" Tool (Jones et al., 2013) including provisional
7 problem description, selected complexity factors, contextual problems and difficulties with
8 education, employment and training. So far, there has been limited use of this data to
9 develop an understanding of the comorbidities and complexities of this population. One
10 study used the "Current View" Tool to estimate problem severity amongst young people
11 accessing mental health services, but they did not use contextual problems to inform this
12 estimate (Edbrooke-Childs and Deighton, 2020). Another study used the "Current View"
13 Tool to assess the presence and impact of psychosocial difficulties and complex problems,
14 but did not assess contextual issues (Liverpool et al., 2021).

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29 The aim of this study was to use data from the "Current View" Tool to understand the multi-
30 agency support needs of autistic young people accessing mental health services. The
31 objectives were:

- 32 - To describe the clinical characteristics of autistic young people accessing CYPMH
33 services.
- 34 - To describe associations between comorbidities and complexity needs in autistic
35 young people and compare it with non-autistic young people accessing CYPMH
36 services.
- 37 - To understand areas for service development and multi-agency focus in order to
38 improve outcomes and reduce health inequalities for autistic young people.

39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 **METHOD:**

54 55 56 **Study Design:**

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3 This was a cohort study using primary data, collected in a mental health out-patient setting,
4 as part of an initial assessment appointment.
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10 **Setting:**

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12 This study was carried out in a large mental health trust in the North West of England,
13 serving a population of approximately 1.5 million and providing health and care services,
14 including mental health, intellectual disability, community physical health and all-age
15 disability care.
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20 **Study population:**

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22 The study population included all young people aged 5-18 years who were referred to the
23 Children and Young People's Mental Health (CYPMH) service and participated in an initial
24 assessment between January 2019 and December 2019. Participants were identified from the
25 electronic patient records.
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31 **Data variables, sources of data and data collection:**

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33 All the data were obtained from the electronic patient record system. The "Current View"
34 Tool (Jones et al., 2013) is completed routinely by Children and Young People's Mental Health
35 service clinicians (e.g. mental health nurses, learning disability nurses, clinical psychologists)
36 at initial assessment to collect clinical data in England. There are 50 items, broken down into
37 4 groups - "provisional problem description" (e.g. social anxiety, psychosis) "selected
38 complexity factors" (e.g. young carer status, looked after child), "contextual problems" (e.g.
39 home issues, community/engagement issues) and "education, employment and training
40 issues" (e.g. attendance difficulties, attainment difficulties). Each item was recorded as yes,
41 no or unknown. "Unknown" included missing data.
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53 Variables collected included: basic demographic data, reason for referral and responses to all
54 the "Current View" Tool items.
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3 Postcodes were used to identify indices of multiple deprivation deciles based on the Index of
4 Multiple Deprivation 2019 (IMD, 2019) which is the official measure of relative deprivation in
5 England. These are commonly reported in deciles ranging from the wards in the most
6 deprived 10% in England to the 10% in the least deprived.
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12 The predominant mental health issue experienced by young people were used to identify the
13 main reason for referral. Young people referred to CYPMHS can present with multiple mental
14 health comorbidities.
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24 Data were extracted from the electronic patient records system in an anonymised form and
25 imported to Excel and *Stata Statistical Software: Release 17* for analysis (StataCorp, 2021).
26 Numbers and percentages were calculated. Odds ratios (OR) with 95% confidence intervals
27 (CI) were calculated for the differences between the “Current View” Tool items for autistic
28 young people and non-autistic young people. Differences at the 0.1% level ($p < 0.001$) were
29 regarded as significant as we were using multiple comparisons. Differences between group
30 means were analysed using T-Tests. The Mean and Standard Error of both groups were
31 reported, and we accepted statistical significance at $p < 0.05$.
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41 **Results:**

42 *Demographic factors*

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44 The demographics for the 2259 young people referred to a CYPMH service in 12 months
45 from January 2019 are in Table 1. Of these, 302 (13%) were recorded as autistic, 1409
46 (63%) were non-autistic and 548 (24%) where it was reported to be unknown if the young
47 person was autistic or not. Of those recorded as autistic, the majority (71%) were male.
48 Almost half of young people referred to the CYPMH service were aged 14-18 years; the
49 majority were from white British background and indices of multiple deprivation (IMD)
50 deciles were evenly distributed across the population. There was no statistically significant
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3 difference in these demographic profiles between autistic young people and non-autistic
4 young people.
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10 *Reason for referral*

