This Month's Highlights

International Variation in ADHD Treatments

Attention-deficit hyperactivity disorder (ADHD) has received wide international recognition as a chronic neurodevelopmental disorder leading to high levels of impairment. Cross-national variation in ADHD prevalence is now thought to be attributable to methodological differences in case finding rather than to cultural or national-level factors. However, as this month's lead article documents, treatment procedures for ADHD vary widely both across and within nations, and economic, historical, and political forces and cultural values play key roles. Stephen P. Hinshaw, Ph.D., and coauthors summarize data from a survey that addressed ADHD treatment policies and procedures in nine nations: Australia, Brazil, Canada, China, Germany, Israel, the Netherlands, Norway, and the United Kingdom. Representatives of these countries met in Berkeley, California, in March 2010 to discuss the survey findings and to develop ways to provide optimal services in light of the wide variation in policies and practices (page 459).

Coercion in Psychiatric Treatment

Seven research reports focus on coercive practices, such as seclusion and restraint and involuntary inpatient and outpatient treatment. For more than three decades, consumers' perception of coercion in their care has been a topic of investigation. Yet no one has undertaken a systematic review of this literature until now. In an analysis of findings from 27 studies, two New Zealand researchers found no strong quantitative evidence that specific patient characteristics consistently predict the perception of coercion. However, the qualitative studies that they reviewed provided ample evidence of the dehumanization felt by patients who experience coercion. Thus the authors conclude, "Clinicians should routinely consider that all patients have the potential to experience an intervention as coercive" (page 465). In a Taking Issue commentary on the literature review, Janice L. LeBel, Ed.D., wonders why we have waited so long for a review of this literature and reflects on changes over the past 30 years that have shifted the focus to consumers' perceptions and experiences (page 453). At two psychiatric hospitals in England, structured interviews with patients revealed high levels of perceived coercion, even among those who were admitted voluntarily. However, patients' ratings of their therapeutic relationship with the admitting clinician mediated their perception of coercion (page 471). When a large state-funded psychiatric hospital decided to implement a four-component model to reduce seclusion and restraint in its five inpatient units, it saw the opportunity to design a rigorous experiment. After 42 months, the model reduced seclusion and restraint by 82%. A single component—inexpensive changes to the physical environment—produced lasting results (page 477). Researchers in Quebec who surveyed direct-care staff at several psychiatric hospitals identified staff perceptions that were associated with use of seclusion and restraint. Rates of these interventions were higher on units where staff perceived that care team members tolerated the expression of anger toward one other, where staff perceived that patients frequently tried to harm themselves, and where staff perceived that workplace safety measures were inadequate (page 484). In Norway, analyses of patient data from acute psychiatric units found four clinical characteristics that predicted use of restraint. Knowing which inpatients are at risk of restraint would allow unit staff to intervene early to build trust (page 492). When a clinician decides to seclude an inpatient, what factors have converged? Experts in the Netherlands developed a series of 64 vignettes that manipulated multiple variables describing a patient and the inpatient setting where the patient was being treated. Researchers administered the series to inpatient clinicians in order to shed light on their decision making (page 498). Finally, researchers in New York State who examined nearly 17,000 person-months of data found that outpatient commitment under "Kendra's Law" reduced arrest rates. They concluded that the coercion necessitated by application of Kendra's Law may forestall for some people the more potent and consequential coercion they would experience in the criminal justice system (page 504).

Briefly Noted . . .

- When five assertive community treatment teams in Indiana implemented an illness management and recovery program, they saw a decrease in consumers' use of inpatient and emergency room care (page 509).
- The Best Practices column describes how illness management and recovery was successfully adapted and implemented across New York State (page 456).
- This month's book review section focuses on books about recovery from mental illness (page 567).