

Attention Deficit Hyperactivity Disorder: New Ways of Working in Primary Care

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Children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and prescribed pharmacotherapy require ongoing regular follow-up for many years. Recent literature outlining the role of primary care in the ongoing medication monitoring of children and young people with ADHD is reviewed. We propose that a General Practitioner with a Specialist Interest (GPwSI) model could be developed in relation to ADHD to ensure that shared care arrangements between CAMHS and primary care for children with ADHD are in place. Clinical materials to support GPs in this new role are described.

Keywords: ADHD; primary care; GPwSI

Introduction

A diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) has been shown to represent the most common reason for follow-up in specialist Child and Adolescent Mental Health Services (CAMHS) in the United Kingdom (Meltzer et al., 2000). Figures from the USA indicate that between 30–50% of referrals to CAMHS can be accounted for by ADHD (Popper, 1988; Barkley, 1996).

The average general practitioner (GP) can now expect to have between two and four children on their list receiving treatment for ADHD (Meltzer et al., 2000). The European clinical guidelines for hyperkinetic disorder suggest that once a child is stabilised on medication for ADHD, then they can be followed-up in primary care (Taylor et al., 1998, 2004). Similar guidance is offered in the USA (AAP, 2001). Despite these recommendations, many GPs in the UK think that both initiation of medication for ADHD as well as its ongoing monitoring should be provided by a specialist (Ball, 2001). We describe the background literature on the involvement of GPs in the management of ADHD and discuss how general practitioner with a special interest (GPwSI) in ADHD posts might be developed to ensure that shared care arrangements between CAMHS and primary care for children with ADHD are in place.

Involvement of GPs in the management of ADHD

In a survey of UK GPs' views about ADHD management in primary care, they seemed to see their role as one of providing ongoing prescribing as directed by specialist CAMHS alongside physical monitoring (Ball, 2001). A similar reluctance to become highly involved in the care of children with ADHD was expressed in a study of Australian GPs who indicated a preference for patients to be referred to specialists for diagnosis and treatment of ADHD and saw their own role as largely supportive

(Shaw et al., 2003). Lack of training about ADHD and its management seems to be a major issue influencing GPs' views (Ball, 2001). Kirby, Davies and Bryant (2005) showed that GP knowledge in the area of ADHD and related developmental disorders was less developed than teachers, and there remained areas of confusion.

Differing views of GPs, parents and specialists as to the underlying causes of the child's ADHD may present an additional barrier to GPs becoming more involved in its management (Klasen & Goodman, 2000; Shaw et al., 2003). Ventner, Van der Linde and Joubert's study (2003) of South African GPs demonstrated that the main obstacles identified were the time required, that parents were perceived to be 'difficult'; and reimbursement was poor. They also highlighted that some GPs reported 'alternative' beliefs in the management of children with ADHD. Thapar and Thapar (2002) suggest that a clear strategy for the management of children with ADHD is devised, with the roles and responsibilities of the different health care sectors being clearly defined and agreed. They also advise that the resource and training implications of providing good quality ADHD monitoring need to be addressed.

Health policy and the creation of GPwSI posts

The NHS Plan has as its aim the modernisation of the NHS and the way doctors and nurses work (DOH, 2000). For GPs, the Plan also highlights the need to create new careers, in particular to create intermediate practitioners. It is envisaged that there will be a larger role for GPs in shaping local services, as more become specialist GPs. The creation of specialist GPs has been supported by the Royal College of General Practitioners (RCGP), which sees it as a means of promoting portfolio careers and diversification of GPs while still maintaining their generalist expertise and role. The RCGP prefers to use the term 'GPs with a specialist interest' (GPwSI). In September 2001, the RCGP launched a

paper entitled, *Implementing a scheme for General Practitioners with special clinical interests*, and this envisaged three broad *clinical* roles for the GPwSI (RCGP, 2001):

- To lead in the development of locality services through working with generalist and specialist teams;
- To deliver a procedure-based service as part of a locality wide clinical team;
- To deliver an opinion or offer a clinical service on the request of clinical colleagues.

One of the biggest advantages of extending the role and responsibility of GPs is that the GPwSI can provide an intermediate tier of expertise and advice to their primary care colleagues, and alternative avenues for referral and access to specialist investigations. Working as a GPwSI should increase job satisfaction, improve retention and delay burnout for GPs. Increasing the numbers and range of clinicians able to provide specialist care should reduce waiting times and improve access for patients. GPs working in specialist areas bring their unique and in-depth knowledge of primary care to the respective specialist clinical area, are able to work across physical, psychological and social paradigms, and have the ability to provide effective multidisciplinary working and service delivery for patients suffering from chronic relapsing conditions (Gerada, Wright, & Keen, 2002). The development of the GPwSI role will also bring a wider range of outpatient services into more convenient and user-friendly community settings (DOH, 2003b).

Creating and consolidating the role of a GPwSI in any particular clinical area will require a clarification of the core skills, competencies, and service level agreements of that role. There are two important principles underpinning the development of the GPwSI role:

- Consultants and other secondary care staff will be pivotal as they will need to provide ongoing support and training to the GPwSIs themselves (DOH, 2003b);
- Training and accreditation criteria need to be defined alongside ways of proving quality assurance and continuing professional development.