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13 The main reasons for referral to the CYPMH service as identified at referral are shown in
14 Table 2. The most common reason for referral was anxiety 452 (20%), followed by self-harm
15 240 (10%), depression 229 (10%) and behaviour issues 223 (10%). Autism was the main
16 reason for referral for 73 (3%) of young people.
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20 *“Current View” Tool*

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23 The number of records that were marked as unknown or missing varied with each item. This
24 ranged from 21 (1%) for “looked after child” to 1083 (48%) for “current protection plan”.
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26 The mean number of records with unknown or missing data for an item was 158, but this
27 was a skewed distribution with a median of 105 records (Interquartile range 71 to 147).
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29 There were 7 items where the records were less than 90% completed.
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37 *“Current View” Tool: “Provisional Problem Description”*

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39 In the “Current View” tool category “provisional problem description”, 19 items were
40 significantly associated with autistic young people ($p < 0.001$) (Table 3). They included a
41 higher prevalence of mental health issues. These were internalized anxiety issues (“anxious
42 away from care givers”, “anxious generally”, “avoids specific things”, “anxious in social
43 situations”, “compelled to do or think things”), and items related to neurodevelopmental
44 issues (“difficulties sitting still or concentrating”, “unexplained developmental needs”) and
45 behavioural issues (“behavioural difficulties”). Further items that were associated with
46 autistic young people may highlight barriers to accessing healthcare (“carer management of
47 the child/young person’s behaviour”, “does not speak”, “avoids specific things”,
48 “adjustment to health issues”). There were also items associated with autistic young people
49 indicating social and developmental difficulties (“peer relationship difficulties”, “self-care
50 issues”).
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6 Four “provisional problem description” items (“drug and alcohol difficulties”,
7 “depression/low mood”, “repetitive problematic behaviours”, and “disturbed by traumatic
8 event”) were significantly negatively associated ($p < 0.001$) with autistic young people
9 compared to non-autistic young people.
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17 *“Current View” Tool: Selected Complexity Factors, Contextual Problems,*
18 *Education/Employment/Training Issues*
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21 The “Current View” Tool categories “selected complexity factors”, “contextual problems”,
22 and/or “education, and employment and training issues” showed seven of the twenty items
23 across these categories were significantly associated with autistic young people (p value
24 < 0.001) (Table 3). One of the items (“experience of abuse or neglect”) was significantly
25 negatively associated ($p < 0.001$) in autistic young people compared to non-autistic young
26 people. The remaining 6 items that were positively associated with autistic young people
27 are listed in (Table 3).
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38 For each individual, the number of items that were scored yes on the “Current View” Tool in
39 “complexity factors”, “contextual problems”, and “education, employment and training
40 issues” were totalled. The mean number of these items for autistic young people was 5.1 (SE
41 = 0.16) and non-autistic young people was 3.45 (SE = 0.07), p value < 0.05 .
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46 **Discussion:**
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48 This is the first UK based study to use the data routinely entered in the “Current View” Tool
49 to assess the profile of autistic and non-autistic young people referred to CYPMH services,
50 using “provisional problem description”, “selected complexity factors”, “contextual
51 problems” and “education, employment and training issues”. There were a number of key
52 findings.
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3 For autistic young people there were a number of associations with comorbidities identified
4 in the category “provisional problem description” indicating the complexity of needs. These
5 included internalising issues (e.g. generalised, social and separation anxiety),
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7 neurodevelopmental conditions, including problems with concentration, and behavioural
8
9 difficulties. This is in line with previous findings (Simonoff et al., 2008). There were
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11 associations between “behavioural difficulties”, “self-care issues”, “doesn’t get to the toilet
12
13 in time”, “carer management of the child/young person’s behaviour” and “poses risk to
14
15 others” and autistic young people. Behavioural difficulties are common amongst autistic
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17 young people, and they can place others at risk (Gorlin et al., 2016). A number of factors
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19 including problems understanding their environment, due to a lack of structure and
20
21 consistency, may account for behavioural difficulties displayed by autistic young people
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23 (Totsika et al., 2010). Providing structure and routine for autistic young people who display
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25 high levels of comorbidities and complexities is likely to prove challenging to parents/carers
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27 without the right multi-agency support, that is involvement from health, social care and
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29 education. For example, while CYPMH services are commissioned to respond to
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31 comorbidities identified as mental health issues, and any associated “behavioural
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33 difficulties”, supporting “carer management of the child/young person’s behaviour” may
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35 require respite support via social care (Salomone et al., 2017). Additionally, to prevent
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37 behavioural difficulties escalating, and any associated risk to others, a multi-agency
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39 response to risk management may be required (NHS England, 2015a).

