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LETTERS

DO ADULTS HAVE ADHD?

Let's debate treatment instead

I thought the days of polarised debates on whether psychiatric diagnoses such as adult attention deficit hyperactivity disorder (ADHD)^{1,2} are valid had been dropped long ago.

Diagnoses in psychiatry tend to be questioned because we don't have objective tests: when we do, psychiatric disorders become neurological disorders. Many other medical diagnoses share this characteristic but their reality is not debated. Pain, fatigue, sinus pressure, and pruritus do not have objective tests, but primary care waiting rooms are full of patients with these symptoms caused by any number of diagnoses, and they expect to be taken seriously and offered some sort of relief. Reducing a diagnosis to a debate trivialises its importance—it becomes more like a philosophical exercise—and increases the stigma of and barriers for patients seeking psychiatric care (as if it isn't already difficult enough).

The value of any diagnosis is its usefulness to the patient, provider, and medical research.³ In this regard adult ADHD is beyond valid. Adult ADHD breeds true, seems true clinically, and responds true to treatment or lack thereof. This was just as true in the 1980s, when it was first being recognised, as it is today, regardless of profit motive. Is it heterogeneous? Yes, and so is cancer. Do we know its specific cause? No, just like hypertension. Has it been recognised comparatively recently? Yes, just like vitamin D deficiency.

The important issue for patients and their providers is not whether ADHD is real but the best way after accurate diagnosis to provide long term predictive value for the health and

wellbeing of the patient. Let's limit the debates about psychiatric diagnosis to that.

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- 1 Asherson P, Adamou M, Bolea B, Muller U, Morua SD, Pitts M, et al. Is ADHD a valid diagnosis in adults? Yes. *BMJ* 2010;340:c549. (26 March.)
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A history lesson

Debates on the legitimacy of a diagnosis of attention deficit hyperactivity disorder (ADHD) in children or adults are still raging^{1,2} because of a lack of understanding of the history of

the disorder. Drug companies have indeed marketed the concept of adult ADHD to potential consumers¹—as they did childhood ADHD to parent-teacher associations in the United States during the 1960s and 1970s—but this is only part of the story. Disorders such as ADHD reflect the disconnection between society's expectations for the academic and occupational performance of children and adults and their ability to live up to such expectations.

My research shows that ADHD as we know it emerged in the United States during the 1950s, when a lot was expected of the baby boom generation, the first hyperactive children and the largest cohort ever born in the US. Concerned about perceived American deficiencies in science and technology, as evidenced by the Soviet launching of Sputnik, education critics demanded more of students, these demands being reified in the National Defense Education Act 1958.

The behavioural characteristics of underachieving children were soon identified and largely enveloped in the 1957 term

hyperkinetic impulse disorder, a precursor for ADHD. Action was taken by school guidance counsellors, a new American profession, to identify and help such underachieving children. This coincided with the emergence of many psychoactive drugs to treat not only hyperactivity but also depression, psychosis, and anxiety. One of these drugs, which had previously been marketed to geriatric and depressed patients as a “pep pill,” was methylphenidate (Ritalin).

The history of psychiatric concepts needs to be understood to deal with them effectively and move away from polarised debates that lead nowhere.

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Competing interests: None declared.

- 1 Moncrieff J, Timimi S. Is ADHD a valid diagnosis in adults? No. *BMJ* 2010;340:c547. (26 March.)
- 2 Asherson P, Adamou M, Bolea B, Muller U, Morua SD, Pitts M, et al. Is ADHD a valid diagnosis in adults? Yes. *BMJ* 2010;340:c549. (26 March.)

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CANNABIS USE DISORDERS

Helping the youngest users

Winstock and colleagues' review of cannabis use disorders in primary care emphasises that the youngest users are at the greatest risk of harm¹—for example, a depressed pregnant adolescent in local authority care. Long term anxiety is common among young people who smoke this drug. Symptoms such as panic and paranoia can emerge abruptly. Doctors often struggle to engage with school age users.

The review seems oriented to general practice surgeries.¹ Excellent advice is available from the Royal College of General Practitioners' Adolescent Primary Care Society. However, case identification (the teachable moment for a young person) is more likely to arise in school health care. In schools, “you're welcome” skills to build trust between clinician and teenager are crucial.² Unprecedented levels of emotional distress are now developing by the age of 15,³ so establishing trust is more important than ever—before talking about illicit drugs.

