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Treating hyperkinetic disorders in childhood

Treatment needs care but is worth while

British doctors are nowadays more likely to diagnose and treat hyperactivity in children. There are three reasons for the change. Firstly, the *International Classification of Diseases, 10th revision* (ICD-10) includes a definition of "hyperkinetic disorder" that is more explicit than previous versions.[1] The disorder is much more than naughtiness or high energy that overtaxes weary or depressed parents. Its essential characteristics are persistent traits of severe and pervasive inattentiveness, overactivity, and impulsiveness, beginning in the first five years of life. Centres that have changed from using ICD-9 to using ICD-10 have already noted that the diagnosis is being made more often.[2]

Secondly, pressure from parents' support groups has forced increased professional recognition. Private clinics, often promoted direct to the public, have been set up to diagnose "attention deficit-hyperactivity disorder." Some prescribe methylphenidate and other stimulant drugs in the North American way; others concentrate on advice about diet and allergies. Thirdly, methylphenidate has recently been made generally available in Britain after some years on a named patient basis.

In the light of these trends should the NHS be providing more specialist services? American and Australian practice is based on the fact that doctors there diagnose attention deficit-hyperactivity disorder very much more commonly than British doctors diagnose hyperkinetic disorder, even when they are all rating the same cases.[3] Strictly, hyperkinetic disorder is a subtype of attention deficit-hyperactivity disorder,[4] with different implications from those of other disturbances such as conduct disorder.[5-7] Children with hyperkinetic disorders are at considerable developmental risk and have high rates of language and motor delays; they are prone to develop antisocial conduct disorders. Severe hyperactivity may continue into adolescence and adult life and it is a risk for social adjustment even when account is taken of any coexistent conduct disorder.[8-10] The point prevalence of the hyperkinetic disorder is about 1·5% in 7 year old boys in inner cities[6]; in the whole population of prepubertal children it is likely to be about 0·5-1%. Administrative data suggest that most cases go undetected.

Recognising that a child has the hyperkinetic disorder is mostly a matter of taking a careful history, focusing on the child's ability to attend to play and learning activities as well as on control of activity. Observation of the child in a standardised setting may fail to detect a problem if there is little distraction and the examiner structures the test tightly. Psychometric tests of attention are useful research tools—and helpful in monitoring change—but not yet discriminating enough for individual diagnosis.

Much can be done to help these children. Identification of the problem is useful in itself. Any harm done by labelling is usually outweighed by the benefits to self esteem when the child and the family understand the nature of the disability that they have to cope with. Often an educational psychologist can advise the school about how to support attention and what extra resources would be useful.

Specific treatment is indicated when simple general measures are not enough. The most powerful is the use of stimulant drugs. Contrary to recent newspaper accounts, treatment with stimulants is neither new nor untried. The effect has been established by scores of double blind randomised trials.[11] Doubt persists about the long term efficacy, but clinical experience leaves little doubt that, for selected patients, the treatment continues to help psychosocial adjustment even after three or more years of treatment. Stimulants may occasionally have adverse psychological effects; they may have actions on sleep and appetite and may exacerbate tics and mannerisms. Careful monitoring is therefore needed, but if this is done the treatment is usually well tolerated.

Drug treatment is not always needed. Behavioural therapy is often effective by itself and may reduce the need for drugs.[12] Family interactions and expectations are likely to influence the course of the disorder and may need modification.[6] A few children may be helped if foods of which they are intolerant are identified and eliminated from the diet.[13] This is seldom just a matter of removing artificial additives: what is required is an arduous process of identifying individual intolerances, which calls for determination and resourcefulness in the family and the dietitian.

Each child should be assessed by a specialist before drug treatment is started. In the United States drugs have sometimes become the only therapeutic resource.[14,15] We need to prevent this happening in Britain, and that will require that the full range of effective treatments is used. We need to develop good cooperation among health professionals from different disciplines, with, for example, joint clinics between child psychiatrists and psychologists, working with developmental paediatric services. Liaison with schools is essential to help in the assessment of the underlying problems and the monitoring and delivery of treatment. Purchasing authorities should review the services provided for this group of children

and consider commissioning a clinic if needs are not being met. An authority buying services for 50 000 children should assume that at least 250 will have a hyperkinetic disorder.