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42 Autistic young people were assessed as having more complex needs at the initial
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44 assessment. Autistic young people had on average a significantly higher number of items
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46 (5.1 v 3.5 $p < 0.05$) scored in the three “Current View” Tool categories: “selected complexity”,
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48 “contextual problems” and “education, employment and training issues” than non-autistic
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50 young people. The items in these categories ranged from “parental health issues”, “deemed
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52 child in need” to the young person’s own “attainment difficulties”. These different
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54 categories once again reflect the challenges inherent in supporting autistic young people
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56 and indicate the need for a multi-agency response to improve health, social care, and
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58 educational outcomes, alongside reducing health inequalities (NHS England, 2015b; NHS
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60 England, 2017).

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3 There were several associations identified on the “Current View” Tool (e.g. “avoids specific
4 things”, “does not speak”) that could contribute to barriers for autistic young people
5 accessing and engaging with services and achieving good health outcomes. The item
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7 “adjustment to health issues” was associated with autistic young people. People with
8
9 neurodevelopmental needs are known to struggle to access health care services, due to the
10
11 lack of reasonable adjustments (Westminster Commission on Autism, 2016), which may
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13 account for difficulties adjusting to both emotional and physical healthcare issues.
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18 In this study there was a significant association between “engagement issues” and autistic
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20 young people. This may mean in some instances that they did not attend the first
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22 assessment, due to difficulties communicating, and parents/carers may have had to
23
24 attended in the absence of the young person. Where mental health and
25
26 neurodevelopmental needs have been identified following the initial assessment, effectively
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28 addressing these needs requires continued engagement with services (Crane et al., 2019).
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31 These different factors such as avoidance of specific situations and difficulties
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33 communicating, as well as co-morbid mental health issues (e.g. anxiety), commonly
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35 experienced by autistic young people, will impact negatively on engagement across school,
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37 home and community environments. This can have other effects such as autistic young
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39 people having difficulties accessing community short breaks provision and engaging with
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41 healthcare systems. These all may prove challenging for these young people, once again
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43 leading to poorer health outcomes.
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45 Young people with autism are vulnerable to traumatization due to their deficits in social
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47 communication and emotional regulation (Hoover, 2015). However, we found that
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49 “Depression/low mood” and “disturbed by traumatic event” were negatively associated
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51 with autistic young people. This may be because trauma-related presentations may be more
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53 difficult to identify in young people with autism, compared to young people without autism.
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55 This may be due to the complexity of how trauma-related disorders are experienced and
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57 expressed by young people with autism, and cause difficulties for their accurate
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59 identification (Ng-Cordell et al., 2022). Autistic young people referred to CYPMH services
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often experience problems communicating their feelings and emotions when accessing

