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A total of 2826 students attended medical schools that provided visits. However, only 1211 students actually attended clinical visits, although some of these went on more than one. The venues for the visits were: high security hospital, 776 students (64%); locked ward, 220 (18%); open ward, 205 (17%); medium secure hospital unit, 110 (9%); prison, 26 (2%); court, 16 (1%); and community forensic service, 10 (1%).

For one medical school a visit for 30 of the 166 students in the year to a locked ward was the only form of teaching in forensic psychiatry provided.

## Special study modules

Four medical schools offered SSMS in forensic psychiatry. These took place on 1 day each week and were based in high security hospitals, medium secure units or prisons, and often incorporated visits to various other forensic settings. The duration of the shortest SSM was 4 weeks and the longest 12 weeks. Up to seven students could take part in each running of the SSMS, which took place several times each year.

## Written work

Two medical schools asked a total of 10 students to produce written work in forensic psychiatry.

## Discussion

The study's response rate of 87% was satisfactory. However, less than three-quarters of the responding medical schools actually provided any forensic psychiatry teaching to their students. Even where teaching was organised, in many schools it was often very limited in

extent and in nearly all of them activities such as visits and placements were only available to a relatively small proportion of the students in the year.

Visits were organised much more frequently to high security hospitals, locked and open wards, than to medium secure hospital units and non-hospital settings, which might indicate that medium secure units, community resources, courts and prisons are underdeveloped for teaching purposes. In particular, the continuing expansion of medium security services provides a valuable teaching resource, and students should also be encouraged to witness at first hand the high prevalence of psychiatric disorder in prisons (Singleton, *et al*, 1998).

Only four of the medical schools provided a SSM in forensic psychiatry. Forensic psychiatry is an ideal subject to be studied in this format, which encourages a longitudinal perspective and allows interested students to explore the subject in depth. Further development should be encouraged.

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CLAIRE BALL

# Attention-deficit hyperactivity disorder and the use of methylphenidate

A survey of the views of general practitioners

### AIMS AND METHOD

General practitioners (GPs) were surveyed on their experience of and attitudes towards attention-deficit hyperactivity disorder (ADHD) treatment using methylphenidate, and asked about prescribing practice.

### RESULTS

Most GPs have experience of children with ADHD and the use of

methylphenidate. The majority felt that it was a drug that should be initiated by a specialist who should continue to provide clinical monitoring, but that primary care could provide ongoing prescribing and physical monitoring. There was a lack of training in this area, with most GPs requesting further training both on ADHD and its management.

### CLINICAL IMPLICATIONS

ADHD is a topical issue both in the health service and with the public. This survey suggests that GPs may be willing to play a role in the management of ADHD once the child has seen a specialist, but that child and adolescent mental health services need to consider how training will be provided.

Attention-deficit hyperactivity disorder (ADHD) (DSM-IV; American Psychiatric Association, 1994) occurs in 3–5%

of school-aged children and the number of referrals to child and adolescent psychiatric services is increasing



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annually. Hyperactivity in primary school aged children is a risk factor for conduct disorder (Taylor *et al*, 1996) and those with ADHD have a higher risk of developing substance misuse problems (Goldman *et al*, 1998), probably mediated through conduct disorder. The presence of ADHD has also been found to be higher in the prison population (Eyestone & Howell, 1994). It is therefore imperative that children with ADHD are appropriately diagnosed and adequately treated. Stimulant medication, most commonly methylphenidate, has been found to be clearly effective in the treatment of ADHD (Spencer *et al*, 1996) and, for example, when the dosage is carefully tailored, shown to be superior to behavioural treatment (MTA Cooperative Group, 1999). Despite this evidence, concern about the use of stimulant medication in children continues to attract public interest, for example as highlighted in the recent *Panorama* programme 'Kids on Pills' (April 2000).

Guidelines on the treatment of ADHD have now been produced in both the US and Europe (Dulcan, 1997; Taylor *et al*, 1998). In the UK there are no clear guidelines on who is responsible for the prescribing and monitoring of methylphenidate. Despite an increased expectation of general practitioners' (GPs) involvement in the 'shared-care' of children with ADHD, little is known in relation to their views of ADHD and the prescribing and monitoring of methylphenidate. Hyperactivity has been found to be one of the presenting problems, seen by GPs, most in need of a child psychiatric service. It is also an area that GPs are most concerned about or feel least experienced in (Adamson & Killelea, 1996). In order to develop guidelines at a service level it would be advantageous to have a better understanding of the views of GPs, thereby enabling child and adolescent mental health services (CAMHS) to work collaboratively with primary care in the management of ADHD.