The same purchasing authority should also expect to have a much larger group of perhaps 2000 less severely affected children with features of attention deficit-hyperactivity disorder but not hyperkinetic disorder. Their parents may be pressing for treatment by diet or drugs. This larger group is likely to be heterogeneous.[5] Some will have other types of learning difficulty, and their attention problem in the classroom will result from wrong expectations; some will have an attention problem as part of a wider emotional disturbance; a few will have an autistic type of social impairment. Since many of them have other psychiatric or medical problems or a family disturbance most European clinicians have preferred not to use drugs as the first line of treatment. They have preferred to begin by looking for remediable sources of stress and insecurity. Family doctors should consider referral to a child mental health service so that a comprehensive assessment can be made.

Even in this commoner and milder group of attention deficit-hyperactivity disorder, biological treatments may play a part. A good response to stimulants is less common than in the narrow category of hyperkinetic disorder, but it may still occur, and a trial of methylphenidate may be indicated—with specialist advice—if environmental manipulation or psychological measures have failed. Treatment can make a considerable difference to the lives of children with hyperkinetic disorder, but, as always, the first need is careful diagnosis.

ERIC TAYLOR
Professor of developmental neuropsychiatry

MRC Child Psychiatry Unit,
London SE5 8AF

ROSEMARY HEMSLEY
Lecturer in clinical psychology

Institute of Psychiatry,
London SE5 8AF

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Do we need an Ofhealth?

Other services have regulatory bodies to promote competition

The internal market was introduced into the NHS to improve patient care by freeing relationships between purchasers and providers. As markets in gas, water, and telephone services have been liberalised, regulatory bodies have been set up to promote competition and limit the behaviour of monopoly suppliers. Does the internal market need an Ofhealth, along the line of Ofgas (the Office of Gas Supply), Ofwat, and Oftel?

To get the benefits of a market there must be scope for comparison and choice between providers and for comparison between purchasers. But several features of the current internal market limit choice and comparison. For example, hospitals are likely to be monopoly suppliers of some of their services. Information on the quality of services may be poor. To enable suppliers to make decisions on investment they need longer term contracts, but these bring the danger of exploitation by one or other party to the contract.

Under current arrangements, purchasers do not directly compete with each other, which is not necessarily a bad thing—competition for patients among purchasers can be accompanied by selection of patients. But if purchasers don't have to worry about losing patients if the services they purchase for them are poor then limited incentive exists for purchasers to be very responsive to the populations on whose behalf they buy.

A case therefore exists for market regulation to protect users and taxpayers. Such regulation will have two goals—to limit monopolies from developing wherever possible and, where they exist, to limit the behaviour of monopolists on either the provider or purchaser side of the market. But regulation has a cost. Too much regulation stifles the incentives for innovation and change. Regulation may be ineffective because the regulator has less information than the regulated, and frequent change in regulatory policy is confusing and reduces incentives for change and growth. Any regulatory strategy for the NHS internal market should therefore aim to be clear and consistent and employ sanctions (not necessarily monetary) against those who break the rules.

To limit the development of monopolies an Ofhealth might scrutinise mergers, look for and outlaw collusion, and promote entry into the market of competitors—that is, introduce procompetitive policies. Actions to control monopolies could include regulation of price or of the return on capital, and responses by the regulator to indications of consumers' dissatisfaction.

The NHS Executive has recently announced that it will pursue procompetitive policies.[1] It will replace the present ad hoc strategy towards competition with a coherent and clear approach to keep the market structure as competitive as possible. This strategy is to be applied to mergers of providers and of purchasers, collusion, and reconfiguration of the market. The executive has defined the circumstances in which it will intervene to limit the behaviour of market participants