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3 services. Diagnostic overshadowing may lead to symptoms consistent with low mood (e.g.
4 withdrawing from activities) and trauma responses, being attributed to their autism, as
5 opposed to the symptoms indicating a deterioration in mood or post-traumatic stress
6 disorder. We are therefore uncertain if this is a true finding.
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10 Autism is a risk factor for substance misuse (Butwicka et al., 2017), leaving individuals
11 susceptible to negative consequences in daily functioning and physical health (Weir et al.,
12 2021). In contrast, “Drug and alcohol issues” were negatively associated with autistic young
13 people. Identify drug and alcohol use may have been a challenge due to the sensitive nature
14 of this topic. Autistic young people participating in this study ranged up to 18 years old, and
15 use of drugs and alcohol may be more prevalent in young adulthood. Furthermore, we know
16 that autistic young people are more likely to struggle to access a peer group due to social
17 and communication difficulties. Consequently, they may be less likely to experience peer
18 interactions, where adolescent exploration of drug and alcohol use takes place.
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20 The item “experience of abuse or neglect” was found to be negatively associated with
21 autistic young people. This finding may be correct but could be interpreted in different
22 ways. For example, it may be that autistic young people struggle to recognise and
23 understand experiences of abuse and neglect and then to articulate them.
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27 We found no associations between “eating issues”, “gender discomfort issues” and autistic
28 young people. This is in contrast to the growing evidence base (Autistica, 2019; Baraskewich
29 et al., 2021; Van Der Miesena et al., 2016). However, this study analysed the data of the
30 “Current View” Tool items completed at initial assessment following referral to a CYPMH
31 services. It is possible that such issues had not been identified by clinicians at this point. It
32 may be that additional training could be beneficial in developing both clinical skills and
33 knowledge to recognise such issues and inform intervention responses accordingly.
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36 In about a quarter (548) (22%) of young people, it was unknown if they were autistic or not.
37 Clinicians may have failed to ask if the young person had autism or not when the “Current
38 View” Tool was completed at initial assessment accounting for unknown responses. Also,
39 some young people may have been awaiting an autism diagnostic assessment, which may
40 also account for unknown responses.
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3 Additional items that were not completed in more than ten percent of records included;
4 “parental health issues”, “living in financial difficulty” and “current protection plan”.
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6 Parent/carer health issues and financial challenges are all pertinent to informing an
7 understanding of the environment in which autistic young people live and informing a multi-
8 agency response to need. Clinicians may have avoided asking what they considered
9 sensitive questions. This may be due to concerns this would impact negatively on the
10 therapeutic alliance, but this does not seem likely for all of the items (e.g. “parental health
11 issues”). Failure to complete all items on the “Current View” tool may mean a less effective
12 care package is initiated.
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21 The clinical implications of this study are firstly, taking all the different issues together, the
22 findings highlight that autistic young people referred to CYPMH services experience a
23 greater number of comorbidities and complexities than non-autistic young people.
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29 The comorbid issues as highlighted in the category “provisional problem description”
30 included anxiety issues. Therefore, mental health clinicians need to ensure that anxiety
31 symptoms are not being dismissed as part of autism, as they are not core symptoms of
32 autism and may require treatment. Both pharmacological and non-pharmacological
33 interventions need to be available to treat anxiety. Capacity needs to be developed within
34 services to deliver non-pharmacological interventions including, specifically adapted anxiety
35 management approaches.
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44 In order to respond appropriately to these comorbidities and complexities, in designing and
45 delivering services for autistic young people, a multi-disciplinary team approach may be
46 recommended. This study found that “self-care issues”, “behavioural difficulties” and
47 “unexplained developmental difficulties” were all associated with autistic young people.
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49 Consequently, input from occupational therapy, speech and language therapy is likely to be
50 useful as part of a team approach to informing intervention responses required
51 (Department of Health and Social Care, 2021).
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58 Secondly, given the varied needs of this population, they are likely to benefit from such
59 needs being addressed using a multi-agency approach. “Integrated care systems” (NHS
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3 England, 2019) are aimed at organisations that meet the health and care needs of the
4 population, and their focus is to promote the coordination and planning of services to
5 improve population health and reduce health inequalities.
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10 It is recommended that the adapted 'Thrive' model for CYPMH services, developed
11 specifically for autistic young people (Wee et al., 2021), is adopted to facilitate a multi-
12 agency approach to address the comorbidities and complexities of this population. The
13 focus on health, social care, and education working in partnerships to coordinate and plan
14 services to respond effectively to autistic young people, and their families, thereby
15 promoting positive outcomes and reducing health inequalities for this population.
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23 Thirdly, large amounts of data are collected via the "Current View" Tool in CYPMH services.
24 This data does not appear to be being used fully to inform how services are planned,
25 delivered or monitored. As we have shown, information about the comorbidities and
26 complexities is available for the population. This could be used alongside other routine data
27 to assess concordance with intervention pathways, if there are problems with loss to follow
28 up with different diagnostic groups and in some cases poorer outcomes.
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36 Fourthly, as trauma related incidents are experienced and expressed differently by autistic
37 young people compared to non-autistic young people, mental health clinicians may fail to
38 identify a trauma presentation. Therefore, training for clinicians focusing on an
39 understanding of the unique effects of trauma on autistic young people is recommended to
40 promote the identification and assessment of trauma, alongside effective treatment
41 strategies. Training focusing on reasonable adjustments, for professionals working with
42 autistic young people will contribute to supporting access and engagement with community
43 and healthcare provision.
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51 Finally, additional research is required to assess how the data entered on the "Current
52 View" Tool correlates with the daily health and care support required by autistic young
53 people and so increase the understanding of the complex multi-agency needs of autistic
54 young people accessing CYPMH services. This could then inform the development of clinical
55 pathways across multi-agency services responsible for meeting the needs of this group of
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3 young people. This approach should be used when implementing the proposed “Integrated
4 care systems”.