## The study

A questionnaire to assess GPs' views on ADHD and the use of methylphenidate was devised and sent to 221 GPs in the Swansea, Neath and Port Talbot area in South Wales between May and September 1999. The questionnaire included items on the GPs' experience and familiarity with ADHD and methylphenidate, the perception of the role of various professionals in the initiating, monitoring and prescribing of methylphenidate, whether their prescribing practice would change under different circumstances and the need for further training.

The questionnaires were sent with an explanatory letter and a prepaid envelope. Initial non-responders were sent a second questionnaire.

## Findings

Of 221 questionnaires sent out, 150 responses (68%) were received. Of those responding, 30% were women and 70% were men. Eight per cent of respondents were aged 25–35 years, 50% were aged 36–45 years, 31% were aged 45–56 years and 11% over the age of 56 years. The mean length in practice was 15.5 years.

## Experience of ADHD

Eighty-five per cent of GPs had a child or children in their practice with a diagnosis of ADHD. A further 13% believed that they had a child in the practice that they suspected might have ADHD.

Only 6% had received formal training on ADHD, for example during their vocational training scheme, and a further 4.5% had attended a conference or course on the subject. However, 28.5% had read journal articles and 21% had gained information from the media, including television, magazine and newspaper articles.

## Current prescribing practice

Eighty-nine per cent of GPs prescribed methylphenidate, with 98% of these being supervised by a specialist – the majority by a child psychiatrist (69%) or by child psychiatry and paediatrics (19%).

Of the 11% who did not prescribe, reasons given included not having enough experience or knowledge of the drug, with only one GP stating it should not be used at all and no one giving cost as the reason for not prescribing.

## The role of professionals

Perception of the role that various professionals, namely child psychiatrists, paediatricians, GPs and practice nurses, can play in the initiation, monitoring and regular prescribing of methylphenidate is shown in Table 1.

Sixty-five per cent of GPs felt that a child psychiatrist should initiate prescribing, with no GPs believing that they should start a child on methylphenidate themselves. The majority also felt that initial physical investigations should be conducted by a specialist – either a child

Table 1. General practitioners' (GPs) views of which professionals should have the primary responsibility for different aspects of care (%)

	Child psychiatrist (CP)	Paediatrician (P)	Either CP or P	GP	Practice nurse	Combination
Initial prescribing	65	7	28	0	0	0
Initial physical investigations	35.5	16	19	5	13.5	11
Ongoing prescribing	34	5	9	46	0	6
Ongoing physical monitoring	21	9	8	26	28	8
Ongoing clinical monitoring	50	0	16	17	5.5	11.5
Combination, primary and secondary care						



psychiatrist (35.5%), a paediatrician (16%) or in combination (19%).

However, only 34% thought that a child psychiatrist should continue prescribing thereafter, with 46% of GPs happy to take over sole prescribing and a further 6% in combination with secondary care.

With reference to ongoing physical monitoring, 54% of GPs felt that the primary care team could perform this, with only 21% believing this was a role for the child psychiatrist.

In contrast, most GPs (66%) felt that clinical monitoring should be carried out by secondary care professionals (child psychiatrist, either individually or in combination with a paediatrician), with only 22.5% believing it could be carried out by the primary care team alone.

## Factors influencing prescribing practice among GPs

Sixty-four per cent felt that they would change their views on prescribing if there was clearer advice from specialists, with 67% stating that they would be influenced if there was a clear protocol on monitoring while a child was on medication.

## Training

Eighty-four per cent felt they wanted further training in ADHD in general and 88% wanted training specifically in the drug treatment of ADHD. The majority expressed a preference for this to be delivered by a tutorial or lecture (68%), with 27% requesting written information, 5% felt advice on the telephone would be sufficient.

## Discussion

The response rate of the survey was 68%, which is encouraging for a postal survey, particularly for GPs – who frequently feel that they are swamped by questionnaires (MacPherson & Bisset, 1995). This may indicate that the management of ADHD in general practice is topical, relevant and important. The high number of respondents who had a child/children with ADHD or suspected ADHD in their practice supports this view.

With reference to the use of methylphenidate, nearly all respondents believed that initial prescribing should be by a specialist, a view supported by Levy (1997). However, almost half (46%) of GPs then felt happy to take over prescribing once a child was stabilised on methylphenidate. In a study of child psychiatrists with a special interest in ADHD, 87% felt that GPs could continue prescribing until the next specialist review (Sayal & Taylor, 1997).