Primary Care Trusts (PCTs), with the help of acute and secondary care practitioners, are ultimately responsible for ensuring that GPwSIs have the appropriate skills and knowledge to deliver services to the highest standards (DOH, 2003b). Training programmes have already been developed in the areas of substance misuse, ear, nose and throat (Gerada et al., 2002) and respiratory medicine (Gruffydd-Jones, 2003). The Department of Health (2003b) issued general guidance on the subject of 'Practitioners with special interests' as well as specific recommendations for GPwSIs in 15 clinical speciality areas. The guidelines for the appointment of General Practitioners with Special Interests: Mental Health states that:

It is recommended that any PCT establishing a GPwSI service for child or adolescent mental health would need to ensure that the GP possesses specific and separate

evidence of having received Child and Adolescent Mental Health Services Training and having acquired competencies relating to CAMH. (DOH, 2003a, p.1)

An information sheet on GPwSIs was also published in March 2004 by the RCGP which included guidelines and concerns about this model of practice. One of the conclusions was the need for the accreditation from Primary Care Organisations of GPwSI services, to ensure consistency of standards and patient safety (RCGP, 2004).

The development of the GPwSI ADHD model

A GPwSI ADHD model has been developed by the authors. AK (a GP and the medical director of the Discovery Centre in Newport) worked in the ADHD medication monitoring clinic in Swansea on a once a month basis for a year, undertaking a GPwSI role under the management and guidance of GS (a Consultant Child and Adolescent Psychiatrist). It was thought that the joint expertise and understanding of both hospital, educational and GP perspectives would enable the GPwSI ADHD model to develop and offered a unique opportunity to do so.

Alongside AK's clinical activity, both she and GS developed the training materials described below. AK's unique position in the ADHD clinic allowed her to reflect upon her own information, training and support needs as she progressed with this new role. This perspective was invaluable in trying to ascertain the needs in these areas of other colleagues who might be interested in taking on a similar role as a GPwSI ADHD. The proposed GPwSI ADHD model entailed developing:

- A clinical model to train up GPwSIs and ensure their competency to run ADHD medication monitoring clinics;
- Provision of suitable training materials/information on ADHD for GPwSIs that were to be easily and freely accessible;
- Consideration of a more formal qualification for GPwSIs in ADHD assessment and management.

A clinical model to train up GPwSIs

The clinical model proposed for training up GPwSIs in the initial phases involves the GPwSI running an ADHD medication monitoring clinic in parallel with a consultant child and adolescent psychiatrist. We recommend that the clinic starts with a short meeting between the GPwSI and the consultant to provide an opportunity for the cases to be discussed in advance. Patients can be seen in parallel at approximately 30–45 minute intervals. If the GPwSI requires immediate advice on a case, the consultant is close on hand to offer this. At the end of the clinic, a further short meeting between the GPwSI and the consultant provides an opportunity for further case discussion and learning to take place. In order to ensure time for the relevant administration/letter writing to take place during the clinic session, we would advise a maximum of 5–6 patients to be booked in for the GPwSI. As the GPwSI gains in confidence and competence, the need to run

clinics in parallel with the consultant could be reviewed. The eventual aim is for the GPwSI to feel able to run ADHD clinics by themselves with support and supervision provided at a distance, perhaps by telephone from the CAMHS consultant.

Provision of training materials/information on ADHD

The aim here was to develop easily accessible background information about ADHD for the GPwSI, both to underpin the initial training phase as well to provide an ongoing source of training and support materials in General Practice. The materials developed are both paper and web-based, with downloadable files and appendices that can be printed out if required. Materials include:

- Information about ADHD in general including comorbidities and differential diagnosis;
- Information on the assessment of ADHD;
- Information on the multi-modal treatment of ADHD;
- Information on initial prescribing and dose titration;
- Development of a protocol for use in ADHD medication monitoring clinics;
- Examples of standard letters that could be used in ADHD clinics when writing to parents, GPs and schools;
- Useful contact information for clinicians, parents and young people including links to other web sites;
- Information sheets for parents and teachers plus links to websites offering similar;
- Information about the educational system, including the special educational needs code of practice, SENDA, and related statutory legislation.

These information/training materials were developed after a thorough evaluation of the available literature on assessment, management and medical follow-up of children with ADHD. The finalised version of the information has been available via 'The ADHD Training and Support for Clinicians' website (<http://www.adhdtraining.co.uk>) since April 2005.

Consideration of a formal qualification in ADHD management

It is envisaged that the information available via the website could form the foundation training material for the GPwSI ADHD. It could also be developed to be incorporated into a personal and professional development portfolio for GPs. The University of Wales, Newport, has validated the training as a post graduate certificate in ADHD and related developmental disorders module worth 30 credits towards a Masters degree. It is proposed that the course will be delivered in a 'blended' format – i.e. face-to-face meetings, online learning via a website, CDROM, e-mail support and would require health professionals to gain experience in a clinic setting in line with the model proposed by the RCGP for GPs with a special interest.

Conclusion

The authors have developed what they hope is a potentially sustainable model to encourage GPs to work with children and adolescents with ADHD in the community. The model allows GPs who may want to develop a new portfolio practice the opportunity to undertake a defined range of tasks in an area that is thought to lend itself to sessional working. A clear training model has been developed and a means of accreditation proposed. The web-based information/training materials allow for both a cost effective and updatable means of sharing experiences and materials.

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