5 6 7 **Strengths and Limitations:**

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9 The study had a number of strengths. This was the first study in England that looked at the
10 routinely collected data using the “Current View” Tool to understand the needs of autistic
11 young people accessing mental health services. The study followed the Strengthening the
12 Reporting of Observational Studies in Epidemiology (STROBE) statement (von Elm E et al.,
13 2007). The study looked at a large data set and used a large sample size for data analysis. As
14 the study was considering a large number of variables for comparison, it set a robust
15 significance level at $p < 0.001$.

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17 There were some weaknesses to the study. It explored the “Current View” Tool category
18 “provisional problem description” using a dichotomous scale, as opposed to the
19 mild/moderate/severe scoring levels which may have reduced the sensitivity of the analysis.
20 Also for 548 (22%) of participants it was unknown if they were autistic or not. It is possible
21 that they did not have autism but this is not certain. If a moderate proportion of them did
22 have autism this could change our findings. By only using the main reason for referral we
23 may have over-simplified the presenting situation of the young people. Some of the
24 concomitant co-morbidities are also likely to have had an impact on the behaviour and care
25 needs of the young person, but including this in the analysis of the reason for referral was
26 going to be too complex.

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28 The majority of participants in the study were white British. To enhance knowledge of the
29 needs of autistic young people from different ethnic backgrounds, and the multi-agency
30 response required to meet their needs, further work with minority groups is required.

31 32 33 **Conclusion:**

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35 This study demonstrates that autistic young people accessing CYPMH services had a greater
36 intricacy of health and care needs than non-autistic young people. These needs were varied
37 including mental health, neurodevelopmental, behavioural, engagement and care needs.
38 The fact that this group have greater needs should be taken into account when planning
39 services, ensuring sufficient emphasis is placed on multi-agency partnerships.

40 41 42 **ACKNOWLEDGEMENTS:**

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3 This project was conducted through the Structured Operational Research and Training
4 Initiative (SORT IT), a global partnership led by the Special Programme for Research and
5 Training in Tropical Diseases at the World Health Organization (WHO/TDR). The training is
6 based on a course developed jointly by the International Union Against Tuberculosis and
7 Lung Disease (The Union) and Médecins sans Frontières (MSF). This specific SORT IT
8 program was run by Cheshire and Wirral Partnership (CWP) NHS Foundation Trust as part of
9 routine work. Mentorship and the coordination/facilitation of these SORT IT workshops
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15 sectors. All the authors declare no conflicts of interest.
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30 **Ethical information:**

31 The study was approved through Cheshire and Wirral NHS Foundation Trust research ethics
32 approval process. Data was extracted and anonymised from the standard electronic patient
33 record system used in routine clinical care. According to the Health Research Authority
34 algorithm (see <http://www.hra-decisiontools.org.uk/research/>) this study was not defined as
35 research and therefore did not require submission to the Integrated Research Application
36 System (a single system for applying for the permissions and approvals for health and social
37 care / community care research in the UK).
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5 [data/file/585376/Lenehan_Review_Report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585376/Lenehan_Review_Report.pdf)
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Table 1. Key demographic variables for autistic young people and non-autistic young people referred to a CYPMH service between January 2019 - December 2019

