

treatments help symptoms although they do not treat the underlying cause.

Even if we do elicit our patients' explanatory model, how much will it change the treatment we give them? For instance, consider an African patient who, in terms of an ICD-10 diagnosis, is suffering from a hypomanic episode. He is physically violent. Both he and his family hold that he is possessed by a spirit. Are we to accept their explanatory model and enlist an exorcist? Will we withhold pharmacological treatment because the patient holds an alternative view of his illness?

What is needed is an approach in transcultural psychiatry that looks at not just what people believe but what they actually do in practice. A comprehensive approach involving participant observation, not just the administration of questionnaires to patients, will lead to greater understanding.

Bhui, K. & Bhugra, D. (2002) Explanatory models for mental distress: indications for clinical practice and research. *British Journal of Psychiatry*, **181**, 6–7.

Callan, A. & Littlewood, R. (1998) Patient satisfaction: ethnic origin or explanatory model? *International Journal of Social Psychiatry*, **44**, 1–11.

Dein, S. (2001) The use of traditional healing in South Asian psychiatric patients in the UK: interactions between professional and folk psychiatrists. *Transcultural Psychiatry*, **38**, 245–259.

Kleinman, A. (1980) *Patients and Healers in the Context of Culture*. Berkeley, CA: University of California Press.

Last, M. (1981) The importance of knowing about not knowing. *Social Science and Medicine*, **15**, 387–392.

Pelto, P. J. & Pelto, G. H. (1997) Studying knowledge, culture and behaviour in applied medical anthropology. *Medical Anthropology Quarterly*, **11**, 147–163.

Weiss, M. G., Doongaji, D. R., Siddhartha, S., et al (1992) The Explanatory Model Interview Catalogue (EMIC). Contributions to cross-cultural research methods from a study of leprosy and mental health. *British Journal of Psychiatry*, **160**, 819–830.

Williams, B. & Healy, D. (2001) Perceptions of illness causation among new referrals to a community health team: explanatory model or exploratory map? *Social Science and Medicine*, **53**, 465–476.

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Pathways to care in ADHD

I was interested to read Sayal *et al*'s (2002) article on pathways to care for children at risk of attention-deficit hyperactivity disorder (ADHD). By using Goldberg & Huxley's (1980) pathway to care model I felt that the study oversimplified the complexity of professional input to this group of

children, a point raised by the authors in their discussion. I think it is important, when considering improvements to services for children with ADHD, that the role of education is highlighted.

Teachers, as a profession, are well placed to observe children and are familiar with age-appropriate behaviour. Indeed, Goodman *et al* (2000) found that teachers were more sensitive at identifying children with hyperactivity than were their parents. Although teachers' involvement in the assessment and monitoring of children with ADHD is well established (Dulcan *et al*, 1997), their role in identification is less clear. This is highlighted by the fact that only some child and adolescent mental health services (CAMHS) accept referrals directly from schools. By involving teachers in the identification of children with ADHD, access to children would improve from 74% seen in primary care to nearly 100%. This would significantly improve the sensitivity of any screening measure.

It is essential that CAMHS do not develop services for children in isolation, but instead utilise the skills of other professionals to improve care. If children with ADHD are to have their needs met, it is essential that we start to think outside of the medical model.

Dulcan, M. and the Work Group on Quality Issues, American Academy of Child and Adolescent Psychiatry (1997) Practice parameters for the assessment and treatment of children, adolescents and adults with attention-deficit/hyperactivity disorder. *Journal of American Academy of Child and Adolescent Psychiatry*, **36** (suppl.), 855–1215.

Goldberg, D. & Huxley, P. (1980) *Mental Illness in the Community: The Pathway to Psychiatric Care*. London: Tavistock.

Goodman, R., Ford, T., Simmons, H., et al (2000) Using the Strengths and Difficulties Questionnaire (SDQ) to screen for psychiatric disorders in a community sample. *British Journal of Psychiatry*, **177**, 534–539.

Sayal, K., Taylor, E., Beecham, J., et al (2002) Pathways to care in children at risk of attention-deficit hyperactivity disorder. *British Journal of Psychiatry*, **181**, 43–48.

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Authors' reply: Dr Cribb's comments are welcomed. Our discussion (Sayal *et al*, 2002) also highlights the potential role of both parents and teachers in making referrals to child and adolescent mental health services (CAMHS). The paper is developing

new methodology and we deliberately posed it on a simplified system, selecting an area where most referrals come from general practitioners (GPs). GPs are also the main referrers to CAMHS nationally and their role in primary care trusts will be of great importance in shaping specialist services. Nevertheless, this is only one component of tier 1 services and 48% of CAMHS referrals come from other sources (Audit Commission, 1999). We plan to widen our programme to examine the role of other sources of referral.

Restricting referrals to particular agencies imposes barriers to access, and the resulting delay in referrals might exacerbate severity or chronicity of problems. Kurtz *et al* (1996) described a service that only accepted GP referrals. It failed to reduce the number of referrals and generated resentment from other agencies. Comparisons of CAMHS with different referral systems will improve knowledge in quantifying the barriers to access to services. This could contribute to assisting the successful implementation of the National Service Framework for Children.

The role of teachers in the pathway to care merits particular comment. Relationship difficulties with teachers are a predictor of referral of hyperactive children to CAMHS (Woodward *et al*, 1997). Our study has demonstrated that selective targeting can lead to particularly high rates (98%) of teacher participation in research. This is likely to reflect their concern about behavioural and emotional difficulties in children. Teachers are a rich potential source of child mental health information for parents. However, in considering referrals from schools, it is imperative that teachers fully discuss their concerns with parents. Parents need to agree to any referral. For hyperactivity, in particular, it needs to be ascertained that the problems are pervasive. Unless this happens, there is a risk that learning difficulties are wrongly identified as hyperactivity. This also highlights the importance of adequately resourced educational psychology services to support schools, and health service input in the training of teachers.

Audit Commission (1999) *Children in Mind. Child and Adolescent Mental Health Services*. London: Audit Commission.

Kurtz, Z., Thornes, R. & Wolkind, S. (1996) *Services for the Mental Health of Children and Young People in England: Assessment of Needs and Unmet Need. Report to the Department of Health*. London: South Thames Regional Health Authority.