Adolescent cannabis use appears in many other community services yet referrals for clinical management are rare. How can we improve health care for young users? Most have families, and family intervention



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projects and parenting early intervention programmes are spreading.⁴ Appropriate whole family assessments should include a clinical assessment of the impact of smoking cannabis on children in the family, including use by siblings and carers. For that most vulnerable pregnant teenager in local authority care mentioned above, the Children Act 2004 promised a lead professional. Her local authority has a duty to ensure registration with a general practitioner. That general practitioner needs to collaborate with her lead professional—and with her.

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Competing interests: None declared.

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NHS COMMISSIONING SYSTEM

No data, no commissioning

A parliamentary advisory committee has rightly found that commissioning by primary care trusts is adding little, if anything, to the NHS.¹ Regardless of the quality of management, data on much trust spending are lacking. Even when the cost of acute hospital care is known, clinical thresholds are not, and trusts seem to have little idea of whether their patients are getting care at above or below the national rate. Outside of acute hospital care, trusts have almost no idea of costs and none of outcomes. With so few data, how can they commission effectively?

Without a major investment in more and better data at primary care trust level, commissioning will inevitably be ineffective. The government quotes examples of trusts having made a difference, but scrutiny is likely to show that they are rare, entail small sums of money, are mainly the result of local enthusiasm, and lack a clear evidence base. That is certainly my experience of looking at projects that have come under the spotlight. Why are only two or three economists working in primary care trusts? Because there are no data for them to work with.

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Competing interests: PAW is a health economist and has worked for primary care trusts, many other parts of the NHS, the Department of Health, and the private sector.

- 1 O'Dowd A. Entire NHS commissioning system may need to be scrapped, MPs say. *BMJ* 2010;340:c1792. (30 March.)

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What took so long?

GP fundholding seemed to make a difference, but many would argue that it came at a high cost. Little else has come out of the purchaser-provider split. The big moves forward like stroke services and cardiac networks have happened through collaboration between providers and commissioners, or through central targets. Primary care trusts, however, have a huge self interest in keeping the farce of locality commissioning, practice based commissioning, world class commissioning, etc, going.¹ Who will have the courage to stop it and face the redundancies and loss of face that will ensue? Locally our main achievement has been to send patients home after cataract operations with two bottles of eye drops instead of one, and that took a year to achieve.

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- 1 O'Dowd A. Entire NHS commissioning system may need to be scrapped, MPs say. *BMJ* 2010;340:c1792. (30 March.)

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OPEN ACCESS PUBLISHING

And now, e-publication bias

In open access publishing scholarly communication is made available free of charge on the internet. In biomedical research, authors or sponsors often pay a fee to a publisher to enable immediate free online access.^{1,2} A few journals operate entirely under this model, whereas others use a hybrid model allowing authors to choose between subscription access and author-paid open access.

We investigated the association between funding of biomedical research by industry and author-paid open access publishing in the *Annals of the Rheumatic Diseases*, a journal in the BMJ Group. We included extended

reports published during October 2007 to September 2008, defining primary exposure as study funding from an industrial source with commercial interests in the area studied, and secondary exposure as other author-industry affiliations. Access (the outcome measure) was defined as locked (subscription access) or unlocked (open access).

Of 216 extended reports, 71 had received funding from an industrial sponsor. A significantly higher proportion of industry funded studies were published unlocked (12/71 (17%) v 11/145 (8%)) (table). Studies with at least one author declaring other affiliations with industry also showed a significantly higher frequency of unlocked papers. There was no significant interaction between study design and funding in relation to open access.

Our results show that author-paid open access publishing preferentially increases accessibility to studies funded by industry. This could favour dissemination of pro-industry results.³⁻⁵ We suggest the term e-publication bias for this emerging type of publication bias in open access hybrid journals, which may be relevant beyond the *Annals of the Rheumatic Diseases* and rheumatology.

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Competing interests: RC is editor in the Cochrane Collaboration (Cochrane Musculoskeletal Review Group).

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Cite this as: *BMJ* 2010;340:c2243

Effect of primary and secondary exposures and potential confounders on open access status

Variable	Odds ratio (95% CI)	P value
Industry funding	2.48 (1.03 to 5.94)	0.037
Employment	4.02 (1.62 to 9.98)	0.002
Equity	7.22 (2.29 to 22.70)	<0.001
Other grants	12.73 (4.57 to 35.46)	<0.001
Fees to individual researchers	16.78 (5.95 to 47.30)	<0.001
Randomised controlled trials	2.92 (0.86 to 9.84)	0.073
No of authors*	1.65 (0.82 to 3.34)	0.163

*In univariate logistic regression model.