

Highlights of this issue

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ADHD AND THE LAW IN CHILD PSYCHIATRY

Diagnostic criteria for attention-deficit hyperactivity disorder (ADHD) require symptoms or impairments in two or more settings. While information relevant to the home environment is usually provided by parents, collecting other information in a time-efficient and standardised fashion can be difficult. Holmes *et al* (pp. 74–78) describe the development of a structured interview schedule, taking approximately 15 minutes to complete and used to interview teachers over the telephone. They demonstrated good reliability and stability of this interview in a clinical sample of children with suspected ADHD. The 'In debate' column (pp. 8–9) discusses the risks and benefits of diagnosing ADHD. Dr Sami Timimi considers the neglect of psychological and sociological approaches in the understanding and treatment of ADHD and the failure to consider context, which leads to unnecessary prescribing of potentially toxic drugs for the affected children. Professor Eric Taylor suggests that ADHD is neither a social construct nor a genetic disease but requires an understanding of both areas. He is of the opinion that social factors can influence the presentation of, rather than cause, ADHD. He concludes that social influences contribute to the recognition of the disorder and that most evidence suggests undertreatment of ADHD within the UK. An editorial examines the discrepancies within the current UK legal framework that allow children of 10 years of age to be accountable for criminal activities, while 17-year-olds may not be able to refuse a medical procedure, and all children can be treated for mental disorder without their consent (regardless of their competency). Potter & Evans (pp. 1–2) suggest that a specific statutory mental health legislation addressing the needs of children with mental disorder is required, which is not present in the current Mental Health Bill.

DEPRESSION AND ANTIDEPRESSANT-RELATED DEATHS

Low birth weight is associated with increased risk of childhood behavioural problems, but there is little evidence of its effects on vulnerability to depression. Gale & Martyn (pp. 28–33) use the longitudinal follow-up data from the 1970 British birth cohort to demonstrate that women weighing less than 3 kg at birth had an increased risk of being depressed at the age of 26 years. Explanations include the possibility that adverse environmental exposure *in utero* may influence both size at birth and the set point of the hypothalamic–pituitary–adrenal (HPA) axis; this has some support from animal models. Alternative possibilities are that women who are depressed during pregnancy are at elevated risk of having babies of low birth weight, and their children are at higher risk of developing emotional problems; both could be mediated via gestational stress effects on the HPA axis or via postnatal effects of negative maternal behaviour. A prospective study of postnatal depression in Hong Kong showed increased rates of depression to be associated with marital dissatisfaction, a history of depression, and conflict with the mother-in-law. Lee *et al* (pp. 34–40) discuss the importance of sociocultural factors in shaping maternal emotional well-being and emphasise the nature of the extended family and tradition in assessing families of Asian background. The benefits of antidepressant therapy in the treatment of depressive illness are well established. However, Cheeta *et al* (pp. 41–47) demonstrate variations in the number of deaths associated with certain classes of antidepressants; tricyclics and monoamine oxidase inhibitors were overrepresented in deaths reported to the National Programme of Substance Abuse Deaths when compared with the relative number of prescriptions written within the UK. They found selective

serotonin reuptake inhibitors to be under-represented and the risks of death to be higher when patients were also using alcohol or opiate-based drugs.

OBESITY, TRAUMA AND TREATMENT OF PRISONERS

Antipsychotic-related side-effects include weight gain, which can lead to further comorbidity, including diabetes and cardiovascular disease. Zhang *et al* (pp. 58–62) demonstrated significant increases in abdominal body fat, assessed using magnetic resonance imaging, after treatment with antipsychotic medication. There was a threefold increase in leptin secretion alongside elevations in lipids and glucose. They suggest that patients lose the normal inhibitory control of leptin on body mass when treated with antipsychotic medication, and show an increase in fasting lipids and non-fasting glucose. Bisson *et al* (pp. 63–69) report a 13-month follow-up of patients attending accident and emergency departments with physical injury and evidence of acute psychological distress who were randomised to receive four sessions of cognitive-behavioural therapy or no intervention. The treatment group showed a significant decrease in their Impact of Events Scale score, suggesting a reduction in the symptoms of post-traumatic stress disorder. This study offers some guidance in a contentious therapeutic area, and the authors suggest that a stepped care approach – offering this treatment to patients still symptomatic at 3 months after the accident – may be cost-effective way forward. The take-over of prison health care by the Department of Health is seen by Wilson (pp. 5–7) to offer an opportunity to address the provision of mental health care in prisons, especially when the elevated rates of mental disorder in prison are taken into account. He examines the discrepancies between policy and practice in the level of mental health care offered to prisoners in the UK and notes that the avowed principle of 'equivalence of care' is not evident in prison hospital wings, which have no equivalent outside prison, lack adequate treatment facilities and operate in the absence of a clear legal framework for treatment of patients detained there.

AND FINALLY . . .

The Editor and Editorial Board wish all our readers a healthy and happy New Year.