| Characteristic | Total N | Autistic N (%) | Non-autistic N (%) | Unknown N (%) |
|--------------------------------------|------------|-------------------|-----------------------|------------------|
| Gender | | | | |
| Male | 1018 | 215 (21.1) | 495 (48.6) | 308 (30.3) |
| Female | 1230 | 86 (7.0) | 907 (73.7) | 237 (19.3) |
| Other | 11 | 1 (9.1) | 7 (63.6) | 3 (27.3) |
| Age | | | | |
| 4-6 | 128 | 29 (22.7) | 47 (36.7) | 52 (40.6) |
| 7-10 | 437 | 82 (18.8) | 203 (46.5) | 152 (34.8) |
| 11-13 | 611 | 79 (12.9) | 364 (59.6) | 168 (27.5) |
| 14-18 | 1083 | 112 (10.3) | 795 (73.4) | 176 (16.3) |
| Ethnicity | | | | |
| White British | 1455 | 218 (15.0) | 862 (59.2) | 375 (25.8) |
| Asian British | 13 | 3 (23.1) | 9 (69.2) | 1 (7.7) |
| Black | 3 | 2 (66.7) | 0 (0.0) | 1 (33.3) |
| Mixed | 25 | 1 (4.0) | 21 (84.0) | 3 (12.0) |
| Other | 4 | 1 (25.0) | 2 (50.0) | 1 (25.0) |
| Missing | 759 | 77 (10.1) | 515 (67.9) | 167 (22.0) |
| Index of Multiple Deprivation | | | | |
| Decile 1 | 364 | 54 (14.8) | 231 (63.5) | 79 (21.7) |
| Decile 2 | 268 | 34 (12.7) | 164 (61.2) | 70 (26.1) |
| Decile 3 | 214 | 26 (12.1) | 122 (57.0) | 66 (30.8) |
| Decile 4 | 168 | 19 (11.3) | 96 (57.1) | 53 (31.5) |
| Decile 5 | 129 | 17 (13.2) | 84 (65.1) | 28 (21.7) |
| Decile 6 | 152 | 25 (16.4) | 94 (61.6) | 33 (21.7) |
| Decile 7 | 229 | 24 (10.5) | 151 (65.9) | 54 (23.6) |
| Decile 8 | 209 | 34 (16.3) | 130 (62.2) | 45 (21.5) |
| Decile 9 | 197 | 28 (14.2) | 130 (66.0) | 39 (19.8) |
| Decile 10 | 317 | 40 (12.6) | 199 (62.8) | 78 (24.6) |

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Table 2 – Reason for referral to a CYPM service

| Referral Reason | Total No. | % |
|--|-------------|------------|
| Anxiety | 452 | 20 |
| Self-Harm | 240 | 10 |
| Depression | 229 | 10 |
| Behaviour | 223 | 10 |
| Emotional Problems | 126 | 6 |
| Suicidal Thoughts | 117 | 5 |
| Autism | 73 | 3 |
| Eating Disorder | 68 | 3 |
| Attention Deficit Hyperactivity Disorder | 61 | 3 |
| Post-Traumatic Stress Disorder | 57 | 3 |
| Unknown | 152 | 7 |
| Other | 461 | 20 |
| Total | 2259 | 100 |

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Table 3. The relationship of different items in the “Current View” tool to autistic young people and non-autistic young people referred to a CYPMH service during 2019