With physical monitoring (such as height, weight, blood pressure and blood tests, where necessary), 70.5% of GPs felt this should be performed by a specialist initially, but thereafter the majority of respondents concluded that it could be carried out in primary care,

with 28% indicating that the practice nurse could perform this.

In contrast, most GPs perceived that clinical monitoring is the domain of secondary care, generally the child psychiatrist.

It is interesting that among the GPs who did not prescribe methylphenidate at all, cost did not feature as a reason and only one felt that methylphenidate should not be part of the treatment package for ADHD. The most common reasons for not prescribing were either a lack of knowledge or experience about the drug. This highlights the need for more training in ADHD and in the use of medication, which is supported by the findings in this study that showed that 84% of respondents would value further training in the former and 88% in the latter. Few had received any formal training on ADHD, although more had read relevant journal articles. A significant number of respondents had gained information from the media, which could be misleading or biased depending on the source.

In order to treat children with ADHD effectively there needs to be consensus on optimal management and it is important that GPs are involved in this discussion. In a climate where GPs are feeling under increased pressure, there is the danger that they will not want to contribute to the management of often difficult and complex cases as seen in mental health services (Watters *et al*, 1994). This view was supported by additional comments, for example, “GPs will be asked to take over yet another duty monitoring and clinical supervision programme – marvellous idea for the secondary sector doctor but it never comes with resources” and “my workload is overwhelming, I do not have the time or resources to monitor yet another new specialist treatment”. However, many comments included the general principle of “diagnosis and initial prescribing done by the child psychiatrist or specialist, then shared-care for monitoring with consultant advice readily available”. As suggested by one GP, “to empower GP colleagues as partners in the management” could be the way forward in devising management strategies that would satisfy all professionals.

Although the survey was of only one area of the UK, it suggests that CAMHS needs to provide training for GPs and actively engage in discussions of shared-care for the management of ADHD.

## Limitations of the study

The study included only one area of the country and therefore may not represent the views of GPs in general. There may also be a bias of interest, as 32% did not respond and these may be GPs who have differing views to the respondents.

## Acknowledgements

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ALEX MEARS AND ADRIAN WORRALL

# A survey of psychiatrists' views of the use of the Children Act and the Mental Health Act in children and adolescents with mental health problems

## AIMS AND METHOD

To identify psychiatrists' concerns relating to the use of legislation in children and young people with mental health problems. Four hundred and eighty members of the child and adolescent faculty of the Royal College of Psychiatrists were asked to list their main concerns.

## RESULTS

Two hundred and fifty-eight members responded. The four most reported themes were: choosing between the Mental Health Act and the Children Act; general issues around consent to treatment; issues with social services departments; and the stigma associated with using the Mental Health Act.

## CLINICAL IMPLICATIONS

The range of themes identified from this survey have served to focus the evaluation of the use of the Children Act and the Mental Health Act in Children and Adolescents in Psychiatric Settings (CAMHA-CAPS), and informed the design of subsequent data collection tools. The project report has now been submitted to the Department of Health for consideration.

Both the Mental Health Act 1983 and the Children Act 1989 can be used to compulsorily detain a child or adolescent exhibiting mental health problems. Various Sections of the Mental Health Act can be used, including Section 2 (admission for assessment) and Section 3 (admission for treatment). Section 25 of the Children Act can be used to detain a young person, but only if he or she fulfils certain specific criteria: a) if the child has a history of absconding and is likely to abscond from any other accommodation and is likely to be a risk to himself/herself if he/she absconds; or b) if he/she is kept in any other accommodation he/she is likely to injure himself/herself or others. The Children Act can also be used to give a local authority parental responsibility for the child, and thus the power to consent for admission and treatment. There are no definitive guidelines as to which Act should be used under what circumstances, although the issue has been considered in the NHS Health Advisory

Service report (NHS Health Advisory Service, 1996). Further, little is known about the prevalence of the use of each of the Acts in such circumstances. The Department of Health has responded to this need for information by funding an evaluation of the use of the Children Act and the Mental Health Act in Children and Adolescents in Psychiatric Settings (CAMHA-CAPS).

As part of CAMHA-CAPS, a survey of the members of the Child and Adolescent Faculty of the Royal College of Psychiatrists was carried out. The purpose was to ascertain members' views on the use of the two types of legislation for people under the age of 18, and ensure that CAMHA-CAPS addresses these issues.

## Method

A questionnaire was sent to all 505 members of the Child and Adolescent Faculty with addresses in England and