| Current View Item | Total for this item† N | Total for this item with autism N (%) | Total for this item with no autism N (%) | OR | (95% CI) | P value. |
|---|---------------------------|--|---|-----|-------------|----------|
| Provisional Problem Description | | | | | | |
| 1. Anxious away from caregivers | 758 | 189 (25) | 569 (75) | 1.9 | (1.5-2.4) | <.0001* |
| 2. Anxious in social situations | 1080 | 218 (20) | 862 (80) | 2.0 | (1.5-2.7) | <.0001* |
| 3. Anxious generally | 1154 | 263 (23) | 891 (77) | 1.8 | (1.4-2.3) | <.0001* |
| 4. Compelled to do or think things | 366 | 110 (30) | 256 (70) | 2.2 | (1.7-2.9) | <.0001* |
| 5. Panics | 692 | 121 (17) | 571 (83) | 0.8 | (0.6-1) | 0.7 |
| 6. Avoids going out | 484 | 122 (23) | 372 (77) | 1.3 | (1-1.7) | .05 |
| 7. Avoids specific things | 300 | 86 (29) | 214 (71) | 1.9 | (1.4-2.5) | <.0001* |
| 8. Repetitive problematic behaviours | 272 | 111 (41) | 161 (59) | 0.1 | (0.1 - 0.2) | <.0001* |
| 9. Depression/low mood | 1144 | 182 (16) | 962 (84) | 0.5 | (0.4-0.6) | <.0001* |
| 10. Self-harm | 755 | 151 (20) | 604 (80) | 1 | (0.8-1.2) | 0.7 |
| 11. Extremes of mood | 290 | 75 (26) | 215 (74) | 1.5 | (1.1-2) | 0.007 |
| 12. Delusional beliefs/hallucinations | 61 | 11 (18) | 50 (82) | 0.9 | (0.5-1.7) | 0.7 |
| 13. Drug and alcohol difficulties | 156 | 16 (10) | 140 (90) | 0.4 | (0.2-0.7) | <.0001* |
| 14. Difficulties sitting or concentrating | 516 | 195 (38) | 321 (62) | 4.4 | (3.4-5.6) | <.0001* |
| 15. Behavioural difficulties | 501 | 176 (35) | 325 (65) | 3.2 | (2.5-4.1) | <.0001* |
| 16. Poses risk to others | 350 | 134 (38) | 216 (62) | 3.3 | (2.5-4.2) | <.0001* |
| 17. Carer management of behaviour | 497 | 145 (29) | 352 (71) | 2.1 | (1.7-2.7) | <.0001* |
| 18. Doesn't get to the toilet in time | 94 | 48 (51) | 46 (49) | 5 | (3.3-7.6) | <.0001* |
| 19. Disturbed by traumatic event | 482 | 54 (11) | 428 (89) | 0.5 | (0.3-0.6) | <.0001* |
| 20. Eating issues | 368 | 70 (19) | 298 (81) | 0.9 | (0.7-1.2) | 0.4 |
| 21. Family relationship difficulties | 848 | 144 (17) | 704 (83) | 0.7 | (0.6-0.9) | 0.005 |
| 22. Problems in attachment to parent | 466 | 80 (17) | 386 (83) | 0.9 | (0.6-1.1) | 0.3 |
| 23. Peer relationship difficulties | 917 | 235 (26) | 682 (74) | 2.3 | (1.8-3) | <.0001* |

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|--|-----|---------|----------|-----|------------|----------|
| 24. Persistent relationship difficulties | 292 | 80 (27) | 212 (73) | 1.7 | (1.3-2.2) | 0.0005 |
| 25. Does not speak | 68 | 44 (65) | 24 (35) | 8 | (4.8-13.4) | < .0001* |
| 26. Gender discomfort issues | 44 | 13 (30) | 31 (70) | 1.9 | (1-3.6) | 0.1 |
| 27. Unexplained physical symptoms | 102 | 22 (22) | 80 (78) | 1.4 | (0.8-2.3) | 0.2 |
| 28. Unexplained developmental needs | 75 | 33 (44) | 42 (56) | 3.4 | (2.1-5.5) | < .0001* |
| 29. Self-care issues | 205 | 82 (40) | 123 (60) | 3.2 | (2.3-4.3) | < .0001* |
| 30. Adjustment to health issues | 143 | 44 (31) | 99 (69) | 1.9 | (1.3-2.8) | <.0001* |

Selected Complexity Factors

| | | | | | | |
|---------------------------------------|-----|-----------|----------|-----|------------|---------|
| 1. Looked after child | 122 | 18 (15) | 104 (85) | 0.6 | (0.4-1.1) | 0.1 |
| 2. Young carer status | 67 | 11 (16) | 56 (84) | 0.7 | (0.4-1.4) | 0.4 |
| 3. Learning disability | 124 | 88 (71) | 36 (29) | 124 | (9.2-21) | <.0001* |
| 4. Serious physical health issues | 90 | 22 (24) | 68 (76) | 90 | (0.8-2.1) | 0.3 |
| 5. Pervasive developmental disorder | 302 | 302 (100) | 0 (0) | ref | | |
| 6. Neurological issues | 50 | 22 (44) | 28 (56) | 3.4 | (1.9-6) | <.0001* |
| 7. Current protection plan | 196 | 35 (18) | 161 (82) | 0.7 | (0.5-1.1) | 0.1 |
| 8. Deemed child in need | 179 | 64 (36) | 115 (64) | 2.4 | (1.7-3.4) | <.0001* |
| 9. Refugee or asylum seeker | 7 | 0 (0) | 7 (100) | 0.3 | (0-4.6) | 0.4 |
| 10. Experience of war/torture | 7 | 3 (43) | 4 (57) | 4.1 | (0.9-18.6) | 0.1 |
| 11. Experience abuse or neglect | 362 | 43 (12) | 319 (88) | 0.5 | (0.3-0.7) | <.0001* |
| 12. Parental health issues | 432 | 69 (16) | 363 (84) | 0.8 | (0.6-1.1) | 0.2 |
| 13. Contact with youth justice system | 74 | 12 (16) | 62 (84) | 0.7 | (0.4-1.4) | 0.4 |
| 14. Living in financial difficulty | 78 | 9 (12) | 69 (88) | 0.6 | (0.3-1.2) | 0.1 |

Contextual Problems

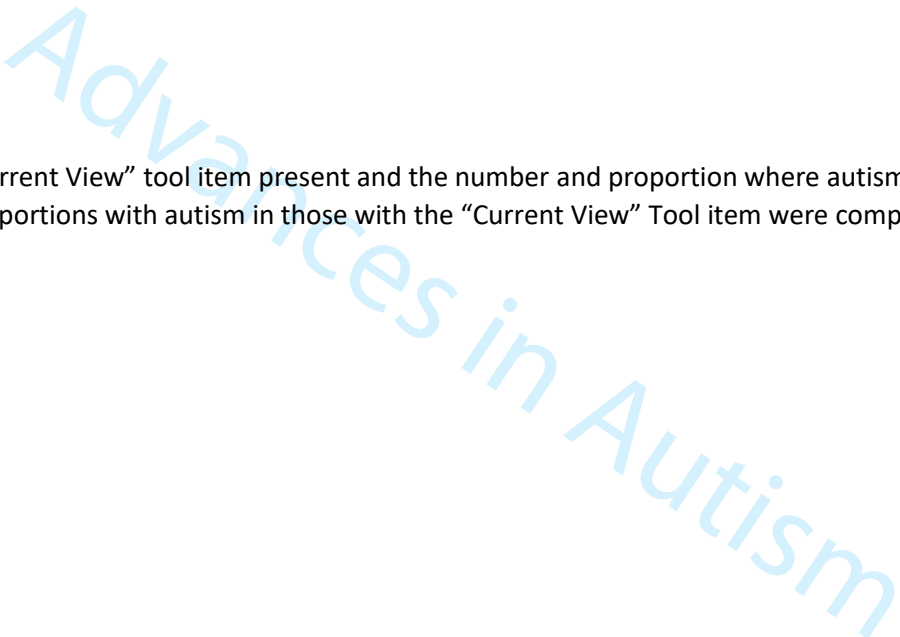
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|----------------------|------|----------|----------|-----|-----------|---------|
| 1. Home issues | 1021 | 210 (21) | 811 (79) | 1.1 | (0.9-1.4) | 0.3 |
| 2. School issues | 1162 | 245 (21) | 917 (79) | 1.2 | (0.9-1.6) | 0.1 |
| 3. Community issues | 595 | 144 (24) | 451 (76) | 1.5 | (1.2-1.9) | <.0008* |
| 4. Engagement issues | 474 | 123 (26) | 351 (74) | 1.7 | (1.3-2.2) | <.0001* |

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| Education/employment/training | | | | | | | | | |
|--------------------------------------|-------------------|-----|-----|------|-----|------|-----|-----------|---------|
| 1. | Attendance issues | 609 | 128 | (21) | 481 | (79) | 1.1 | (0.9-1.4) | 0.4 |
| 2. | Attainment issues | 558 | 169 | (30) | 389 | (70) | 2.7 | (2.1-3.5) | <.0001* |

†Data shows total records with the “Current View” tool item present and the number and proportion where autism is also present. Full data for OR calculations not shown: in brief the proportions with autism in those with the “Current View” Tool item were compared with the proportions with autism in those where the item was not present.

*= Significant at <0.001 or less



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